Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting Part 1 (held in Public)

Wednesday 5 June 2024
10.00am -12.30pm
Trust Conference Room Warrington/MS Teams

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 5 June 2024, 10.00am – 12.30pm
Trust Conference Room, Warrington Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/24/06/028	**10:00**	Engagement Story – Emergency Department Experience *(to be presented on the day)*	***To note***	**Presentation /Video**	Yasmin Habib, Lead Nurse for Urgent and Emergency Care
BM/24/06/029	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/24/06/030	**10:17**	Minutes and Action Log of the previous meeting held on **2 April 2024**	***For approval***	***Minutes***	Chair
BM/24/06/031	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/24/06/032	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/24/06/033	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Chair
BM/24/06/034	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:					
BM/24/06/035	**10:45**	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) 09.04.24, 07.05.24	***For assurance***	***Report & Presentation***	Chief Nurse, Chief Operating Officer & Deputy Chief Executive, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee (SPC) 17.04.24, 15.05.24	***For assurance***	***Report & Presentation***	Chief People Officer Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard Including**	***For assurance***	***Report & Presentation***	Chief Finance Officer

		Assurance Reports Finance and Sustainability Committee (FSC) 24.04.24, 22.05.24			John Somers, Committee Chair
(d)		Audit Committee Assurance Report 25.04.24	***For assurance***	***Report & Presentation***	Mike O'Connor – Senior Independent Director
Strategic aim:					
BM/24/06/036	**11:10**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/24/06/037	**11:20**	Inpatient Survey	***To note for assurance***	**Report**	Chief Nurse
BM/24/06/038	**11:30**	Maternity & Neonatal Update Summary Report to cover: • Maternity Quality & Safety update February 2024 • Maternity Quality & Safety update March 2024 • Maternity Incentive Scheme Year 5 and 6 • PMRT Annual Review • PMRT Q4 2023/24 • Maternity Self-Assessment biannual review • Ockenden position • Midwifery Safe Staffing Q4 2023/24	***To note for assurance***	***Report***	Director of Midwifery
BM/24/04/039	**11:40**	Maternity Review of 2023/24 Progress Report	***To note for assurance***	***Report***	Director of Midwifery and NED Maternity Safety Champion
Strategic aim:					
BM/24/06/040	**11:50**	Health and Wellbeing Guardian Annual Report	***To note for assurance***	**Report**	Chief People Officer
BM/24/06/041	**11:55**	Gender Pay Gap Annual Report	***To note for assurance***	**Report**	Chief People Officer
Strategic Aim					

BM/24/06/042	**12:10**	Estates Strategy	***For approval***	**Report**	Chief Operating Officer & Deputy Chief Executive

Governance					
BM/24/06/043	**12:20**	Code of Governance Compliance & Compliance with Licence Annual Return – completion of Cos7	***To note for assurance***	**Report**	Company Secretary
BM/24/06/044	**12:25**	Updates to the WHH Constitution	***For approval***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/24/06/045	Strategic People Committee - Chairs Annual Report	Strategic People Committee Date: 15.05.24 Ref: SPC/23/05/31 Outcome: Noted	***To note for assurance***	**Report**	Chair of Strategic People Committee
BM/24/06/046	Patient Experience Strategy Annual Report	Quality Assurance Committee Date: 09.04.24 Ref: QAC/24/04/15 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/06/047	Infection Prevention & Control Q4 Update	Quality Assurance Committee Date: 07.05.24 Ref: QAC/24/05/38 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/06/048	Learning From Experience Summary Report Q4	Quality Assurance Committee Date: 07.05.24 Ref: QAC/24/05/37 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/06/049	Violence Reduction Strategy	Quality Assurance Committee Date: 07.05.24 Ref: QAC/24/05/39 Outcome: Noted	***To note for assurance***	**Report**	Chief Operating Officer & Deputy Chief Executive
BM/24/06/050	Guardian Of Safe Working Report Q3	Strategic People Committee Date: 17.04.24 Ref: SPC/23/04/10 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/24/06/051	Guardian Of Safe Working Report Q4	Strategic People Committee Date: 15.05.24 Ref: SPC/24/05/30 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director

BM/24/06/052	EPPR Compliance Update following Dec 2023 Report	Finance & Sustainability Committee Date: 24.04.24 Ref: FSC/24/04/011 Outcome: Noted	***To note for assurance***	**Report**	Chief Operating Officer & Deputy Chief Executive
BM/24/06/053	Digital Strategy Group Update	Finance & Sustainability Committee Date: 22.05.24 Ref: FSC/24/05/41 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
Closing					
BM/24/06/054	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/24/06/055		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting - 7 August 2024, Halton Education Centre, Halton Hospital					

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 3 April 2024 Halton Education Centre & Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Ali Kennah (AK)	Chief Nurse
Jane Hurst (JH)	Chief Finance Officer
Dan Moore (DM)	Chief Operating Officer
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Jan O'Driscoll (JO'D)	Partner Non-Executive Director
In Attendance	
Lucy Gardner (LG)	*(in attendance for Agenda Item BM/24/04/001)*
Kate Henry (KH)	Director of Communications & Engagement
Ailsa Gaskill-Jones (AGJ)	Director of Midwifery
Claire Grice (CG)	Head of Patient Experience, Equality, Diversity & Inclusion (*in attendance for Agenda Item BM/24/04/001)*
Corrine Roe (CR)	Paediatric Ward Manager (*in attendance for Agenda Item BM/24/04/001)*
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Liz Walker	Secretary to the Trust Board **(minute taking)**
Observing	
Norman Holding	Lead Governor
David Holden	

Agenda Ref	Agenda Item
BM/24/04/001	**Engagement Story – A Parents Story** The Trust Board received the patient story presented by CG and CR, on behalf of the mother of an 18-month-old baby boy admitted to A&E in December 2023. The focus of the story detailed the baby's journey, through the eyes of the mother, after being cared for by the Paediatric Emergency Team and then transferred to Ward B11. It was found the baby was suffering from a collapsed lung and pneumonia due to a viral infection. The parent had noted the care

	shown to her son in both A&E and Paediatrics However, also identified areas for improvement. The Patient Experience Team had reached out to the mother ***to identify the key areas for improvement.*** to provide additional support. The Board took assurance, noting the parents' journey was on the whole a positive experience, and that improvements would be taken forward from the action plan developed to improve the patient and carer journey. SMcG reflected on the patient's story and talked about a recent experience and the care and support his family had received at the Trust. One particular area was that phone signals were poor in certain areas and while not, on the surface a care issue, it was a big experience issue. CR responded that this was something that was being looked at and PF added that a network refresh was being looked at. However, due to the age of the building it did pose some challenges but hopefully would improve with these changes. AK further highlighted the lessons learnt from the case, noting that Paediatrics usually received positive feedback. CR responded that once the plan was in place it was important to ensure this was communicated to parents as soon as possible, and this would be key in the journey to be taken. **The Trust Board discussed and noted the Engagement story.**
BM/24/04/002	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, invited presenters and observers to the meeting, apologies were received as noted above, and declarations of interest made. In particular welcomed AK in her new role as Chief Nurse and DM in his new role as Deputy Chief Executive. **The Trust Board noted the welcome, and no apologies or declarations of interest were noted at the meeting.**
BM/24/04/003	**Minutes and Action Log from the previous meeting held on 7 February 2024** The minutes of the meeting held on 7 February 2024 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 7 February 2024 and noted the Action Log.**
BM/24/04/004	**Matters Arising**

	The Trust Board noted that there were no matters arising.
BM/24/04/005	**Chief Executive's Report** SC introduced the paper, which was taken as read and welcomed any questions. JJ asked about the CMAST workforce programme and why it was ceasing. SC responded this would be taken up by the ICB. SMcG asked about the Thank You Awards and asked if anyone knew of any organisation willing to donate raffle prizes or provide additional sponsorship to ask them to get in touch. In relation to the Dashboard for the IPR, SMcG asked if future reports could include a summary of the three indicators that were going well and three not so well or where there were concerns. SC responded that the dashboard was consistent with the IPR but would happily add further information in the summary going forward. SC highlighted the current worries relating to access, non-elective and elective pathways, finance. The areas of concern included workforce, complaints, and basic areas of care. SMcG raised a query about any medical negligence claims made and how would Board be sighted on this. JC advised that a bi-annual claims report was presented to the Quality Assurance Committee and would be escalated to Board if required. JS asked about the Newton work and how this was going to move forward. SC responded that due to financial restraints, the Newton work would , be taken forward at a system level. A future paper would be presented to the Finance and Sustainability Committee, outlining this workplan. **The Trust Board;** **1. Noted the Chief Executive's Report.** **2. SC to amend future reports to include information about areas of concern and of least concern**
BM/24/04/006	**Chair's Report** SMcG introduced the report, which was taken as read, no further questions were raised by Board members. SMcG expressed his thanks in relation to the new Day Case Centre, however concerns had been raised in relation to the current costs and if it was Value for Money, suggesting further discussion take place regarding this. SC added he would highlight at the Chief Executive meeting on Friday. SMcG formally noted his thanks to staff for their hard work in times of the strikes. **The Trust Board noted the Chair's Report.**

BM/24/04/007	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the strategic risks. The key highlights from the report, were as follows: • No new risks have been added; • changes to the ratings of any of the risks, however risk #1134 was proposed to be reduced and would be submitted to the Strategic People Committee in April. • No updates to the descriptions of any of the risks, however a proposed update to risk #1757 would be presented at the Strategic People Committee • No risks closed or de-escalated • The risk appetite of one risk (#1134) has been updated 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. **The Trust Board:** **1. Discussed and approved the changes and updates to the Strategic Risk Register** **2. Noted the risk appetites applied to each risk on the Strategic Risk Register**
BM/24/04/008	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance and the report was taken as read, however the Board noted the importance of viewing the IPR metrics from a triangulation perspective. DM highlighted the following key areas; • ED • 78 week wait • Cancer The board noted the 78 week waits and patient choice associated with not achieving target, and also noted that WHH was an outlier in this respect. It was hoped the backlog would be cleared by the end of April. Gynaecology target was on course to achieve; however, this had been affected by the recent strikes, with a number of patients had been passed back from ASET, a third-party provider who were providing support to manage backlog. Healthcare acquired infections were also flagged, and as a seasonal outlier there had been an increase in cases. Anti-microbial prescribing had improved at 90%, compared to the last audit of 86% with learning was being shared. It was noted that a Deep Dive on E Coli would be presented to the Quality Assurance Committee (QAC) on 9 April, and this work would continue to make improvements, although the Trust was not a major outlier. JD queried causes of death, and if any were related to Sepsis. AK responded this would be reviewed, and formally reported through the mortality review

group. PF added that medical examiners would pick this up and data did not show this to be the case. No concerns had been raised and this was not routinely reported to coroner unless Sepsis was the direct cause of death itself.

JJ sought assurance around pressure ulcers and how the Trust benchmark against others. AK responded this was not easy data to collate as it was difficult to compare data from others in the Cheshire & Merseyside group, with data from 2021/22 showing the trust benchmarked well.

MOC asked about ambulance handovers, DM advised the data showed improvement in month and this continued to be the case. There had been a recent site visit by NWAS and discussions were taking place to suggest changes to the process for ambulance handover.

Quality (CR)

The report was noted, and CR highlighted the RAG rating accuracy as from a quality perspective things were green, but from a context of the severity of the issues, the rating may be different. It was suggested that the reports could include a section to highlight areas outside of the committee's remit.

JC added the changes to the RAG ratings had been made in line with CQC recommendations, however a caveat could be applied, a formatting update would be considered.

People (Workforce) (MC)

The report was noted, and SC asked MC to highlight workforce retention in relation to Pharmacy, Midwifery and ED.

MC noted that a tailored *onboarding approach* in Midwifery had been put in place which had started to shift the balance. For ED, this area was reliant on temporary staffing and had looked at widening participation and shifting the balance. For Pharmacy, it was more attractive to go into private Pharmacy work, however work was ongoing to review a system approach. PF added that a fellowship has been awarded to one of the trusts pharmacists and there was further work to be done in relation to medicines reconciliation.

JJ added that the time for hire had reduced dramatically since the implementation of the new recruitment system Trac.

Finance & Sustainability (JH)

JH highlighted the following from the finance section of the report:

- Landing position year end c.27.5m and on track to achieve
- Cash distress with support provided and includes 14m of capital which is treated separate to revenue

JS added that a lot of work had been done, and felt the Trust was in control of the finances. However, there would still be a CIP issue into next year (2024/25), with the need to shift to recurrent CIP, and if the oversight framework rating of 2 increased to 3, this would come with another degree of oversight and regulatory focus.

	JH responded this was across the whole of Cheshire & Merseyside not just the Trust. SC can see it moving as both a Trust and ICB, and fully anticipating it would not just be WHH involved, but all other Trusts being asked to work in collaboration. LG added in relation to spending, additional money for the Living Well Hub would not be part of any capital monies, and conversation with partners were taking place around sharing any additional costs and creating a separate pot. ***Audit Committee*** The report was noted and no further questions received. ***Charitable Funds Committee (KH) no further questions received.*** The report was noted and no further questions received. **The Trust Board:** **1. Noted the update in relation to the IPR report** **2. Agreed that assurance keys to be updated for all assurance reports to include two rag ratings around assurance and the performance.** **3. Approved the capital contingency**
Quality	
BM/24/04/009	**Fragile Clinical Services Update** PF introduced the report which provided the Board with a high-level overview of services currently identified as being Fragile. A number of services remained as Fragile, and it was noted that overall improvements had been seen across each of the services. The Fragile Services included; • *Urology –remained the highest risk, due to demand and capacity mismatch driven predominantly by workforce issues and increased demand* • *Gynaecology – some improvements in month and good week at Halton where high and low complexity cases had been undertaken* • *Orthopaedics – Fractured Neck of Femur – insufficient theatre capacity for Trauma workload* • *ENT - Demand and capacity mismatch – driven predominantly by workforce issues and increased demand* • *Paediatric Ophthalmology – a new locum had commenced in paediatric ophthalmology and had already been very proactive in discharging patients not requiring an operation. No harm identified to date.* CR noted a lot of the services had become fragile due to staff shortages. SC added that the long-term NHS plan doesn't marry up with the long-term

	operational plan so it was important to be sensible and our approach. It was noted that fragile service specialities were uniform across the system , hence the importance of driving system improvements and collaborative working. **The Trust Board noted the current list of Fragile Services and associated high level progress updates.**
BM/24/04/010	**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 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. ii. **Maternity & Neonatal Quality Review** AGJ introduced the paper which provided an update in relation to maternity and neonatal quality for December 2023 and January 2024. The paper had been presentded to and discussed in detail by the Quality Assurance Committee with no escalations. **iii. Cheshire & Merseyside Perinatal Mortality (PMRT)** The following key ponts were highlighted from the report: 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 would be reported in the Quarter 4 2023/24 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 was 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) **iv Midwifery Safe Staffing Report** The report was noted. **v Avoiding Term Admissions into Neonatal Units (ATAIN)** SMcG asked about an overarching paper that reviews the progress against all the programmes of work. It was agreed that AGJ and JD would discuss outside of the meeting. **The Trust Board** **1. Discussed and noted the maternity reports as per national recommendations.** **2. AGJ and JD to discuss producing a joint paper of all the work done in all areas of midwifery, including safety champions.**
People	
BM/24/04/11	**NHS National Staff Opinion Survey** MC introduced the report which provided an overview of the annual NHS Staff Survey results for the organisation for 2023. These are aligned to the NHS People Promises as set out in the NHS People Plan. The paper also provided 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. It was noted that; • 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 was better than the Acute Trust average in all nine themes of the NHS Staff Survey. • Sexual safety questions raised, info from FTSU used with some positive scores. From PSIRF some improvements need to be made on confidence of people to speak up, • The results showed the Trust was better than the Acute Trust average in all nine themes of the NHS Staff Survey. SMcG added that the question around sexual harassment was the first time it had been included in the survey, and a surprisingly high number of staff had

	reported unwanted sexual behaviour. He asked if this could be broken down from a gender perspective as instinctively it appeared more likely to be female members of staff most affected. MC responded that it could be split by gender, however it would not necessarily triangulate with the data in Datix. It was noted that WHH was middle of the pack but that this should still be a source of concern as it suggested a 'lot' of staff across the NHS were subjected to sexual harassment of a physical nature. There was further discussion about Trust wide priorities presented to Board and to understand how these were being reviewed. JJ added that 1 in 5 people reported bullying and therefore brought into question if people felt confident of reporting these types of incidents and if a strong message needed to be communicated to staff. **The Trust Board discussed and noted the results from the NHS Staff Survey.**
BM/24/04/12	**Communications & Engagement Dashboard Quarterly Report Q4** KH introduced the paper which provided updates on communications and engagement activity during quarter 4 of 2023-34 and incorporates quarterly reporting on the Working with People and Communities Strategy. • Thank you awards • Campaigns with ICB and regional team • Redevelopment of intranet and website – make it easier to manoeuvre • Experts by experience programme continues to grow – 61 recruited in the last 12 months involved in 40 projects during the year offered training and support from AQuA **The Trust Board noted the contents of the report.**
	Sustainability
BM/24/04/13	**Freedom to Speak Up Guardian Report** JH introduced the paper which provided an update for Q3 2023/24 and noted 21 disclosures had been managed during this period. 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. It was noted that a new FTSU Guardian and Deputy had commenced in post from February 2024, working two days and one days respectively.

	From 1 April will collate protective characteristics. **The Trust Board noted the report for information and assurance.**
Governance	
BM/24/04/14	**Trust Board – Cycle of Business** JC introduced the paper and noted that 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. Once approved this would guide the planned business for the Trust Board Agendas throughout 2024/25. **The Trust Board approved the Cycle of Business.**
BM/24/04/15	**Committee Cycles of Business and Terms of Reference** JC introduced the paper which provided updated Cycles of Business and Terms of Reference for the Quality Assurance, Finance and Sustainability, Strategic People and Audit committees, for consideration by the Trust Board. Each had been reviewed and agreed by the respective Committees and were being presented to the Trust Board for ratification. **The Trust Board approved the Cycles of Business and Terms of Reference for all committees.**
BM/24/04/16	**Board and Board Development Effectiveness Review Outputs** The report included the full response from the survey, with 13 out of 16 respondents, and a number of questions had received comments. It was noted that the response to the multiple-choice questions were largely positive. The Trust board approved the actions as set out in the papers these were: - Development of an in-house training guide on effective report writing for senior staff (report authors) - 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. - The topics suggested by Board members (will be built into the 2024/25 schedule. **The Trust Board:** 1. **Noted the results of the Board and Board Development Effectiveness Review** 2. **Agreed actions for improvement to take forward and monitor in 2024/25.**
Supplementary Papers	

BM/24/04/19 **BM/24/04/20** **BM/24/04/21** **BM/24/04/22** **BM/24/04/23** **BM/24/04/24** **BM/24/04/25**	Compliance Q3 Update Infection Prevention and Control Q3 Update Learning from Experience Q3 Report Summary Learning from Deaths Q3 Report Summary Mortuary Inquiry (Fuller) Phase 1 – Gap Analysis Paediatric Audiology Brainstem Digital Strategy Group Update The papers were received for noting.
BM/24/04/26	**Review of the Meeting** SMcG reflected on the meeting, noting the meeting had gone well with good discussion. **The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items.**
BM/24/04/27	**Any Other Business** No further business was raised. **Meeting ended at 12:27pm**
The Date and Time of the next Trust Board Meeting is Wednesday 5 June 2024, Trust Conference Room, Warrington Hospital.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/24/06/030	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	5 June 2024

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/04/11	03.04.24	Maternity Updates	Overarching report to be produced incorporating all areas of maternity work.	AGJ	June 2024		AG-J has noted the action and the Maternity & Neonatal summary report has been added to the CoB. Agenda Item **BM/24/06/040**	
BM/24/04/11	03.04.24	Maternity Updates	Maternity Review of 2023/24 Progress Report To update on annual progress against schemes of work Ockenden, PMRT etc. to per presented by DoM & NED Maternity Safety Champion	AGJ & JD	June 2024		AG-J has noted the action and the item has been added to the CoB **BM/24/06/041**	
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		See agenda item **BM/24/06/057** Supplementary Papers.	
N/A	N/A	Health Inequalities	To present to Board	LG	June 2024		Deferred from May Board Development Day to June Board **BM/24/06/046**	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/032**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	5th June 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/24/06/032

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 3rd April 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 1 - April 2024. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

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

2.2 Senior Leadership Changes

In April I announced that, after what will be nearly 10 years in this Trust, firstly as medical director and then as chief executive, I will be leaving the organisation at the end of August to join University Hospitals of North Midlands NHS Trust (Royal Stoke University Hospital and County Hospital, Stafford) as their chief executive.

As Chair of the Trust, it will be Steve McGuirk's job to secure my successor. That process is ongoing at the time of writing.

I am really delighted to be able to announce that Dr Eshita Hasan has been appointed as our next Deputy Executive Medical Director. Having joined the Trust as a Consultant in Obstetrics and Gynaecology in 2010, Eshita has been Associate Medical Director for Patient Safety since 2020 and Associate Medical Director for Planned Care since 2023. Eshita has a particular interest in patient safety and is one of the Trust's Patient Safety specialists.

Eshita will take up her position from 1st July upon Dr Anne Robinson's retirement.

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 Greater integration within Warrington and Halton

Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare have a shared overriding aim of delivering a sustainable healthcare system for patients and staff.

The challenges facing the NHS are well-documented and are reflected locally here in Warrington and Halton, as they are elsewhere regionally and nationally. Our urgent care

system is not working optimally, we are currently unsustainable financially and we have identified significant opportunities to improve care for our patients.

It is clear there are opportunities for further integration between our two organisations.

With that in mind, and working with system colleagues across Warrington and Halton, we are developing plans to bring our two organisations together, along with local system partners, to integrate our teams and maximise the benefit of our collective expertise. This will help us to jointly make best use of resources, but more importantly to improve care for our patients.

We are currently in the earliest stages of discussions, with the full backing and support of NHS Cheshire and Merseyside.

2.5 Thank You Awards 2023/24

I was delighted to join 300 staff, volunteers, sponsors and supporters who came together to celebrate our annual Thank You Awards on Friday 10th May 2024. Under the wings of British Airways' most famous aircraft in the Concorde Conference Centre at Manchester Airport, it was an uplifting evening of inspiration, admiration and positivity, with 12 awards handed out during the ceremony.

It really was wonderful to see so many colleagues come together under one roof and I was truly heartened to see once again the camaraderie and support shown by all guests towards our finalists and winners.

I am particularly pleased that we managed to keep the presentation of this year's very special Outstanding Achievement Award top secret until the big reveal. It was a pleasure to personally hand over the award to a very deserving recipient, Deputy Medical Director, Dr Anne Robinson, ahead of her retirement later this year.

Not only has Anne been a highly dedicated clinical lead, WHH champion and mentor to so many colleagues over many years, she's particularly skilled in securing the most impressive raffle prizes from local businesses and sponsors. Anne and our charity team surpassed themselves again this time around and raised a record £2,394 for WHH Charity.

Congratulations to all this year's winners and finalists, and indeed everyone who was nominated.

Here's our full list of Thank You Awards 2023-24 winners:

- **Clinical Team of the Year** – Acute Medicine Team
- **Support Team of the Year** – Security and Portering Teams
- **Patient Safety Award** – Paediatric Seven Day Services Project Team
- **Innovation and Improvement Award** – Strategy and Partnerships Team
- **Inclusion Champion** – Clare Payne, Knowledge and Evidence Service
- **Rising Star Award** – Gill Tyrer, Discharge Team
- **Leadership Award** – Jaclyn Proctor, Advanced Practice Trust Lead
- **Special Recognition Award** – Diane Skidmore, Finance
- **Living our Values Award: Colleague of the Year** – Dr Liz Nolan, Consultant Geriatrician
- **You Made a Difference Award** – Warrington Theatres, Midwifery, Anaesthetic, Transfusion, Surgical and Intensive Care Teams
- **Outstanding Achievement Award** – Dr Anne Robinson, Consultant in Emergency Medicine and Deputy Medical Director
- **People's Choice Award** – Neonatal Unit Team

I must also thank those involved in making the event such a success. That includes everyone who took the time to send in a nomination, our WHH stars who were shortlisted and became our 2023-24 finalists and winners, and our sponsors for making the event possible – I know they enjoyed it as much as we did.

I also wish to thank our TYA organising committee and Communications and Engagement Team, who worked so hard and went the extra mile to make the night one to remember.

2.6 Warrington Guardian Inspiration Awards

Congratulations to the following three teams and volunteers on their awards:

- Health Hero of the Year - Team Lunar (home birth team)

Team Lunar received multiple nominations from families they have cared for, acknowledging the life-changing experiences the team deliver for families across Warrington and Halton. The award recognised the exceptional care the team provide, and how they go above and beyond to fundraise and develop the service with special facilities for families.

- Charity of the Year – Warrington and Halton Teaching Hospitals Charity

Our hospital charity dedicates itself to raising smiles and lifting the spirits of our patients and visitors and is the only charity in the area that supports patients and their families from birth through to end of life, and everything in between. The award recognised the work the team do to raise funds to improve the comfort, care and experiences for patients and their families in some of the most difficult times.

- Lifetime Achievement Award - Keith Inman, Radio General

Keith Inman has volunteered at Warrington's Radio General since 1974, and this year will mark 50 years of service. The prestigious award recognised the outstanding contribution Keith has made to Warrington over the years, from live broadcasting royal visits to bringing radio to the hospital bedside. Keith works tirelessly to bring patients updates on events which they would otherwise be unable to attend.

I would also like to extend my congratulations to volunteer Mike Shaw, who was highly commended in the Health Hero of the Year category. Mike goes above and beyond as one of the first points of contact for patients and visitors to our hospitals and is committed to supporting others and making a positive impact to others lives.

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:

- International Day of the Midwife: 5 May 2024
- Deaf Awareness Week: 6 – 12 May 2024
- National Day for Staff Networks: 8 May 2024
- International Nurses' Day: 12 May 2024
- Operating Department Practitioner Day: 14 May 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 (March 2024): Sandra Pinnington

Sandra (a midwife on the Early Pregnancy Unit) was nominated by a patient for the care and support shown to both the patient and their partner throughout their pregnancy journey, including supporting them both through a miscarriage. This included going out of her way to visit them on the day of a surgical procedure and supporting them through a diagnosis of a genetic condition affecting fertility and causing recurrent miscarriage, their IVF journey in London at a specialist clinic, and their current pregnancy made possible via IVF.

Sandra arranged additional regular scans leading up to the 12-week mark to provide peace of mind and extra reassurance for the couple.

The nomination said that Sandra went "*above and beyond to help this pregnancy be more enjoyable and less distressing" and that her "kindness, compassion and dedication has made such a difference in our journey here to date and we honestly don't know what we would have done without Sandra and the rest of the team*."

You Made A Difference Award (April 2024): Procurement Team

Our Procurement Team are an integral part of the running of the Trust and support all areas within it. The team were consistently going the extra mile every day and ensuring that patient care is at the heart of everything the team does, despite challenges with staffing and recruitment levels that the team face.

The nomination stated that "*the team has not been fully staffed for a number of years due to difficulties in recruiting into this profession. Despite this they have continued to perform to a high standard every day and have continued to develop our services. All staff are engaged and participate in team meetings, they manage the workload so well despite the vacancies we struggle to fill and therefore go the extra mile every day*."

The team may often be working behind the scenes, but their contribution is absolutely vital to the safe and efficient running of our hospitals and it is important that we recognise everything that the team do, from handling the day-to-day workload, to embracing change with a new collaborative approach working alongside Cheshire & Merseyside colleagues. The hospitals would not be able to function without the work and services that the Procurement Team provide.

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

Chief Executive's Award (January 2024): Workforce Information Team

The team - Louise Rylett, Lisa Heaton, Kimberley Boag-Munroe, Tony Lo and Jacqui Brindle - were nominated by their manager for the brilliant work they do behind the scenes, ensuring we have access to key data to make informed decisions, provide statutory returns, ensure staff get paid correctly and cover all data related to our people that is needed.

This year they have delivered an incredible amount for the organisation in terms of data and reporting; tackled new ways of reporting information, built new dashboards, enhanced our offering, and helped to quickly develop ways of capturing information for things such as strike action reporting and data collation.

As a support service, supporting the entire organisation, the difference they quietly make on a day-to-day basis deserves to be recognised.

Chief Executive's Award (May 2024): Adam Harrison-Moran

Adam was invited to attend and speak at a national conference in Nottingham organised by NHSE to discuss our approach and experience with Rainbow Badge Phase 2 implementation. It is great to see the WHH approach to ED&I recognised nationally.

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

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

- Dr Joel Lambert, Foundation Year 1 Doctor - Digestive Diseases
- Patricia Malone, Mental Wellbeing Hub Counsellor - HR/OD
- Ben Stevens, Divisional Accountant - Finance & Procurement
- Sandra Millington, Sister - Early Pregnancy Unit, Women's & Children's Health
- Sarah Melvin, Senior Domestic Supervisor - Estates and Facilities
- Claire White, Support Services Manager - Estates and Facilities
- Natalie Crosby, Associate Chief Nurse - Corporate Nursing
- Lucy Gardner, Director of Strategy & Partnerships
- Helen Winsor, Staff Nurse - Fracture Clinic, Surgical Specialities
- Ali Kennah, Chief Nurse
- Michelle Cloney, Chief People Officer
- Colette Hollins, Outpatient Services Manager - Clinical Support Services
- Dr Mohamed Kaleel Rahman, Consultant Haematologist - Clinical Support Services
- Robert Brooks, Contracts Manager - Procurement
- Deborah Carter, Midwife - Women's & Children's Health
- Amanda Clough, Respiratory Team Administrator - Clinical Support Services
- Mr Paul Adinkra, Consultant Obstetrician - Women's & Children's Health
- Lisa Duffy, Catering Assistant - Estates and Facilities
- Zoe Robinson, Medical Staffing Officer - HR/OD
- Laura Barnes, Midwife - Women's & Children's Health
- Ben Pimblett, Administrator - Safeguarding
- Deborah Howard, Associate Chief Nurse - Corporate Nursing
- Jacqui Brindle, Workforce Information Assistant - HR/OD
- Katie Wilson, Pharmacy Technician - Clinical Support Services
- Amy Morrison Purchasing Assistant, Procurement Team
- Matthew Reddington, Purchasing Assistant - Procurement Team

- Tim Furfie, Purchasing Assistant - Procurement Team
- Acute Medicine Team, Urgent & Emergency Care
- Ward C23 Team, Women's & Children's Health
- Radiology CT Team, Clinical Support Services
- Security and Portering Teams, Clinical Support Services
- Transfusion Team, Clinical Support Services
- Quality Academy Team, Medical Directorate
- Paediatric Seven Day Services Project Team, Women's & Children's Health
- Maternity Triage Team, Women's & Children's Health
- Strategy & Partnerships Team
- Pharmacy Team, Clinical Support Services
- Dr Liz Nolan, Consultant Geriatrician - Integrated Medicine & Community
- Gill Tyrer, Discharge Coordinator - Integrated Medicine & Community
- Sarah Robinson, Divisional Accountant - Finance & Procurement
- Clare Payne, Knowledge & Evidence Services Manager - Medical Directorate
- Dr Premkumar Martin, Specialty Trainee, Neonatal Team - Women's & Children's Health
- Diane Skidmore, Assistant Accountant - Finance & Procurement
- Jaclyn Proctor, Advanced Practice Trust Lead - Corporate Nursing
- Neonatal Unit Team, Women's & Children's Health
- Daniel Masters, Education Centre Assistant, Halton Education Centre - HR/OD
- Olivia Rogers, Healthcare Assistant, SDEC
- Acute Respiratory Virtual Ward Team, Medical Care
- Peer Café Team, HR/OD
- Esstta Griffiths, Engagement & Involvement Officer - Communications
- Daniel Palmer, Lead Physician Associate - Emergency Department
- Janette Pennington, Advanced Scrub Practitioner - Trauma Theatres
- Claire Hulmes, Specialist Nurse Practitioner - Paediatrics
- Derek Gates, Volunteer - Halton Radio
- Warrington Diabetic Foot Clinic Team, Medical Care
- Anthony Connolly, Specialist Nurse Practitioner - Rheumatology
- Sheila McNie, Healthcare Assistant - Ward B18
- Robyn Mayer, Sister - Emergency Department
- Hayley Smith, Deputy Director of Communications & Engagement - Communications
- Zainab Sesay, Occupational Therapist - Clinical Support Services
- Gillian Whitfield, Specialist Registered Dental Nurse - Surgical Specialities
- Alan Vaughan, Head of Medical Engineering - Estates and Facilities
- Brian Burston, Charge Nurse - Ward K25
- Phillipa Day, Healthcare Assistant - Emergency Department
- Hannah Dixon, Ward Sister - Ward A4
- Georgia Parsons, Radiology Assistant - Clinical Support Services
- Zoe Evans, Senior Radiographer - Clinical Support Services
- Julijana Berkovic, Senior Physiotherapist - Clinical Support Services
- Marie Garnett, Head of Contracts & Performance - Finance & Procurement
- Ian Wright, Associate Director of Estates and Facilities
- Angela Glassbrook, Sister - Ophthalmology

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 April and May 2024 since the last Trust Board Meeting.

- NHS England CEO Leadership Conference, London (1st May 2024)
- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)
- CMAST Clinical Pathways Programme (Various)
- Steven Broomhead, Chief Executive, Warrington Borough Council
- Stephen Young, Chief Executive, Halton Borough Council
- Carl Marsh, ICB Place Director (Warrington)
- Anthony Leo, ICB Place Director (Halton)
- Warrington & Halton System Executive Oversight Group (Weekly)
- 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 1 (April 2024)
Appendix 2: CMAST Brief Issue 25 April 2024

CMAST Briefing

April 2024

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

CMAST Update

CMAST Leadership Board met on 3rd May. The meeting was a joint meeting with both Trust CEOs and Chairs in attendance.

A key area of discussion was a review of the CMAST delivery priorities and commitments for 2024/5. The proposals are summarised below and were endorsed by the membership, from part of system planning submissions and are due to be reported to the ICB, at their request, over the summer by Ann Marr OBE.

The Board were also updated in LIMS decision making. At the time of meeting 4 of 5 Core Trusts had approved LIMS investment and delegation of implementation to CMAST Leadership Board. Agreement from the 5th Trust is expected before the end of May.

CMAST Programme deliverables for 2024/5 at a headline level are as set out below (more detail exists supporting each of these headline deliverables on a metric basis):

Elective Recovery and Transformation Programme:

1. Reducing long waits, and improving waiting list management
   - Maintain zero 104 week position
   - Maintain zero 78 week position
   - Eliminate 65 week waits
   - Validation – meet national target

2. Reducing variation between providers
   - Achieve 85% theatre utilisation for all Trusts capped
   - Reduction in fallow theatres
   - Increase utilisation in elective hub theatre utilisation
   - Advice and guidance
   - Outpatient follow-up reduction
   - Maximising elective hub usage
   - Reduction in capacity-related insourcing & outsourcing

3. Improving productivity and efficiency within the providers
   Pre-referral specialist advice utilisation rate
   - Target: greater than 21% pre-referral specialist advice diversion rate.
   - Target: greater than 55% post-referral specialist advice utilisation rate.
   - Target: greater than 21% post-referral specialist advice diversion rate.

   PIFU utilisation rate
   - Target: greater than 5%

We have also established a task and finish group to review ad-hoc independent sector spend to ensure we are not incurring costs for ad-hoc provision where there is local capacity available. We will be working closely with high-spend trusts to support access to local capacity where possible before incurring unnecessary IS costs.

Diagnostics Programme

1. Reducing waiting times

a. Productivity
- Endoscopy - 95% lists utilisation
- CT – 4 scans per hour
- MRI – 2.5 scans per hour
- NOUS - 3 scans per hour
- Echos - 45 mins per test

This will mean:
- 95% of patients seen within 6 weeks
- No patient waits more than 13 weeks

b. Radiology
- Deliver increased quality, reduced duplication, and reduced reporting waits.
- Meet Royal College of Radiology (RCR) Guidelines:
    - CT - 95% urgent with 7 days
    - CT – 95% routine within 28 days
    - MRI – 90% of urgent within 7 days
    - MRI – 95% routine within 28 days

c. Histopathology
- Maximise our efficiency and resilience in histopathology
- 80% cancer cell path samples reported within 10 working days

2. Digitise and innovate

- Reduce duplicate tests and ensure that patients don't need to attend repeat appointments - Save £10m over 10 years across the system.
- Ensure abnormal tests are prioritised - Save consultant reporting time enabling other images to be reported on quicker
- Potential to reduce appointment times from 45 minutes to 20 minutes - Increase capacity, reduce waiting times and reduce IS spend.
- Ensure abnormal tests are prioritised. Reducing the turnaround time for reports and the impact on urgent care.

3. Workforce resilience

- Provide support and resilience for healthcare scientists - Ensure the 40+ Physiological Science tests have a strong workforce in place.
- Do it 'once and well' attracting staff for the trust of their preference - Reducing vacancy rates.
- Ensure we adjust to help staff to remain in post - Reducing use of bank and agency.
- Ensure that we have a pipeline of staff coming into our system.
- Ensure that we have resilience for years to come.

Clinical Pathways Programme

1. Improved access to services and health outcomes across C&M
2. Improving clinical pathways whilst actively supporting a reduction in health inequalities across C&M
3. Systems working collectively to improve service delivery, clinical outcome, patient experience and where possible release efficiency savings.

Focus and clinical groups have been established across Dermatology, Cardiology, ENT, Ophthalmology, and Gynaecology

Efficiency at Scale

Systems working collectively to improve service delivery and where possible release efficiency savings in 204/5 this programme is targeting savings of £32.5m by focussing on:

- Reduction in fragile services across C&M
- Improved service delivery & quality
- Optimisation of assets/systems and expertise
- Improved productivity & value of money

Specific areas of work include:

1. Support a productive & efficient workforce
   - Support the continued reduction in agency costs
   - Optimisation of assets/systems and expertise

2. Reduce corporate running costs.
   - Simplification and standardisation of processes across the system
   - System collaboration where appropriate
   - Reduce corporate running costs.

3. Optimisations of purchase at scale opportunities across the C&M system
   - Reduce procurement and supply chain costs.
   - Improved inventory management across C&M
   - Optimisation of Value Based Procurement

4. Improved Medicines Optimisation across C&M
   - Improved patient outcomes
   - Support Health Inequalities and levelling-up agenda
   - Using best value biologic medicines
   - Optimisation of high-cost drugs (Blueteq & Homecare)
   - Purchase medicines at the most effective price point
   - Address problematic polypharmacy

ICB Update

NHS Cheshire and Merseyside is establishing an Integrated Research and Innovation System (IRIS) which aligns with both local and national research and innovation priorities.

The plan is in line with NHS England's guidance on maximising the benefits of research and the statutory responsibility for Integrated Care Boards (ICBs) to deliver research and innovation under the Health and Social Care Act 2022.

The primary aim of IRIS is to create a research and innovation-driven healthcare ecosystem that benefits the entire population by enhancing healthcare quality, fostering innovation, and improving patient outcomes.

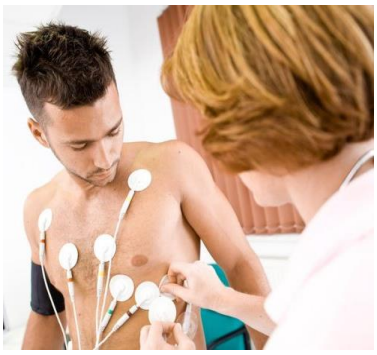
IRIS will add value to the local health system by helping to attract research investment, strongly supporting innovation, and enabling Cheshire and Merseyside to evolve into a world-class system of research and innovation excellence.

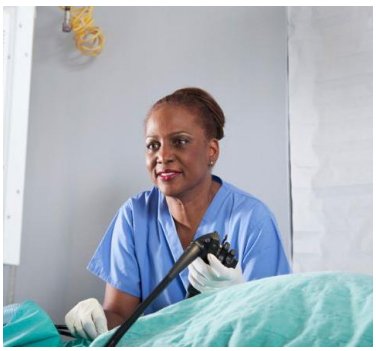
In collaboration with system stakeholders, a Cheshire and Merseyside research and innovation strategy will now be developed to support health and care leaders to understand the local research and innovation capability, workforce, activity and needs - and to set ambitions around research and innovation.

Elective Recovery and Transformation Programme

Waiting times reduction

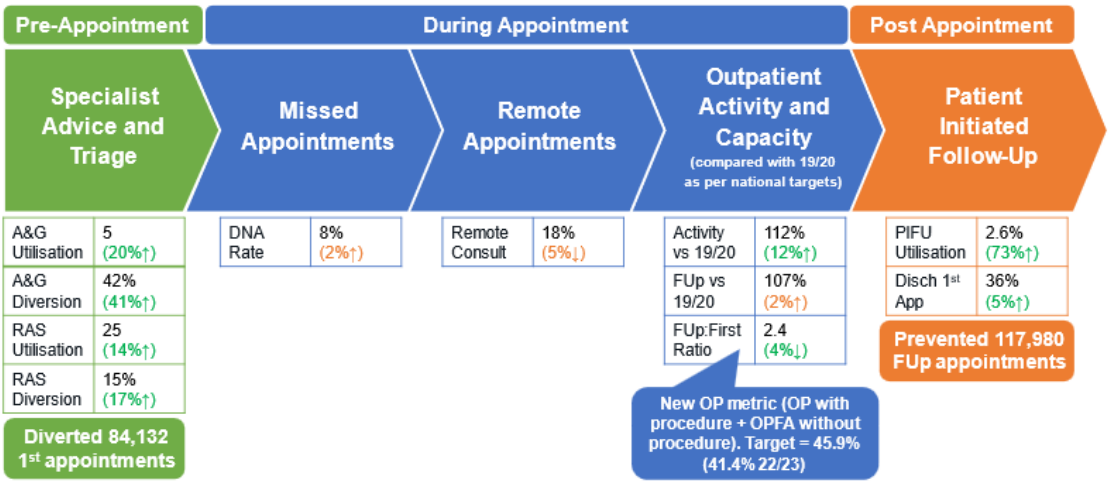
- The C&M end of March position was 2,053 patients waiting over 65 weeks. This includes 101 patients who were waiting over 78 weeks. Of the 78 week patients, only 15 are capacity breaches, as the others are either patient choice or clinically complex.
- By the end of September 2024, 48,872 need to be cleared from the 65 week potential breach cohort. The potential breach cohort includes all patients that will reach 65 weeks by the end of September. This time last month there were 64,850 in the potential breach cohort.





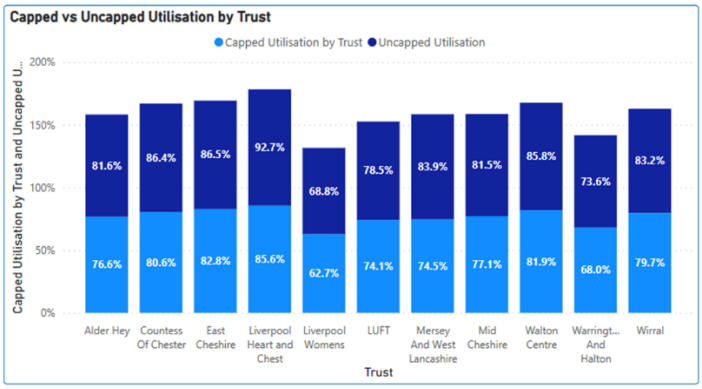
Outpatients

- Improvements are being targeted on all Specialist Advice metrics. This includes Advice and Guidance (A&G) utilisation and A&G and RAS diversion rates. Over 84,000 appointments have been diverted (previous month was 77, 000) through specialist advice initiatives.
- Missed appointment rates have improved with DNAs now reduced to circa 8%.
- Focus remains on new-follow up ratios, measures which have so far prevented over 115,000 follow up appointments.



Theatres

- For March, C&M performance is 82% uncapped, and 76% capped utilisation rates. Liverpool Heart and Chest are currently the only trust meeting the capped target of 85% utilisation.
- Additional intensive work to support the most challenged Trusts is underway.



Trust	Capped Utilisation	Uncapped Utilisation
Alder Hey	77%	82%
Countess Of Chester	81%	86%
East Cheshire	83%	87%
Liverpool Heart and Chest	86%	93%
Liverpool Womens	63%	69%
LUFT	74%	78%
Mersey And West Lancashire	74%	84%
Mid Cheshire	77%	82%
Walton Centre	82%	86%
Warrington And Halton	68%	74%
Wirral	80%	83%
Total	**76%**	**82%**

Clinical Pathways

The CPP Programme continues to work with Orthopaedics, Dermatology, ENT, Gynaecology and Cardiology. In addition, from April 2024 onwards, updates for Ophthalmology will be included within the CPP updates.

Orthopaedics

- A meeting of the C&M Trauma and Orthopaedic Alliance (OA) was held at Cheshire and Merseyside Surgical Centre – Clatterbridge on the 19th March 2024. This was well attended and incorporated a site walkaround for clinical and operational leads from all trusts to see the facility and what it offers. At the meeting an update was provided on Length of Stay Improvement work for Primary Arthroplasty – progress has already been made in 2023-24, tangible actions have been identified to make further improvements.
- An update was also provided regards the length of stay improvement work related to fracture neck of femur.
- A paper was circulated outlining options for the ongoing provision for open fractures across C&M and all trusts invited to comment on the preferred option so that a collective system view can be communicated.
- The Orthopaedic dashboard is fully updated and with links established with the C&M BI team for ongoing support.

Dermatology

Teledermatology

- Pre-Market engagement took place on the 22nd March with 4 suppliers; Accenda, Cinapsis, Consultant Connect and E-derma.
- Progress in this area requires linkages and alignment with the ICB. As such engagement has take place with Place C&M Associate Directors of Transformation Group and is scheduled for the ICB Clinical Effectiveness Group on 3rd April.
- The service specification will be updated following feedback from suppliers at pre-market engagement sessions held on 22nd March.
- The programme continues to explore take up rates and usage across the system. For example, in one place only 21 of 62 practices are not actively using the available telederm solution.

Other Workstreams

- Sub-workstream proposal presented to Dermatology Alliance, that will see workstreams formed such as: Digital, transformation, Cancer pathways and Inflammatory conditions.

Gynaecology

- CPP Gynaecology lead Medical Director identified and progress has been made to define workstreams within CPP remit. These discussions will conclude with draft PIDs.

  - Menopause pilot (collaboration between LWH & Liverpool PCN) continues, and CPP support is being provided to complete full evaluation for formal reporting.
  - Benefit realisation dashboard requirements defined and will be spearheaded by the Menopause pilot; anticipation of outputs to be shared with Gynaecology Network and Department of Health in June – pilot aims to achieve meeting new patient 18WW by September 2024, alongside other qualitative patient, primary care and financial benefits.

ENT

- Great progress has been made to engage with all teams across C&M to ensure consistency of attendance and participation moving forward. All providers except one, have had 1-2-1 sessions and these have been well received.
- There is acknowledgement from feedback that clinical time is limited within ENT; feedback around structure of alliance has therefore been amended to establish a network and operational managers forum and this will be formalised at the ENT Alliance Relaunch Event on 25th April 2024.

Cardiology

- A workshop is arranged for 16th May 2024, the purpose of the workshop is to provide and review a data intelligence pack for cardiology and agree the scope and priorities for the provider alliance work.

Ophthalmology

- Network meeting held on 6th March which agreed network priorities for 24/25. The group continue to progress plans to visit individual providers to observe theatre session and conduct deep dive with clinical and operational teams, agreeing provider and system level actions aligned with GIRFT metrics.

Glaucoma Monitoring Service

Procurement waiver completed and signed off at audit committee in March. Some challenges have been identified which are being worked through to resolution.

Eyecare Accelerator Project

  - Procurement of SPoA launched following co-ordination of cross system action to sign off launch. supported by an agreed specification for advice and guidance pilot.
  - Meetings with Optical bodies, to seek assurance around governance arrangements for Optometrists when offering advice and guidance, have taken place.
  - Engagement with Trusts and Places to agree scope of advice and guidance pilot and agree mobilisation plans.
- Communications and engagement with primary care continues via regional meetings, PCN and optical practices in Cheshire.

Diagnostics Programme

Key Performance Headlines

- 1,150,253 accumulated diagnostics activity for year to date – 12% above plan
- Activity levels reduced from 116,479 in January to 110,964 in February, but 22% higher than February planned activity. Performance overall has improved or been maintained for all 7 tests.
- 89% of patients waiting 6 weeks or less (5% increase since last month)
- Total number of patients waiting reduced to 66,163 (was 66,837 last month)
- ICS continues to rank 4th out of 42 ICSs.
- 6721 patients have waited 6 weeks or more (reduction of 3,924 patients since last month).

Endoscopy

- 3 trusts utilising >100% of their core capacity.
- £8.1m Transformation Programme progressing on track – film produced to share outputs and impact.
- Transnasal gastroscopy activity began at East Cheshire Hospital.
- 30 colonoscopies provided to MWL as mutual aid.
- Continued focussed support meetings in place with MWL and CoCH to deliver improved performance. Commitment from Chief Operating Officers in place.

Pathology

TOM (3 Hub Target Operating Model)

- Outputs from Exec Planning Session in March shared at meeting 19th April 2024. Further work required to finalise proposed governance, programme plan and engagement and expect to be agreed mid-May.
- To support 2022/2023 benchmarking data collection progressing against plan initial data collection has been completed and validation and sense checking of data is being performed by the labs.

LIMS (Laboratory Information Management System)

- Exec Leads for five trusts currently sharing full business case and supportive documentation through Trust Boards for approval.
- As of 30th April 2024, four trusts have approved, with WHH Trust Board meeting in May. Resourcing of central team still requires review and support. Contract award planned for May.

Histopathology

- NHSE funding to support histopathology improvement plans being made available and network submitted requirements in April. Awaiting feedback on success of bid.

Physiological Science

Launch of the Cheshire & Merseyside Physiological Science Network

- Launch took place on 18th April 2024. Attended by modality leads and key stakeholders. Network blueprint, priorities and enabling themes communicated and confirmed. Clinical Lead recruitment to start in May.

Enhanced GP Direct Access for COPD, asthma and heart failure –

- Developing proposal for increased access via CDCs. Engagement with trust teams commenced, and activity and workforce data being collected.

Artificial Intelligence (AI) in Echocardiology Clinics

- Funding bid submitted to NHSE for improvement fund ~£45K.

Radiology

AI for Chest X-Rays –.

- Contract and funding approved. Clinical decisions made on priority groups.

Cyber Security

- Funding for years 2-5 for PACs (Picture Archiving and Communication System) cyber security product agreed through LIMS underspend. Cyber resilience risks discussed with Cheshire & Merseyside Digital Design Authority and Chief Information Officers to mitigate.

Other Ologies (So that images from all specialities can be shared)

- MWL Clinical Safety Working Group approved Clinical Safety Case with go-live date 15th April 2024. System configuration completed for Liverpool University Hospitals Stoma Team.

PACS Based Reporting –

- Alder Hey completed training to 75% of staff - site will be 100% compliant by end April.

Interventional Radiology (IR) Review –

- Radiology Service Managers to nominate local trust leads for the review and inviting clinicians to submit Expressions of Interest to become Clinical Lead for project.

Target operating model –

- Workshop with Clinical Directors held, with good attendance. Outputs from the workshop are being shared at the April CAMRIN Management Group including next steps.

Community Diagnostic Centres (CDCs)

- Progressing as planned in all 10 CDC sites
- Capital plans for 2024/2025 agreed and delivery timescales in place and shared with NHS England central team
- Commenced working on CDC sustainability review
- Mutual aid delivery extended to 5 CDC sites

Efficiency at Scale

Overarching programme

The E@S 2024/2025 annual plan was recently presented to the CMAST SROs and was well received. Finalisation of the plan progresses, and will be presented at the May E@S Board.

Several workshops have taken place to explore automation opportunities with additional workshop scheduled to progress these at pace.

Finance/Legal

Funding options for the single ledger SBS proposal continue to be explored with the national team.

A phased approach for the Liverpool Legal Services (LLS) collaborative is proposed to commence on 01st May 2024, beginning with Liverpool Women's Hospital NHS FT. This will result in all aspects of legal services being provided via LLS including the transfer of existing staffing resources. The approach will ensure increased control of external legal spend with immediate financial savings for LWH.

Medicines Optimisation

YTD (February 2024) savings has been reported at approximately £16m and £18m with Apixaban windfall, this being above £17m annual target. Total savings are estimated to be £18.2m and £23.7m with Apixaban windfall.

Work continues with Specialised Commissioning on the homecare/high costs drugs investment proposal. A decision is expected in late April which will support the finalisation of the medicine's optimisation targets.

Procurement

The 2024/25 projected outturn is reported to land at £3.9m FYE and £1.38m IYE. The 2024/25 workplan has been finalised and has identified £7m savings for new schemes.

Workforce Programme

CMAST Workforce Programme

The final Workforce Programme Board took place on 26th March 2024. The Board reviewed the final project updates and confirmed closure of the Programme Board. The Workforce Programme Risk Log was also closed down during the meeting.

Development of Band 6 Ward & Department Nurse Roles

The Working Group met for the final time on 18th March 2024 to reflect on the success of the pilot scheme, agree the key recommendations and determine the next steps for the Toolkit. The final report for the Developing Band 6 Nurses in C&M project was shared with the Workforce Programme Board on 26th March 2024 which outlines these recommendations and next steps. The paper was approved by the Workforce Programme Board and the agreed actions will be taken forward by the relevant owners.

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.

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 an improvement for patients admitted, transferred, or discharged within 4 hours, with March performance at 71.9%% compared to 68.1% in February. This is against a 2023/24 year-end national recovery target of 76%. Current performance is 5% below our local 2023/24 trajectory, however, is performing better than the North West (70.7%).

The percentage of beds occupied by patients with a length of stay over 14 days was 36.7% at 14/4/2024, whilst length of stay over 21 days continues to account for around a quarter of occupied beds (26.2%).

Appendix 1 - CEO Dashboard Month 1 – April 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	89.17%	F
RTT 18 Weeks	92.00%	57.60%	F
RTT 65+ Weeks	0	2287	F
A&E % patients seen within 4 hours	> 75.00%	66.56%	F
A&E % waiting longer than 12 hours	< 2.00%	19.46%	F
Cancer 28 Day Faster Diagnostic Standard	75.00%	78.10%	?
Cancer 62 Day Wait	85.00%	83.97%	No SPC
Ambulance Handovers within 60 mins	100%	85.71%	F
Discharge Summaries 24 hours	95.00%	90.78%	F
Cancelled Operations – 28 days	0	0	?
Super Stranded Patients	Trajectory	108	No SPC
Uncapped Theatre Utilisation	85.00%	73.40%	F
Capped Theatre Utilisation	85.00%	68.80%	F

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	P
Sepsis Screening Emergency	90.00%	78.00%	F
Sepsis Screening Inpatients	90.00%	72.00%	F
Sepsis Antibiotics Emergency	90.00%	64.00%	F
Sepsis Antibiotics Inpatient	90.00%	84.00%	F
Inpatient Falls	20.00% reduction	29	P
VTE	95.49%	93.31%	F
Pressure Ulcers	10.00% reduction	14	?
Medication Reconciliation (24 hrs)	80.00%	43.00%	F
Complaints over 6 months	0	0	P
Healthcare Infections - MRSA	N/A	0 YTD	P
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	11 YTD	F
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	9 YTD	F
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	6 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	0 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	4.30%	No SPC
MUST nutritional assessment completion	85%	57.43%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (£m)	-£3.66	-£4.16	No SPC
Capital Spend (£m)	£0.58	£0.58	?
Cash Balance (£m)	£9.70	£11.69	No SPC
Better Practice Payment Code (£m)	95%	94%	F
CIP In Year Delivered (£m)	£0.65	£0.65	P
CIP Forecast (Recurrent) (£m)	£0.65	£0.06	F
Agency Ceiling	Less than 3.2%	1.20%	P

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.61%	F
Retention	85.00%	87.10%	P
Core/Mandatory Training	85.00%	89.90%	P
PDR Compliance	85.00%	74.23%	F

Strategy

- Since opening to the public on the 1st March this year, the Living Well Hub has successfully offered advice and guidance to over 700 people during drop in visits and provided a location for over 400 booked appointments in the first 7 weeks of opening. It is expected that this visitor rate will continue to increase as more services come online and public and professional knowledge of the Hub increases.
- WHH business planning meetings have been conducted with Clinical Business Units and Care Groups. Strategic priorities for 2024-25 have been identified for approval by the executive team.
- Development of the community diagnostic centre continues, with contracts for phase 3 (new build at Halton Hospital) being signed and enabling works have commenced. Funding to implement a new pathway for paediatric respiratory diagnosis in phase 2 (Runcorn Shopping City) has been secured and a project team is being established to implement it.
- A programme has been established to drive system improvement in urgent and emergency care. The programme has established workstreams in response to the diagnostic work undertaken by Newton and will deliver system improvement in partnership with Bridgewater, Warrington Borough Council and Halton Borough Council.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/06/033**			
SUBJECT:	**Chair's Report**			
DATE OF MEETING:	5 June 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**
	  ○ Integration and Collaboration – next steps
	  ○ Changes to the Executive Team
	  ○ Opening of the new Day Case Unit
	• **WHH Meetings and Events**
	  ○ Start of Year Conference
	  ○ Thank You Awards
	  ○ Council of Governors Meeting			

	• **System Working & National Updates/Events** ○ CMAST Update • **Governor Observation Visits**		
PURPOSE: ***(please select as appropriate)***	**To note** ✓	**Approval**	**Decision**
RECOMMENDATION:	The Trust Board is asked to: I. Note the matters being brought 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/24/06/033

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
3 April 2024	Halton Hospital	Opening of new same day unit
18 April 2024	Halliwell Jones Stadium	WHH Start of the Year Conference
24 April 2024	Warrington Hospital	Extraordinary Trust Board meeting
15 May 2024	Digital	CMAST Chairs Meeting
21 May 2024	Lakeside, Warrington	Warrington System Meeting

KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

1. General Update

1.1 Integration and Collaboration Next Steps

In recent weeks there has been media interest related to the potential coming together of ourselves with Bridgewater Community Healthcare, our local community provider and its worth being clear where we are with that situation.

We did considerable work pre-Covid to explore the possibility of closer integration with Bridgewater but as those discussions were coming to conclusions, the Pandemic happened, and it was agreed sensible by all parties that the considerations were put on hold for a period of time.

Of course, we share an overriding aim with colleagues at Bridgewater to deliver a sustainable system for patients and staff, and it remains is clear that there are opportunities for further integration that can deliver both patient benefits and financial savings. As just one example, the Newton diagnostic work recently undertaken highlighted significant opportunities across the urgent and emergency care pathway in Warrington and Halton.

We are therefore now working closely and collaboratively with Bridgewater on plans that will eventually bring the two organisations together as one.

This work is at an early stage, and we are developing plans for what we can achieve together over the next 6, 12 and 24 months, as well as ensuring the appropriate governance mechanisms are put in place.

Lucy Gardner, our Director of Strategy and Partnerships, is leading this work on behalf of both organisations.

Clearly developments of this nature can create many questions and possibly leave some people feeling unsettled about what the future holds for them. We will of course continue to communicate openly and transparently as plans progress. Nevertheless, I would like to stress that there are

currently no discussions about compulsory redundancies, the hope and ambition is to utilise the natural churn of both organisations to absorb the impact of any changes, so there should no need for staff to feel concerned about their jobs.

1.2 Changes to the Executive Team

Linked to these integration plans is the appointment of a new CEO for WHH to replace Simon, who leaves us at the end of August to take up a new post as chief executive of University Hospitals of North Midlands NHS Trust.

Simon has helped lead the Trust through significant improvements, moving from a Care Quality Commission rating of 'Requires improvement' to 'Good' in 2019, as well as responding to the unprecedented Covid-19 pandemic and its aftermath over recent years. He leaves behind a leadership team where there is remarkable continuity, stability and organisational memory, and who share the same values and ambitions to effectively serve the people of Warrington and Halton, as well as the wider region.

I personally want to commend Simon for being an outstanding and compassionate leader and for all he has done for Warrington and Halton, and beyond, over recent years. He will be dearly missed by all of us at the Trust. I have thoroughly enjoyed working with Simon and wish him every success in his next role.

Notwithstanding, in light of the proposed joining together of the two organisations it is not felt appropriate to make a substantive appointment to the CEO position just yet. Rather we have decided to make an interim appointment of up to two years in anticipation of then being able to recruit a new CEO for the integrated organisation going forward.

The recruitment for a new Chief Executive has progressed well, we had a very positive response to the job advert and we shortlisted several very strong candidates who attended interviews on the 29th May 2024. One candidate has been offered the position, following a Nominations and Remunerations Committee meeting and approval at an Extraordinary Council of Governors meeting. Trust wide Communication plans are in place to circulate the news to staff and external stakeholders.

1.2 Opening of the new Day Case Unit

I attended the opening of the new theatre and day case unit based in the Captain Sir Tom Moore (CSTM) Building at Halton Hospital.

The work is the first phase of a £9.2 million project to re-configure theatres and create additional capacity for the treatment of elective patients and help to reduce waiting lists for surgery. The development is part of a wider project to further improve the elective care facilities, patient access and increase the number of patients treated at Halton Hospital.

The unit has been designed to provide 10 new day case pods, a state-of-the-art laminar flow theatre and a new treatment room for low complexity surgery, supporting new ways of working and innovative methods of delivering care to provide an excellent experience for elective patients.

2 WHH Meetings and Events

2.1 WHH Start of the Year Conference

On the 18 April, I welcomed the Trusts senior managers to the Start of Year conference held at Halliwell Jones Stadium. The focus of the day was on our priorities for the year and the approaches we can adopt to address the challenges we face in ways that reflect our values. Guest speakers included Matt Lindley a former RAF pilot who shared his experiences in leadership, accountability and culture and Lady Kitty Chisolm who shared her knowledge around development and change management.

2.2 Thank You Awards

Dedicated teams from across Warrington and Halton NHS Teaching Hospitals NHS Foundation Trust came together on the evening of Friday 10 May for an uplifting awards ceremony filled with inspiration, admiration, and positivity.

Winners in 12 categories were announced as 300 staff, volunteers and sponsors attended the Trust's annual Thank You Awards, held at the Concorde Conference Centre.

Individuals and teams gathered to recognise their hard work, outstanding achievements and those who have excelled in their field. This year there were more than 300 nominations for the awards. The People's Choice Award went to the Neonatal Unit Team. New this year, the award invited members of the public to submit a nomination for an individual, team, ward or department that has made a positive difference to their experience at Warrington and Halton Hospitals during the past 12 months. The nomination recognised the teams who work to care for the most vulnerable infants and provide support during the most precious yet challenging times that some families face.

2.3 Council of Governors Meeting

The Council of Governors meeting took place on: 16 May 2024, Cliff Richards chaired on my behalf as Deputy Chair. The next Council of Governors meeting will take place on Thursday 15 August 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.

In addition, Governors have been kept informed via scheduled Chairs briefings during months that a formal Council of Governors meeting is not scheduled, the last taking place on 11 April 2024.

3 System Working and National Updates

3.1 CMAST Update

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

4 Governor Observation Visits

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

- 4 April 2024 – Ward A3

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.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/034**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	5th June 2024	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
	✓		
Further Information:			

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*

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

Since the last meeting:

- No new risks have been added;
- The rating of one risk (#1134) has been reduced.
- The description of one risk (#1757) has been updated.

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/24/06/034

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 and following discussion as part of the deep dive at the February meeting of the Strategic People Committee and the subsequent Risk Review Group on 5th March 2024, it was agreed at the Strategic People Committee on 17th April 2024 to decrease the rating of risk #1134 (detailed below) from 20 to 12.

The agreement to reduce risk was as a result of sustained reduction in the sickness absence rate, the significant improvement in long terms sickness absence rates, improvement in permanent staff turnover and a reduction in Bank and Agency reliance.

ID	Risk description	Rating (previous)	Rating (current)	Executive Lead
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	20 (4x5)	12 (3x4)	Michelle Cloney

2.3 Amendments to descriptions

Since the last meeting there has been an update to the description of one risk.

Following discussion as part of the deep dive at the February meeting of the Strategic People Committee and the subsequent Risk Review Group on 5th March 2024, it was agreed at the Strategic People Committee on 17th April 2024, to amend the description on one risk (#1757).

It was felt the risk no longer related to the ability to *'effectively plan for and manage industrial action'.* The agreed updated description is detailed below:

Previous: *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*

Current: *If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.*

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 there have been no changes to the risk appetites of any of the risks

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>Controls</u> • Introduction of the new Manchester Triage Process that went live on 14th April 2024. The aim is to support reduced overcrowding in ED and improve clinical quality and patient experience. • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) agreed to remain open throughout April 2024 to support flow; to be reviewed 10th May 2024.	20	No impact on risk rating
1215	If the Trust does not have sufficient capacity	<u>Controls</u>	20	No impact

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	(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.	• New theatre day case unit opened on 1st April 2024 in CSTM as part of the first phase of national TIF investment. <u>Assurances</u> • Improvement & Productivity Group established from May 2024 supported by the appointment of a Head of Improvement. This Group will oversee improvements in productivity and utilisation of current services i.e. Theatres and Out Patients.		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> • Appointed Head of Improvement • Capital Plans for 2024/25 approved by the Trust Board in March 2024. • Draft revenue plans 2024/25 approved by the Trust Board in March 2024 • In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • NHSE have approved (March 2024) Cash support c£7m & April £5.3m – Enhanced controls regarding pay and non-pay expenditure must be adhered to and are part of the controls outlined above. • Enhanced ECF meetings in place with Chief Executive sign off • High Level 5 year plan presented to the Finance & Sustainability Committee in April 2024 • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 <u>Assurances</u> • Subject to Audit 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 Capital Plan (subject to audit)	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• We have allocated CIP targets for 2024/25 • Working with the ICS on the 2024/25 Operational Plan • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements. • Draft 2023/24 Accounts submitted on time <u>Gaps</u> • Not all cost pressures have been funded in plan for 2024/25 • New 65 and 52 week target will require investment in insourcing during 2024/25 • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP		
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	<u>Assurance:</u> • On 5th April 2024 following weeks of voting the consultants committee accepted the latest Government offer on pay for consultants in England. 83% of eligible BMA consultant members voted 83% with a (62% turnout). The effective date for the new pay structure will be 1 March 2024. <u>Gaps in Assurances & Controls</u> Letter from GMB shared 26/03/24 re a pay claim to the secretary of state.	20	No impact on risk rating
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.	• Paediatric Ophthalmology removed from the Fragile Services Oversight Programme • Stoke Services added to the Fragile Services Oversight Programme	20	No impact on risk rating
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then	<u>Controls</u> • Weekly ERostering KPI sign off meetings in place.	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	this may impact the delivery of basic patient care.	• Local recruitment in place targeting ED and Endoscopy who have had recent investment / establishment increases. • Open advert for RN / HCSW recruitment • Quarterly recruitment events in place • Sickness absence being manged in line with Trust policy. <u>Assurances</u> • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 11.6 % in April 2024 • Overall CHPPD sustained improvement at national standard of 8.1 in April 2024 • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.9% in April 2024 • Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy • Cost avoidance of £1.8m from agency managed service contract started August 2022 • Reduction in agency spend of £508 k since April 2023. • Increased cohort of CSWDs for 2024 • The number of wards achieving 90% fill rate increased to 22 in April 2024 from 17 in December 2023 <u>Assurance Gaps</u> • Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – Beds were opened in escalation areas 187 times in April 2024 • 11% increase in red flags in April due to enhanced care demand / escalation- 90 red flags raised during April 2024 due to accelerated discharge process. • 99 Menal Health Carer shifts were requested in April 2024 – highlighting increasing numbers of mantal Health patients attending the Trust		
1114	If we see increasing demands upon current	<u>Controls</u>	16	No impact

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	• 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 Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. <u>Gaps in Controls</u> • Backup storage being end of life and out of support		on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	<u>Gaps in Assurance</u> • Further assurance required regarding state of readiness for implementation • Complexity of coterminus LIMS implementation presents an emerging risk which requires a mitigating plan	16	No impact on risk rating

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>Controls</u>
		
		• Estates strategy incorporating options and enablers for new hospitals plans complete.
		
		<u>Assurances</u>
		
		• 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
			16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
125	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	Assurances • Associate Director of Estates & Facilities and Director of Strategy & Partnerships represents the Trust on ICB Estates meetings from an operational and strategic perspective	15	No impact on risk rating
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.60% as at February 2024 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 isa slight month on month increase since the lowest sickness absence rate reported in December 2024 since April 2020. Target remains 4.2%. Assurances • 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 2.889% % in February 2024. **Turnover and Attraction** Turnover in February 2024 was below target at 11.57% and is showing an improving variation. Turnover of permanent staff in February 2024 was 10.78 % which was below Trust target. Target is 13%. Assurances • The responses to Exit Interviews are positive, only 10% 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. February 2024 staff in post is 4,216 FTE. • Staff completing apprenticeships is above target at 3.94%, target is 2.3%	20	Rating reduced to 12

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Temporary Staffing & Agency Spend Bank and Agency reliance in February 2024 was 15.30% . Target is 9%. Bank reliance continues to increase and is 12.10% in February 2024 as agency reliance continues to decrease to 4% in February 2024.		

5 RECOMMENDATIONS

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

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; 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
1757	Michelle Cloney/Paul Fitzsimmons	If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.	2	20 (L5xC4)	8 (L4xC2)	Cautious	Strategic People Committee
2001	Paul Fitzsimmons	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
115	Ali Kennah	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (L4xC4)	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
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Open	Strategic People Committee

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

Risk Appetite Statement

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

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

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

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

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

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

<u>Quality</u>

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

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

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

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

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

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

Board Assurance Framework

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

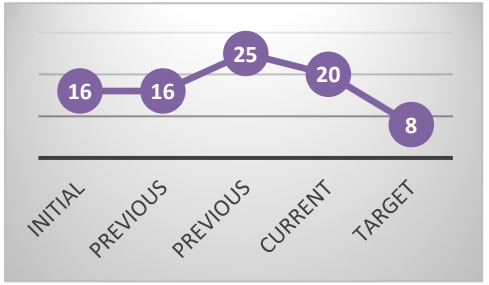
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 24.
- Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter
- Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E
- Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside
- 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



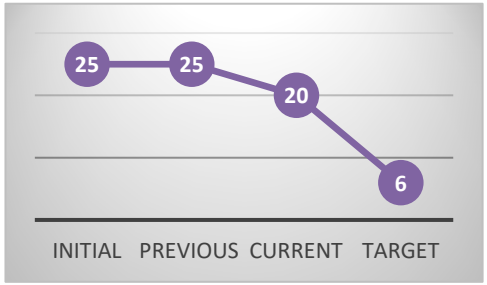
	• Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy. • Introduction of the new Manchester Triage Process that went live on 14th April 2024. The aim is to support reduced overcrowding in ED and improve clinical quality and patient experience • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) agreed to remain open throughout April 2024 to support flow; to be reviewed 10th May 2024. **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** • Ongoing industrial action across a number of staffing groups including junior medical staff.	

	Gaps in Assurances • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Bowman, Karen	31/03/2025 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Bowman, Karen	31/03/2025 (ongoing)	
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

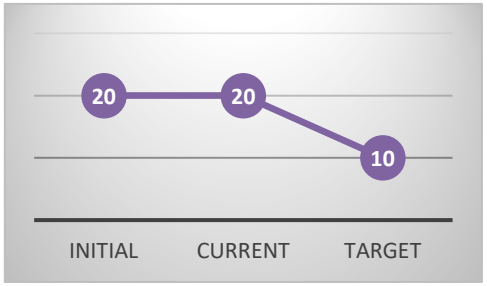
Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial:**	25 (L5xC5)
				Current:	20 (L4xC5)
				Target:	6 (L3xC2)
Risk Appetite	**Cautious** – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Controls** • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • 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 24. • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. • Waiting lists are reviewed through the Performance Review Group Weekly • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reservice programme of work. • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends. • Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients • Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae 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 • New theatre day case unit opened on 1st April 2024 in CSTM as part of the first phase of national TIF investment **Assurances** • All elective patients have been clinically reviewed and categorised in line with national guidance.				

	• New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Additional ultrasound contract awarded and commenced in January 2022 • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems. This is being progressed with the support of the estates and capital planning team. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • GIRFT/Efficiency programme to increase theatre productivity and utilisation • 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. • Improvement & Productivity Group established from May 2024 supported by the appointment of a Head of Improvement. This Group will oversee improvements in productivity and utilisation of current services i.e. Theatres and Out Patients.	
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	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	134	**Executive Lead:**	Hurst, Jane	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			**Initial:**	20 (L5xC4)
				Current:	20 (L5xC4)
				Target:	10 (L5xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Assurance Details:	**Controls** •Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning • Weekly CEO led improvement 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. • Appointed Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5 year plan presented to the Finance & Sustainability Committee in April 2024 • CDC phase 2 application approved for £4.5m capital over three years • Capital Plans for 2024/25 approved by the Trust Board in March 2024. • Draft revenue plans 2024/25 approved by the Trust Board in March 2024 • 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, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee • Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023 • Tightening controls of non-pay expenditure • 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 & Q1 – Enhanced controls regarding pay and non-pay expenditure must be adhered to and are part of the controls outlined above. • Enhanced ECF meetings in place with Chief Executive sign off • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 **Assurances**				

	• Achieved ICS control total in 2022/23 • Subject to Audit 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 Capital Plan (subject to audit) • Unqualified audit opinion (2022/23) • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge is to reduce agency to below the 3.2% ceiling and reduce bank. • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We have allocated CIP targets for 2024/25 • 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 2024/25 Operational Plan • 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. • Several drafts of the 2024/25 Operational Plan have been submitted with further iteration to be submitted to the ICS by end of May 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 • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements • Draft 2023/24 Accounts submitted on time	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP 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 / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • 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 2024/25 • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted	

	• New 65 and 52 week target will require investment in insourcing during 2024/25 • Further assurance required in relation to controls for pay and non-pay costs due to cash support position • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1757	**Executive Lead:**	Cloney, Michelle/Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future. Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.			**Initial:**	16 (L4 xC4)
				Current:	20 (L5 xC4)
				Target:	8 (L4 xC2)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				

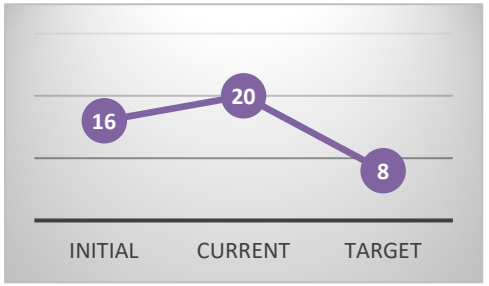
Control & Assurance Details:

Controls

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

Assurance

- Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
- AfC pay agreement implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24
- RCN ballot that closed on the 23/06/23 did not meet the mandate therefore no further planned RCN IA at present time. Society of Radiographers did not meet their mandate at WHH.
- 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.

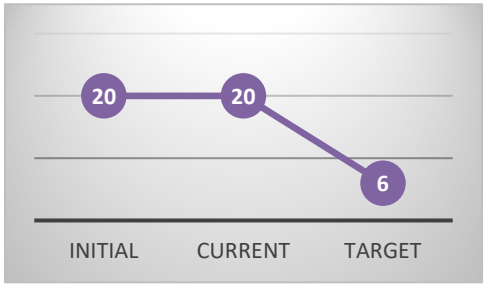


	• BMA SAS doctors mandate for industrial action on hold whilst a ballot is underway on a government pay offer dates of the ballot to be confirmed by the BMA. • On 5th April 2024 following weeks of voting the consultants committee accepted the latest Government offer on pay for consultants in England. 83% of eligible BMA consultant members voted 83% with a (62% turnout). The effective date for the new pay structure will be 1 March 2024.	
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. • Letter from GMB shared 26/03/24 re a pay claim to the secretary of state. No national update provided re this claim as of yet.	

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	
Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Laura Hilton	31/12/24	
Consistency panel meetings established to review and consider Band 2 HCA banding review claims.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Ali Kennah	31/12/24	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

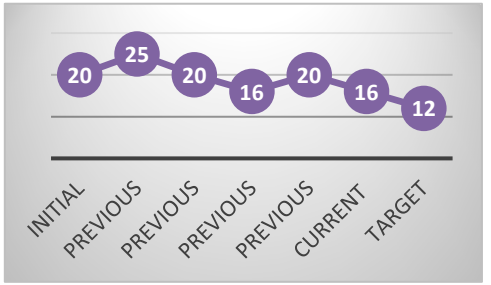
Risk ID:	2001	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust is unable to mitigate for the challenges faced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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial:** 20 (L5xC4) **Current:** 16 (L4xC4) **Target:** 12 (L4xC3)
Risk Appetite	**Minimal – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.**			



Assurance Details:

Controls

- 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG)
- Weekly ERostering KPI sign off meetings in place.
- Progress against recruitment to fill Trust vacancies monitored by Associate Chief nurses and Deputy Chief Nurse at WRG, areas of concern escalated to Chief Nurse, 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
- Local recruitment in place targeting ED and Endoscopy who have had recent investment / establishment increases.
- Open advert for RN / HCSW recruitment
- Quarterly recruitment events in place
- Sickness absence being manged in line with Trust policy.

Assurances

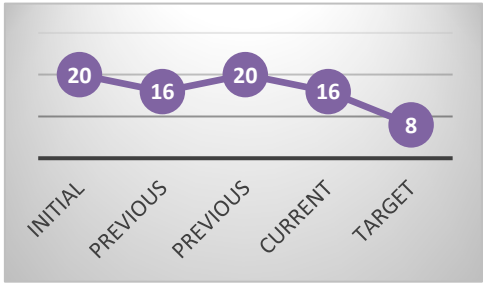
- Increase in registered nursing establishment in the Emergency Department, January 2024
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 11.6 % in April 2024
- Overall CHPPD sustained improvement at national standard of 8.1 in April 2024
- No requirement for staffing incentive scheme YTD
- Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.9% in April 2024
- Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy m
- Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme.
- Cost avoidance of £1.8m from agency managed service contract started August 2022
- Reduction in agency spend of £508 k since April 2023.
- International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus.
- Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead

	• Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly. • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift. • Rolling recruitment for RN and HCA posts, weekly interviews • Leaver data is closely monitored, and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner. • Retention – Internal Transfer process in place for staff • A7, A8 and A9 uplift in healthcare support workers for night shifts has been approved to support the provision of enhanced care. • Re-launch of what was the Safe Staffing Group, now the Nurse Staffing and Clinical Outcomes Group to provide a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk. • Increased cohort of CSWDs for 2024 • The number of wards achieving 90% fill rate increased to 22 in April 2024 from 17 in December 2023	
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – Beds were opened in escalation areas 187 times in April 2024 • Increased request to provide enhanced care. • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients. • Continued escalation of ward A10 and intermittent escalation of Cardiac Catheter lab • Partially funded revenue requests • Time to post when recruiting new staff. • 11% increase in red flags in April due to enhanced care demand / escalation- 90 red flags raised during April 2024 due to accelerated discharge process. • 99 Menal Health Carer shifts were requested in April 2024 – highlighting increasing numbers of mantal Health patients attending the Trust	

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			**Initial:**	20 (L5xC4)
				Current:	16 (L4xC4)
				Target:	8 (L2xC4)
Risk Appetite	**Minimal** – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Assurance:** • 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 including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • External NHS England approved Cyber Training for the Trust Exec Board • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • [DSPT Standard(s): 7.3.4] Secondary secure backup at Halton Data Centre • [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy				

	• 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 • Backup storage being end of life and out of support	

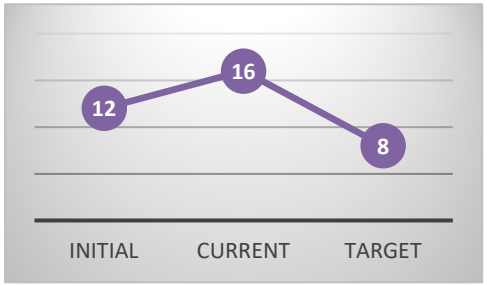
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for 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.	Contacted Director of Communications regarding the proposed date of the 30th May for turning off the servers. Communications are supportive of this. Waiting on Clinical Audit Manager on the confirmation of migration of their clinical documents.	Deacon, Stephen	31/05/2024	

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 May 2024 WHHMUSEV1 Third party are installing the software on the new server with completion for May 2024 WHHMUSEV2 Third party are installing the software on the new server with completion for May 2024 WHHLEV1 90% of the work has been done. Decommissioning of service will be completed in in Q4 once the remaining tasks have been completed. WHHCONWRXV1 Pathology working with Siemens with completion for April/May 24 WHHCONWRXV2 Pathology working with Siemens with completion for April/May 24	Waterfield, Tracie	31/05/2024	
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 has been signed off by the Deputy CIO. Once order complete the software can be rolled out to the desktops and laptops, it estimated to take a few weeks after scoping the connected devices.	Waterfield, Tracie	31/05/2024	
Seek funding for Cynerio Medical Devices Module	Seek funding for Cynerio Medical Devices Module	Funding being provided at ICB level. Waiting delivery of the collector devices to be installed to gather the information from our network and the training from Cynerio	Deacon, Stephen	30/06/2024	

Backup storage being end of life and out of support	To purchase and replace the old backup storage	To purchase and replace the old backup storage	Waterfield, Tracie	31/05/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

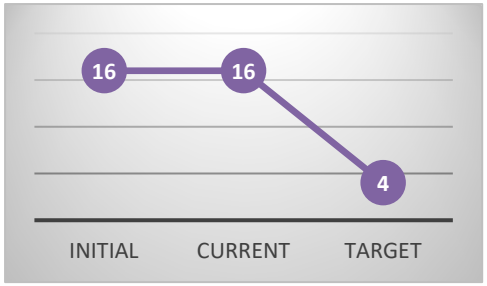
Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then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

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

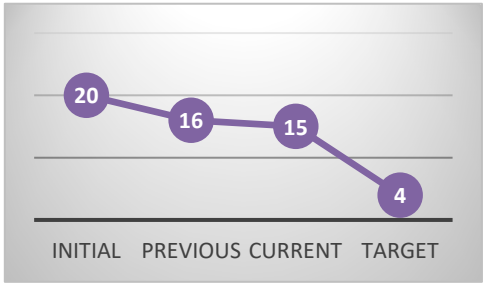
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have 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

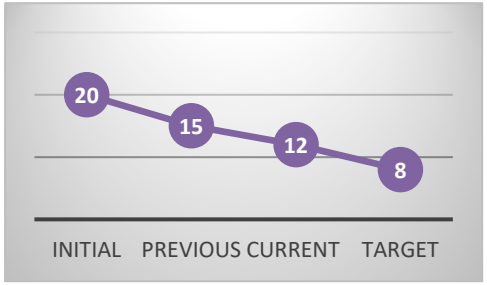
Risk ID:	125	**Executive Lead:**	Moore, Dan	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the hospital estate is not sufficiently funded to enable appropriate 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. Associate Director of Estates & Facilities and Director of Strategy & Partnerships represents the Trust on ICB Estates meetings from an operational and strategic perspective				
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	

Risk ID:	145	**Executive Lead:**	Constable, Simon
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.		
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.		

Rating	
Initial	20 (L5xC4)
Current	12 (L3xC4)
Target	8 (L4xC2)



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	

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 5.60% as at February 2024 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 isa slight month on month increase since the lowest sickness absence rate reported in December 2024 since April 2020. Target remains 4.2%.

Controls

•New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023.

•Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers.

•Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported.

•Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management.

•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.

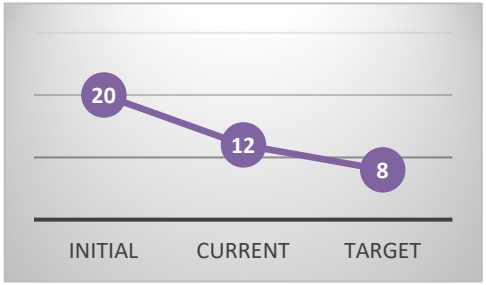
•The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.889% % in February 2024.

• 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 February 2024 was below target at 11.57% and is showing an improving variation. Turnover of permanent staff in February 2024 was 10.78 % 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 10% 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. February 2024 staff in post is 4,216 FTE. •Staff completing apprenticeships is above target at 3.94%, target is 2.3% **Temporary Staffing and Agency spend** Bank and Agency reliance in February 2024 was 15.30% . Target is 9%. Bank reliance continues to increase and is 12.10% in February 2024 as agency reliance continues to decrease to 4% in February 2024. **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	Laura Hilton	31.03.2025	

		• Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff			
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	30.04.2024	
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	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/06/035**			
SUBJECT:	**Integrated Performance Report**			
DATE OF MEETING:	5 June 2024			
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#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:			
		Yes	**No**	***N/A***

	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	**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 **7 indicators that are both failing and have special cause variation of a concerning nature**, these are: **Quality:** • *7. Healthcare Acquired Infections (Klebsiella)* • *10. VTE Assessment* • *22. Mixed Sex Accommodation Breaches (Non ITU Only)** • *25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis* **Access and Performance:** • *34. RTT - Number of patients waiting 65+ weeks* • *61. Uncapped Theatre Utilisation* **Finance:** • *74. Cost Improvement Programme (recurrent forecast) – In year performance to date* The below indicators now have normal variation, so have been removed from the top category since the Month 11 IPR: • *5. Healthcare Acquired Infections (CDI)* • *6. Healthcare Acquired Infections (Ecoli)* • *23. Sepsis - % screening for all emergency patients* • *35. Referral to treatment Open Pathways* • *37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge* At Month 1 the plan is a £3.7m deficit, however, the actual deficit was £4.2m with the overspend being due in the main to enhanced care and escalation, Urgent Treatment Centre opening hours and Nursing costs due to acuity and activity delivered under plan.

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

RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support of up to £10.373m from NHSE for Q2 2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 3. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	FSC/24/05/32; FSC/24/05/41
	Date of meeting	22/05/2024
	Summary of Outcome	Cash support application supported for approval at Trust Board. 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/24/06/035

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** 7. Healthcare Acquired Infections (Klebsiella) **(6 YTD – *2 YTD threshold*)** ⬇ 10. VTE Assessment **(93.31% - *95% target*)** 22. Mixed Sex Accommodation Breaches (Non ITU Only)* **(17 - *0 target*)** 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis **(64% - *90% target*)** **A&P** 34. RTT - Number of patients waiting 52+ weeks **(1521 - 0 *target*)** 61. Uncapped Theatre Utilisation **(73.4% - *80% target*)** **Finance** 74. Cost Improvement Programme (recurrent forecast) – In year performance to date **(£0.06m – *£0.65m target*)** ⬇	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) ⬆ 13. Medication Safety - Reconciliation within 24 hours 23. Sepsis - % screening for all emergency patients ⬆ 24. Sepsis - % screening for all inpatients 27. Ward Moves between 10pm and 6am * 31. MUST nutritional assessment completion **A&P** 33. Referral to treatment Open Pathways ⬆ 35. A&E Wait Times - % patients waiting under 4 hours 36. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 41. Ambulance Handovers within 15 minutes 42. Ambulance Handovers within 30 minutes 43. Ambulance Handovers within 60 minutes 44. Discharge Summaries - % sent within 24hrs 45. Discharge Summaries - Number NOT sent in 7 days 62. Capped Theatre Utilisation **Finance** 72. Better Payment Practice Code	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 21. Friends and Family (ED and UCC) 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis **A&P** 32. Diagnostic Waiting Times 6 Weeks **Workforce** 63. Supporting Attendance 66. Bank and Agency Reliance ⬆ 68. PDR	**CONSISTENTLY FAILING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **Quality** 12. Pressure Ulcers	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 6. Healthcare Acquired Infections (Ecoli) ⬆ 8. Healthcare Acquired Infections (PA) 28. Acute Kidney Injury 29. Maternity Postpartum Haemorrhage **A&P** 47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation **Finance** 73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m) ⬇	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 11. Inpatient Falls & harm levels 15. Staffing Care Hours per patient day (CHPPD) **A&P** 55. Elective Outpatient Activity 56. Patients seen in the Fracture Clinic within 72 hours **Finance** 71. Capital Programme	**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) **A&P** 46. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 48. Urgent Operations Cancelled for 2nd Time	**Quality** 3.Healthcare Acquired Infections (MRSA) 14. Staffing - Average Fill Rate 18. NICE Compliance **A&P** 38. 28 Day Faster Cancer Diagnosis Standard ⬆ **Workforce** 64. Retention 65. Turnover 67. Core/Mandatory Training **Finance** 75. Agency Ceiling	
	NO ASSURANCE SPC & DECLINING PERFORMANCE	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**
No SPC/Not Enough Datapoints/Not Applicable		**Quality** 3. Healthcare Acquired Infections (MSSA) 30. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 37. Average time in department ED 49. Super Stranded Patients 50. No Criteria to Reside (NCTR) 57. Type 5 attendances 58. Reduction in Outpatient Follow Ups 59. % Patients discharged to their usual place of residence	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 16. Mortality ratio – HSMR 17. Mortality ratio - SHMI ⬆	**A&P** 39. Cancer 31 Days First Treatment 40. Cancer 62 Days First Treatment 51. Elective Recovery Activity (Grouped SPCs) 52. Elective Recovery Diagnostic Activity 56. % patients referred to long COVID service not assessed within 15 weeks 60. Virtual Appointments **Finance** 69. Trust Financial Position (£m) 70. Cash Balance (£m)

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

Areas exceeding the target and continuously maintaining/improving performance

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

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

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 April 2024 is attached in **Appendix 5**.

Cheshire & Merseyside ICS has set the Trust a control total of £30.8m deficit (excluding share of £5m integration stretch target). There are several risks to the achievement of the planned £30.8m deficit. The key risks are as follows:

- CIP delivery.
- Cost pressures – there was an overspend of £0.7m in month 1. If cost pressures continue to overspend at the same rate, then the Trust will have an overspend of circa £8m. An enhanced monitoring process will be in place from M2.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), activity delivered is under plan resulting in loss of income.
- 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 April is £11.7m. Given the current cash position and the planned deficit for 2024/25 the Trust is in receipt of cash support. A request for £4.508m has been submitted for June 2024. FSC discussed and supported the Q2 application for cash support from NHSE. The Trust Board is asked to approve up to £10.373m cash support for Q2. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

CIP

At 30 April 2024, the Trust has delivered a CIP of £0.6m against a target of £0.6m however it should be noted that this delivery has been mainly achieved from non-recurrent central items. The full year CIP target is £19.4m of which £9.6m has been identified (49%). The current level of identified recurrent CIP is £7.2m. There is a significant risk to the Trust if it cannot deliver recurrent CIP in 2024/25 therefore further work is required to identify recurrent CIP.

Capital Programme

The Trust total capital funding consists of £7.63m CDEL and £15.49m external funding, a total of £23.12m. The Trust also has £1.84m IFRS16 CDEL.

The Trust capital spend for month 1 is £0.58m which is £0.03m over the Trust plan of £0.55m.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 1		**546**
Proposed changes in month		
VAT rebate		**16**
Requests supported at CPG 10/05/2024		
Overspend in CDC in 2023/24 to offset underspend in TIF/Endo	743	
Underspend in TIF / Endo in 2023/24 to be funded by CDC	- 575	
Mitigate remaining oversubscription	- 300	
Replacement Cell Washer - Halton Transfusion Laboratory	- 8	
Induction of Labour	- 153	
Sub Total		**- 293**
Contingency as at end of month 1		**269**

The Trust Board is asked to:

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve cash support of up to £10.373m from NHSE for Q2
2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
3. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	QUALITY	Plan/Target	Actual	Period	Variation	Actual	Period	
1	Incidents	0	0	Apr-24		0	Mar-24	P
2	Duty of Candour (serious incidents)	100.00%	100.00%	Apr-24		100.00%	Mar-24	P
3	Healthcare Acquired Infections (MRSA)	0	0	Apr-24	L	0	Mar-24	P
4	Healthcare Acquired Infections (MSSA)	No threshold set	5	Apr-24		1	Mar-24	No SPC
5	Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	11	Apr-24		6	Mar-24	F
6	Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	9	Apr-24		6	Mar-24	?
7	Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	6	Apr-24	H	3	Mar-24	F
8	Healthcare Acquired Infections (PA)	Less than 2 - annual	0	Apr-24		1	Mar-24	?
9	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	1	Apr-24	L	0	Mar-24	No SPC
10	VTE Assessment	95.00% (quarterly position)	93.31%	Apr-24	L	94.35%	Mar-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	Inpatient Falls & harm levels	20% or more decrease from previous year	29	Apr-24		33	Mar-24	
12	Pressure Ulcers	10% reduction	14	Apr-24		18	Mar-24	
13	Medication Safety Reconciliation within 24 hours	80.00%	43.00%	Apr-24		40.00%	Mar-24	
14	Staffing - Average Fill Rate	90.00%	97.77%	Apr-24		90.43%	Mar-24	
15	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	8.1	Apr-24		7.7	Mar-24	
16	Mortality ratio - HSMR	No target set	86.31	Apr-24		86.59	Mar-24	No SPC
17	Mortality ratio - SHMI	No target set	92.53	Apr-24		92.22	Mar-24	No SPC
18	NICE Compliance	90.00%	92.63%	Apr-24		92.55%	Mar-24	
19	Complaints	Zero complaints open over 6 months old/in the backlog	0	Apr-24		0	Mar-24	
20	Friends and Family (Inpatients & Day cases)	95.00%	97.00%	Apr-24		98.00%	Mar-24	
21	Friends and Family (ED and UCC)	87.00%	77.00%	Apr-24		75.00%	Mar-24	

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

22	Mixed Sex Accommodation Breaches (ITU Only)	0	17	Apr-24	H	7	Mar-24	F
23	Sepsis - % screening for all emergency patients.	90.00%	78.00%	Apr-24		62.00%	Mar-24	F
24	Sepsis - % screening for all inpatients	90.00%	72.00%	Apr-24		60.00%	Mar-24	F
25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	64.00%	Apr-24	L	66.00%	Mar-24	F
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	84.00%	Apr-24	H	75.00%	Mar-24	F
27	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	8	Apr-24		8	Mar-24	F
28	Acute Kidney Injury	Less than previous month	154	Apr-24		194	Mar-24	?
29	Maternity Postpartum Haemorrhage	3.70%	4.30%	Apr-24		3.40%	Mar-24	?
30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	27%	Apr-24		17%	Mar-24	No SPC
31	MUST nutritional assessment completion	above > 85%	57.43%	Apr-24		52%	Mar-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

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
32	Diagnostic Waiting Times 6 Weeks	95.00%	89.17%	Apr-24	H	89.57%	Mar-24	F
33	Referral to treatment Open Pathways	92.00%	57.60%	Apr-24		56.78%	Mar-24	F
34	RTT - Number of patients waiting 52+ weeks	0	2287	Apr-24	H	2508	Mar-24	F
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	66.56%	Apr-24		64%	Mar-24	F
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	19.46%	Apr-24		19.5%	Mar-24	F
37	Average time in department ED	No Target	377	Apr-24		404	Mar-24	No SPC
38	28 Day Faster Cancer Diagnosis Standard	75%	78.10%	Mar-24	H	79.37%	Feb-24	P
39	Cancer 31 Day Wait	96%	98.70%	Mar-24	No SPC	97.62%	Feb-24	No SPC
40	Cancer 62 Day Wait	85%	83.97%	Mar-24	No SPC	77.36%	Feb-24	No SPC
41	Ambulance Handovers within 15 minutes	65%	31.44%	Apr-24		32.35%	Mar-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

42	Ambulance Handovers within 30 minutes	95%	68.75%	Apr-24		63.68%	Mar-24	F
43	Ambulance Handovers within 60 minutes	100%	85.71%	Apr-24		80.58%	Mar-24	F
44	Discharge Summaries - % sent within 24hrs	95%	90.78%	Apr-24		88.21%	Mar-24	F
45	Discharge Summaries - Number NOT sent within 7 days	0	0	Apr-24		1	Mar-24	F
46	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.15%	Apr-24		0.02%	Mar-24	P
47	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	0	Apr-24		0	Mar-24	?
48	Urgent Operations Cancelled for 2nd Time	0	0	Apr-24		0	Mar-24	P
49	Super Stranded Patients	Trajectory	108	Apr-24		143	Mar-24	No SPC
50	No Criteria to Reside (NCTR)	No Target set	176	Apr-24		168	Mar-24	No SPC
51	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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52	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
53	Elective Outpatient Activity	106%	86%	Apr-24	H	100%	Mar-24	?
55	Patients seen in the Fracture Clinic within 72 hours	95%	100.00%	Dec-23	H	99%	Nov-23	?
56	% patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Apr-24	No SPC	0	Mar-24	No SPC
57	Type 5 attendances	No Target set	2035	Apr-24		2055	Mar-24	No SPC
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	86%	Apr-24		100%	Mar-24	No SPC
59	% Patients discharged to their usual place of residence	No Current Threshold	95%	Apr-24		96%	Mar-24	No SPC
60	Virtual Appointments	No Target set	13%	Apr-24	No SPC	13%	Mar-24	No SPC
61	Uncapped Theatre Utilisation	85%	73.40%	Apr-24	L	71%	Mar-24	F
62	Capped Theatre Utilisation	85%	68.80%	Apr-24		67%	Mar-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
63	Supporting Attendance	4.20%	5.61%	Apr-24	L	5.61%	Mar-24	F
64	Retention	86.00%	87.10%	Apr-24	H	87.52%	Mar-24	P
65	Turnover	Below 13%	12%	Apr-24	L	12%	Mar-24	P
66	Bank and Agency Reliance	9% or Below	15.01%	Apr-24	L	15.35%	Mar-24	F
67	Core/Mandatory Training	85.00%	89.90%	Apr-24	H	90.41%	Mar-24	P
68	PDR	85.00%	74.23%	Apr-24	H	74.07%	Mar-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
69	Trust Financial Position (£m)	-£3.66	-£4.16	Apr-24	No SPC	-5.68	Mar-24	No SPC
70	Cash Balance (£m)	£9.70	£11.69	Apr-24	No SPC	17.63	Mar-24	No SPC
71	Capital Programme (£m)	£0.58	£0.58	Apr-24	H	£29.14	Mar-24	?
72	Better Payment Practice Code	95%	94%	Apr-24		91%	Mar-24	F
73	Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£0.65	£0.65	Apr-24		15.97	Mar-24	?
74	Cost Improvement Programme (recurrent) – In year performance to date (£m)	£0.65	£0.06	Apr-24	L	17.90	Mar-24	F
75	Agency Ceiling	Less than 3.7%	1.2%	Apr-24	L	2%	Mar-24	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Appendix 2

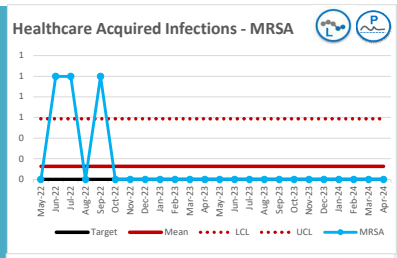
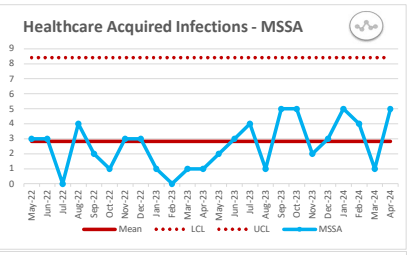
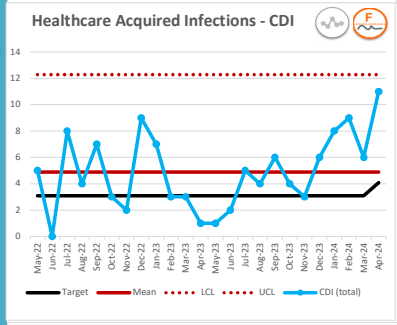
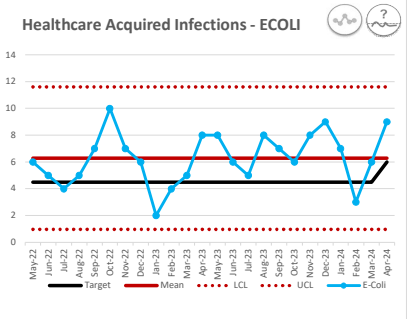
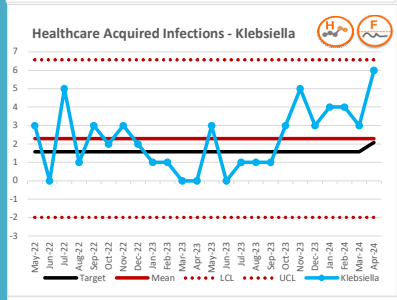
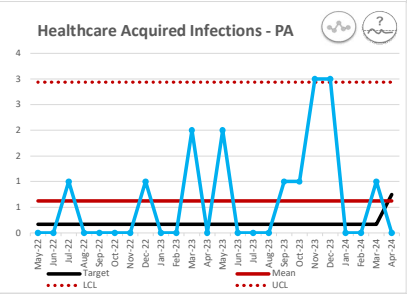
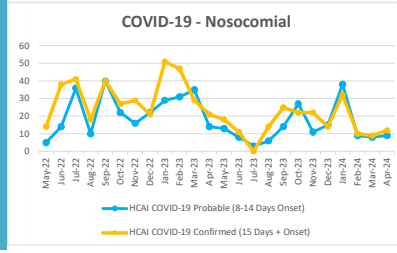
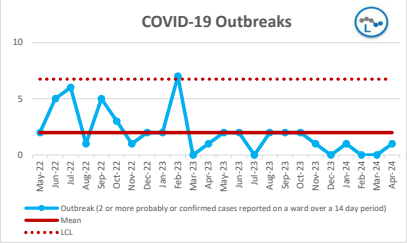
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	Open Incidents - 40 Days; Total Incidents Reported; Total PSIIs recorded in month; PSII Actions Breached; Never Events; Prevention of future death orders	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There has been a slight increase in the number of Incidents reported in April 2024. This reflects a positive reporting culture. The number of open incidents is within normal control limits. There are no overdue 40-day incidents at the time of reporting. There were three PSIIs reported in April 2024, two of which were declared as Never Events. There have been no breached patient safety incident investigation(PSIRF) actions since the launch of PSIRF in September 2023.	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 where required. Serious Incidents / PSII's Weekly monitoring continues with appropriate escalation to the CBU leads. The Trust moved to PSIRF on the 1 September 2023 compliance with closing PSIRF actions is monitored weekly at the Executive led Safety Oversight Meeting. Action plans have been developed following the two Never Events and the Theatre Service has now been declared a Fragile Service will be required to provide High Level Briefing Papers to Patient Safety and Clinical Effectiveness Group to enable greater oversight of risks, actions and progress.
There were 0 incidents over 40 days old.				
2. Duty of Candour (serious incidents)	Duty of Candour (DoC) - Moderate Incidents; Duty of Candour (DoC) - Serious Incidents	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There is no variance, the Trust remains 100% compliant.	Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.
The Trust achieved 100% for Duty of Candour in month.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Appendix 2

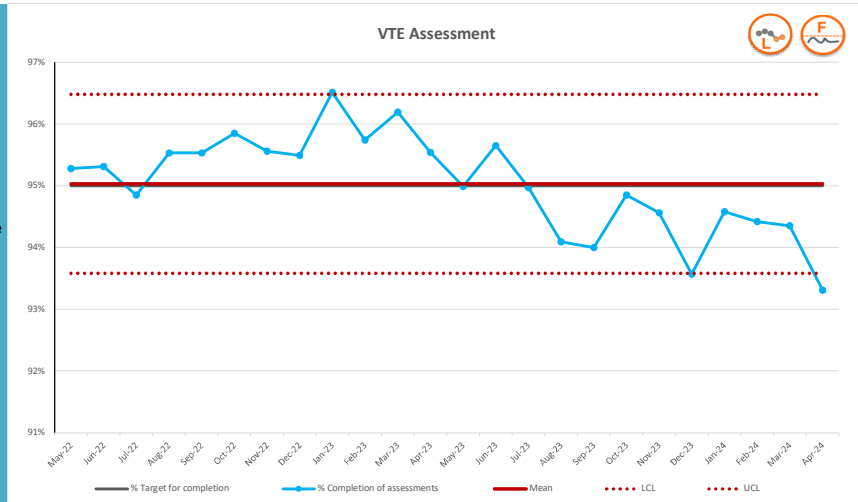
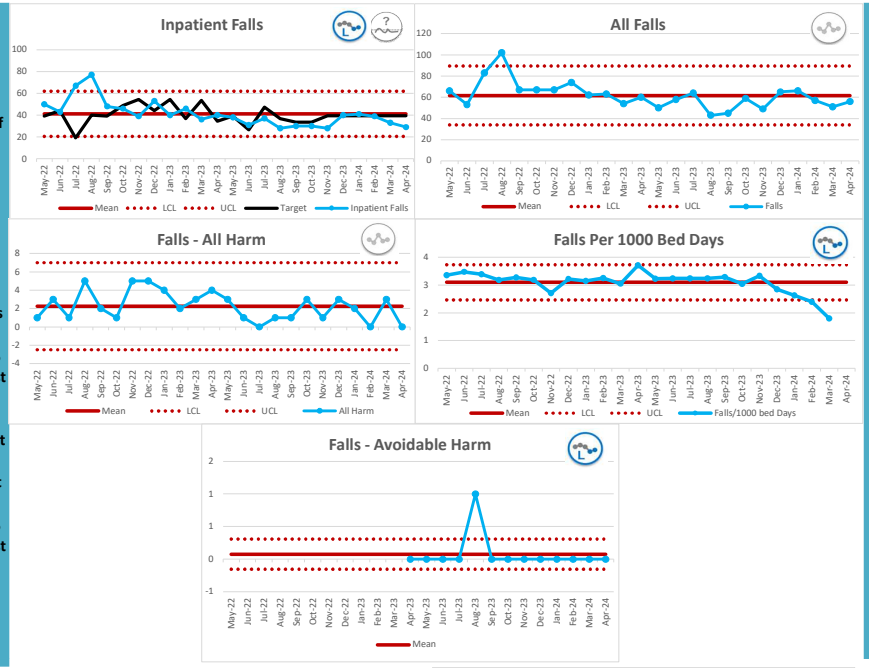
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO	Local thresholds have been set for 2024/25, based on a 10% reduction from 2023/24 MRSA cases YTD - annual threshold exceeded by 0 MSSA 5 cases YTD - no threshold set CDI 11 cases YTD - annual threshold exceeded by 0 E. coli 9 cases YTD - annual threshold exceeded by 0 Klebsiella spp. 6 cases YTD - annual threshold exceeded by 0 P. aeruginosa 0 cases YTD - annual threshold exceeded by 0		(MRSA) Assurance: The Trust consistently passes the target. (MRSA) Special cause variation of an improving nature.	MRSA: Nil returns for Apr 24: Rolling 19 months free MSSA:WHH saw a higher number of Trust apportioned cases in Apr (5) this is in normal control limits. CDI: A rise has been seen with 11 Trust apportioned cases in April. ECOLI: 6 Trust apportioned cases in Mar; 81 cases YTD: Mainly UTI associated cases, followed by hepatobiliary. FY threshed breached by 27 cases against annual threshold of 54 cases Klebsiella: 6 Trust apportioned cases in Apr. This is an increase of 3 cases from March. Pseudomonas aeruginosa: 0 Trust apportioned case in Apr.	CDI: CDI prevention action plan in place and a Brilliant Basics campaign is being launched in June. MDT review meetings are aligned to PSIRF, SIGHT mnemonic education will continue. The Infection Control Team are attending wards offering support and monitoring practices to ensure good IPC practices are maintained. ECOLI: Klebsiella: Pseudomonas aeruginosa: Audit of hepatobiliary cases has commenced. Hospital onset GNBSI investigations are being aligned to PSIRF approach. The protocol for urinary catheter use and protocol for nurse led removal is under review. Additional support is being provided on wards with higher UTI cases. The GNBSI Prevention Group has been reconvened and Lead Nurses engaged to drive prevention activity. Audit of P. aeruginosa cases has commenced. HCAI Thresholds are under review and not yet published. IPC Patient safety investigation templates are being aligned with PSIRF.
4. Healthcare Acquired Infections (MSSA) Target: Less than 32 - annual					
5. Healthcare Acquired Infections (CDI) Target: Less than 49 - annual			(CDI) Assurance: The Trust consistently fails the target. (CDI) Variation: Common Cause (Normal) variation.		
6. Healthcare Acquired Infections (Ecoli) Target: less than 72 - annual			(ECOLI) Assurance: The Trust inconsistently passes/fails the target. (ECOLI) Variation: Variation: Common Cause (Normal) variation.		
7. Healthcare Acquired Infections (Klebsiella) Target: Less than 25 - annual			(K) Assurance: The Trust consistently fails the target (K) Variation: Special cause variation of a concerning nature.		
8. Healthcare Acquired Infections (PA) Target: Less than 9 - annual			(PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Common Cause (Normal) variation.		
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)	1 in month COVID-19 outbreak. Covid-19: 9 day 8-14 cases probable healthcare associated cases YTD 12 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

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

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment **Target: 95% (quarterly position)**	SOF S **The Trust did not achieve the required target at 93.31% for VTE assessments in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of a concerning nature**	**End of the financial year performance was slightly below the required mandatory target at 94.65%.** **April 2024 performance was 93.24 % which is below the lower contol limit of 93.31%.** **EAU ward area in Urgent Care setting has been included since November 2023 which has impacted overall compliance with end of the year compliance of completed VTE RA at 88.33% (within 14 hours compliance data at 69.43%).**	**1. A GIRFT In-patient Ward productivity dashboard has been developed by WHH that includes daily ward level VTE risk assessment this is shared to raise awareness and improve overall compliance.** **2. Localised work ongoing with Clinical Business Units at ward level to improve overall performance to meet target threshold >95%.** **3. SPC chart of VTE risk assessments shared at care group/CBU/ward is in development by the Data Analytics Team to drive performance.** **A deep dive undertaken in May to understand challenges to completion which will inform Quality Improvement initiatives to improve compliance.**
11. Inpatient Falls & harm levels **Target: 20% or more decrease from 22/23 (610 Inpatient Falls in 2022/23)**	CQC S **56 total falls were reported in month. 29 of these were inpatient falls.** **There were 0 fall(s) in month with harm.** **There were 758 total falls in 2022/23. There have been 667 total falls YTD in 2023/24.** **We are expecting a 19% decrease in falls from last year.** **There were 545 inpatient falls in 2022/23. There have been 415 inpatient falls YTD in 2023/24.** **We are expecting a 30% decrease in falls from last year.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**WHH continues to see high volumes of frail and elderly patients who are high risk of falls.** **Despite this WHH continues to see sustained improvement with falls prevention.**	**Results from the Trust wide falls audit completed during February have been shared at Operational Patient Safety Group and the Ward Managers Meeting during April. The Patient Safety Improvement Nurse (PSIN) commenced a thematic review in April to look at all falls with harm, so learning can be shared. Weekly themes from the Harm Free Care Meeting continue to be shared to all Ward Managers and link nurses. The presentation regarding recording lying and standing blood pressures produced in March has been received positively by front line staff.**

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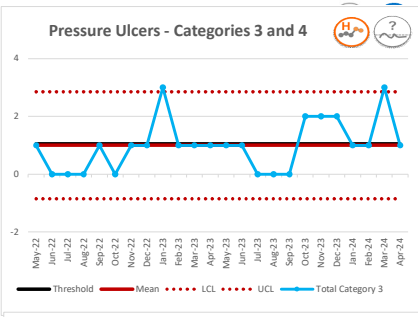
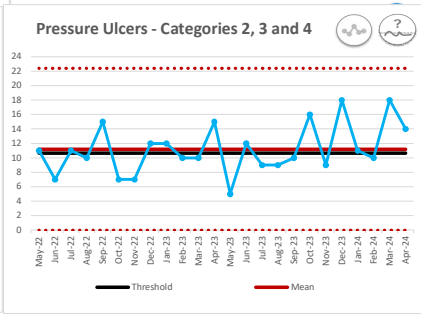
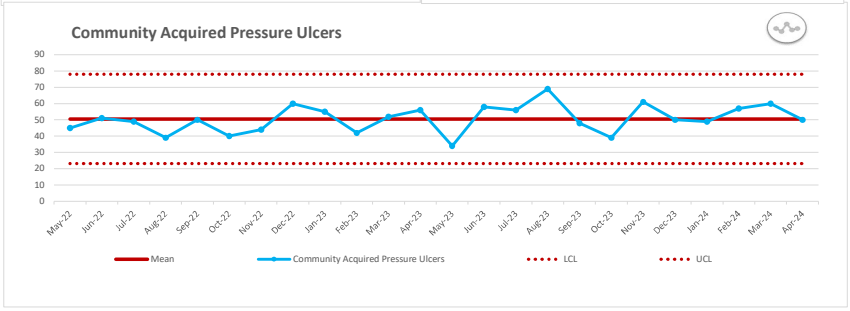
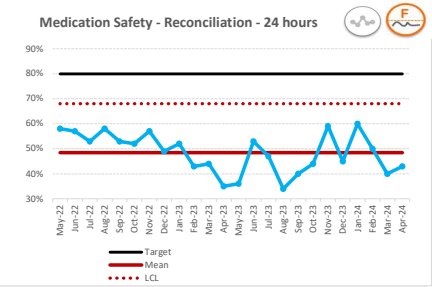
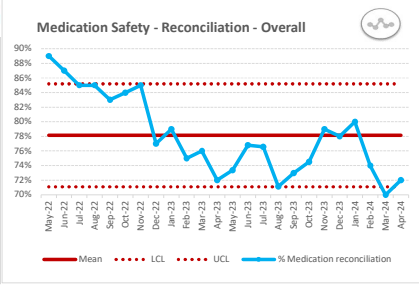
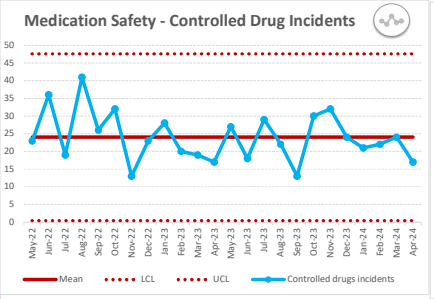
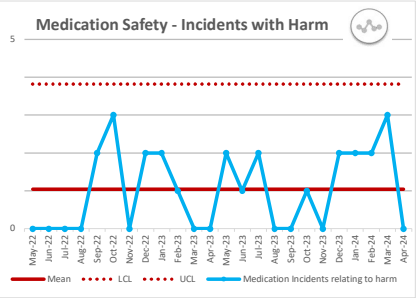
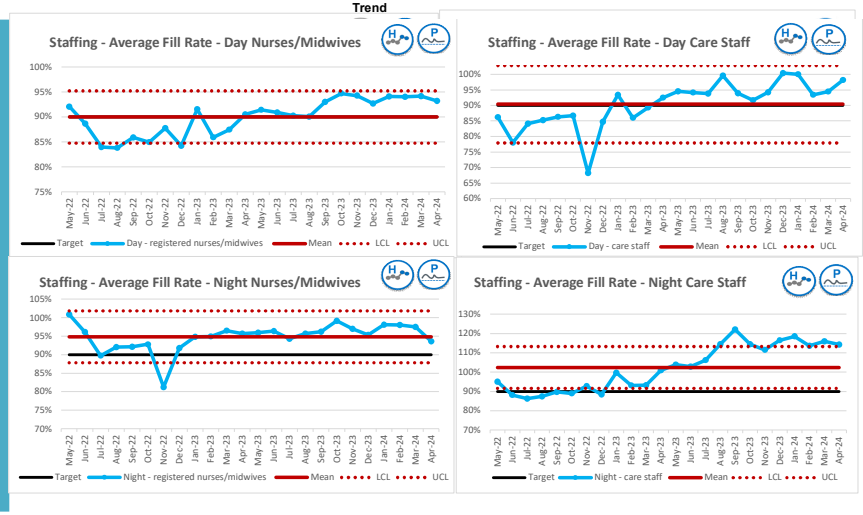
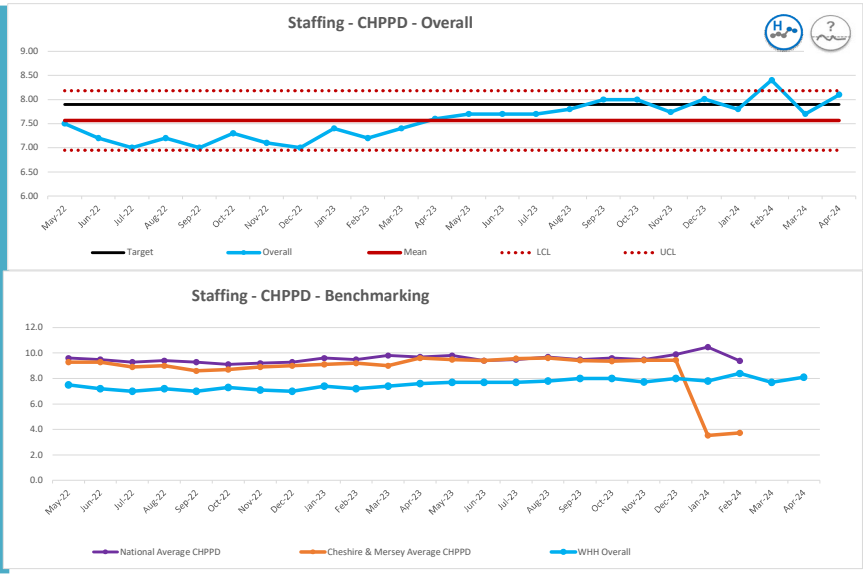
Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Pressure Ulcers (Category 2 and above) **Target: 10% reduction based on 91 in 2021/22** **There were 13 hospital acquired category 2 pressure ulcers, 1 Category 3 pressure ulcers and 0 Category 4 ulcers in month.** **There were 50 community aquired pressure ulcers in month.**	  	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**A reduction in all pressure ulcers has been seen in April following increased focus on prevention.** **A number of areas have been highlighted that contribute to the development of pressure ulcers including mattress provision, use of medical devices, and documentation.** **The Trust continues to report large numbers of patients admitted with pressure ulcers from the community. (April – 50) .**	**Actions to improve the position include:** **The First Pressure Ulcer Task and Finish Group was held in May 2024. A themed analysis was reviewed identifying a number of areas of focus.** **Following the meeting a 12 month work plan has been produced that will focus on pressure ulcer prevention and Tissue Viability Care.** **Priority Actions for the next month include.** **•Mapping of community pressure ulcers to inform system wide pressure ulcer prevention.** **•Relaunch of SSKIN bundle across all areas.** **•Test of change on Respiratory ward and ITU regarding device related pressure ulcers** **•Review of TED stockings** **•Explore documentation challenges.** **•Review availability of Repose wedges across the Trust** **•Review ED trolley matrasses exploring alternative options.** **•Development of Education in Practice Programme**
13. Medication Safety **Reconciliation within 24 hours Target: 80%** **Medicines reconciliation was completed within 24 hours of admission for 43% of patients. 72% of patients had MR completed during inpatient stay.** **There were 17 controlled drug incidents.** **There was 0 medication harm incident reported in month.**	   	**Assurance: The Trust consistently fails the target.** **Variation: Variation: Common Cause (Normal) variation.**	**Medicines Reconciliation: Deterioration in performance linked to ongoing vacancy factor in pharmacy establishment.** **This leads to some wards/areas having reduced/no pharmacy cover.** **Controlled drug incidents: there is no target for this metric. There were 17 controlled drug incidents in April 2024, with administration errors (n=5) being the most common incident type, followed by prescribing (n=3) and dispensing (n=3). No new themes were identified.** **Incidents causing harm: there is no target for this metric, and no incidents causing moderate harm or above were reported in April 2024.**	**Actions to improve performance against the medicine's reconciliation target:** **1.Deliver actions agreed in Pharmacy Recruitment Plan – 12 additional Pharmacists due to start between April and November 2024, which will significantly reduce vacancy rate.** **2.Identify and recruit additional locums to support Pharmacy staffing – 2 additional locum Pharmacists starting April/May 2024.** **3.Advertisement of all additional vacancies (band 8a) ongoing.** **A medicines deep dive has been undertaken in April reviewing incidents. Key themes have been identified. Actions to reduce medication incidents are reported through the Pharmacy governance structure and to Quality Assurance Committee.**

Quality Improvement - Trust Position

Appendix 2

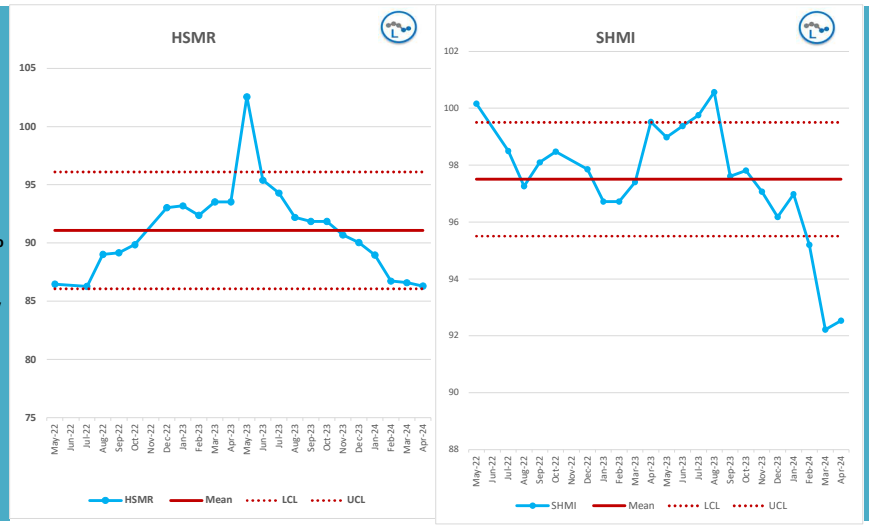
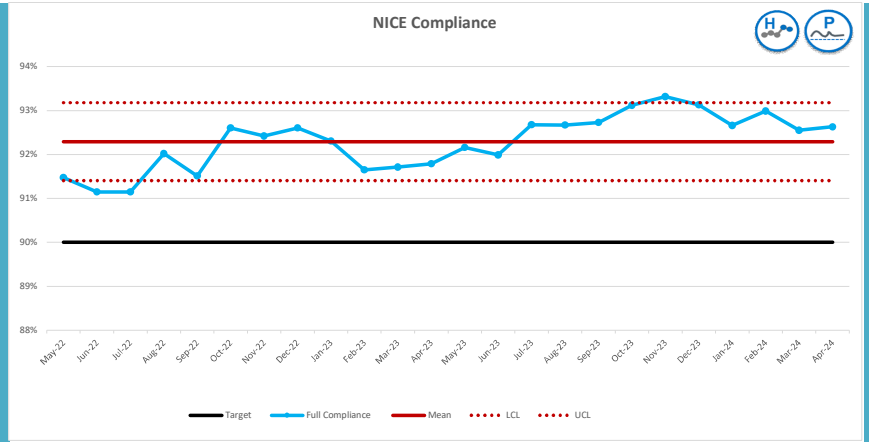
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate **Target: 90%** In month, the average staffing fill rates were: Day (Nurses/Midwife) 93.22% Day (Care Staff) 98.24% Night (Nurses/Midwife) 93.62% Night (Care Staff) 114.23% RR115 RR110F		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	A slight reduction in fill rate for registered nurses has been noted in April to 95%. Registered nurse vacancy in April was reported at 88.7 wte , this is partially influenced by the increase in establishments in the Emergency Department and Endoscopy There are 66 WTE Health Care Support Worker (HCSW) vacancies reported for April.	Twice daily Safe Staffing Meetings are in place to ensure staffing is reviewed and staff are allocated across the Trust in line with patient needs. All wards are overseen by a matron and lead nurse. There are 45.0 WTE registered nurses who are progressing through recruitment processes. Further recruitment events are planned throughout the year. The frequency will be adjusted in line with the determined vacancy. Specialist targeted recruitment is also ongoing to reduce the Emergency Department vacancies. 19 HCSW's have been appointed; these are being progressed through recruitment processes. Further interviews are planned for 17 May 2024. The Care Support Worker Development programme has been increased to an intake of 36-45 members per year to support a reduction in HCSW vacancies.
15. Staffing - Care Hours Per Patient Day (CHPPD) **Target: 7.9 CHPPD** In month, the average CHPPD were: Nurse/Midwife: 4.5 hours Care Staff: 3.6 hours Overall: 8.1 hours		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The CHPPD April is 8.1 which is over the national target of 7.9. A small reduction has been seen in sickness and turnover for HCSW's which has positively impacted fill rates, particularly for day shifts.	Staffing is reviewed at the twice daily Staffing Meeting by the Senior Nursing Team to ensure wards are staffed safely. Staff are moved to accommodate nursing gaps and support increased patient acuity. There are clear escalation processes in place to ensure wards are suitably staffed. Recruitment events are planned throughout the year for both registered nurse and health care support worker vacancies.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

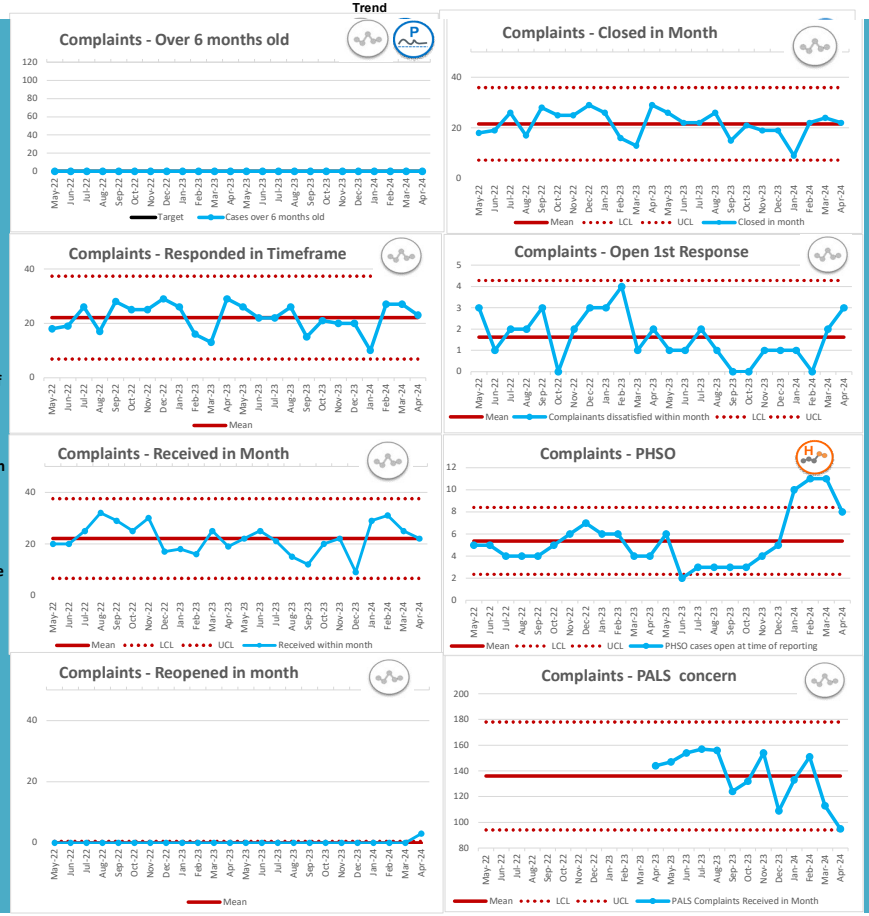
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Mortality ratio - HSMR **Target: Plan** **17. Mortality ratio - SHMI** **Target: Plan** **SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 86.31. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 92.53.**	 	**(HSMR) Assurance: NA - no target** **Variation: Special Cause Variation of an improving nature.** **(SHMI) Assurance: NA - no target** **Variation: Special Cause Variation of an improving nature.**	**HSMR and SHMI figures are reducing , with SNMI falling below the lower control limits which is a positive indicator. Note -NHS Digital have made some changes to the definition of SHMI due for publication May 2024.Any changes relevant to Warrington will be monitored and featured in future reports where appropriate. Key changes are:** **a) Reintroduction of COVID activity from September 2021 onwards** **b) Removal of activity from sites with 'hospice' in their title for trust level SHMI figures** **c) SHMI figures no longer to be published for certain sites (no change for Warrington)** **d) Methodology for identifying primary and secondary diagnoses for spells with multiple episodes expanding to review all episodes, not just the first two** **e) Activity with an invalid primary diagnosis moved to a separate diagnosis group.**	**It is noted that Warrington is an early adopter for 'SDEC' (Same Day Emergency Care). As from 2 November 2023. Following changes this activity will be reported as an Emergency Care Data Set. Therefore, this activity will therefore no longer be included in mortality calculations. This means that the remaining patient population will, on average, will appear to have a higher mortality risk, which is likely to make mortality scores for Warrington increase, until all Trusts move to the same position.**
18. NICE Compliance **Target: 90%** **The Trust achieved 92.63% 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 works closely with the CBUs to ensure the completion of baseline assessments within the specified times. The Clinical Effectiveness Manager also liaises with the Senior Management Teams within CBUs to review any 'partial compliance' guidance. Oversight of compliance with Nice guidance is reviewed in Quality Assurance Committee. There are presently no known risk in relation to outstanding or partial implementation of guidance this includes NICE guidance relevant to Fragile Services.**

Quality Improvement - Trust Position

Appendix 2

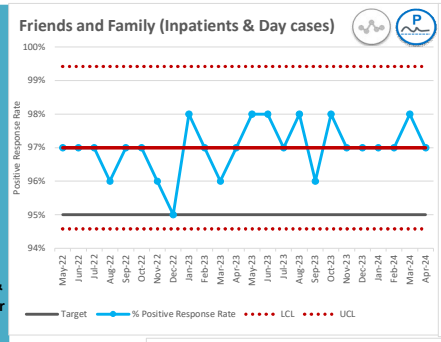
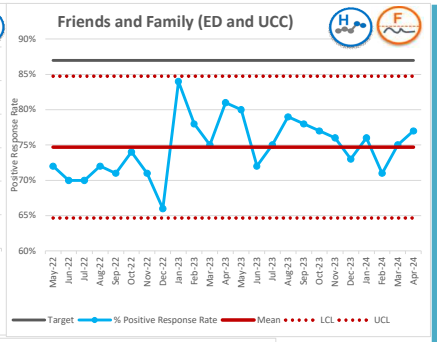
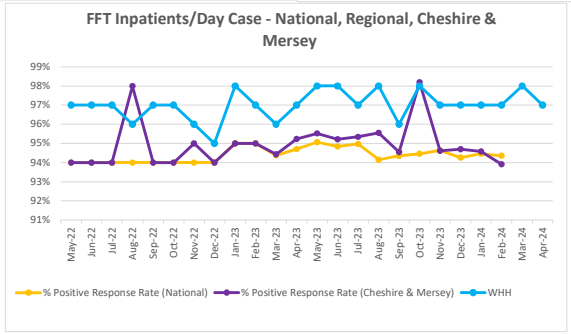
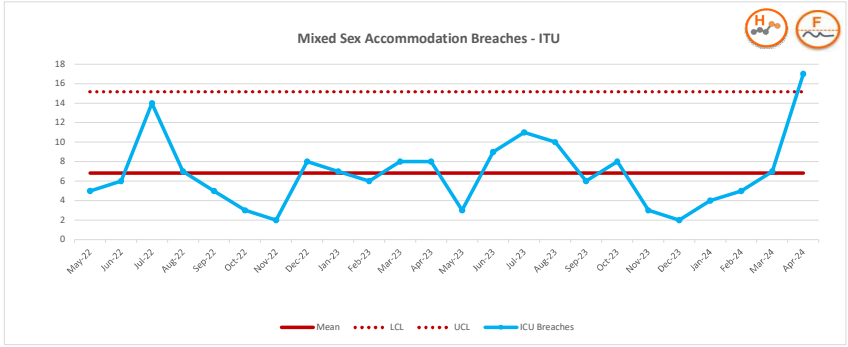
19. Complaints

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

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)?
In month, 22 new complaints were received to the Trust which was a decrease of 3 from the previous month. There were 3 dissatisfied complaints received in month, which is an increase from the previous month. 4 PHSO cases were opened in January, these were not linked to a specific area or theme.		Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There were fewer complaints (22) opened in April 2024 compared to previous months, thus allowing WHH to sustain its position for timely completion of complaints. There are 13 open complaints under review with the PHSO which is an increase from the previous position. Concerns raised to the Patient Advocacy Liaison Service (PALs) have reduced, this is in line with seasonal variance.	The Trust currently has 53 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. Following and increase in PHSO cases , a review of complaints processes is underway to improve both the quality of responses as well as the complainants experience when raising a concern.

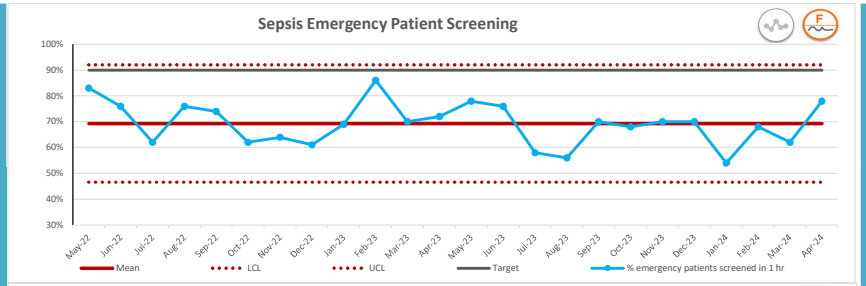
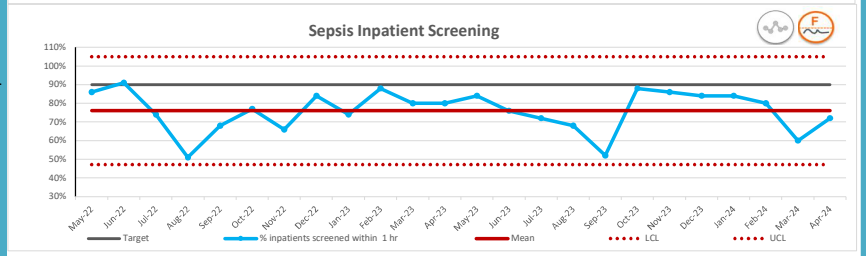
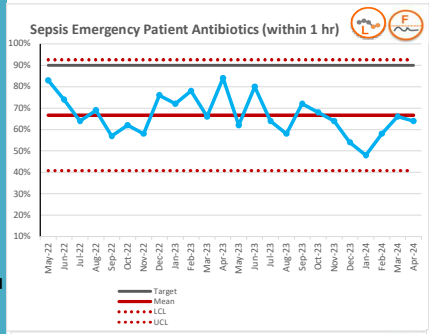
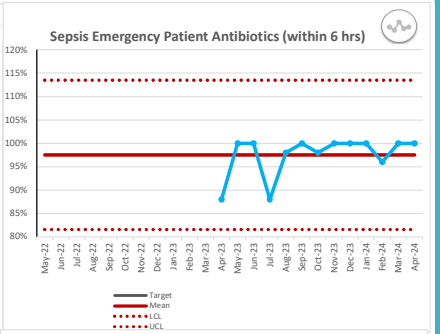
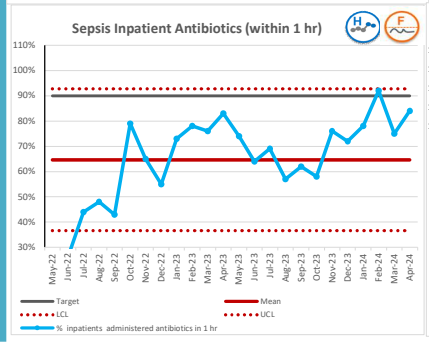
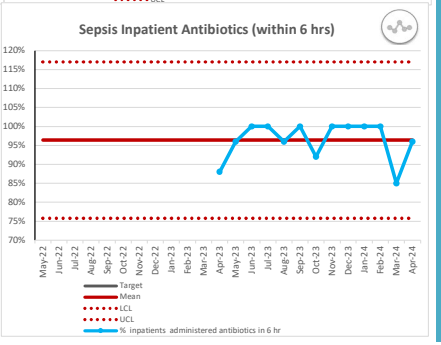
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) **Target: 95%** **21. Friends and Family (ED and UCC)** **Target: 87%**	CQC S **The Trust achieved 97% in month for Inpatient & Day case FFT and 77% for ED/UCC FFT.** **The most recent National average for FFT inpatients/Day Case was 94.36% and for C&M was 93.91%.**	  	**(IP/DC) Assurance: The Trust consistently passes the target.** **(IP/DC) Variation: Common Cause (Normal) variation.** **(ED/UCC) Assurance: The Trust consistently fails the target.** **(ED/UCC) Variation: Special Cause variation of an improving nature.**	**Inpatient/Day Case - The Trust achieved 97% positive recommendation rate in April 2024. The Departmental Teams continue to maintain a high response rate by monitoring feedback regularly.** **ED/UCC - The Trust achieved 77% positive feedback in Friends and Family Test results in April 2024: an increase from the previous two months.** **Emergency Department improvements 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.**	**Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and themes on a monthly basis to look for improvement areas and share best practice. Teams are currently working on increasing response rates, using QR codes and volunteers with our Quality Improvement Team.** **ED/UCC - Key themes for improvement include communication, waiting times, pain management and the environment. Workstreams continue to progress improvements in these areas. These are overseen in the Executive led Emergency Department Improvement Group.** **The Patient Experience Team also visit and audit areas, providing feedback locally and Trust wide.**
22. Mixed Sex Accommodation Breaches (ITU Only) **Target: Zero**	**There were 0 mixed sex accommodation (MSA) incidents outside of the ITU in month. There were 17 MSA incidents within the ITU.**		**Assurance: The Trust consistently fails the target.** **Variation: Variation: Special Cause variation of a concerning nature.**	**There were 17 mixed sex accommodation breach reported in April 2024 in the Intensive Care Unit, an increase from previous months. These were due to the delayed discharge of level 1 patients. All delayed discharges are escalated to the Patient Flow Team and Tactical Manager of the day, and discussed at each Bed Meeting.** **There were zero breaches within any other ward area.**	**Work is underway in the Unplanned Care Group in relation to ongoing patient flow to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each Bed Meeting. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.**

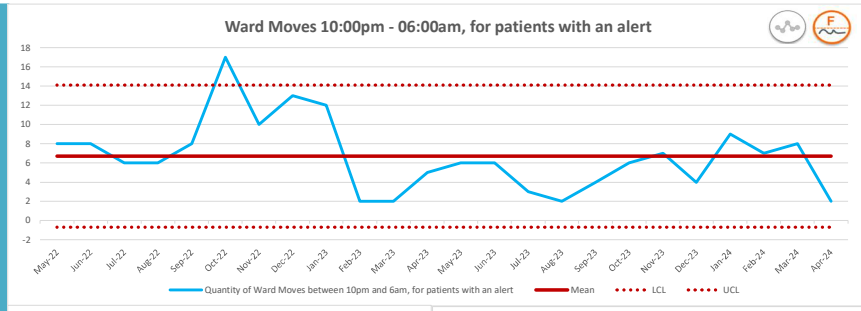
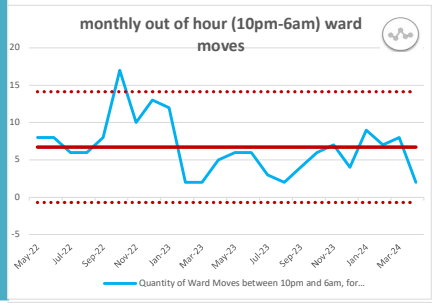
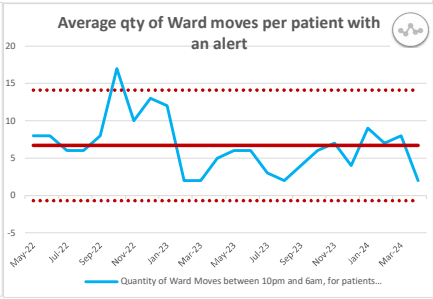
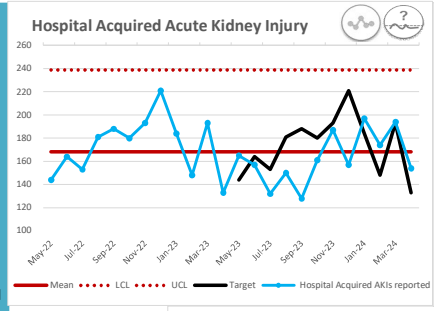
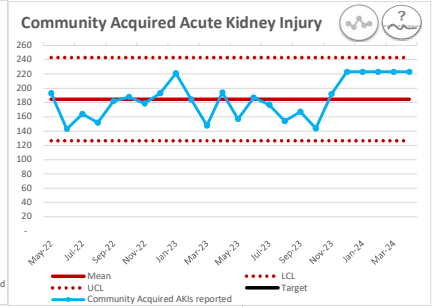
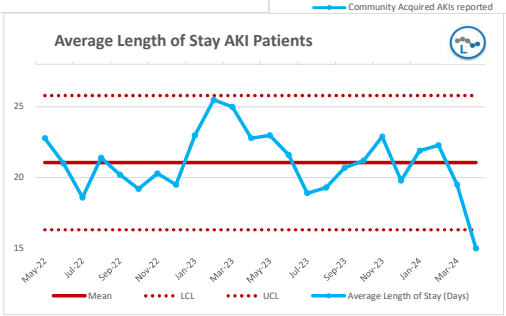
Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%** **24. Sepsis - % screening for all inpatients** **Target: 90%** **The Trust achieved:** • **78% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** • **72% screening for all inpatients with suspected sepsis within 1 hour.**	 	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**An increase in screening in month is noted for in patients and those in the Emergency Department. The remaining patients were partially screened with delays to obtaining blood cultures as the contributory factor, compounded by the consistently high numbers of patients within the ED.**	**Blood culture training figures are discussed by each CBU representative at Operational Patient Safety Group, with training plans in situ where appropriate. A test of change is underway to seek to ringfence beds for suspected sepsis patients to ensure they are not cared for on the ED corridor. This is expected to reduce the risk of partial screening and enable appropriate treatment to be given timely.**
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:** • **64% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** • **84% 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.**	**Delays in administration are noted to be due to delays in prescribing, a contibutory factor is the high number of patients within the Emergency Department**	**NG51 updated at the end of January 2024, with the new changes to be discussed. A meeting with Clinical Leads is being held in May to progress forward with the NICE Guidance. A guide on how to launch the Sepsis Tool on Lorenzo has been recirculated to ward managers to share with staff.**

Quality Improvement - Trust Position

Appendix 2

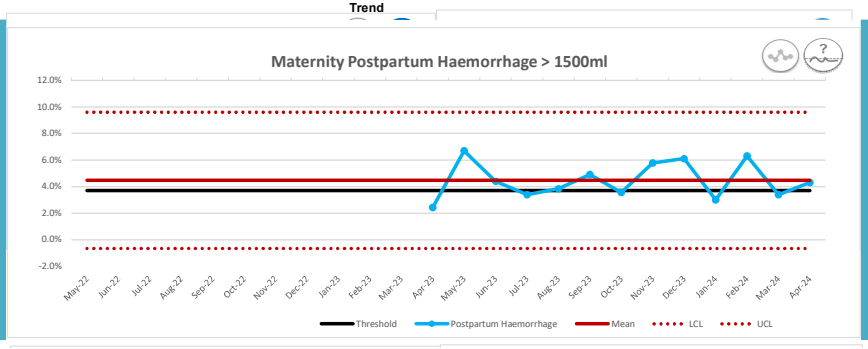
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am with a dementia, LD and/or Mental Health alert **No Target** **There was a total of 2 ward moves in month between 10pm-6am for patients with an alert, compared to 5 in April 2023.**	  	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours Patient Flow and the Senior Manager On Call minimising non essential clinical patient moves.**	**The Senior Manager On Call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who review any patients that have been moved inappropriately.**
28. Acute Kidney Injury **Target: Less than month in previous year** **There were 154 acute kidney injuries reported in month compared to 194 last month.**	  	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**LOS and HA-AKI within lower limits as expected.**	**There is a focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient.** **A deteriorating patient bundle is being driven to reduce work unnecessary work to release clinicians to 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 is planned.** **Utilisation of the AKI clinics each week to reduce the 30-day readmission rate.**

Quality Improvement - Trust Position

Appendix 2

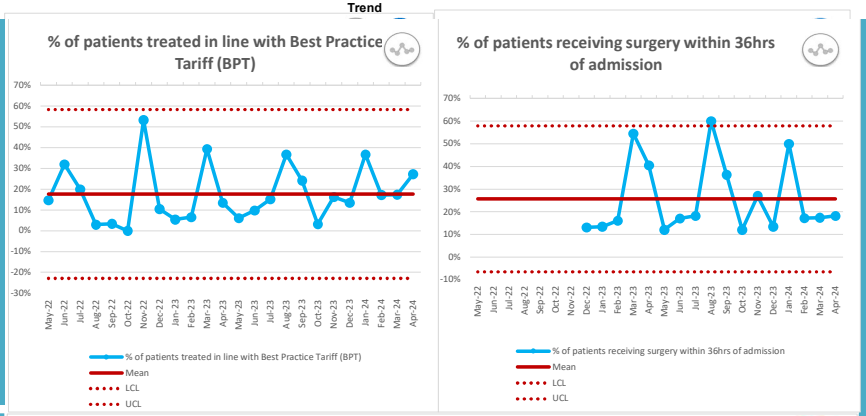
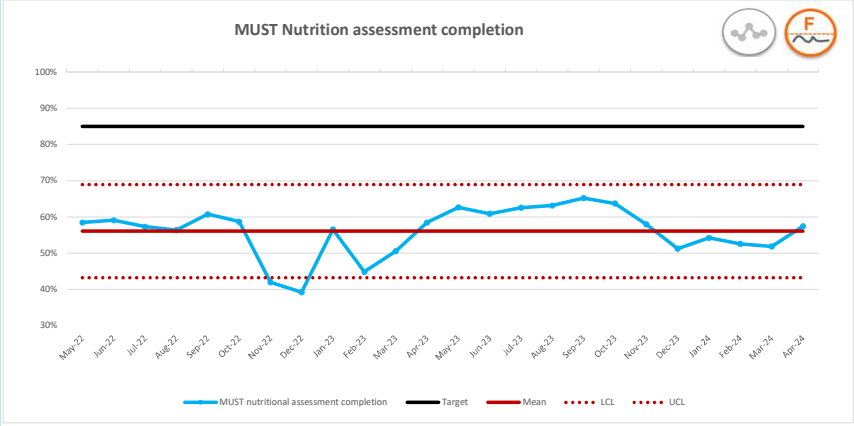
29. Maternity Postpartum Haemorrhage >1500ml

Threshold: < 3.7%

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)?
There were 4.3% Postpartum Haemorrhages >1500ml in month.		N/A - Not enough datapoints.	Rates for April are above the benchmark. A full audit of PPH >1500mls March 2023 - September 2023 was reported to Quality Assurance Committee in January 2024 with learning and actions identified. QI work is ongoing but rates continue to fluctuate. The benchmark is based on historical regional data. The service is waiting for recent data to more accurately compare the service with other providers.	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.

Quality Improvement - Trust Position

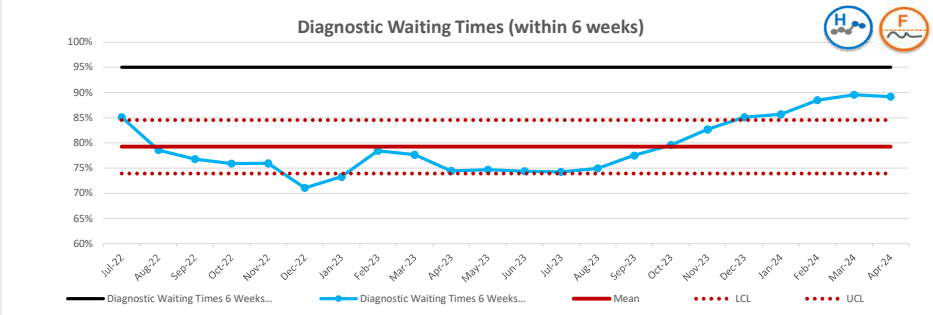
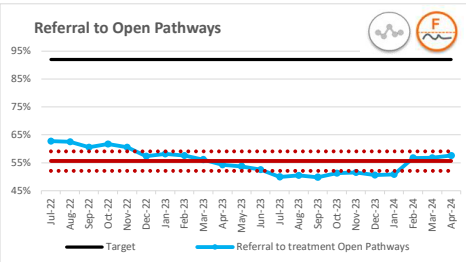
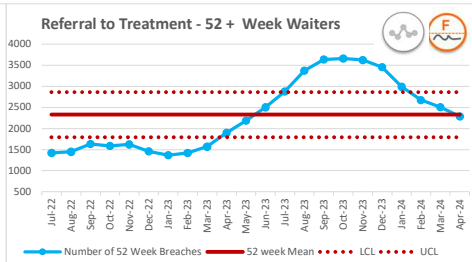
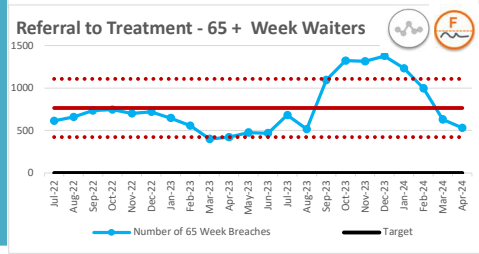
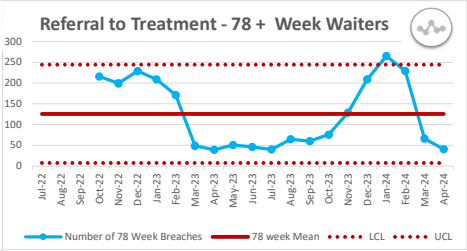
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
30. Fractured Neck of Femur **Target: Best Practice Tariff**	**17.39% of patients were treated in line with Best Practice Tariff (BPT) in Mar-24.**		**Variation: Common Cause (Normal) variation.**	**Improvements in % of patients treated in line with best practice tariff in April.** **Smaller patient cohort than previous month (30 Vs 37)** **Test of Change in theatres to improve efficiency of Trauma List**	**Continue theatre improvement work to increase efficient performance of trauma lists** **Further work with Clinical Leads for Trauma & Orthopaedics and Best Practice Tariff, senior nursing and operational leads to interrogate action plan further to identify opportunities to sustain and build upon improvement** **Escalation process to trigger when high number of trauma patients are waiting for theatre and risk of timely surgery negatively impacted.**
31. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 57.43% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**MUST compliance remains below Trust target in all 3 metrics on the Lion Dashboard. This is due to challenges related to the EPR MUST Assessment Tool and requirement for specific types of weighing devices in some areas.**	**A MUST Task and Finish Group commenced in May to identify barriers to completion of the MUST Assessment Tool. Key issues have been identified and are being addressed, these include purchase of weighing pat slides for immobile patients. Access for HCSW to input weight measurements on the EPR system and flagging of MUST scores opposed to weight recording on the admission tasks on EPR. Weekly compliance push reports are being produced and circulated to drive compliance across all areas.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

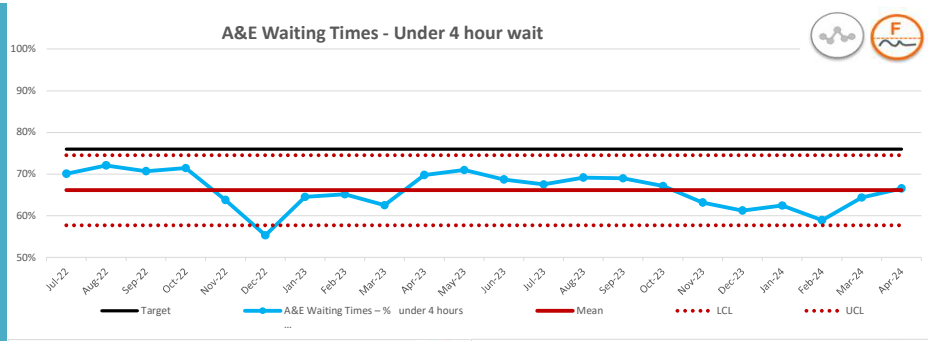
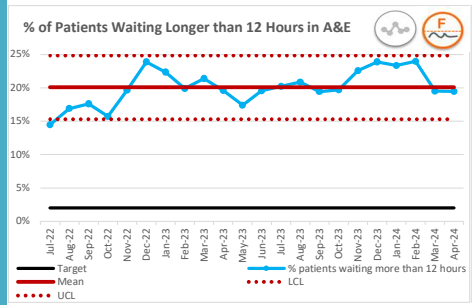
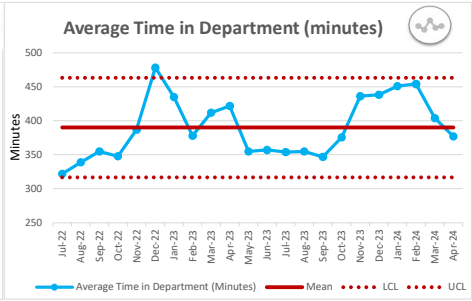
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

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)?
32. Diagnostic Waiting Times 6 Weeks Target: 95% **The Trust achieved 89.17% 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**
33. Referral to treatment Open Pathways Target: 92% 34. RTT - Number of patients waiting 52+ weeks Target: 0 **The Trust achieved 57.6% in month. There were 2287, 52 week breaches, 41, 78 week breaches and 531, 65 week breaches.** RR1125 RR1215	   	**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.** **(52+) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**RTT performance - 52 and 65 week waits are performing in line with the trajectories, 78 weeks remains challenged with a forecast to clear in June , mitigation plans through use of insourcing and mutual aid are supporting recovery plans**	**Recovery of the elective programme is taking place with:** **• Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.** **• Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.** **• Restoration and recovery plans for 2024/25 have been drawn up in line with current Operational Planning Guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

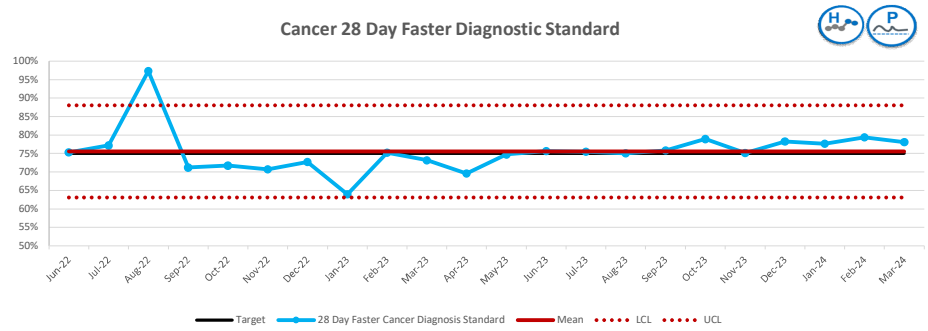
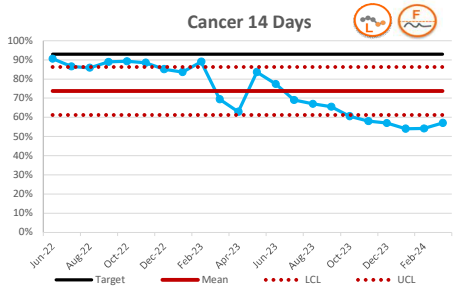
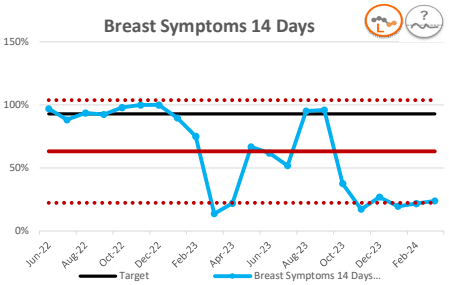
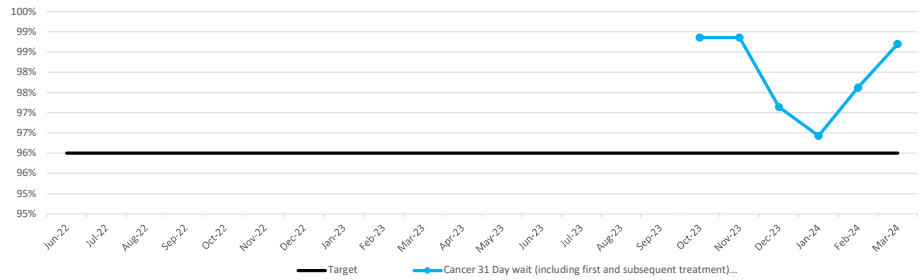
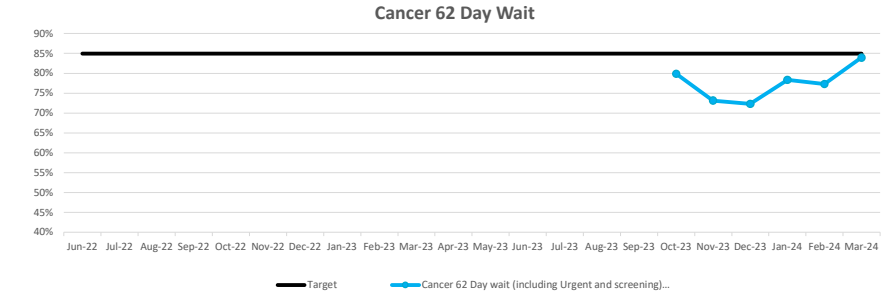
Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
35.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 75%	CQC **The Trust achieved 66.56% excluding Widnes walk ins in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy**	**• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** **• System resource investment in order to support Pathway 1 discharges.** **• Additional beds remain open on the Halton site to support bed capacity and flow.**
36. Average time in department ED No Target					
37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	RR224 **19.46% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 377 minutes.**	 	**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in ED.**	**The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 24/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 24/25 is set up to support improvement.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
38. 28 Day Faster Cancer Diagnosis Standard Target: 75% The Trust achieved 78.1% 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 and an interim target of 77% by March 25.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG)
39. Cancer 31 Day wait Target: 96% The Trust achieved 98.7% in month for Cancer 31 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	The Trust achieved the 31 day target	
40. Cancer 62 Day wait Target: 85% The Trust achieved 83.97% in month for Cancer 62 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	The 62-day referral to treatment target remains challenging but is seeing some improvement due to the combined standards. From the 1st October 2023 this standard will be combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 70% by March 2025. The Trust is currently achieving this.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

Access & Performance - Trust Position

Key:
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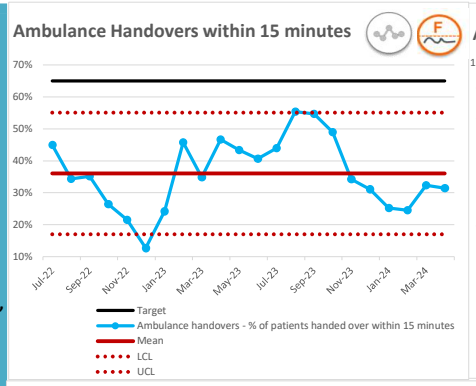
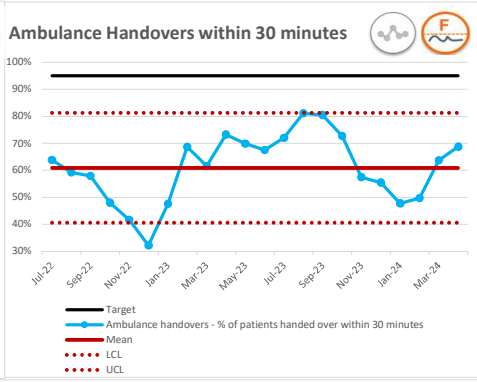
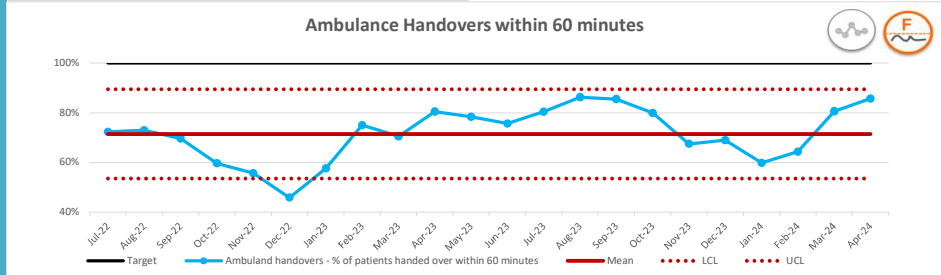
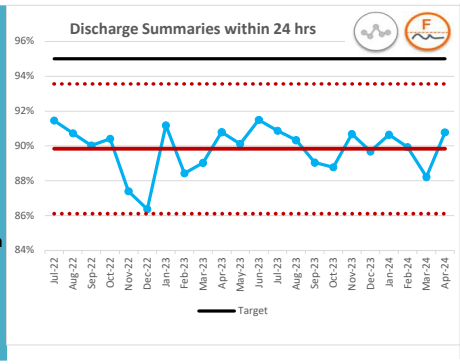
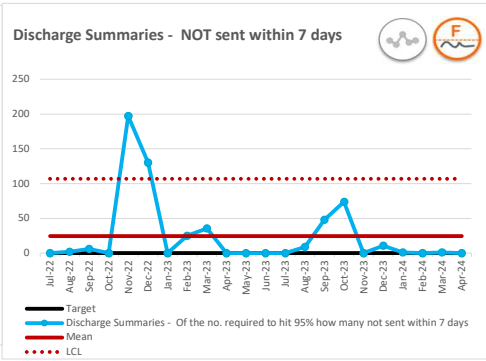
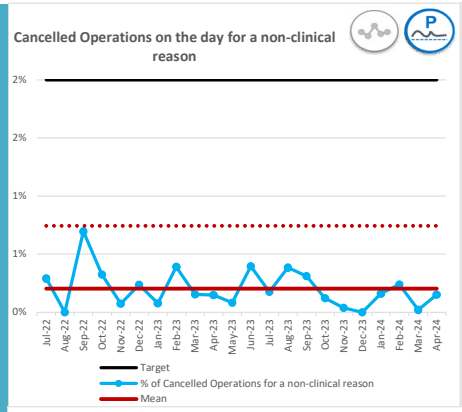
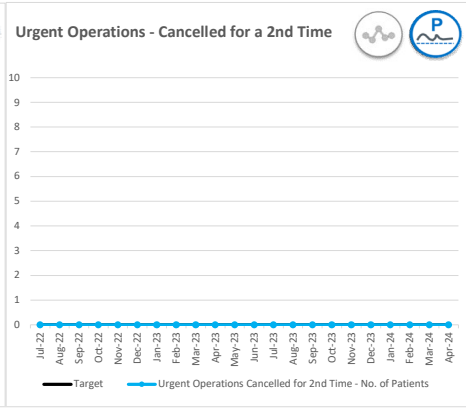
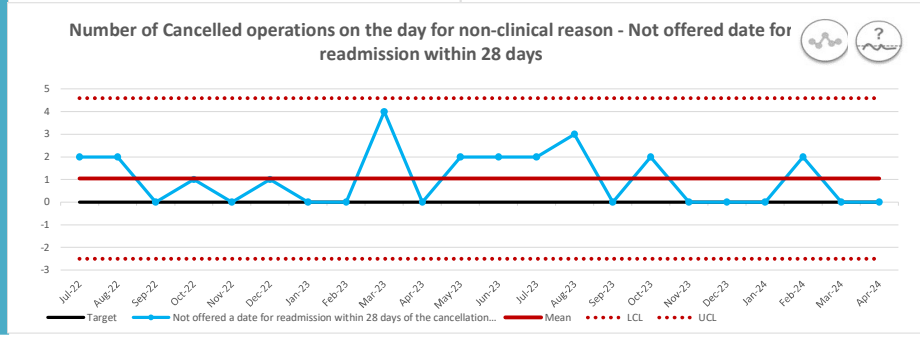
SOF System Oversight Framework
CQC Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
41. Ambulance Handovers within 15 minutes Target: 65% 42. Ambulance Handovers within 30 minutes Target: 95% 43. Ambulance Handovers within 60 minutes Target: 100% SOF	  	**In month 31.44% of patients were handed over within 15 minutes, 68.75% were handed over within 30 minutes and 85.71% 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 continues to be a priority, it has been challenged due to surges in demand and workforce constraints**	**The Trust will continue to work in partnership with NWAS to identify and implement improvements.**
44. Discharge Summaries - % sent within 24hrs Target: 95% 45. Discharge Summaries - Number NOT sent within 7 days Target: ZERO	 	**The Trust achieved 90.78% 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.**

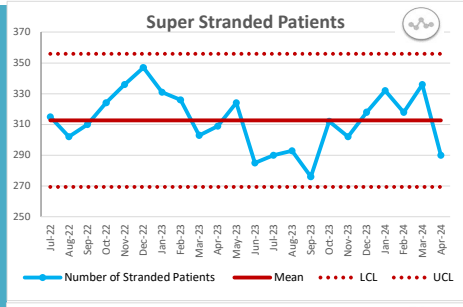
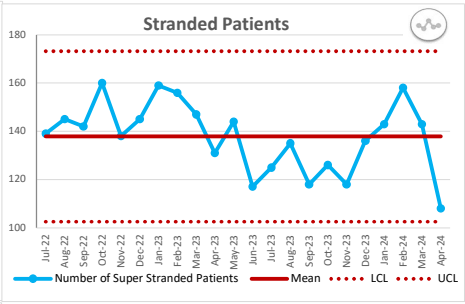
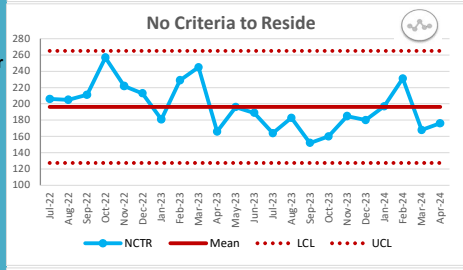
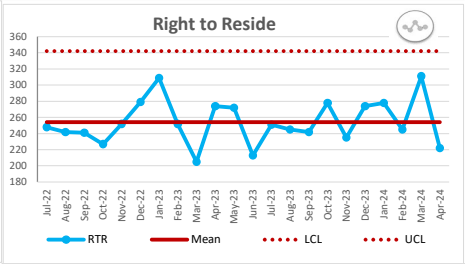
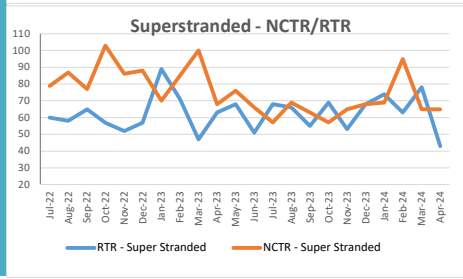
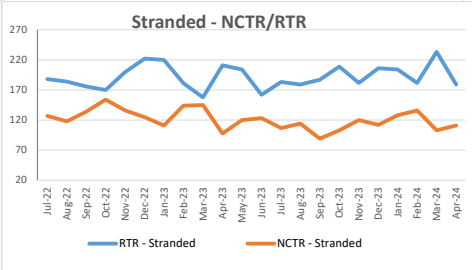
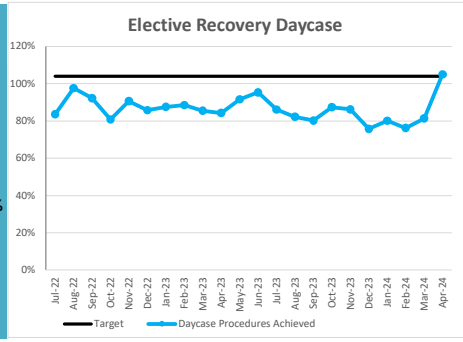
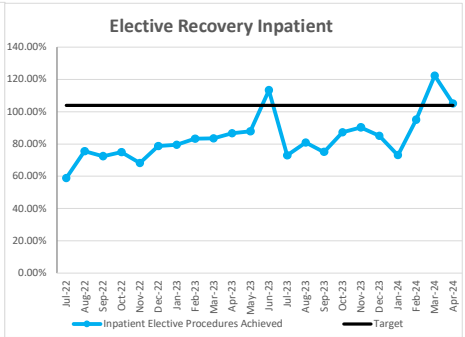
Access & Performance - Trust Position

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

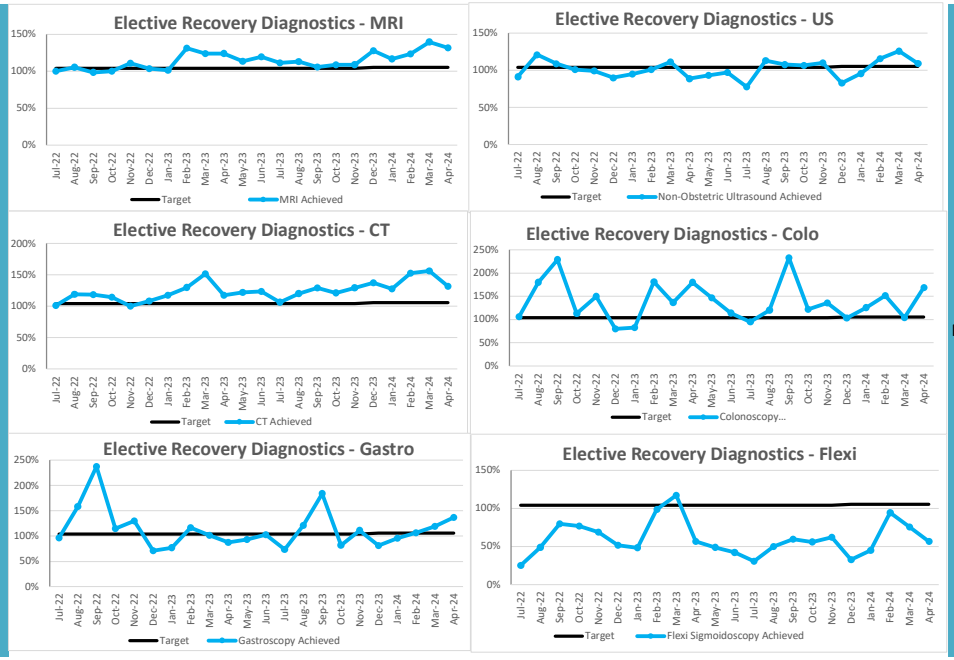
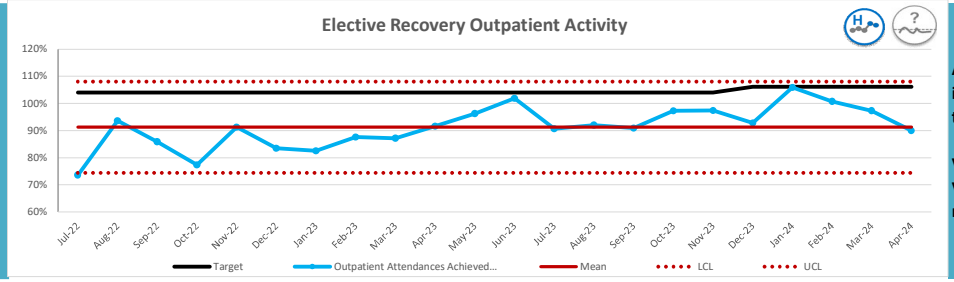
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
46. Cancelled Operations on the day for a non-clinical reason Target: Less than 2% 47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO 48. Urgent Operations Cancelled for 2nd Time **Cancelled operations for a non-clinical reason was 0.15% in month. 0 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.**

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)?
49. Super Stranded Patients Target: Trajectory 50. No Criteria to Reside (NCTR)	There were 290 stranded and 108 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 decreased and is largely been driven by patients with criteria to reside, daily MDT meetings review all non criteria to reside patients, the current numbers are reflective of seasonal variation	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
51. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included 105% of Daycase Procedures and 104.99% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Both Day case and inpatient electives had a strong performing month	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.

Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
53. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
SOF RR1125 **In month, the Trust achieved the following % of activity against 2019.** **This included:** **131.6% of MRI** **131.81% of CT** **109.14% of Non-Obstetric Ultrasound** **56.62% of Flexi Sigmoidoscopy** **168.69% of Colonoscopy** **136.63% 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.**
54. Elective Recovery Outpatient Activity Aggregate Target: 104%				
SOF RR1125 **In month, the Trust achieved 89.95% of Outpatient activity against 2019.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The Trust continues to deliver Outpatient activity inline with operational planning guidance**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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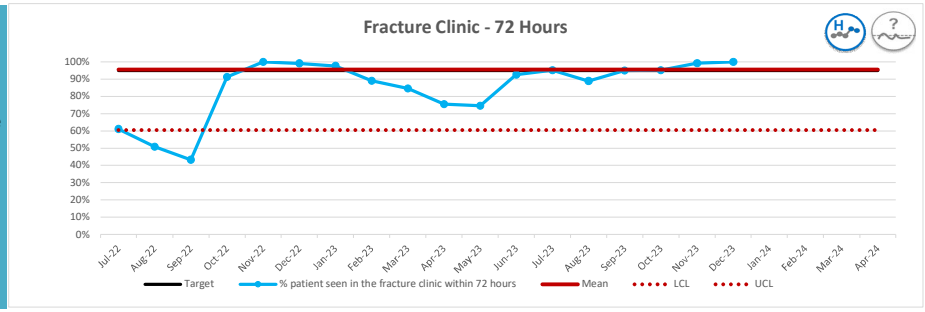
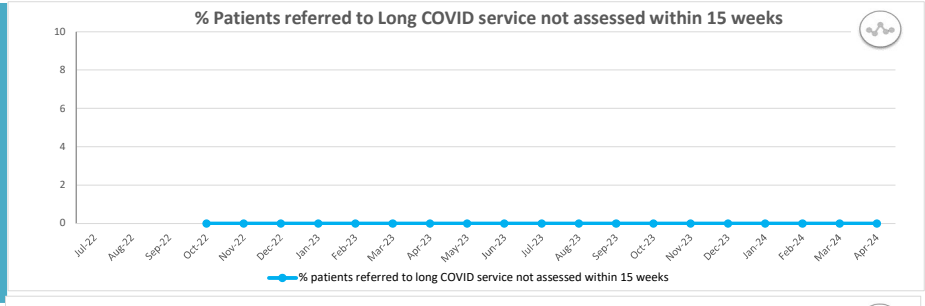
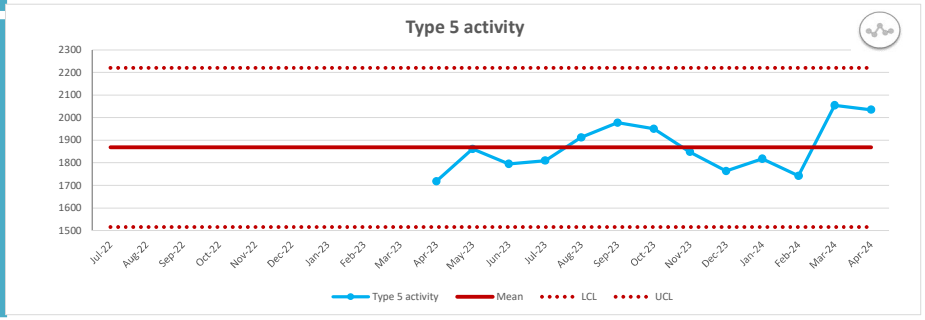
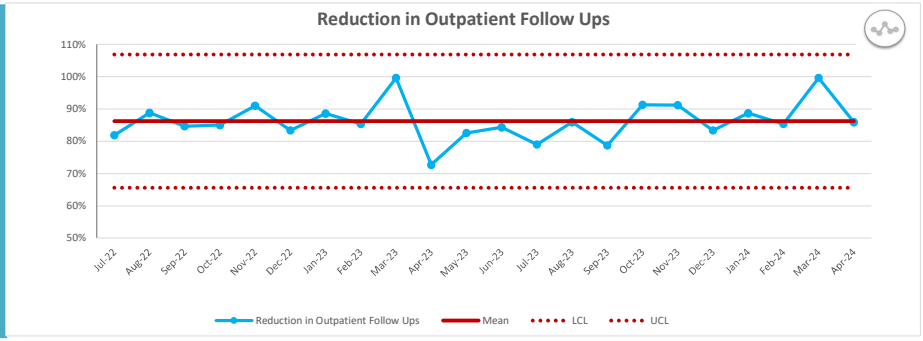
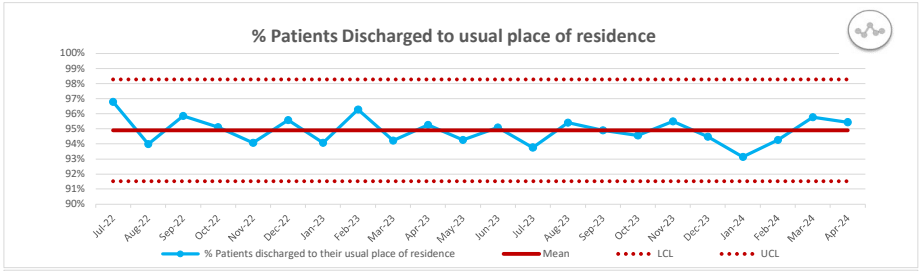
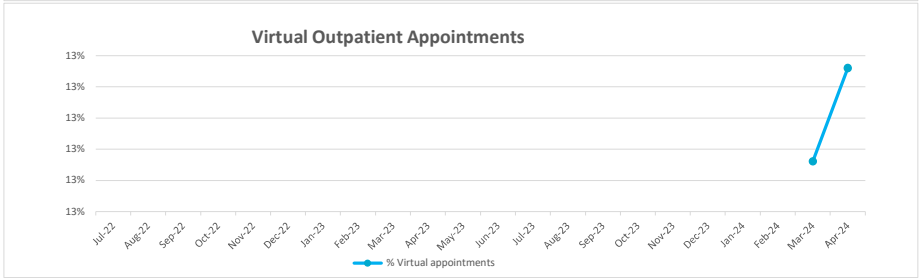
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In monthly, the fracture clinic saw 0% of patients within 72 hours.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	Good performance position is being sustained	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
56. % patients referred to long COVID service not assessed within 15 weeks	This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.		
57.Type 5 (previously SDEC) activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 203500 Type 5 Attendances.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.	As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

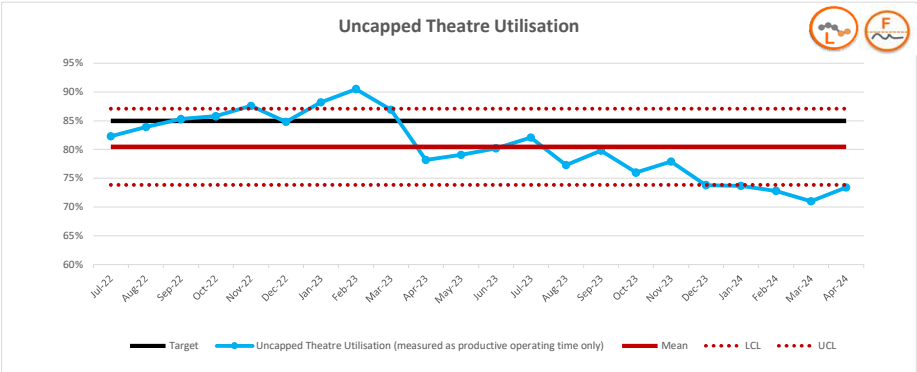
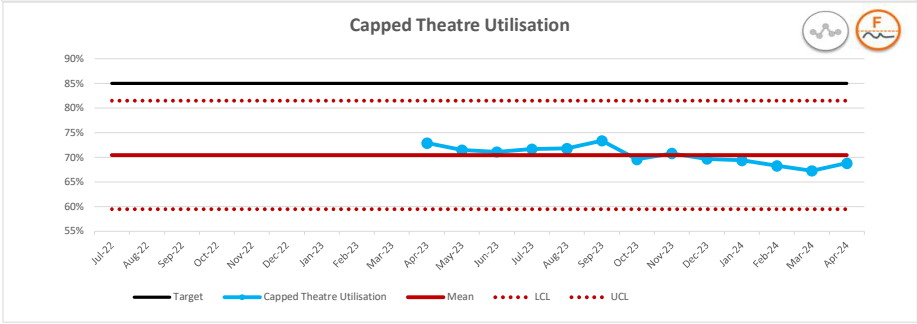
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

	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)?
58. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 85.9% of 19/20 activity in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Common Cause (Normal) variation.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
59. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.44% patients in month were discharged to their usual place of residence.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Common Cause (Normal) variation.**		
60. Virtual Appointments (figures have been derived using SUS logic to determine the contact type and clinics which need to be held F2F have been excluded)	**13.03% Virtual Outpatient appointments in month.**		**N/A - Not enough datapoints.**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

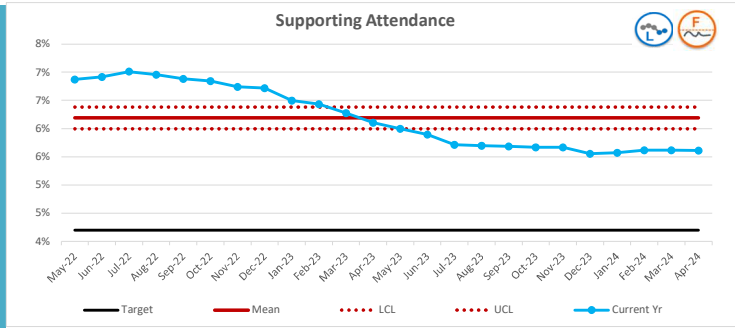
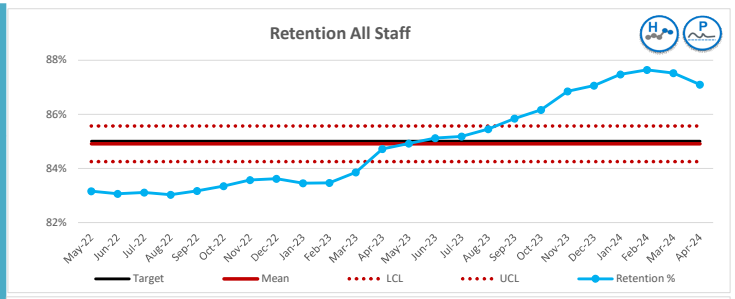
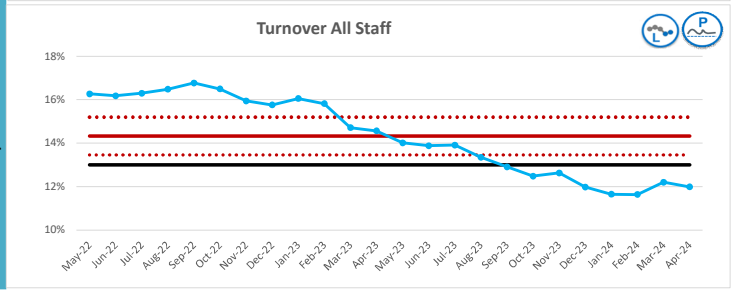
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	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)?
61. Uncapped Theatre Utilisation (measured as productive operating time only) Target: 85%	**73.4% Uncapped Theatre utilisation in month (measured as productive operating time only).** **68.8% Capped Theatre utilisation in month (measured as productive operating time only).**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: There is special cause variation of a concerning nature.**	**Theatre Utilisation remains a challenged area, a focus on late starts and improving productivity are key priorities for 24/25** ***Please note, data in the IPR has been revised to reflect utilisation - previously a combined utilisation and productivity figure. As a result, figures are different from those previously reported in the IPR.**	**The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data.** **Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors.**
62. Capped Theatre Utilisation Target: 85%			**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**		**The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates.** **Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
Trust Strategy
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)?
63. Supporting Attendance Target: Below	UoR SOF S The Trust's annualised sickness rate was 5.61%.		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 April 2024 was 5.6%, which is very similar to the previous 5 months. Reasons for the variation can be attributed to the reduction in Long Term Sickness following implementation of the new Attendance Management policy and the People Health and Wellbeing Group being established.	Sickness absence levels remain below 2022/23 absence rates. The People Health and Wellbeing Group (PHWG) are maintaining oversight of the absence reasons, monitoring the trend for anxiety, stress and depression, and monitoring the reduced position in MSK absences. A focus on improving sleep, noting the impact on sickness absence has been launched, with specific support available via trained Occupational Health (OH) professionals. OH are working in partnership with Maximus Service which is a government run, self-referral scheme, to support staff returning to work from LTS. The team continue to work closely with Rugby League Cares who offer 1:1 and group sessions for staff.
64. Retention Target: 85%	UoR RR1108 RR1134 The Trust's annualised retention of all staff was 87.1%.		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 April 2024 was above Trust target at 87.1%, an slight decrease from 88% in March 2024. Retention for permanent staff in April 2024 remains above Trust target at 89.67%.	Work/life balance, relocation, retirement and promotion are the main reasons people leave WHH. Improving flexible working continues to be a priority and is embedded into the We Are WHH Culture Plan. The We Are WHH Culture Plan will further enhance the benefits and health and wellbeing offers/initiatives to support the workforce. These already include financial, physical and mental wellbeing offers.
65. Turnover Target: Below 13%	S CQC SOF UoR The Trust's annualised turnover of all staff was 11.99%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in April 2024 was 12% compared to the trust target of 13%. Turnover of permanent staff in April 2024 was a better position than the Trusts target at 11.12%.	Improvements in turnover and retention are reflected in the overall increase in substantive workforce numbers, thus leading to a reduction in temporary staffing.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

KEY:
SOF System Oversight Framework
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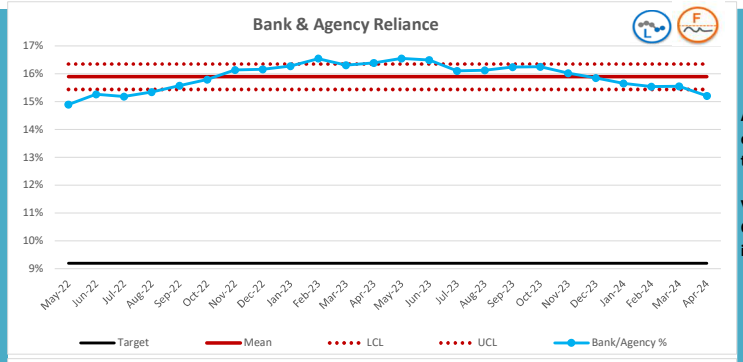
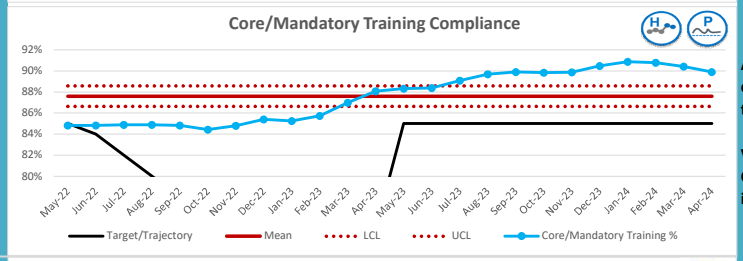
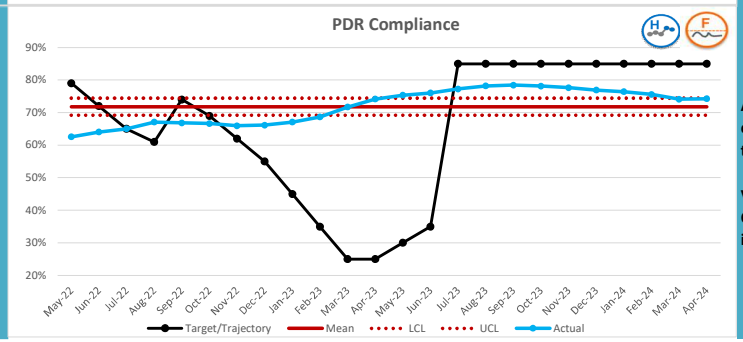
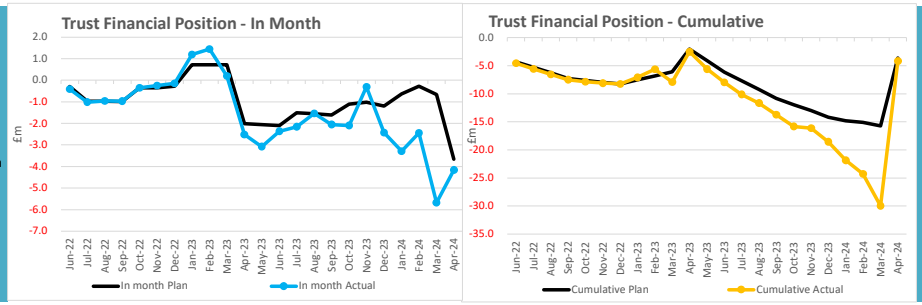
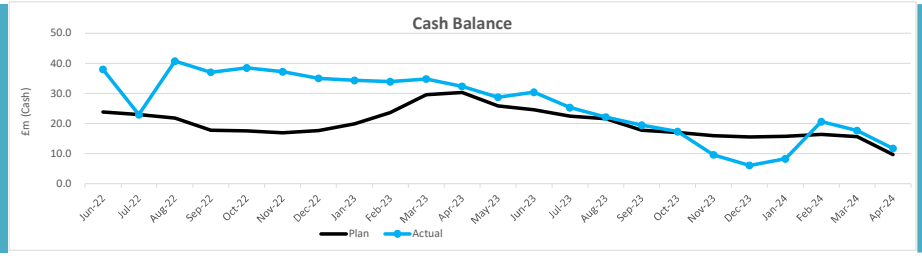
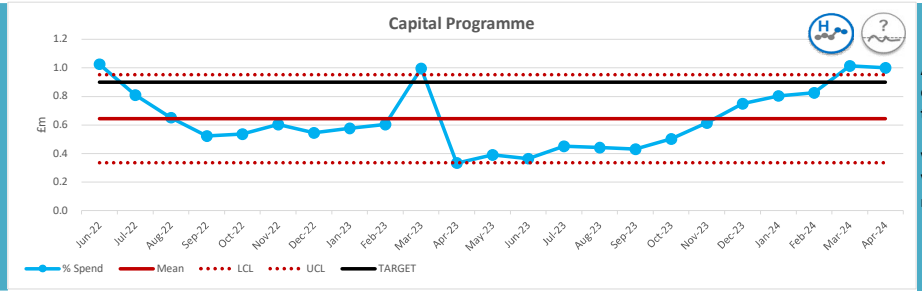
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Bank and Agency Reliance Target: 9% or Below	Annualised Bank and Agency Reliance was 15.01%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Bank and Agency reliance is showing an Improving Variation. Bank and Agency reliance in April 2024 was 15%, a slight improvement from February 2024 at 15.3%. Bank reliance has remained static during the last two months and is 12.2%, whilst Agency reliance continues to decrease to 3.3% in April 2024.	A refined temporary staffing ECF process is being developed to supplement the new Vacancy Request process. Focus is starting to shift to Bank usage, being mindful that the Trust doesn't inadvertently start to increase agency reliance. This will be achieved through the recruitment of substantive employees. The Trusts Effective Workforce Deployment framework and ECF processes continue to focus on ensuring bank workers have the opportunity to fill any gaps and only securing agency workers as a last resort, for short periods, with clear mitigation plans in place.
67. Core/ Mandatory Training Target: 85%	Core/Mandatory training compliance was 89.9% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training is showing an Improving Variation. In April 2024, CSTF Mandatory Training compliance was 89.9%.	Care Groups report compliance at Operational People Committee with actions required to ensure targets are met. National changes are being mandated to how Trusts deliver CSTF training, early indications are there will be limited changes to WHH, as the Trust has always closely followed the national guidance using the systems provided.
68. PDR Target: 85%	Annualised PDR compliance was 74.23%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In April 2024, Appraisal compliance was 74.2%, a decrease from 74.67% in February 2024. Currently Appraisal rates are below the trajectories but higher than 2022.	Care Groups and Corporate areas report their PDR compliance within OPC and have set trajectories to achieve 85% compliance by July 24. Progress against the trajectories will be discussed at June OPC. As a reminder, 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.

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)?
69. Trust Financial Position Target: Plan	The Trust has recorded a deficit position of £4.2m at 30 April 2024 against a deficit plan of £3.7m.			The main drivers for the deficit being worse than plan are enhanced care and escalation, Urgent Treatment Centre opening hours and Nursing costs due to acuity and activity delivered under plan.	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.
70. Cash Balance Target: On or better than plan	UoR The cash balance at 30 April 2024 is £11.7m. RR134			The current cash balance is £11.7m which is £2m better than the cash plan. This is due to the timing of receipt of income. Of the £11.7m cash, £5.2m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. Cash support of £7.2m was received in March 2024 and a request for £4.5m has been submitted for June 2024.
71. Capital Programme Target: On plan 90%-100%	UoR Capital expenditure at the end of month 1 is £0.6m against a plan of £0.6m.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Capital expenditure is in line with plan at month 1.	All capital paperwork for approved capital schemes is required to be completed by the end of Q1 to ensure that the capital programme continues to spend in line with plan throughout the year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
- SOF System Oversight Framework
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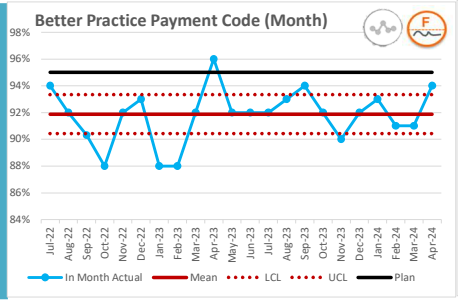
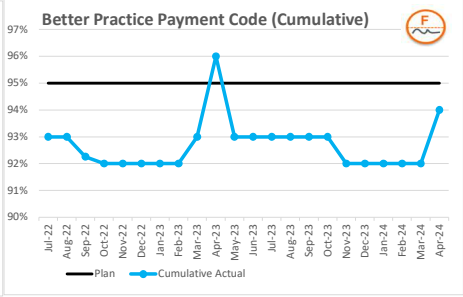
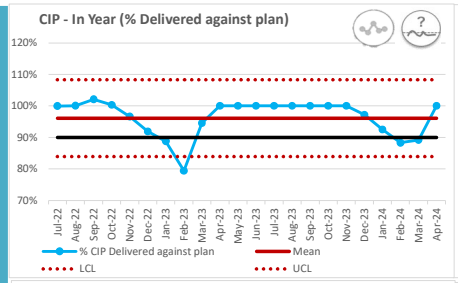
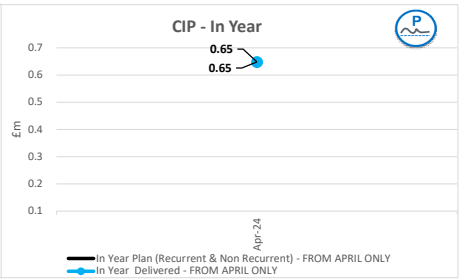
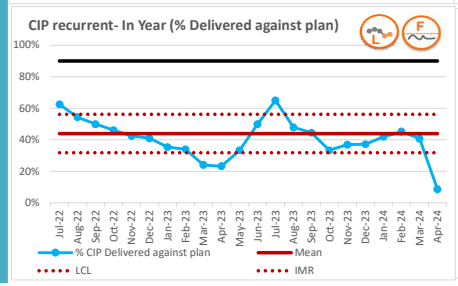
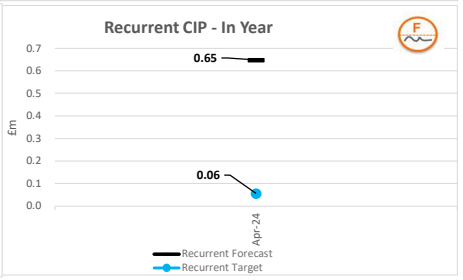
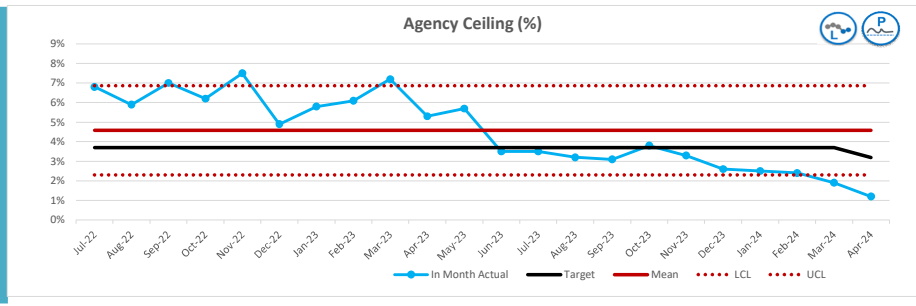
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
72. Better Payment Practice Code **Target: Cumulative performance 95%**				
Cumulative BPPC performance is 94% which is below the national target of 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 94%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.
73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**				
The month 1 CIP plan is £0.6m and £0.6m has been delivered.	 	Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Although CIP has been achieved in month 1, it should be noted that this delivery has been mainly achieved from non-recurrent central items.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. Plans are underway to identify schemes to meet the 2024/25 CIP target.
74. Cost Improvement Programme (recurrent) – In year performance to date **Target: Recurrent Forecast is more than 90% of annual target**				
£0.1m CIP has been delivered recurrently against the target of £0.6m.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	Where recurrent CIP has not realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.	The Trust is continuing to identify recurrent CIP schemes for 2024/25. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT are being used.
75. Agency Ceiling **Target: Agency spend should not exceed 3.2% of total pay (ICS target)**				
The Trust Agency spend in month is 1.2% against a target of 3.2%.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The agency ceiling has reduced from 3.7% in 2023/24 to 3.2% in 2024/25. Trust agency spend is still significantly below the target at 1.2%.	The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: - Agency controls best practice - Rostering compliance - Rate card compliance - Establishment Control compliance (or an alternative approach) - Unplanned absences - Recruitment activity

Appendix 3 – Trust IPR Indicator Overview

Indicator	KPI	Detail	Target	Additional Context
Quality				
Incidents		Number of incidents reported in month.		Nationally incidents are no longer referred to as SIs. This has been replaced by PSIIs in accordance with the nationally mandated Patient Safety Incident Response Framework.
	1	Number of incidents open over 40 days.	0	
		Total PSIIs recorded in month.		
		Number of PSII Actions Breached.		
		Number of never events reported in month.		
		Number of 'prevention of future death' orders.		
Duty of Candour		Duty of Candor (DoC) – Moderate Incidents		Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where the Trust contacts the patient or their family to advise of the incident; this must be done within 10 working days.
	2	Duty of Candor – Serious Incidents	100%	
Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)	**3**	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.	Reduction from previous year	
	4	MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.		
	5	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.		
	6	Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.		
	7	Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis.		
	8	Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.		
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	**9**	Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission.		
		Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).		
VTE Assessment	**10**	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month, however this indicator is reported quarterly.	>= 95%	

Inpatient Falls & Harm Levels		Total number of falls which have occurred in month.		
		Falls per 1000 bed days in month.		
	11	Total number of inpatient falls which have occurred in month.	20% decrease from previous year	
		Levels of harm reported as a result of a fall in month.		
		Level of avoidable harm which has occurred in month.		
Pressure Ulcers		Pressure Ulcers (Categories 3 and 4)	10% reduction on previous year	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).
	12	Pressure Ulcers (Categories 2, 3 and 4)	10% reduction on previous year	
		Community Acquired Pressure Ulcers		
Medication Safety	**13**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
		Number of controlled drugs incidents.		
		Number medication incidents resulting in harm.		
Staffing Average Fill Levels	**14**	Staffing - Average Fill Rate - Day nurses/midwives		Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
		Staffing - Average Fill Rate - Day care staff		
		Staffing - Average Fill Rate - Night nurses/midwives		
		Staffing - Average Fill Rate - Night care staff		
Care Hours Per Patient Day (CHPPD)	**15**	Staffing - CHPPD Overall	>=7.9	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
		Staffing - CHPPD Benchmarking		
HSMR Mortality Ratio	**16**	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Plan	

SHMI Mortality Ratio	**17**	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Plan	
NICE Compliance	**18**	Trust NICE compliance	90%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. This indicator monitors Trust compliance against NICE guidance.
Complaints		Number of complaints received in month.		
		Number of complaints received in timeframe		
		Number of dissatisfied complaints in month.		
		Total number of open complaints in month.		
	19	Total number of cases over 6 months old in month.	0	
		Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month.		
		Number of complaints responded to within timeframe in month.		
		Number of PALS complaints received and closed in month.		
Friends and Family Test (Inpatient & Day Cases)	**20**	Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?	95%	
		National, Regional, Cheshire & Mersey positive response rates for Benchmarking		
Friends and Family (ED and UCC)	**21**	Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?	87%	
Mixed Sex Accommodation Breaches (ITU)	**22**	Number of MSA Breaches in month (ITU).	0	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.
Sepsis	**23**	Sepsis Emergency Patient Screening	>=90%	To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if
	24	Sepsis Inpatient Screening	>=90%	
	25	Sepsis Emergency Patient Antibiotics (within 1hr)	>=90%	

		Sepsis Emergency Patient Antibiotics (within 6hrs)		necessary administered anti-biotics within 1 hour.
	26	Sepsis Inpatient Screening (within 1hr)	>=90%	
		Sepsis Inpatient Screening (within 6hrs)		
Ward Moves Between 10pm and 6am	**27**	Ward Moves 10:00pm - 06:00am, for patients with an alert		Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
		Monthly out of hour (10pm-6am) ward moves		
		Average qty of Ward moves per patient with an alert		
Acute Kidney Injury	**28**	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than month in previous year	
		Number of community acquired Acute Kidney Injuries (AKI) in month.		
		Average Length of Stay (LoS) of patients within a AKI.		
Postpartum Haemorrhage >1500ml	**29**	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard.	<3.7%	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the North West Coast Maternity Dashboard.
Fractured Neck of Femur	**30**	The % of patients treated in line with Best Practice Tariff (BPT).		The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)). Shorter time to theatres significantly reduces risk of mortality and improves pain.
		% of patients receiving surgery within 36hrs of admission		
MUST nutritional assessment completion	**31**	MUST Nutrition assessment completion	>85%	To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE). In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity

Access & Performance

Diagnostic Waiting Times – 6 weeks	**32**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	
RTT Open Pathways and 52 & 65 week waits	**33**	Referral to open pathways	>92%	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
	34	Number of patients waiting over 52 weeks.	0	
		Number of patients waiting over 65 weeks.	0	
		Number of patients waiting over 78 weeks.	0	
4 hour A&E Target and ICS Trajectory	**35**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>75%	
Average Time in Department (ED)	**37**	How long on average a patient stays within the emergency department (ED).		
A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.	**36**	% of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.	<=2%	
Cancer 14 Days	**38**	Cancer 28 Day Faster Diagnostic Standard	>75%	All patients need to receive their first appointment for cancer within 14 days of urgent referral. All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
		Cancer Appointment within 14 Days	>93%	
		Breast Symptoms appointment within 14 days	>93%	
Cancer 31 Day wait	**39**	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat.
Cancer 62 Day wait	**40**	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat.
Ambulance Handovers 15	**41**	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	
Ambulance Handovers 30–60 minutes	**42**	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	
Ambulance Handovers – more than 60 minutes	**43**	% of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).	100%	

Discharge Summaries – Sent within 24 hours	**44**	Discharge Summaries within 24 hrs	>95%	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	**45**	Discharge Summaries - NOT sent within 7 days	0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
Cancelled operations on the day for non-clinical reasons	**46**	% of operations cancelled on the day or after admission for non-clinical reasons.	<=2%	
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	**47**	Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	0	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	**48**	Number of urgent operations which have been cancelled for a 2nd time.	0	
Super Stranded Patients		Stranded Patients are patients with a length of stay of 7 days or more.		
	49	Super stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.		
No criteria to reside (NCTR)	**50**	Number of patients with no criteria to reside		
		Number of patients with right to reside		
		Superstranded - qty of NCTR vs CTR		
		Stranded - qty of NCTR vs CTR		
Elective Recovery Activity	**51**	% of Elective Activity (Inpatients)	month in previous year	
		% of Elective Activity (Day cases)	month in previous year	
Elective Recovery Diagnostics	**52**	% of Elective Diagnostic Activity - MRI	month in previous year	
		% of Elective Diagnostic Activity - Non-Obstetric Ultrasound	month in previous year	
		% of Elective Diagnostic Activity - CT scans	month in previous year	
		% of Elective Diagnostic Activity - Flexi Sigmoidoscopy	month in previous year	

		% of Elective Diagnostic Activity - Gastroscopy	month in previous year	
		% of Elective Diagnostic Activity - Colonoscopy	month in previous year	
Elective Recovery Outpatients	**53**	% of Elective Recovery Outpatient Activity	104%	
Fracture Clinic	**55**	Fracture Clinic - patients seen within 72 Hours	>95%	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
% Outpatient referred to long covid service within 15 weeks	**56**	% of Patients referred to Long COVID service not assessed within 15 weeks		
% of zero-day length of stay admissions (Type 5)	**57**	Type 5 activity		Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.
Reduction in Outpatient Follow Ups	**58**	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
% Patients discharged to their usual place of residence	**59**	% of patients who were discharged to their usual place of residence.		
Virtual Outpatient Appointments	**60**	Virtual Outpatient Appointments		
Theatre Utilisation (measured as productive operating time only)	**61**	Uncapped theatre utilisation	>85%	Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.
	62	Capped theatre utilisation	>85%	

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

Appendix 4 - Statistical Process Control

1.0 What is SPC?

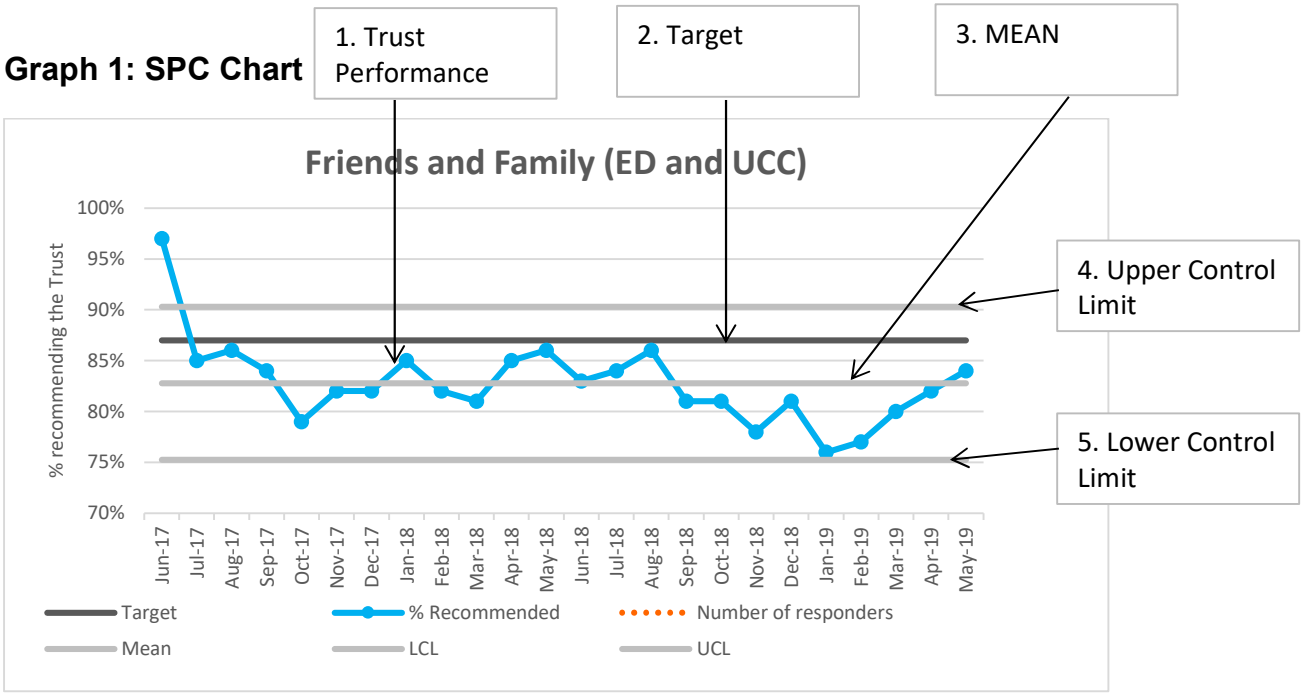
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

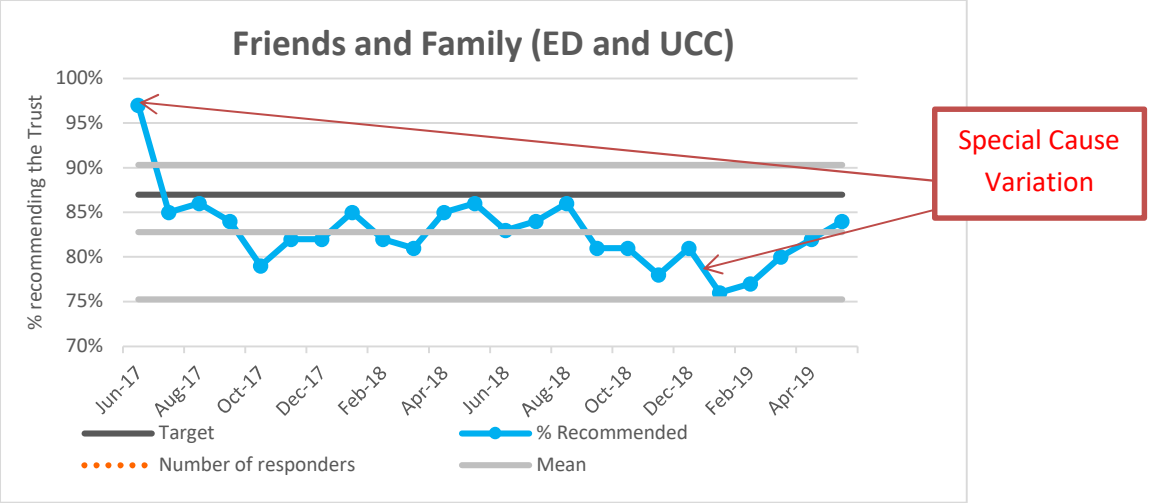


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

For 2022/23 the Trust has introduced the "Making Data Count" variation and assurance icons. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five

variation icons which is based solely on the data and the SPC rules. Ideally the assurance icon should be blue “P” icon which notes the indicator is consistently passing its target over the last 6 months. Again, ideally the variation icon should be either the grey “common cause variation” icon or a blue “H” or “L” icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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

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

Income Statement, Activity Summary and Use of Resources Ratings as at 30th April 2024

Income Statement	Annual	Month		
	Budget £000	Budget £000	Actual £000	Variance £000
Operating Income				
NHS Clinical Income	**315,856**	**25,977**	**25,960**	**-17**
Non NHS Clinical Income				
Private Patients	8	1	0	0
Non NHS Overseas Patients	70	6	7	1
Other non protected	670	56	114	58
Sub total	**748**	**62**	**121**	**59**
Other Operating Income				
Training & Education	9,541	795	929	134
Donations and Grants	95	8	8	0
Miscellaneous Income	14,338	1,194	1,170	-24
Sub total	**23,974**	**1,997**	**2,107**	**110**
Total Operating Income	**340,578**	**28,036**	**28,187**	**151**
Operating Expenses				
Employee Benefit Expenses	-258,564	-22,170	-22,590	-420
Drugs	-21,980	-1,832	-2,076	-245
Clinical Supplies and Services	-24,184	-2,115	-2,125	-10
Non Clinical Supplies	-46,765	-3,886	-3,952	-66
Depreciation and Amortisation	-15,843	-1,320	-1,320	0
Net Impairments (DEL)	0	0	0	0
Net Impairments (AME)	0	0	0	0
Restructuring Costs	0	0	0	0
Total Operating Expenses	**-367,337**	**-31,323**	**-32,064**	**-741**
Operating Surplus / (Deficit)	**-26,759**	**-3,287**	**-3,876**	**-589**
Non Operating Income and Expenses				
Profit / (Loss) on disposal of assets	0	0	-4	-4
Interest Income	393	33	129	96
Interest Expenses	-147	-12	-13	-1
PDC Dividends	-5,130	-428	-428	0
Total Non Operating Income and Expenses	**-4,884**	**-407**	**-316**	**91**
Surplus / (Deficit) - as per Accounts	**-31,643**	**-3,694**	**-4,192**	**-498**
Adjustments to Financial Performance				
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0
Less Donations & Grants Income	-95	-8	-8	0
Add Depreciation on Donated & Granted Assets	487	41	41	0
Total Adjustments to Financial Performance	**392**	**33**	**33**	**0**
Adjusted Surplus / (Deficit) as per NHSI Return	**-31,252**	**-3,661**	**-4,160**	**-498**

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/35 (a)	Meeting	Trust Board	Date Of Meeting	5 June 2024

Date of Meeting	9 April 2024
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/04/007	**Patient Safety and Clinical effectiveness Sub-Committee Exception Report**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the committee which included reporting on fragile services: • **Paediatric Opthalmology** • **Urology** • **Fractured Neck of Femur** • **ENT** • **Gynaecology** Of the items escalated to the Sub-Committee, of particular note was: 1. Escalation of patients with suspected stroke and utilisation of the stroke pathway. 2. Theatre utilisation in relation to patients with Fractured Neck of Femur (NOF) due to increasing capacity demand across other surgical pathways	**Moderate:** **Continued backlog in Urology/ENT** **Challenge in time to theatre for NOF**	**Substantial:** **Monthly reporting with Executive oversight through PSCESC** **Escalation processes in place**	**PSCESC** **Stroke Pathway Deep Dive Hot Topic to be presented to the committee Q2**
QAC/24/04/08	**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:	**Moderate:**	**Substantial:**	**Quality Assurance**

		• Continuing themes of increased acuity in the waiting room • Continued high acuity of patients on the ED corridor. Harm profile was presented with incident themes noted as increased occupancy in the waiting room/triage and corridor areas department as a factor. Immediate actions and responses presented to the committee. Recommendations from ECIST report noted further to visit March 2024.	**Continued increased numbers and acuity of patients in ED** **Trust escalation areas remain open** **Reliance on external stakeholders**	**Bi- weekly ED Improvement Meetings in place** **Will be agenda item for new Quality Oversight Group** **Reports to UEC System Improvement**	**Committee May 2024**
QAC/24/04/09	**Cancer Nurse Specialists**	Further to a Deep Dive in October 2023 an update report was presented to the Committee, the following key challenges and risks were highlighted: • Current establishment • Increased demand on service • Risk to quality of patient care- attendance with patients at clinic appointments. External investment for funding for Cancer Nurse Specialist posts sought and quality monitoring continues.	**Moderate:** **Increased caseload for existing staff**	**Substantial:** **Cancer Outcomes Data Set** **PESC** **Quality Surveillance Standards**	**Trust Executive Meeting Q2**
QAC/24/04/15	**Inpatient Survey and Action Plan/Patient Experience**	The Committee received the Patient Experience Annual Report and Inpatient Survey Action Plan. Areas covered were • Patient Feedback • Volunteers • Good practice	**Moderate:** **Ongoing action plan in place**	**Substantial:** **Monthly review and oversight at**	**Patient Experience Sub-Committee**

	Annual Report	• National inpatient survey PLACE survey results were discussed with improvements needed across the Trust estate for patients living with dementia. A point of discussion was the expression of interest submitted by WHH to be selected as an early implementer for the roll out of Martha's Rule		**Sub-committee**	**Quality Assurance Committee Q3 2024**

The Committee also received the following items;

QAC/24/04/04 Patient Story "Privacy and Dignity in Endoscopy"
QAC/24/04/05 Deep Dive – Infection Prevention and Control
QAC/25/04/06 Board Assurance Framework
QAC/24/04/08 CQC Engagement Meeting update (verbal)
QAC/24/04/10 Quality IPR Metrics
QAC/24/04/11 Maternity Update
- Ockenden
- Perinatal Mortality Annual Report
- Maternity and Neonatal Review
- Maternity Incentive Scheme including Saving Babies Lives

QAC/24/04/12 Arbury Court Update
QAC/24/04/13 Cardio-pulmonary Resuscitation Decisions- 6 Monthly Position
QAC/24/04/14 Palliative and End of Life Care Bi-annual Report
QAC/24/04/16 Claims Update Report

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

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

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/35 (a)	Meeting	Trust Board	Date Of Meeting	5 June 2024

Date of Meeting	7 May 2024
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/05/28	**ED Harm Profile, Triage and Pathways**	The Committee received a presentation providing an update on the ED harm profile, triage and pathways. The following key challenges, risks and actions were highlighted: • Increased acuity continues in waiting room and long waits in the department • Patients held on ambulances due to capacity • Review of harm • Reallocation of staff to meet demand (waiting room nurse) • Mental Health bed demand- long delays • Manchester Triage go live April • Review SDEC to support streaming A point of note was in relation to the harm profile and the triangulation against harm and occupancy/corridor care.	**Moderate:** **Continued increased numbers and acuity of patients in ED** **Trust escalation areas remain open** **Reliance on external stakeholders**	**Substantial:** **Bi- weekly ED Improvement Meetings in place** **Will be agenda item for new Quality Oversight Group** **Reports to UEC System Improvement**	**Quality Assurance Committee June 2024**

QAC/24/05/29	**Deep Dive Culture Plan**	The Committee received a presentation providing the Trust Culture Plan. Launched at the Start of the Year Conference the presentation provided a baseline assessment of departments in relation to their stage on the continuum of culture improvement. Information and data to inform this measurement from • Staff Survey • DATIX • Freedom to Speak Up (FTSU) • DATIX • EDI • Grievances Areas requiring support with culture improvement were highlighted. A discussion point, and included in the presentation, was the integration across executive portfolios as the Trust Ward Accreditation programme has been recently updated to align to the culture work.	**Substantial:** **Departments received plan and actions developing** **Culture Champions** **Staff voices forum to commence June 2024** **Ward Accreditation Programme in place**	**Substantial:** **Progress reporting into Strategic People Committee** **Quality Assurance Committee oversight**	**Strategic People Committee June 2024**
QAC/24/05/34	**Maternity Update**	The Maternity Update Reports were presented to the committee which included: • Ockenden • Perinatal Mortality Review Update Q4 2023/24 • Maternity and Neonatal Review • Maternity Incentive Scheme including Saving Babies Lives • Maternity Self-Assessment Tool A point of note was the increased rate of still birth for Q4 (5). Initial safety reviews to be undertaken for all cases. The annual mean stillbirth rate at WHH for 2023/24 is 2.71 per 1000 births, below the national average of 4.1/1000 births.	**Substantial:** **Below mean national average for Stillbirth (increased in Q4)** **Neonatal Mortality rate increase**	**High:** **Robust oversight processes in place** **Monthly reporting to Quality Assurance Committee**	**Trust Board June 2024** **Quality Assurance Committee June 2024**

			Further work ongoing related to diabetes in pregnancy	**LMNS** **Oversight at Trust Board**	
QAC/24/05/35	**Mental Health Update**	The committee received a verbal update in relation to Mental Health which included: • Right Care Right Person Phase 1 went live in January • Complexity and acuity of patients with mental health presentations continues to increase • Escalation processes in place • Training- Enhanced Care/Mental Health Act paperwork • Mental Health Strategy • Escalation process A point of discussion was in relation to delays noted in discharge of mental health in patients and the challenges associated with the legal framework during their stay.	**Moderate:** **Increased acuity and attends continue** **Reliance on external stakeholders**	**Moderate:** **Mental Health Steering Group Safeguarding Committee** **Mental Act Paperwork (in relation to inpatients)**	**Quality Assurance Committee August 2024**

The Committee also received the following items;

QAC/24/05/30	Compliance Update Q4
QAC/24/05/31	Quality Account (Draft)
QAC/24/05/32	Patient Safety Clinical Effectiveness Sub Committee – Exception Report
QAC/24/05/33	Sepsis High Level Update Q4
QAC/24/05/36	CIP/GIRFT Quality Impact Assessment Compliance
QAC/24/05/37	Learning from Experience Report Q4
QAC/24/05/38	Director of Infection & Prevention Control Q4 Report
QAC/24/05/39	Violence Reduction Strategy Update
QAC/24/05/40	Enabling Strategies Alignment Progress Report

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

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

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/035	Meeting	Trust Board	Date Of Meeting	5 June 2024

Date of Meeting	17 April 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/24/04/04	**Hot Topic – Vacancy Management**	The Committee received a detailed presentation in relation to the Vacancy Request ECF process. The Committee noted that the Trust received a letter in March 2024, regarding the initiation of a temporary vacancy freeze for non-clinical roles with immediate effect. As such, a review of current establishment control processes has been undertaken and the Committee praised the quick response undertaken to establish this review. The Committee discussed that further steps may include CEO and ICS sign off however this was still to be determined. Whilst assurance was provided, discussions included staff welfare and morale, the Committee were assured that robust processes were in place to manage this. The Committee noted the strong assurance regarding the process and actions taken to ensure staff welfare has been considered.	The Committee discussed the presentation and received **substantial assurance**.	**N/A**
SPC/24/04/05	**Deep Dive – Culture**	The Committee received a presentation which introduced the We Are WHH: Culture Plan. The Committee noted the intelligence and evidence-based practice which has informed the plan, whilst	The Committee discussed the presentation and received **substantial assurance**.	**Bi-Annual**

		also receiving an overview of the approach to be taken and direction of travel. Discussions at the Committee included the connection between the Culture Plan and the Ward Accreditation process, allowing for synergy of both programmes. Additionally, mapping the Fragile Services reporting into the Culture Plan ensuring data is triangulated. The Committee discussed receiving an update on this work on a bi-annual basis to ensure measures of improvement are monitored.		
SPC/24/04/06	**Board Assurance Report**	The Committee received an update on the Board Assurance Framework further to discussions held at the previous meeting. A discussion by the Committee approved the reduction of risk 1134 from a score of 20 to 12, this follows the robust conversation in February 2024. In addition, the Committee approved the updated risk description for risk 1757 and noted good assurance on the dynamic approach to the management of risks.	The Committee discussed the presentation and received **substantial assurance**.	**June 2024**
SPC/24/04/07	**Workforce Brief on National, Regional, ICB or Local Workforce Issues**	The Committee received the report with updates on the Consultant pay offer, Operational Planning Guidance and the national People policies guidance and local oversight. The Committee were assured on the updates provided regarding national and local issues.	The Committee discussed the presentation and received **substantial assurance**.	**N/A**
SPC/24/04/08	**Chief People Officer Report**	The Committee received the report which included updates on agile and flexible working, annual leave entitlement and the Payroll and Pensions Team. The Committee were assured however noted a progress update on the flexible working pilots would need to come back to the Committee with a report linked to retention.	The Committee discussed the presentation and received **substantial assurance**.	**Bi-Annual**

SPC/24/04/09	**People Strategy Update**	The Committee noted the report and assurances provided. The Committee highlighted positive progress in delivery of the strategy. Discussions arose around the organisation's response to the Band 2-3 Health Care Assistants Industrial Action and subsequent re-banding framework. The Committee noted positive assurance regarding the response and actions which have been undertaken.	The Committee discussed the presentation and received **substantial assurance**.	**Bi-Annual**
SPC/24/04/10	**Guardian of Safe Working**	The Committee noted the update and assurances provided. The Committee also noted that in future the Guardian of Safe Working will be attending the Strategic People Committee to present updates on the report quarterly.	The Committee discussed the presentation and received **substantial assurance**.	**Quarterly**
SPC/24/04/11	**Safe Staffing Report**	The Committee received the report noting particularly the positive workforce metrics regarding a reduction in turnover. The Committee however did note that an update of the Safer Nursing Care Tool, which is an evidence-based tool utilised by Chief Nurses was being reviewed. The Committee noted the new tool takes account of additional criteria for patients who require enhanced care. The Committee were assured this review would be completed internally and be aligned to the updated vacancy control measures and staffing levels in place. The Committee were assured of the update however noted an update on the Safer Nursing Care Tool would be presented as part of future updates to the Committee.	The Committee received **moderate assurance** with further clarity regarding the Safer Nursing Care Tool required.	**Monthly**

The Committee also received the following items:

Matters to Note for Assurance
SPC/24/04/12 – Review of use of Red Flags (Safer Staffing)
SPC/24/04/15 – Committee Effectiveness Review Results 2023/24

Sub-Committee Minutes/Notes
SPC/24/04/13 – Workforce Review Group
SPC/24/04/14 – Workforce Equality, Diversity and Inclusion Sub-Committee

Assurance Key:

Level of Assurance	Description
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/035	Meeting	Trust Board	Date Of Meeting	5th June 2024

Date of Meeting	Wednesday 15th May 2024
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
SPC/24/05/22	Deep Dive – Bank Reduction	**Chief Nurse** The Committee received an overview of the top reasons for bank use which include covering vacancies, escalation of site and sickness absence, particularly amongst HCAs and a further deep dive will be undertaken. There has been a positive impact on the workforce in relation to the drive to reduce agency reliance resulting in positive recruitment, safer corridor care, improved morale and improved workforce metrics. A bank reduction plan was presented to provide additional assurance to the Committee which includes a focus on e-roster; increased frequency of recruitment; delivering the people promise and culture plan; review of enhanced care approach and police, mental health strategy rollout to support staff with increasing mental health patient demands; and increase in volunteer presence in clinical areas.	The Committee received **limited assurance** as the actions to support improving bank reliance have not yet started.	The Committee received **substantial assurance** on the governance of the process and the approach to reduce bank reliance.	September 2024

SPC/24/05/24	Chief People Officer Report	**Deputy Chief People Officer** An update was provided on the decision by the Trust to pause all deductions for staff breaching the National Living Wage (Salary Sacrifice, lottery, car parking, etc) with employees impacted being informed that a decision will be made on recovery once the pay award for 24/25 is known, and the Trust can calculate if it is reasonable and affordable for people to pay back the various deductions. This is most likely to impact individuals on Bands 1 and 2. The Committee were advised that the Trust have been in talks with HMRC and NHS Employers for the best solutions and NHS Employers stated this approach was pragmatic and sensible. The Committee requested that an evaluation of staff benefits is undertaken to ensure the reward and recognition policy which is currently being drafted is fair to all staff. In addition, the Committee received an update on the HCA rebanding process where a review is being undertaken in areas where low numbers of applications have been received.	The Committee received **limited assurance** on delivery due to the work agreed regarding equity of reward and recognition within the organisation.	The Committee received **moderate assurance** around governance due to further work to be implemented on the advice of HMRC and NHS Employers regarding the national living wage.	August 2024
SPC/24/05/26	Gender Pay Gap Annual Report	**Head of Culture and Inclusion** The Committee received the annual Gender Pay Gap report for the organisation. Headline figures include the gender split remaining the same as the previous year, with the mean and median pay gap continuing to decrease. The Committee was made aware that Local Clinical Excellence Awards will cease moving forward with pre-2018 remaining in place which may have a detrimental impact on the bonus pay figures in future reports.	The Committee received **substantial assurance** on the actions taken to reduce the gender pay gap in the organisation.	The Committee received **high assurance** on the governance processes associated with the delivery of the actions outlined in the paper.	Q4 2024/25

		There is a 3 year action plan and further updates against progress will be brought back to the Committee though the Workforce Equality, Diversity and Inclusion Strategy Committee updates.			
SPC/24/25/27	Health and Wellbeing Guardian Annual Report	**Associate Chief People Officer: Culture and Wellbeing** The Committee received an annual report on the work undertaken against the national Wellbeing Guardian Principles, noting that the principles changed and evolved during Q4 2023/24. Assurance of activity is provided to the Wellbeing Guardian on a monthly basis The approach to supporting health and wellbeing in the workplace is evidence based, and examples were given where interventions have had a positive impact on the health of the workforce. Significant work has been undertaken to support health and wellbeing in the workplace, including triangulation of data to continue to support health promotion and prevention as part of the Public Health approach. The Committee were keen to see data and further information on the cost and impact of interventions which will be provided as part of the 6 monthly update to the Committee.	The Committee received **moderate assurance** relating to the need to understand further the impact of interventions on the workforce which will be reflected in the bi-annual Health and Wellbeing Guardian report and CPO reports as appropriate.	The Committee received **substantial assurance** in terms of the governance processes regarding the health and wellbeing of the workforce.	October 2024
SPC/24/05/29	Midwifery Safer Staffing Q4 report	**Director of Midwifery** The Committee were given an overview of safer staffing within Midwifery. The retention rates within midwifery remain good. Turnover is below Trust target which has been maintained since December 2023. Key items of note presented included the SafeCare reporting episodes. From 1st January 2024 – 31st March 2024, there were no episodes recorded in SafeCare where the Birthing Suite Coordinator was not	The Committee received **substantial assurance** on the work undertaken to support continued improvement within midwifery.	The Committee received **substantial assurance** on the governance processes within midwifery safer staffing.	August 2024

		supernumerary and where a woman in active labour was not receiving 1:1 care which is positive. The Committee were advised that the team are currently undertaking a deep dive in terms of their workforce and activity data against national and local metrics, findings of which will be reported in future Midwifery safer staffing report to SPC.			

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

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/035 (i)	Meeting	Trust Board	Date Of Meeting	5 June 2024

Date of Meeting	24 April 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	Governance	Deliverability	Follow up / Review date
FSC/24/04/004	**Hot Topic – Road to Recovery – 5 Year Plan**	The Committee received the presentation noting:- • Key changes since the recovery plan was submitted to the ICS • Expectation is that sustainability will be reached by 2029/30 compared to 2025/26 in the previous submission due to schemes expected to take longer to be implemented	The Committee **noted** and discussed the presentation receiving **substantial** assurance of the overview presented	The Committee received **limited** assurance based on delivery of the plan	
FSC/24/04/005	**Deep Dive – GIRFT & Transformation**	The Committee received the presentation noting:- • Differing requirements of each speciality therefore to be quantified at this level to increase accountability and deliverability • Governance around the Improvement agenda including external governance relating to UEC • The quantified opportunities for elective theatres and UEC are less than the planned amounts • More scrutiny in the year to monitor trajectories and enforce accountability to ensure delivery in the year	The Committee **noted** and discussed the presentation receiving **substantial** assurance around plans in place	The Committee received **limited** assurance based on delivery of the plan	
FSC/24/04/007	**Corporate Performa**	The Committee received the report noting:-	The Committee **noted** and discussed the	The Committee received **moderate** assurance given	**FSC May 2024**

	nce Report	• The Trust did not achieve 78-week clearance with 66 patients remaining and were worst in the C&M ICS at year end, starting to see an improvement through the month • Will not move into tier 1. If all 65 week waiters cleared by September 2024, out of tier 2 • A10 still in escalation which is not funded, more detail to come back to FSC	presentation receiving **substantial** assurance around level of detail reported	some metrics are not achieving.	
FSC/24/04/009	**Monthly CIP & GIRFT Update**	The Committee received the report noting:- • CIP overview highlighting a shortfall of £1.9m against a £17.9m plan • £7.3m delivered recurrently (41%) • The impact of the £10.6m undelivered and non-recurrent CIP on the 2024/25 financial plan • Review of investments greater than £250k, corporate investment increased by 39% compared to 31% in clinical, further scrutiny needed in the context of further CIP identification • Need to achieve 104% activity for GIRFT to deliver in 2024/25	The Committee **noted** and discussed the report receiving **substantial** assurance around in year delivery and plans in place	The Committee received **limited** assurance based on delivery of next year's plan	**FSC May 2024**
FSC/24/04/012	**Pay Assurance Report**	The Committee received the report noting:- • Externally funded posts to be showed separately in 2024/25 reports • Changes in ECF process given the additional scrutiny on recruitment, with 3 tiers of review including triangulation with CIP achievement • Agency and rate card compliance have seen significant improvement from the prior year • Bank reduction action plan being developed and more detail to be included in future reports	The Committee **noted** the report, receiving **substantial** assurance on the detailed workforce information.	The Committee received **substantial** assurance based on the reduction in agency and rate card compliance.	**FSC May 2024**
FSC/24/04/013	**Operational Plan & Budgets 2024/25**	The Committee received the presentation noting:- • Operational plan has improved from £35.3m to £31.2m and to be submitted to the ICS at this level following Trust Board approval • The plan is being submitted based on the ask of the System, there is a significant risk around deliverability of the plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance due to process being	The Committee received **limited** assurance due to the concerns regarding deliverability of the plan.	

			followed prior to submission		
FSC/24/04/014	**Finance Report**	The Committee received a report noting:- • The year end position is a £30m deficit as agreed by the ICS • Year end accounts have been submitted and are now subject to audit • Revenue requests supported by the Executive Team highlighted in the report	The Committee **noted** the paper receiving **substantial** assurance due to covering all areas required.	The Committee received **moderate** assurance due to the overspend against plan.	**FSC May 2024**
FSC/24/04/016	**Capital Position and Annual Plan 2024/25**	The Committee received a presentation noting:- • The year end capital spend of £29m with an ICS agreed overspend • Final movements in capital contingency for the year were approved, finishing the year with an ICS agreed overspend of £0.3m	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the contingency changes	The Committee received **substantial** assurance due achieving the ICS agreed plan.	**FSC May 2024**

Assurance Key:

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Items for noting

FSC/24/04/006 Board Assurance Report and Risk Register
FSC/24/04/008 Recovery Update (Review of 2023/24 additional spend)
FSC/24/04/010 Cost Pressures M12 2023/24
FSC/24/04/011 EPRR Core Assurance Update
FSC/24/04/015 Laboratory Information Management System (LIMS) Full Business Case verbal update
FSC/24/04/016 Schemes over £500k

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/035c (ii)	Meeting	Trust Board	Date Of Meeting	5 June 2024

Date of Meeting	22 May 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/05/26	**Hot Topic – Bank Reduction Plan**	The Committee received the presentation noting:- • Vacancies and agency usage reducing leading to increase in bank use • M1 bank spend £2.5m (nursing £1.5m) • M1 agency spend £0.27m (nursing £0.11m) • Most bank spend over the last four years is in A&E and ICU • Main reasons for bank usage are vacancies, escalation and sickness • Bank reduction plan includes rosters review and enhanced scrutiny	The Committee received **moderate** assurance based on delivery of the plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance around plans in place	
FSC/24/05/27	**Deep Dive – Theatre Capacity / Productivity**	The Committee received the presentation noting:- • The key challenges for theatres in achieving the 85% utilisation target (currently at 71%, 8th worst out of 122) • Main drivers to achieve utilisation are reduction of on the day cancellations, reduction in late starts, job plan alignment and benchmarking review to focus efforts • Plans to increase utilisation to 75% by the end of Q2, 79% by the end of Q3 and 85% by the end of Q4 in some specialities (others to be in line with provider median), to be monitored by FSC	The Committee received **moderate** assurance based on delivery of the plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance around plans in place	**FSC October 2024**

FSC/24/05/27	**Corporate Performance Report**	The Committee received the report noting:- • Time in department is showing a maintained position however the Trust has not yet received a clear timetable for coming out of tier 1 • Tier 2 metrics, 78 weeks to be achieved by the end of June however some choice and complex patients are likely to be remaining. Plan for 65 week waiters to be achieved by March 2025 • Regional benchmarking, the Trust still remains bottom of the table in relation to 78 week waiters though have closed the gap. No longer bottom of the table for 65 and 52 week waiters (11 out of 12 for both now therefore still work to do) • The Trust's productivity continues to be low however non-elective pressures have an impact on the Trust's ability to improve elective productivity	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the presentation receiving **substantial** assurance around level of detail reported	**FSC June 2024**
FSC/24/05/30	**Monthly CIP & GIRFT Update**	The Committee received the report noting:- • M1 target of £0.65m achieved, mainly by central non-recurrent schemes • £9.6m of £19.4m target identified, gap of £9.8m needs to be bridged • Gap in theatre opportunity of £3.4m, planned achievement of outpatients target however there is a high risk of delivery • Newton work identified a £7m opportunity for the Trust, further work has been undertaken to determine savings in year (£0.25m).	The Committee received **limited** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **limited** assurance around plans in place	**FSC June 2024**
FSC/24/05/31	**Cost Pressures M1**	The Committee received the report noting:- • Some cost pressures have not ceased as planned, if continue at level of M1 there would be an £8m increase in the financial deficit • Peer review by the Executive Team to take place this week	The Committee received **limited** assurance based on continuing spend on cost pressures	The Committee **noted** and discussed the report receiving **substantial** assurance of the review	**FSC June 2024**
FSC/24/05/32	**Cash Support Q1 & Q2**	The Committee received the report noting:- • Reasons for reduction in cash drawdown in March 2024 and Q1 2024/25 compared to initial request	The Committee received **substantial** assurance on the	The Committee **noted** the report receiving **substantial**	**Trust Board June 2024**

		• Support for £10.4m request for cash in Q2	monitoring of cash requirements	assurance and **supported** the cash request for Q2	
FSC/24/05/35	**Pay Assurance Report**	The Committee received the report noting:- • Achievement of workforce reduction in M1, positive from C&M perspective compared to other trusts • ECFs are reducing with more challenge at local and Executives panels as well as behaviours changing throughout the Trust leading to fewer requests being put forward	The Committee received **substantial** assurance based on the controls around the new ECF process.	The Committee **noted** the report, receiving **substantial** assurance on the detailed workforce information.	**FSC June 2024**
FSC/24/05/38	**LIMS Full Business Case**	The Committee received a business case noting:- • The financial risk for the Trust has been raised with the Pathology Network, mechanism agreed to ensure that no organisation will be disadvantaged once benefits are realised • The overall benefits of the business case are significant even though there is a risk to WHH. ICB will cover any shortfall over £100k each year until benefits are realised at which point this funding will be clawed back over a period of 6 years • Supported for approval at Trust Board subject to the risk and gain share agreement being formally agreed by all organisations	The Committee received **limited** assurance based on the financial risk to the organisation	The Committee **noted** and discussed the business case receiving **moderate** assurance and supported the business case for Trust Board approval	**Trust Board June 2024**
FSC/24/05/39	**Estates Strategy**	The Committee received a report noting:- • The 5 year Estates Strategy across both sites, includes option A for a new hospital and option B for site reconfiguration • Supported for approval at Trust Board with an interim review required within 2 years to incorporate the Bridgewater integration once plans are finalised	The Committee received **substantial** assurance based on current plans in place	The Committee **noted** and discussed the report receiving **substantial** assurance and supported the strategy	**Trust Board June 2024**
FSC/24/05/40	**Finance Report Month 1**	The Committee received a report noting:- • Letter from the ICS noting expectations for the 2024/25 plan • Technical adjustments by the ICS reduces the plan to £30.8m deficit • £5m improvement expected from the integration work • Risks around CIP delivery, cost pressures overspending and activity delivery up to the 104% income target	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance due to covering all areas required.	**FSC June 2024**

		• £0.5m off plan at M1, 4th worst in C&M however CIP is backloaded			
FSC/24/05/41	**Capital Position Month 1**	The Committee received a presentation noting:- • M1 spend is in line with plan except the IFRS16 expenditure however phasing will be updated in revised plan submission to correct • Movements in capital oversubscription and contingency were approved	The Committee received **substantial** assurance due to spend being in line with plan.	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the oversubscription and contingency changes	**FSC June 2024**

Items for noting

FSC/24/05/26 Board Assurance Report and Risk Register
FSC/24/05/28 Recovery Update
FSC/24/05/29 Sustainability Strategic Priorities Bi-Annual Report
FSC/24/05/33 Benefits Realisation Q4 Update
FSC/24/05/34 Indicative Financial Cost of Harm
FSC/24/05/36 Medical Workforce Review Group Q4 Update
FSC/24/05/37 A10 and B4 Update
FSC/24/05/41 Schemes over £500k
FSC/24/05/42 Digital Strategy Group Update

Assurance Key:

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Trust Board: Committee Assurance Report

Agenda Reference	BM/24/06/035 (d)	Meeting	Trust Board	Date Of Meeting	5 June 2024

Date of Meeting	25 April 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:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
AC/24/04/04	**Losses & Special Payments – Update from the Chief Pharmacist**	Following a request at the previous meeting, the Chief Pharmacist provided an update to the Committee specifically relating to losses within Pharmacy. It was explained that the losses within pharmacy were broken down in to four categories; stock adjustments, expired stock, chemotherapy losses and aseptic losses	**Moderate** – The Committee received moderate assurance; however, the service was currently under review	**Substantial** – it was evidenced that the Trust had substantial Governance systems and processes in place	**22.08.2024**
AC/24/04/06	**Committee Assurance Updates**	The committee received a verbal update from each of the Chairs of the boards subcommittees, following the review of their effectiveness for 2023/24. The chair noted the effective triangulation of information across the committees ensuring that elements of quality, people and finance and sustainability were reviewed in detail by each of the lead committees and outcomes were shared across the other committees.	**High –** the committee received evidence that committees were functioning to a high standard	***High*** **-** the committee agreed effective governance systems and processes were in place for board sub-committees	**n/a**
AC/24/04/07	**Internal Audit Progress Report on Follow Up Actions**	The committee were informed that as of 31 March 2024, there was 1 audit which had 1 overdue management action:	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust had substantial Governance	**n/a**

		Audit: Critical Application – BadgerNet Maternity Review Assignment Review Assignment Report 2022/23 **Action:** Security arrangements - Link user accounts to Active Directory, and routinely track and where possible remove any exceptions – it was explained that the action was off track due to competing priorities in IT. The committee were advised the action had been reviewed and despite the outstanding issues, the risk had decreased and therefore would be included and signed off in the next report.		systems and processes in place	
AC/24/04/09	**Head of Internal Audit Opinion**	The committee received Assurace that The overall opinion for the period 1st April 2023 to 31st March 2024 provided **Substantial** Assurance, showing there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently. The opinion was provided in the context that the Trust like other organisations across the NHS are facing a number of challenging issues and wider organisational factors particularly with regards to the ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems.	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust had substantial Governance systems and processes in place	n/a
AC/24/04/16	**Going Concern Annual Report**	The Committee received and approved the preparation of the accounts on the Going Concern basis statement for inclusion in the annual report 2023/24	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust had substantial Governance systems and processes in place	**n/a**

Other agenda items:
AC/24/04/05 – Changes or updates to the BAF

AC/24/04/08 - Internal Audit Plans & Fees
AC/24/04/10 - Internal Audit Progress Report, *Review of Capital Budget Management – Fire Alarm Upgrade Project*
AC/24/04/11 - Internal Audit Charter Annual Report
AC/24/04/12 - Anti-Fraud Annual Report
AC/24/04/13 - External Audit Plan & Fees
AC/24/04/14 - Review Losses & Special Payments
AC/24/04/15 - Review of Quotation + Tender Waivers
AC/24/04/17 - DRAFT Unaudited Accounts & Financial Statements
AC/24/04/18 - DRAFT Annual Governance Statement
AC/24/04/19 - DRAFT Annual Report
AC/24/04/20 - Review of Trust Register, Declarations of Interest Annual Report
AC/24/04/21 - Compliance with Code of Governance for NHS provider trusts
AC/24/04/22 - Committee Effectiveness Review Results 2023/24
AC/24/04/23 - Causeway update

Assurance Key:
Delivery Assurance: *Assurance in achieving outcomes*

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

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

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/036**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	05 June 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: Stroke (stepped up) Urology Gynaecological surgery Orthopaedics – Fractured Neck of Femur ENT Paediatric Ophthalmology (stepped down)		
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 Paediatric Ophthalmology has been deescalated from Fragile Services Oversight • Note that Stroke Services have been escalated into Fragile Services Oversight • Receive further Fragile Service Oversight reports		
PREVIOUSLY CONSIDERED BY:	**Committee**		
	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/24/06/036

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

Stroke Services

- Escalated following presentation to April PSCESC
- First fragile services report received at PSCESC 28/05/24
- Issues identified with pathway include the number of direct Acute Stroke admissions to the Warrington site (which is not commissioned to provide an Acute Stroke Service) and delays in repatriation from Whiston to the Warrington site.
- No harm identified.
- Demand and capacity exercise underway, engagement with Whiston service underway, Deep Dive with plan to be presented to QAC.

3. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Increasingly static P2 position (comparative to P3 & P4) reported as being reflective of core theatre capacity constraints.
- 5 in year incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged. 1 low harm incident identified since last report.
- Transperineal Biopsy position very significantly improved from peak (>60% reduction)
- Surveillance cystoscopy position improved (>75% reduction from peak).
- P2 backlog static and remains of concern – reflective of high numbers of referrals and limited core capacity for higher complexity work
- Significant volume of high risk patients confirmed by AI list validation
- Ongoing risk of harm remains given P2/Stone and surveillance cystoscopy backlogs
- Service exceeding clinical activity targets (>105% of 19/20 activity)
- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved and actioned
    - 3 Middle Grade doctors commenced in post – 2 require additional training before full effect will be felt
    - Locum consultants commenced in post April 2024

- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site
    - PCNL Stone patients transferred to Chester
    - Ongoing harm review process
- Ongoing improvement plan actions:
    - Plan to reintroduce PCNL at Warrington site 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 – may need some staggering to avoid an excessive loss of core capacity to training lists
    - Feasibility of moving cystoscopy lists from Halton to UIU to be trialled.
    - Theatres demand and capacity review

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 - Dedicated 2WW / CFT clinic continues to mitigate for risk
- Successful trial of one stop long waiter clinics in WLI / Outsourced capacity
- 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.
    - New consultants - 1 replacement, commences May 2024, 1 new post commences August 2024
    - Successful trial of one stop long waiter clinics in WLI / Outsourced capacity
- Current mitigations
    - Insourcing and WLI as appropriate/available
    - AI aided Harm Review process in place
    - Daily 2WW performance tracker in place
- Ongoing improvement plan actions:
    - Triage/Advice and Guidance workstream
    - Further development of Halton HVLC and Complex patient 'Superweeks'/'Superlists'
    - Incorporate 1-stop clinics into core capacity in consultant job plans

Orthopaedics – Fractured Neck of Femur

- Demand and capacity mismatch – driven predominantly by increased demand and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery is the remaining significant challenge
- Current mitigations:
    - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
    - Additional orthogertiatrican and orthogeriatric fellow in post

- Additional ad hoc fractured neck of femur lists utilising bank locum consultant
- Ongoing improvement plan actions:
  - Focused improvement plan to deliver 'prompt surgery'
  - Development of escalation SOP to ensure that prolonged delays to theatre are escalated and managed appropriately triggered by wait time, rather than numbers waiting
  - Develop plan for sustaining orthogeriatric cover with changes in Geriatric medicine staffing

Ear Nose and Throat Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Significant medical staffing challenges – deanery withdrawal of juniors
- Emergent growth in 2 week wait cancer demand
- ENT currently has the Trust's largest backlog
- No harm reported to date
- Additional capacity via LLP is supporting the reduction of patients awaiting 1st OPD appointment within the 65 and 78-week waiting cohort
- New OP waiting list has reduced significantly in month from >3500 to <2000.
- FU OP waiting lists remain a challenge
- High risk FU patients continue to be prioritised
- Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
  - NHS Locum recruited and has commenced in post
  - Additional ENT stacker and scope procured for Warrington site
- Current mitigations
  - Outsourced sessions funded and underway
  - AI aided Harm Review process in place
- Ongoing improvement plan actions:
  - GIRFT Further, Faster baseline assessment and action plan outstanding
  - Incorporate Triage and clinical waiting list validation into job plans
  - To revisit case for 4th consultant in 2025/26
  - Recruit to ensure sustainable medical staffing

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

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 – no high-risk patients remain on list
- No harm identified

Stepped down from Fragile Services Oversight at PSCESC 28/5/24 – oversight of remaining low risk actions (implementation of Retinopathy of Prematurity camera screening) to be maintained by CBU and Care Group.

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note that Paediatric Ophthalmology has been deescalated from Fragile Services Oversight
- Note that Stroke Services have been escalated into Fragile Services Oversight
- Receive further Fragile Service Oversight reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/037**	
SUBJECT:	**National Inpatient Survey**	
DATE OF MEETING:	5 June 2024	
AUTHOR(S):	Tracy Fennell, Deputy Chief Nurse/Director of Clinical Governance.	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah – Chief Nurse.	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff. **#125** If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns.	
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):*	The National Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission

	(CQC). The survey gathers experiences of adults who stayed a minimum of one night (16 years or older, excluding Maternity) at Warrington and Halton Teaching Hospital (WHH) in November 2022. The National Inpatient Survey results were published by CQC in September 2023. The National Adult Inpatient Survey uses both online and paper methodology, the results are compared against the 2021 results and benchmarked against other Trusts both regionally and nationally. In total 133 NHS Acute and Specialist trusts were survey in England, with responses from 63,224 patients. WHH overall response rate was 29% compared to a national average response rate of 40%. At WHH patient participant demographics consisted of: WHH did not benchmark lower than other Trusts in any areas and ranked somewhat better than other Trusts on 2 questions. The 2022 action plan has been produced, containing 42 actions across the 11 question categories. All actions remain on track. The action plan has been shared with existing workstreams and the overall action plan is tracked and reported quarterly though Patient Experience Sub-Committee, any escalations will be reported to Quality Assurance Committee (QAC).		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Board of Directors are asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/04/15**	
	Date of meeting	9 April 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	National Inpatient Survey	AGENDA REF:	BM/24/06/037

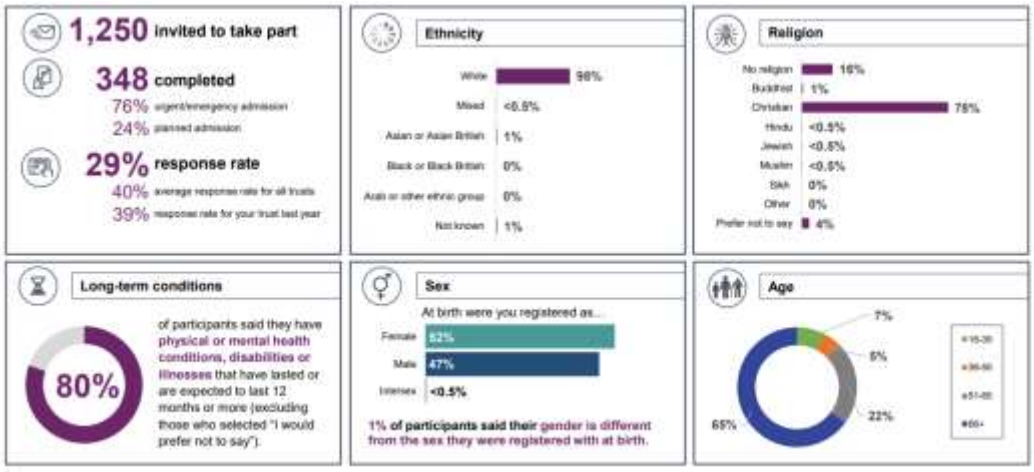
1. BACKGROUND/CONTEXT

The National Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission (CQC). The survey gathers experiences of adults who stayed a minimum of one night (16 years or older, excluding Maternity) at Warrington and Halton Teaching Hospital (WHH) in November 2022. The National Inpatient Survey results were published by CQC in September 2023.

2. KEY ELEMENTS

The National Adult Inpatient Survey uses both online and paper methodology, the results are compared against the 2021 results and benchmarked against other Trusts both regionally and nationally. In total 133 NHS Acute and Specialist trusts were survey in England, with responses from 63,224 patients.

WHH overall response rate was 29% compared to a national average response rate of 40%. At WHH patient participant demographics consisted of:



WHH did not benchmark lower than other Trusts in any areas and ranked somewhat better than other Trusts on 2 questions:

- Were you prevented from sleeping at night due to hospital lightning?
- To what extend did you understand the information you were given about what you should or should not do after leaving hospital?

The survey compares WHH 2022 internal results to 2021 performance, this comparison can be seen below:

Section	WHH 2021	WHH 2022
1. Admission to hospital	6.8	6.6
2. The Hospital and ward	7.8	7.7
3. Doctors	8.8	8.8
4. Nurses	8.5	8.4
5. Care and treatment	8.1	8.2
6. Operation and procedures	8.4	8.6
7. Leaving hospital	7.2	7.2
8. Feedback on the quality of your care	1.7	1.9
9. Respect and dignity	9.2	8.8
10. Overall Experience	8.1	8.0
11. Long term condition – not comparable as new question in 2022	NA	6.7

WHH did see decline in 2 individual questions compared to the WHH 2021 survey, however these were not seen as statistically lower than other Trusts.

- Did you get enough help to eat your meals?
- Do you think the hospital staff did everything they could do to help your pain?

Actions to improve these areas feature in the 2022 Inpatient Survey Action Plan and remain on target these will be monitored via Patient Experience Sub Committee quarterly.

Areas identified where patient experience is best at WHH:

- Patients are not concerned with disturbance from hospital lighting and staff, patients at night (both sites).
- Cleanliness of hospital and wards across both sites.
- Taking own medications when needed, including being given pain relief. Higher scores noted on Halton site.
- Questions regarding discussing operations and procedures, pre and post operation provided better than expected results for the Trust as a whole.
- Many positive responses for questions regarding leaving hospital. This included patients, families and carers being involved in decisions when leaving hospital, being given information on advice after discharge, take home medications, contact points for patients who were worried post discharge and knowing what would happen next with care.
- Positive results seen for questions that patients felt they were treated with respect and dignity whilst in the hospital.
- Long term conditions were felt to be taken in account during patients care and treatment in hospital, across both sites.
- Overall experience whilst in hospital was rated much better than expected for both Halton and Warrington sites comparable to other Trusts.
- Waiting list times also noted positive scores in survey results.

Where patient experience could improve (to note: WHH is at national average when benchmarking, areas below are highlighted where scores could show further improvement to achieve higher than the national average)

- Hospital food quality: further improvements possible for patients to have greater access to food outside of set mealtimes.

- Communication: understanding information given by medical/nursing staff, being involved in your care at Warrington site.
- Nursing staffing question and ability to get staff attention when required on Warrington site.
- Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital.
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital.
- Pain control: where patients were in pain, did hospital staff do everything they could to help control their pain.
- Long term conditions: patients feeling that their long-term condition is taken into consideration whilst they were in hospital.

All actions have been completed and closed for the 2021 National Inpatient Survey Action Plan. Key areas identified for improvement for the 2022 action plan are, but not limited to:

- Waiting times.
- Ward moves.
- Communication.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The 2022 action plan has been produced, containing 42 actions across the 11 question categories. All actions remain on track. The action plan has been shared with existing workstreams and the overall action plan is tracked and reported quarterly though Patient Experience Sub-Committee, any escalations will be reported to Quality Assurance Committee (QAC). 2023 National Inpatient Survey results are now being collected. Following widespread Trust promotions, survey responses have already seen a noted increase in a response rate of 36% as of early April (compared to 29% in 2022). The exercise concluded on 19 April 2024 the number of final responses is now being collated.

It is noted WHH has performed well in the 2022 National Inpatient Survey and has mechanisms to further improve and monitor further achievements throughout 2024.

4. RECOMMENDATIONS

The Board of Directors are asked to note the contents of this report.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/038**	
SUBJECT:	Maternity & Neonatal Update	
DATE OF MEETING:	5 June 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of activity performance and quality within the maternity and neonatal services for the months of February and March 2024.

<table>
<tr><td></td><td colspan="4">The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 (Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues) alongside emerging local and regional matters.

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

• Maternity Quality & Safety update February 2024 – appendix 1
• Maternity Quality & Safety update March 2024 – appendix 2
• Maternity Incentive Scheme Year 5 and 6 – appendix 3
• PMRT Annual Review – appendix 4
• PMRT Q4 2023/24 – appendix 5
• Maternity Self Assessment biannual review – appendix 6
• Ockenden position – appendix 7
• Midwifery Safe Staffing Q4 2023/24 – appendix 8</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note the contents of this report ..</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Quality Assurance Committee and Strategic People Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">QAC/24/04/012
QAC/24/05/34
SPC/24/05/29</td></tr>
<tr><td>Date of meeting</td><td colspan="3">9th April 2024
7th May 2024
15th May 2024</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update Summary Report	AGENDA REF:	BM/24/06/038

1. BACKGROUND/CONTEXT

This paper provides an overview of activity, performance and quality within the maternity and neonatal services for the months of February and March 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.

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

- Maternity Quality & Safety update February 2024 – appendix 1
- Maternity Quality & Safety update March 2024 – appendix 2
- Maternity Incentive Scheme Year 5 and 6 – appendix 3
- PMRT Annual Review – appendix 4
- PMRT Q4 2023/24 – appendix 5
- Maternity Self Assessment biannual review – appendix 6
- Ockenden position – appendix 7
- Midwifery Safe Staffing Q4 2023/24 – appendix 8

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

2. QUALITY & SAFETY METRICS

A review of Quality & Safety within the Maternity and Neonatal services is shared with Quality Assurance Committee (QAC) each month across a range of key themes and areas of national and local focus

2.1 Patient Safety Events

In February and March 2024 themes from patient safety events were as follows:

- Admission of term babies to Neonatal Unit
- PPH >1500ml
- PPH >1000ml
- Shoulder Dystocia
- Incidence of 3rd and 4th degree
- PPH >1000ml
- Intrauterine deaths
- Antenatal and Newborn Screening (ANNB) issues.

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

2.2 Workforce metrics

Work remains ongoing across the maternity and neonatal teams to improve and sustain compliance with mandatory training and completion of staff appraisals. At the end of March compliance for mandatory training across maternity and child health colleagues is above the Trust target, with compliance of 87.77% for Trust mandatory training, 87.69% for role specific training and mandatory safeguarding training at 85.73%.

Compliance with PDR completion remains a challenge. Rates in March (excluding long term absence) for maternity and child health services is 72.33%, a reducing position despite an action plan for improvement. A process of reviewing all outstanding PDRs is underway with a trajectory to meet the Trust target by the end of May 2024.

Compliance with PROMPT (multidisciplinary team skills drill training) and fetal surveillance training competencies is good. Prompt has compliance of 98% (target 90%) and fetal surveillance training and competencies is now meeting national targets for all staff groups (90%)

Turnover for maternity and child health staff (permanent staff) has slightly increased in March to 11.58% (February 11.03%) and will be monitored closely, feedback from exit interviews will be captured and used to support ongoing activity in relation to our workforce. Turnover remains below the Trust target of 13%.

2.3 Service User Feedback

As reported to Trust Board in April, the results of the NHS Maternity Services Survey 2023 have been received. Results have been reviewed, with a plan underway as follows:

- For all 'worse than'/bottom scores, a hotspot audit of experience has been completed to ascertain current position in relation to these specific measures (recognising the changes and service improvements within the maternity service since February 2023)
- The outcome of hotspot survey will inform the development of an action plan in collaboration with maternity colleagues and the Maternity and Neonatal Voices Partnership.
- The action plan will be shared to Quality Assurance Committee on 11th June 2024.
- The action plan is required to be submitted to the LMNS for external oversight by 30th June 2024.

2.4 Staff feedback

Maternity Safety Champion Walkarounds took place on 12th March 2024 and 9th April 2024 with a focus on the maternity ward, neonatal unit (NNU) and antenatal services (antenatal day unit and antenatal Clinic) .

Key areas of discussion with the team:

- The longstanding challenges of the antenatal services footprint were discussed and the challenge of physical (space) and obstetric clinic capacity to meet increasing demand.

- The positive impact of the preterm birth workstream was highlighted by colleagues from NNU. It was noted this work is already being further enhanced following the recruitment of the Specialist Midwife – Preterm birth.
- The ward environment was discussed with staff. It was acknoweldged the ward can sometimes feel noisy which can be problematic for famillies and staff. A piece of work is underway to identify and implement measures to improve experience.

2.5 Maternity Triage

In March 2024 526 triage attendances were recorded on the BadgerNet patient record system. 94% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes and an improved position from January and February 2024. 99% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes and again an improved position.

A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance. Initially, the cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require an increase in establishment of 3.0fte registered midwives and 2.69fte midwifery support workers and a reduced investment of £278,645. This has been presented to Executive Board. The Executive Board have requested further information prior to any decision to move to a formal revenue request.

In the interim, and to maintain safety, 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.

As part of the ongoing improvement work in relation to Maternity Triage, an audit of timeliness of medical review has been completed for the period Jan-March 2024 and has highlighted some challenges:

Category	% of patients seen for medical review within target time
Yellow	36.2%
Orange	26%

A further review of the data identified delays in medical reviews of Yellow/Orange category patients were due to:

- 60% of cases - Obstetric staff busy on Birth Suite, responding to emergency buzzers or carrying out reviews in other areas (A&E, C23, Gynae)
- 21% of cases - Obstetric staff in emergency theatre
- 19% of cases - No documented narrative

During the same recording period there were three Datix raised regarding delay in medical review involving the care of six women. There was no harm recorded as a result of these patient safety events.

Further work has now commenced to improve systems and processes with regard to this and full findings of the audit will be taken to Women's Health audit meeting for discussion and development of a plan to improve.

2.6 Post-partum haemorrhage

In March 2024 3.4% of women experience a PPH ≥1500ml, this is below the benchmark of 3.7%. This rate has fluctuated, therefore a project aimed at reducing rates of PPH has been established as a formal QI project within the maternity service.

All cases of PPH ≥1500mls are also reviewed via the MDT Intrapartum Review Group to ensure any urgent learning is enacted and fed into the PPH QI project.

The PPH action plan is shared as part of CBU governance processes and monthly QAC. Rates of PPH ≥1500ml will be reported to QAC via SPC chart from June.

2.7 Complaints

Seven complaints were received in the CBU in March 2024 four of which were related to care within the maternity and neonatal services.

Specialty	Description	Current Stage
Maternity	Concerns relate to management plan not being followed, the incorrect cannula being inserted, inadequate pain relief, attitude of staff and communication.	Meeting with family arranged
Paediatrics	Concerns regarding care provided to patient on NNU, communication regarding diagnoses and queries / concerns of whether appropriate care plan was followed.	Investigation ongoing
Maternity	Traumatic birth 8 years ago for which the complainant had a debrief meeting at the time. Has since read a CQC report which has raised questions re care.	Draft response complete
Maternity	Complainant has concerns regarding a lack of clear communication and explanation after the birth of her child.	Investigation ongoing

Individual learning from complaints is shared with the team. However, it is recognised there is an opportunity for further triangulation of data/learning from complaints.

A complaints deep dive of maternity complaints for the period Q2-Q4 2023/24 has been completed. The majority of maternity complaints related to the antenatal and postnatal periods. Half the complaints referenced issues with care on the maternity ward and three out of ten highlighted care on Birth Suite. In total there were three recurring key themes across the complaints as follows:

- Communication – a feature in five cases
- Clinical Care – a feature in three of the cases – no themes identified
- Staff behaviour/attitude – a feature in four of the cases.

All complaints are investigated via robust governance processes and learning shared at an individual and service level. Following the previous deep dive, work is ongoing via the Consultant Midwife and Maternity Voices Partnership to explore how we communicate with families to ensure we embed a positive communication culture across the service.

There is also the ongoing work around culture and behaviour underway as part of the NHSE Perinatal Culture and Leadership Programme Programme which will dovetail into wider Trust work recently launched around culture.

2.8 Coroner regulation 28 Enquiries

No Regulation 28 enquiries have been received

3. MATERNITY INCENTIVE SCHEME

Guidance for the launch of MIS Year 6 was received on 2 April 2024. Meetings have been held with leads for all 10 Safety Actions to review the required specifications for each action with no concerns to be escalated.

Progress will be monitored on a monthly basis with action leads and support will be available from the senior leadership team as and when required. Quarterly MIS Year 6 meetings have also been scheduled with the LMNS to review Trust progress against the safety actions.

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

4. PERINATAL MORTALITY ANNUAL REVIEW

In January 2023 a paper was submitted to Quality Assurance Committee (QAC) to review WHH MBRRACE-UK Reports over 5 years (2016-2020).

The paper proposed a number of recommendations which included providing an annual report to include all relevant deaths in the previous year and the findings of the reviews, including trends and themes and improvement activities

During 2023 WHH reported 14 babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This comprised of four late fetal losses (gestation 22-24 weeks) seven stillbirths and three neonatal deaths. The three neonatal deaths comprised two babies born alive but at early gestation (24 weeks) and one baby born at term.

WHH stillbirth rate for 2023 was 2.02 per 1000 births. The most recent MBRRACE-UK national rate is 4.0 per 1000 births.

WHH Neonatal mortality rate for 2023 was 1.2 per 1000 live births. The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate (non NICU providers) for 2023 across the ODN of 0.8 per 1000 live births and across Cheshire & Merseyside of 0.9 per 1000 live births.

The NWODN will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier.

WHH has also received the annual report from MBRRACE for 2022 births.

The reports notes:

- The stabilised and adjusted stillbirth rate for WHH for 2022 was 2.69 per 1000 total birth. This is around average for similar trusts and health Boards.
- The stabilised and adjusted neonatal mortality rate was 1.12 per 1000 live births. This is more than 5% higher than the average for similar Trusts and health Boards.
- The stabilised and adjusted extended perinatal mortality rate is 3.81 per 1000 total birth. This is around average for similar trusts and health Boards.

Excluding deaths due to congenital anomalies:

- The stabilised and adjusted stillbirth rate for WHH for 2022 was 2.49 per 1000 total birth. This is around average for similar trusts and Health Boards.
- The stabilised and adjusted neonatal mortality rate was 0.9 per 1000 live births. This is more than 5% higher than the average for similar Trusts and Health Boards.
- The stabilised and adjusted extended perinatal mortality rate is 3.39 per 1000 total birth. This is around average for similar trusts and Health Boards.

In light of the neonatal mortality rate (rate for all deaths and rate excluding deaths due to congenital anomalies) being more than 5% higher than the average for similar Trusts and Health Boards MBRRACE recommends the following:

a. Review the data that was entered locally about the trust to ensure it is accurate and complete
b. Ensure that a review using the PMRT tool has been carried out for all deaths to assess care and implement service improvement.

All cases have been reviewed using the PMRT tool. The recommendations have also been shared with Trust Governance team who have provided assurance that all data submitted was accurate.

5. Q4 2023-24 PERINATAL MORTALITY REVIEWS

The Perinatal Review Tool was 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 6) to ensure Trust Boards receive quarterly perinatal mortality review reports.

This report presents the WHH NHS Foundation Trust Quarter 4 (Q4) PMRT report for the period covering 01/01/2024 – 31/03/2024.

During this period, WHH reported six babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This comprised five stillbirths and one neonatal death.

Five Stillbirth:

- One baby born at 23+4 weeks
- One baby born at 39+4 weeks
- One baby born at 40+5 weeks
- One baby born at 29+0 weeks
- One baby born at 40+0 weeks

WHH stillbirth rate for Q4 2023/24 was 8.50 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.

There has been an increase in stillbirths in Q4 2023/24. Initial safety reviews (ISR) have been completed for each case and any urgent learning shared. No themes have been identified as part of these ISRs. All cases will be explored via a PMRT review panel which will include external representation and a Maternity and Newborn Safety Investigations (MNSI) external investigation (where the case meets the criteria for MNSI).

One Neonatal Death:

- One baby born at 38+6 weeks

This case will be reviewed via the PMRT review process.

The WHH Neonatal mortality rate during Q4 2023/2024 was 1.59 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

The key findings, learning, good practice, and action plan for all cases will be reported as part of the Q1 2024/25 PMRT review report to Quality Assurance Committee and Trust Board .

PMRT Reviews

During Q4, WHH undertook three PMRT review panels. Parental perspective of the care they received were sought in all cases.

In two cases, there were no issues with care identified for the mother and baby up to the point that the baby was born.

In two of the cases, there were no issues with care identified for the mother and baby up to the point that the baby was confirmed to have died.

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.

In three 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.

6. MATERNITY SELF ASSESSMENT

The Maternity Self-Assessment is completed biannually and is a review against 159 criteria collated from national maternity review findings, including the Kirkup Report (2015) and recommendations for good safety principles within maternity services. The current tool has been further influenced by the findings of the Ockenden review (2020), 7 features of safety culture and the emerging themes from services on the safety support programme, and the trusts found to be outstanding following Care Quality Commissioners (CQC) reviews in other maternity services across England.

As at 31st March 2024, WHH is fully compliant with 117/159 criteria. This equates to 73.6% of the criteria. This is an improvement from 63.5% when the last assessment was completed. Activity is underway in relation to all red and amber actions with completion planned as part of the 2024/25 workplan.

A further review will be undertaken in September 2024, the findings of which will be reported to Quality Assurance Committee and to Trust Board.

7. OCKENDEN RECOMMENDATIONS UPDATE

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

WHH has 3 Ockenden action plans: Ockenden Part 1a, developed following release of the first report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second report.

The WHH Ockenden update as of 31st March 2024 is:

- **Ockenden Part 1a**: WHH is 100% compliant.
- **Ockenden 1b**: WHH is 100% compliant.
- **Ockenden 2**: WHH is 98.55% compliant. The remaining one amber action is on track to be completed by 30 June 2024.

8. MIDWIFERY SAFE STAFFING

Midwifery safe staffing is reported quarterly to Strategic People Committee to provide assurance specifically in relation to midwifery staffing against national recommendations alongside triangulation against maternity red flag incidents.

The most recent paper to Strategic People Committee provided an overview of the staffing position at as 31st March 2024 (the latest available data) and red flag position for the period January – March 2024 alongside other key workforce metrics.

A full maternity workforce planning review using the nationally recognised Birthrate Plus® workforce planning tool was completed at the beginning of 2022. The calculated total

workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust at that time was 116.70wte, this included 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. Subsequently, as part of the process of stabilising the maternity service in early 2023, 5.4fte Band 6 continuity posts were transferred to the Core Team (the team working in the hospital across Birth Suite, the Nest, Antenatal Services and maternity ward) to support a more robust maternity triage staffing model.

The maternity funded establishment at the 31st March 2024 was 125.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 31st March 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 the January 2022 assessment 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). All new posts have been funded within the service via reallocation of existing establishment or via external funding streams.

Review of the maternity workforce using the Birthrate Plus® workforce planning tool is required every three years in line with Maternity Incentive Scheme Year 6 - Safety Action 5. Therefore, a full review will be required at WHH by March 2025. Work has commenced to arrange this assessment.

Midwifery retention rates remain good with turnover at 8% at the end of March 2024. Rates below the Trust target have been maintained since December 2023.

Sickness rates for March 2024 for registered midwifery staff were 6.69%, this is a decrease from February 2024 when the rate was 7.64%. It is however a slight increase from end of March 2023 when the rate was 6.2%.

Within the maternity service, staffing red flags across the maternity service are recorded within the SafeCare module of the health roster. As part of Maternity Incentive Scheme Year 6 - 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 January 2024 – 31st March 2024 there are no episodes recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary.

In the period 1st January 2024 – 31st March 2024 there are no episodes recorded in SafeCare where a woman in active labour is NOT receiving one-to-one care.

A deep dive is underway to review all workforce and acuity related data and metrics, the findings and actions of which will be included in the next Midwifery Staffing Summary to Strategic People Committee in August.

9. MONITORING/REPORTING ROUTES

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

10. ASSURANCE COMMITTEE

The contents of this report has previously been noted and discussed at Quality Assurance Committees on 9th April 2024 and 7th May 2024 and at Strategic People Committee on 15th May 2024.

11. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/038**			
SUBJECT:	Monthly Maternity & Neonatal Quality Update			
DATE OF MEETING:	5 June 2024			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate***)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** **X**	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** **X**	**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** **X**
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update in relation to maternity and neonatal quality and provides Quality Assurance Committee with oversight of key national safety and quality issues in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 6 (Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality			

issues). This information will be reported monthly to Quality Assurance Committee and Trust Board.

In particular:

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

In February 2024 there were three moderate harm events within the maternity service. Of the three cases, one required reporting to MNSI (a baby transferred for cooling). This case has been accepted by MNSI who are completing the investigation.

Two cases (intrauterine death at term) have been reported to MBRRACE and will be investigated via the PMRT tool and pathway.

Themes from maternity/neonatology patient safety events in February are as follows:

- Admission of term babies admitted to Neonatal Unit
- PPH >1500ml
- Incidence of 3rd and 4th degree
- PPH >1000ml
- Intrauterine deaths
- Antenatal and Newborn Screening (ANNB) issues.

At the end of February compliance for mandatory training across maternity and child health colleagues is 86.96% for Trust mandatory training and 86.76% for role specific training, both above the Trust target of 85%. Compliance for mandatory safeguarding training has increased slightly from 84.06% to 84.3%, slightly below the Trust target.

Improvement in workforce measures related to retention and vacancy rate is being sustained.

Compliance with PDR completion is an ongoing piece of work. Rates in February (excluding long term absence)

	for maternity staff is 84.05%. The rate for child health colleagues is 70.68%. The overall rate for maternity and child health services is 76.14%, a reducing position despite an action plan for improvement. A process of reviewing all outstanding PDRs is underway with a trajectory to meet the trust target by the end of May 2024. Compliance with PROMPT (multidisciplinary team skills drill training) is excellent with an overall rate of 97.4%, above the MIS target of 90%. Improving and maintaining 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 amongst midwifery and agency colleagues. Work is ongoing to sustain improvement with a particular focus on medical staff.. A breakdown/comparison of results of the NHS Maternity Services Survey 2023 across the Cheshire & Mersey have now been received. Next steps are included within the paper. A Maternity Safety Champion Walkaround took place on 12th March 2024 with a focus on the maternity ward and Neonatal Unit. In February 2024 91.7% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes. 98.3% 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. One complaint was received in the CBU in January 2024. This did not relate to care within the maternity and neonatal services. No Regulation 28 enquiries have been received.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/24/04/012iii
	Date of meeting	9 April 2024
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF:	BM/24/06/038

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month of February 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 6 *(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

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

Severity	Jan 24	Feb 24
1 – No Harm	95	101
2 – Low Harm	28	35
3 – Moderate Harm	0	3
4 – Severe Harm	0	0
5 – Fatal	0	0
Total	123	139

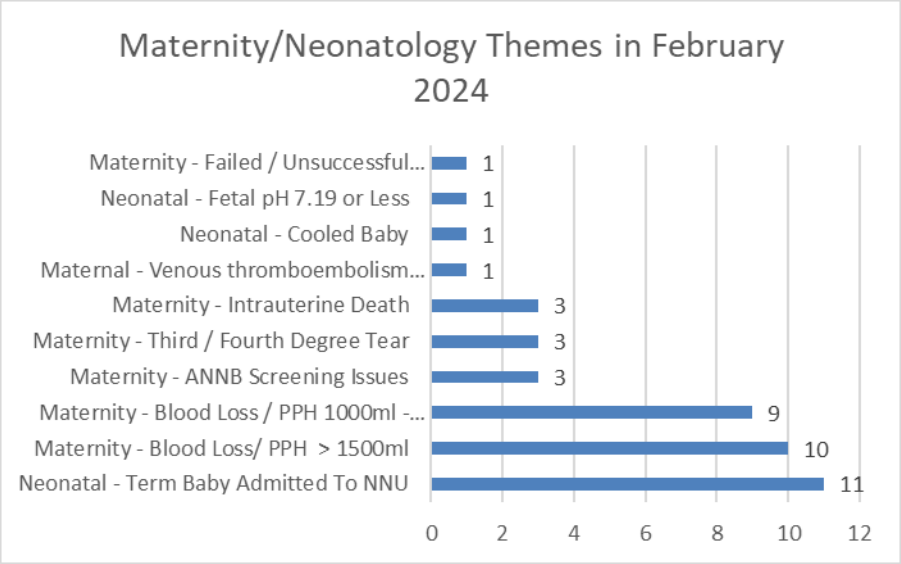
There were six Initial Safety Reviews (ISR) undertaken across the CBU in February. Three of the six ISRs related to events in the maternity service. These were moderate harm events. One required reporting to MNSI (a baby transferred for cooling). This case has been accepted by MNSI who are completing the investigation.

Two cases (intrauterine death at term) have been reported to MBRRACE and will be investigated via the PMRT tool and pathway.

Some urgent learning was identified as part the ISR into the baby which was transferred for cooling. This related to adherence to fetal monitoring guidelines when undertaking intermittent auscultation. There was also learning in relation to

escalation. Actions from the ISR have been implemented and completed. There was no urgent learning from the two cases reported to MBRRACE.

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



The highest number of cases related to term babies admitted to Neonatal Unit (NNU). All cases of term admission are reviewed via ATAIN. ATAIN reports quarterly to QAC. Learning and actions from cases of babies admitted to NNU will be shared in the Q4 2023/24 ATAIN paper which will be presented to QAC in June.

PPH >1500ml is another key theme. QAC will be aware work around PPH is a current QI project within the maternity service. The PPH action plan is attached for information in Appendix One. All cases of PPH >1500mls are reviewed via the MDT Intrapartum Review Group to ensure any urgent learning is enacted as well as feeding into the PPH QI project. Incidence of 3rd and 4th degree are also reviewed via IRG.

There were nine PPH >1000ml reported. These cases have all been reviewed locally utilising the standard proforma. No themes were identified.

There were three intrauterine deaths in February. One was a second trimester pregnancy loss, two were intrauterine death at term. The second trimester loss was identified at the anomaly scan, an ISR has been completed. The term cases are those previously mentioned, have undergone an ISR and urgent actions completed. A further individual review which includes external scrutiny via the PMRT process will now take place. PMRT reports quarterly to QAC. Any learning and actions from these will be shared with a future QAC

Three ANNB Screening issues were reported in February. These were all no harm events. Exploration of these safety events have highlighted process/administrative issues which have now been resolved.

3. WORKFORCE METRICS & MEASURES

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

At the end of February compliance for mandatory training across maternity and child health colleagues is 86.96% for Trust mandatory training and 86.76% for role specific training, both above the Trust target of 85%. Compliance for mandatory safeguarding training has increased slightly from 84.06% to 84.3%, slightly below the Trust target.

Below shows the current position with regard to mandatory training as at 29/2/2024, 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 February (excluding long term absence) for maternity staff is 84.05%. The rate for child health colleagues is 70.68%. The overall rate for maternity and child health services is 76.14%, a reducing position despite an action plan for improvement. A process of reviewing all outstanding PDRs is underway with a trajectory to meet the trust target by the end of May 2024.

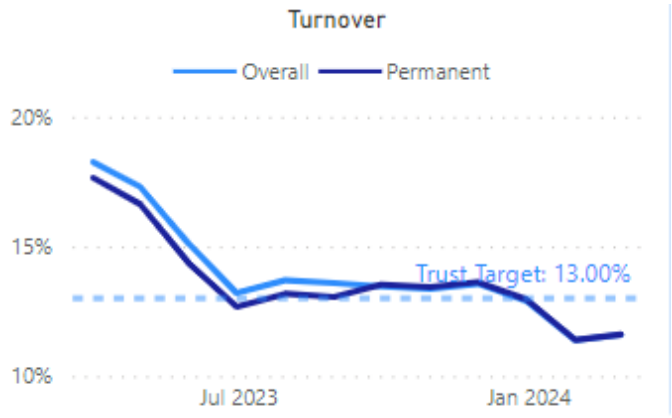
Compliance with PROMPT (multidisciplinary team skills drill training) is excellent. WHH met the Maternity Incentive Scheme Year 5 target of 90%. Compliance overall for PROMPT is 97.4%.

Compliance for MAMU2 at end of February 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%
February 24:	98.4%	89%	100%	98.3%	89%	82.3%

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 amongst midwifery and agency colleagues. Work is ongoing to sustain improvement with a particular focus on medical staff. A further update will be provided to May Quality Assurance Committee.

Turnover for maternity and child health staff has slightly increased in February to 11.59% and will be monitored closely. Turnover remains below the Trust target.



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 6.65% in February 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 February this rate was 3.83%, an improvement of 16.14%.

4. SERVICE USER FEEDBACK

As reported to QAC in April, the results of the NHS Maternity Services Survey 2023 have been received with an internal plan underway as follows:

- For all 'worse than'/bottom scores, a hotspot audit of experience will be completed to ascertain current position in relation to these specific measures (recognising the changes and service improvements within the maternity service since February 2023)
- Outcome of hotspot survey to inform a formal action plan.

Subsequently the LMNS has provided an overview of results from across Cheshire & Mersey in the form of a SWOT analysis.

Strengths:

- National results relative to 2022, show signs of improvement in many areas
- 5 of 7 Trusts showed improvement with no decreases (all except MCHT & S+O)
- All 7 Trusts had a statistically significant improvement in at least 1 question since 2022
- Staff Caring for you – MCHT highest section score in NW region
- COCH in top 5 Trusts in NW region for 7 of 8 section scores- 'Better than expected' for 4 questions including '*During labour and birth, were you able to get a member of staff to help you when you needed it?'* and 'Somewhat better than expected' for 2 questions including *'Were you given information about changes you might experience to your mental health after having a baby?'*
- LWH had highest score since 2013 for *'During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?'*
- MCHT 'Better than expected' for 3 questions including *'Thinking about your care during labour and birth, were you involved in decisions about your care?'* and 'Somewhat better than expected' for 4 questions including *'Thinking about your care during labour and birth, were you treated with respect and dignity?'*
- Ormskirk, MCHT and WHH had highest score since 2019 for *'Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?'*
- Ormskirk 'Better than expected' score for '(Care at home after birth) *Did a midwife or health visitor ask about your mental health?'*
- Whiston had significant score increase since 2022 for 10 questions including '*Did you feel that Midwives and other health professionals gave you active support and encouragement about feeding your baby?'* and '*Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?'*
- WUTH had significant score increase since 2022 for 3 questions including '(Postnatal Care) *If you contacted a midwifery or health visiting team, were you given the help you needed?'* and '*Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?'*
- WUTH in top 5 Trusts in NW region for 2 section scores (*Care in ward after Birth* and *Care at Home after Birth*)

Weaknesses:

- Care in the ward after birth- LWH had lowest section score in NW region- 'Worse than expected' for *'If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?'*
- MCHT significant score decrease since 2022 for '*On the day you left hospital, was your discharge delayed for any reason?'*
- Ormskirk 'Worse than expected' in 4 questions related to antenatal care including *'Did you get enough information form either a midwife or doctor to help you decide where to have your baby?', 'During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?', 'During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?' and 'During your antenatal check-ups, did your midwives listen to you?'*
- Ormskirk significant score decrease since 2022 for *'Were you involved in the decision to be induced?'*
- Whiston 'Somewhat worse than expected' in 5 questions including *'During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?', 'During your antenatal check-ups, did your midwives listen to you?', 'Did you have confidence and trust in the staff caring for your during your antenatal care?', 'If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?' and 'Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?'*
- WHH 'Worse than expected' for 3 questions *including 'Did you get enough information from either a midwife or doctor to help you decide where to have your baby?', 'During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?' and 'During your pregnancy did midwives provide relevant information about feeding your baby?'*
- WHH 'Somewhat worse than expected' for 2 questions including *'Were you offered a choice about where to have your baby?' and 'Did you have confidence and trust in the staff caring for you during your antenatal care?'*

Threats

- 2 of 7 Trusts had a statistically significant decrease in at least 1 question between 2022 and 2023 (MCHT & MWL Ormskirk)
- C&M average response rate has fallen to 41% (53% in 2022)
- At a national level, the 2023 maternity survey shows that people's experiences of care have deteriorated in the last 5 years.

Opportunities

- Shared learning across providers for improvement:
    - Antenatal Care- Ormskirk, Whiston and WHH had lowest scores in C&M for this section in 2023
    - IOL information/decision making- Ormskirk significant score decrease in 2023
    - Care in the ward after birth- LWH had lowest section score in NW region
    - Mental Health- WUTH, COCH and MCHT showed significant improvements in 2023
    - Infant feeding- Whiston showed significant improvements in 2023. COCH highest score in C&M for this section in 2023
    - Discharge Delay- COCH could support MCHT and WHH
    - Care at Home after birth- WUTH and COCH in top 5 scores in NW. WUTH highest score in C&M in 2023
    - New PPHS services- National results showed respondents with pelvic floor problems reported worse experiences in being treated with kindness, understanding and compassion, as well as pain management.
- Significant improvements across C&M for 'Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?'

The LMNS has requested the following actions be implemented:

- Trusts produce a SMART action plan developed with the MNVP Lead and local engagement network to address the issues (including analysis of free text data), and share it with their Trust Board in time for the LMNS to receive it by 30th June 2024
- All providers to develop quality improvement plans working closely with the MNVP and user representatives to improve satisfaction with maternity services based on their own individual reports.
- Engage MNVP leads and other user representatives including LMNS engagement team to support shared learning and improvement.
- Trusts to promote participation in survey to target cohort to ensure response rate is maximised.
- All Providers to ensure workforce are aware of survey, local results and action plan.
- MNVP to be encouraged to support improvement in response rate for survey – note women who gave birth in February 2024.

The midwifery leadership team are moving forward with these actions. The detailed action plan will be presented to May Quality Assurance Committee and to June Trust Board to enable the service to meet the LMNS deadline.

5. STAFF FEEDBACK

A Maternity Safety Champion Walkaround took place on 12th March 2024 with a focus on the maternity ward and Neonatal Unit. Feedback from staff was both constructive and positive. The preterm birth workstream was discussed with colleagues from the Neonatal Unit who advised this was going well and could see some improvements in practice. These developments would be further enhanced following the recruitment of the Specialist Midwife – Preterm birth.

Within the maternity ward, the ward environment was discussed with staff. It was acknoweldged the ward can sometimes feel noisy which can be probelematic for families and staff. This was discussed further with the ward manager who will take this feedback in to the wider piece of work around improving the ward environment.

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 February 2024 553 triage attendances were recorded on the BadgerNet patient record system.
- 20.7% attendees were seen immediately on arrival, this is an increase decrease of 5% from January.
- The longest wait recorded for initial review was 65 minutes.
- 91.7% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes and an improved position from January 2024.
- 98.3% 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 and again an improved position.
- 0.18% of attendees were categorised as red on arrival. Appropriate ongoing care was provided.

Activity in place to support a safe service

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. A paper will be taken to the Executive Board at the end of March/beginning of April 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.

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. COMPLAINTS

One complaint was received in the CBU in January 2024. This did not relate to care within the maternity and neonatal services.

8. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

9. MONITORING/REPORTING ROUTES

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

10. ASSURANCE COMMITTEE

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

11. RECOMMENDATIONS

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

Appendix One – 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/AC	Ongoing	
To invite a member of the QI team to the group	MG	Complete 8.11.23	
To liaise with KJ for digital proforma update	KF	Complete 8.11.23	
Actions - 8.11.23			
Walk through of PPH- Room/theatre	AC/CH/VM/SD	15.11.23- Update- Amelia to set up with QI team next week.	
		20.12.23- Unable to set date with QI team- To meet in the new year	
		27.2.24- Walk through of PPH in room to theatre complete. OI team will send an updated presentation of next steps	
PPH Simulation in theatre	AC/JF	15.11.23-carried over to next meeting	
		20.12.23- Awaiting date from RC.	
		27.2.24 PPH SIM stepped down this week due to acuity on the ward. Re-booked for next week	
		13.3.24-PPH Simulation stepped down due to ward acuity to re-book	
		27.3.34-Meeting stepped down. PEF has re-booked SIM beginning of April	
Process mapping support from QI team at next meeting	VM/SD	15.11.23- Unable to map until data set/audit finalised	
		31.1.24- 1st process map complete	
To share learning from most recent thematic review- Documentation/recognition of loss in theatre	CB/CH/	To include in all safety briefs.	
		15.11.23- Safety brief will be updated at the end of the month	

Actions - 15.11.23			
KF to ensure that PPH guideline has been re-circulated with added comments	KF		
KF to set meetings to Bi-weekly	KF		
Actions- 22.11.23			
Data Analysis MDT meeting TBA	KF/MG/CH/AC	20.12.23 Data analysis has now been sent to AK/CB to present at QAC in January. Currently data analysis is in progress.	
Actions- 20.12.23			
KJ- To include on Badger newsletter an issue that was raised in Prompt. PPH proforma completion will save even if baby not yet admitted.	KJ	To include in newsletter	
AC- To ensure theatre algorithm of recognition escalation is in view of staff	AC		
KF- To liaise with RA/CB as to surgeon responsibility of escalating loss.	KF	No reply from e-mail- for update next week- 13.3.34 - Update from CB - Part of the ongoing QI - recognition.	
Actions-31.1.24			
AC to invite team to theatre SIM next wed	AC	28.2.24 -SIM not completed due to ward acuity- Team where invited.	
Next PPH group meeting to process map another walk through- Kim to book the croft	KF	28.2.24- Walk through complete	
Actions- 28.2.24			
Process mapping of walk through (completed today)- Book croft for next meeting	KF/QI	13.3.24-Process mapping now complete for elective c-section	
Actions-13.3.24			
Walk through of PPH- Room/theatre (completed)- Process mapping in croft for next meeting	QI Team	Process mapping at next meeting. 27.3.24- Meeting stepped down due to acuity and no availability of a Consultant Obstetrician	

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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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	
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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		

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/038 - Appendix 1**	
SUBJECT:	Monthly Maternity & Neonatal Quality Update	
DATE OF MEETING:	5 June 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***		

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	X		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	X		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			X
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			

EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update in relation to maternity and neonatal quality and provides Quality Assurance Committee with oversight of key matters to provide assurance to the Board on maternity and neonatal safety and quality issues. This information will be reported

	monthly to Quality Assurance Committee and Trust Board. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position There were two moderate harm events in March 2024. One case was within the maternity service (intrapartum stillbirth). This case has been reported to MBRRACE and to Maternity and Newborn Safety Investigations (MNSI) who have accepted the case and will complete the investigation. There was one severe harm event. This was not in the maternity or neonatal service. This case was a cardiac arrest on the gynaecology ward of a patient six days post elective surgery. The appropriate review of the case has taken place. Two Initial Safety Reviews (ISR) were completed in March within the maternity and neonatal services. One was the intrapartum stillbirth referred to above. The second was a 22 week intrauterine death, this has been reported to MBRRACE and will be reviewed by the PMRT review process. Themes from maternity/neonatology patient safety events in March are as follows: • Admission of term babies admitted to Neonatal Unit • PPH >1500ml • PPH >1000ml • Shoulder Dystocia At the end of March compliance for mandatory training across maternity and child health colleagues is 87.77%% for Trust mandatory training, 87.69% for role specific

	training, and 85.73% got mandatory safeguarding training all above the Trust target of 85%. Improvement in workforce measures related to retention and vacancy rate is being sustained. Compliance with PDR completion remains a challenge. Rates in March (excluding long term absence) for maternity and child health services is 72.33%. An action plan and trajectory is in place to meet the Trust target by the end of May 2024. Compliance with PROMPT (multidisciplinary team skills drill training) and fetal surveillance training and competencies is now meeting national targets for all staff groups. A Maternity Safety Champion Walkaround took place on 9th April 2024 with a focus on Antenatal Services. In March 2024 94% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance). 99% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Seven complaints were received in the CBU in March 2024. Four related to care in the maternity and neonatal services. These are detailed in the report. A deep dive of all maternity complaints Q2-Q4 2023/24 has been completed and identifies key themes as follows: • Communication • Clinical Care • Staff behaviour/attitude In addition to activity alrready oingoing aorund workplace culture and communication a further workplan is underway to respond to the findings of the deep dive. No Regulation 28 enquiries have been received.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/24/05/34iii
	Date of meeting	7 May 2024
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF:	BM/24/06/040 – Appendix 2

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month of March 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 6 *(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

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

Severity	Feb 24	Mar 24
1 – No Harm	101	100
2 – Low Harm	35	22
3 – Moderate Harm	3	2
4 – Severe Harm	0	1
5 – Fatal	0	0
Total	139	126

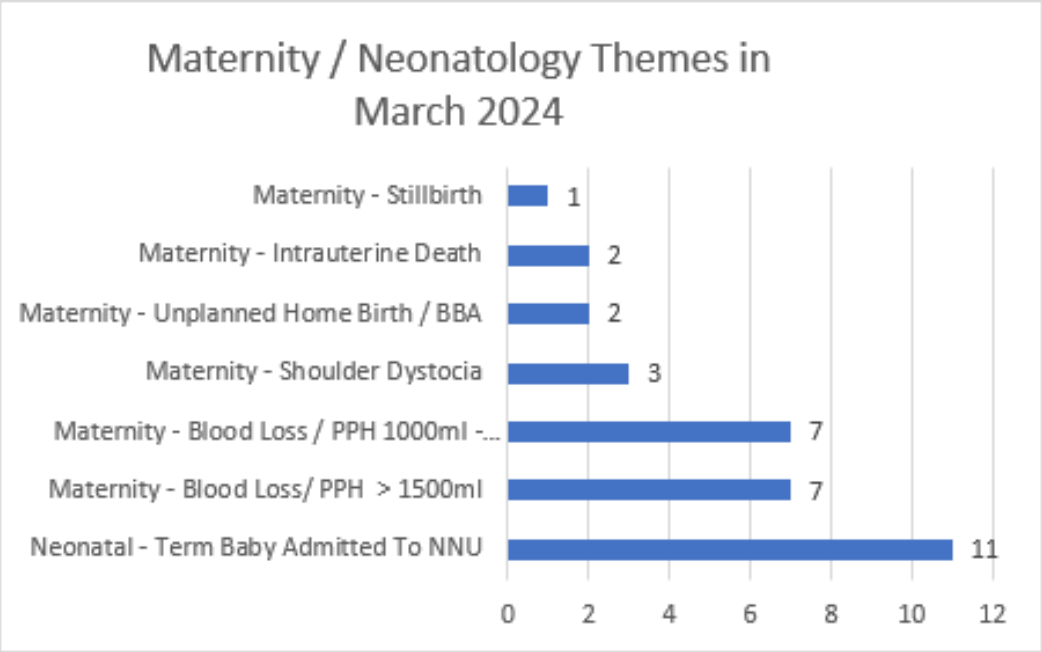
There were two moderate harm events in March 2024. One case was within the maternity and neonatal services and was an intrapartum stillbirth. An ISR was completed and urgent learning identified. Actions from the ISR have been implemented and completed.

This case has been reported to MBRRACE and to MNSI who have accepted the case and will complete the investigation.

There was one severe harm event. This was not in the maternity or neonatal service.

Two ISRs were completed in March within the maternity and neonatal services. One was the intrapartum stillbirth referred to above. The second was a 29 week intrauterine death, this has been reported to MBRRACE and will be reviewed by the PMRT review process. There was no urgent learning from this case.

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



This highlights the highest number of cases related to term babies admitted to Neonatal Unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC. Learning and actions from cases of babies admitted to NNU will be shared in the Q4 2023/24 ATAIN paper which will be presented to QAC in June.

PPH >1500ml is another key theme. QAC will be aware work around PPH is a current QI project within the maternity service. The PPH action plan is attached for information in Appendix One. All cases of PPH >1500mls are reviewed via the MDT Intrapartum Review Group (IRG) to ensure any urgent learning is enacted as well as feeding into the PPH QI project. Incidence of Shoulder Dystocia are also reviewed via IRG.

There were seven PPH >1000ml reported. These cases have all been reviewed locally utilising the standardised proforma. No themes were identified.

There was one stillbirth, this was the 29 week gestation, second trimester pregnancy loss as per above which will be reviewed via the PMRT process.

There were two intrauterine deaths, one is the intrapartum stillbirth referenced above which has undergone an ISR with urgent actions completed and is currently being investigated by MNSI. The remaining case was an intrauterine death following termination of pregnancy due to antenatal identification of a rare genetic disorder. This is coded as an intrauterine death due to the gestation of the pregnancy.

As referenced at previous Quality Assurance Committees two thematic (cluster) reviews have been instigated. The first will review all cases reviewed via the PMRT process where maternal diabetes was identified as a factor in the case. There are four cases within this cluster.

The second analysis will review all cases referred to MNSI in 2023. In total there are seven cases within this cluster (all relating to babies transferred for cooling) albeit only three were progressed by MNSI. In those cases where the case did not move to a full MNSI investigation will be reviewed utilising the rapid review/ISR findings and other local learning.

The purpose of these two cluster reviews is to ensure the service has captured all learning from the events, identified links as well as any wider system issues and themes which may not be identified when cases are reviewed in isolation.

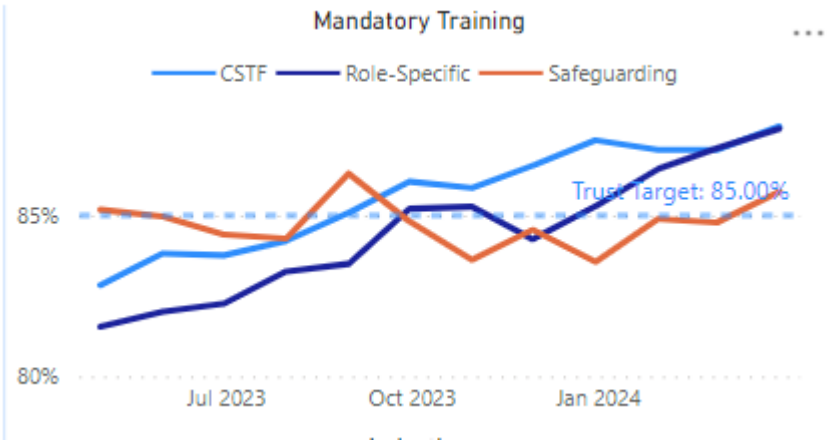
The findings of the reviews will be shared to a future Quality Assurance Committee, to Trust Board and via CBU governance processes.

3. WORKFORCE METRICS & MEASURES

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

At the end of March compliance for mandatory training across maternity and child health colleagues is 87.77% for Trust mandatory training, 87.69% for role specific training and mandatory safeguarding training is 85.73%.

Below shows the current position with regard to mandatory training as at 31/3/2024, action plans remain in place maintain compliance in these areas.



Compliance with PDR completion remains a challenge. Rates in March (excluding long term absence) for maternity and child health services is 72.33%, a reducing position despite an action plan for improvement. A process of reviewing all

outstanding PDRs is underway with a trajectory to meet the Trust target by the end of May 2024.

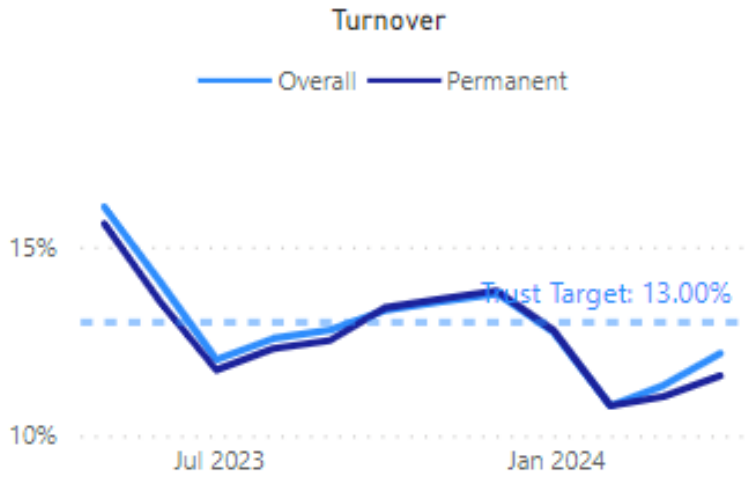
Compliance with PROMPT (multidisciplinary team skills drill training) is excellent with overall compliance of 98% (target 90%).

Compliance for MAMU2 at end of March 2024:

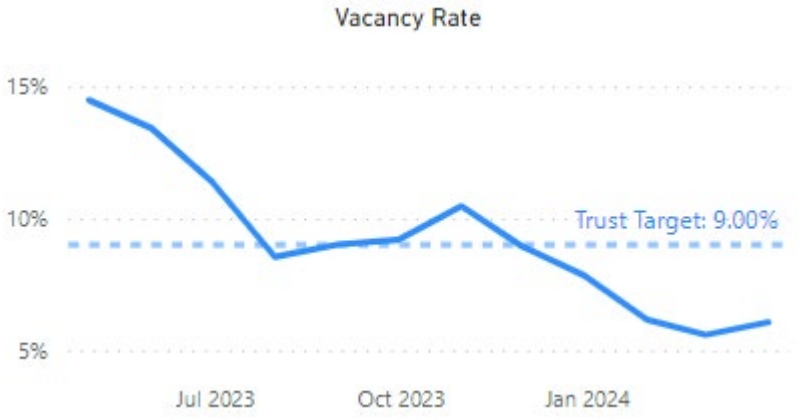
	Percentage of staff who have received CTG and IA training:			Percentage of staff who have successfully completed competency assessments:		
	Midwives	Doctors	Agency staff	Midwives	Doctors	Agency staff
July 23:	97%	100%	80%	86%	76%	80%
August 23:	88%	94%*	72%	56%*	50%*	67%
September 23:	88%	93%	72%	51%	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%
February 24:	98.4%	89%	100%	98.3%	89%	82.3%
March 24:	97.7%	100%	100%	92%	95%	94.1%

Compliance with fetal surveillance training and competencies is now meeting national targets for all staff groups (90%). Ongoing updates will be provided to Quality Assurance Committee to provide ongoing assurance.

Turnover for maternity and child health staff (permanent staff) has slightly increased in March to 11.58% (February 11.03%) and will be monitored closely, feedback from exit interviews will be captured and used to support ongoing activity in relation to our workforce. Turnover remains below the Trust target of 13%.



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 6.07% in March 2024. This is illustrated in the graph below:



At the end of March 2024, the vacancy rate for registered midwives was 5.66%, this remains a much improved position but is an increased rate from February (3.83%). This increase is due to internal promotions and approval of reduction in hours to support both flexible retirement and flexible working requests.

4. SERVICE USER FEEDBACK

As reported to QAC in April, the results of the NHS Maternity Services Survey 2023 have been received with an internal plan underway as follows:

- For all 'worse than'/bottom scores, a hotspot audit of experience is underway to ascertain current position in relation to these specific measures (recognising the changes and service improvements within the maternity service since February 2023)
- Outcome of hotspot survey to inform a formal action plan.

The LMNS has requested Trusts produce a SMART action plan developed with the MNVP Lead and local engagement network to address any issues identified. This work is underway. Once developed the LMNS require the SMART action plan be shared with QAC by 30th June 2024.

5. STAFF FEEDBACK

A Maternity Safety Champion Walkaround took place on 9th April 2024 with a focus on Antenatal Services (Antenatal Day Unit and Antenatal Clinic). Feedback from staff was both constructive and positive. The longstanding challenges of the Antenatal Services footprint were discussed with the team and they were updated with progress in relation to potential solutions. More generally the challenge of physical (space) and obstetric clinic capacity to meet increasing demand for antenatal clinic appointments was discussed.

The team were positive regarding the impact of the new Antenatal Services Manager and also reflected how team cohesion had improved and the supportive relationship in place with the consultant workforce. Staff also acknowledged the work already ongoing across the service to review and streamline clinics and to increase capacity where possible.

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 March 2024 526 triage attendances were recorded on the BadgerNet patient record system.
- 20.7% attendees were seen immediately on arrival, this is on a par with February 2024 and a reduced position from January.
- The longest wait recorded for initial review was 40 minutes. This has been investigated and was due to high acuity within maternity Triage.
- 94% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes and an improved position from January and February 2024.
- 99% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes and again an improved position.
- 2% of attendees were categorised as red on arrival, an increase of 1.82% from February. Appropriate ongoing care was provided in all cases.
- 21% of attendees were categorised orange on arrival, this is an increase from January and February, 18% and 17.7% respectively.

Activity in place to support a safe service

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. This paper has been presented to Executive Board with a final outcome awaited.
- 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.
- The audit of timeliness of medical review has been completed for the period Jan-March 2024 and has highlighted some challenges:

Category	% of patients seen for medical review within target time
Yellow	36.2%
Orange	26%

A further review of the data identified delays in medical reviews of Yellow/Orange category patients were due to:

- 60% of cases - Obstetric staff busy on Birth Suite, responding to emergency buzzers or carrying out reviews in other areas (A&E, C23, Gynae)
- 21% of cases - Obstetric staff in emergency theatre
- 19% of cases - No documented narrative

During the same recording period there were three Datix raised regarding delay in medical view involving the care of six women. There was no harm recorded as a result of these patient safety events.

Further work has now commenced to improve systems and processes with regard to this and full findings of the audit will be taken to the Joint Maternity, Obstetrics, Gynaecology and Children's Health Clinical Audit meeting on the 10th May 2024 for discussion. A further update will be provided to June Quality Assurance Committee. The Consultant Midwife in her extended role of Advanced Midwifery Practitioner will also provide some support to the service where practical.

In the interim the Triage team are aware of the importance of timely escalation of delays via both the red flag system and maternity bleep holder to ensure the continued safety of the service.

Next Steps (January – June 2024)

- Maternity Triage task and finish group in place.
- Shift leader for triage to be identified from next roster to support oversight and effective escalation processes
- Action plan to improve timeliness of medical reviews to be agreed and implemented.
- Implementation of new staffing model
- Telephone triage to be moved from the clinical triage area, this will be dependent on the new staffing model being implemented.
- Telephone system to be upgraded

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

7. COMPLAINTS

Seven complaints were received in the CBU in March 2024 four of which were related to care within the maternity and neonatal services.

Specialty	Description	Current Stage
Maternity	Concerns relate to management plan not being followed, the incorrect cannula being inserted, inadequate pain relief, attitude of staff and communication.	Meeting with family arranged
Paediatrics	Concerns regarding care provided to patient on NNU, communication regarding diagnoses and queries / concerns of whether appropriate care plan was followed.	Investigation ongoing
Maternity	Traumatic birth 8 years ago for which the complainant had a debrief meeting at the time. Has since read a CQC report which has raised questions re care.	Draft response complete
Maternity	Complainant has concerns regarding a lack of clear communication and explanation after the birth of her child.	Investigation ongoing

Individual learning from complaints is shared with the team. However, it is recognised there is an opportunity for further triangulation of data/learning from complaints. Discussion have taken place with the Trust governance team regarding a piece of work around this which will commence in June.

Further to Quality Assurance Committee in January 2024, a complaints deep dive of maternity complaints for the period Q2-Q4 2023/24 has been completed.

In total 11 complaints were received in the period. One related to care in 2016 and was therefore excluded from the deep dive. There were an average of 1.1 complaints per month (an improvement from two per month in the previous deep dive).

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

The majority of maternity complaints related to the antenatal and postnatal periods. Half the complaints referenced issues with care on the maternity ward and three out of ten highlighted care on Birth Suite. In total there were three recurring key themes across the complaints as follows:

- Communication – a feature in five cases
- Clinical Care – a feature in three of the cases – no themes identified
- Staff behaviour/attitude – a feature in four of the cases.

All complaints are investigated via robust governance processes and learning shared at an individual and service level. Following the previous deep dive, work is ongoing via the Consultant Midwife and Maternity Voices Partnership to explore how we communicate with families to ensure we embed a positive communication culture across the service.

There is also the ongoing work around culture and behaviour underway as part of the NHSE Perinatal Culture and Leadership Programme Programme which will dovetail into wider Trust work recently launched around cultureOne complaint was received in the CBU in January 2024. This did not relate to care within the maternity and neonatal services.

8. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

9. MONITORING/REPORTING ROUTES

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

10. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committees on 7th May 2024.

11. RECOMMENDATIONS

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

Appendix One – PPH QI Project Action Plan

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

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

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/040 - Appendix 3**	
SUBJECT:	**Maternity Incentive Scheme Year 6 Update**	
DATE OF MEETING:	5 June 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	X		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	X		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			X
Further Information: The paper relates to care of /those on the pregnancy continuum. The principles of CNST and the maternity incentive scheme is to ensure safer care for this cohort. Achieving the principles of MIS year 5 and year 6 will have a positive impact on this group.			

EXECUTIVE SUMMARY ***(KEY ISSUES):***	NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The Trust was notified of successfully achieving compliance with all 10 safety standards for MIS Year five on 10 April 2024. NHSR is now operating Year six of the Clinical Negligence Scheme for Trusts (CNST) MIS following publication of guidance on 2 April 2024. Conditions of eligibility for payment under the Scheme are set out in the guidance and a completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/24/05/34iv		
	Date of meeting	7 May 2024		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Incentive Scheme Year 6 Update	AGENDA REF:	BM/24/06/040 Appendix 3

1. BACKGROUND/CONTEXT

The Trust was notified of successfully achieving compliance with all 10 safety standards for MIS Year 5 on 10 April 2024.

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

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

2. CURRENT POSITION

2.1 Overall position

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

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

A meeting has been scheduled by the LMNS on 29 April 2024 for the launch of MIS Year six, and a quarterly MIS check-in point meeting on 5 June 2024.

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

Following the latest quarterly meeting on 7 March 2024, LMNS is assured that WHH is on track with completion of all elements of this safety action and has assessed the 6 elements as follows:

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	40%	Partially implemented	90%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	25%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Not implemented	0%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Not implemented	0%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	4%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Not implemented	0%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	14%	Partially implemented	94%	CNST Met

Progress towards full compliance with Safety Action 6 is ongoing. Where full compliance has not yet been achieved, robust action plans are in place. The maternity team is monitoring progress to ensure actions are effective

3. MONITORING/REPORTING ROUTES

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

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

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 7 May 2024.

5. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/040 – Appendix 4a**			
SUBJECT:	Perinatal Mortality Annual Review 2023			
DATE OF MEETING:	5th June 2024			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** **X**	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** **X**	**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** **X**
	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):*	Since 2013 “Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK” (MBRRACE-UK) produces an annual “Perinatal Mortality Surveillance Report”. This report provides rates for stillbirths and neonatal deaths for each provider as well			

	as reporting the national picture. Warrington and Halton NHS Foundation Trust (WHH) participates in reporting data into the Perinatal Mortality Review Tool (PMRT) which allows the analysis to take place. The timelines for submissions of deaths and the analysis of these means that when the reports are published by MBRRACE that they are based on deaths that occurred two years previously. In January 2023 a paper was submitted to Quality Assurance Committee (QAC) to review WHH MBRRACE-UK Reports over 5 years (2016-2020). The paper proposed a number of recommendations including: • Provide an annual report to QAC in April each year which includes all relevant deaths in the previous year and the findings of the reviews, including trends and themes and improvement activities This report presents an overview of Warrington and Halton Teaching Hospitals (WHH) NHS Foundation deaths from 1/1/2023-31/12/2023 and an overview of the key findings, learning and good practice for these cases. This learning is identified utilising the Perinatal Review Tool which has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland and Wales. During 2023 WHH reported 14 babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This comprised of four late fetal losses (gestation 22-24 weeks) seven stillbirths and three neonatal deaths. The three neonatal deaths comprised two babies born alive but at early gestation (24 weeks) and one baby born at term. WHH stillbirth rate for 2023 was 2.02 per 1000 births. The most recent MBRRACE-UK national rate is 4.0 per 1000 births. WHH Neonatal mortality rate for 2023 was 1.2 per 1000 live births. The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate (non NICU providers) for 2023 across the ODN of 0.8 per 1000 live births and across Cheshire & Merseyside of 0.9 per 1000 live births.

	The NWODN will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier. During 2023 WHH undertook 13 PMRT review panels reviewing 15 cases. Parental perspective of the care they received were sought in all cases. WHH has also received the annual report from MBRRACE for 2022 births. The reports notes: • The stabilised and adjusted stillbirth rate for WHH for 2022 was 2.69 per 1000 total birth. This is around average for similar trusts and health Boards. • The stabilised and adjusted neonatal mortality rate was 1.12 per 1000 live births. This is more than 5% higher than the average for similar Trusts and health Boards. • The stabilised and adjusted extended perinatal mortality rate is 3.81 per 1000 total birth. This is around average for similar trusts and health Boards. Excluding deaths due to congenital anomalies: • The stabilised and adjusted stillbirth rate for WHH for 2022 was 2.49 per 1000 total birth. This is around average for similar trusts and Health Boards. • The stabilised and adjusted neonatal mortality rate was 0.9 per 1000 live births. This is more than 5% higher than the average for similar Trusts and Health Boards. • The stabilised and adjusted extended perinatal mortality rate is 3.39 per 1000 total birth. This is around average for similar trusts and Health Boards. In light of the neonatal mortality rate (rate for all deaths and rate excluding deaths due to congenital anomalies) being more than 5% higher than the average for similar

	Trusts and Health Boards MBRRACE recommends the following: a) Review the data that was entered locally about the trust to ensure it is accurate and complete b) Ensure that a review using the PMRT tool has been carried out for all deaths to assess care and implement service improvement. All cases have been reviewed using the PMRT tool. The recommendations have also been shared with Trust Governance team who have provided assurance that all data submitted was accurate.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/24/04/012ii		
	Date of meeting	9 April 2024		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Perinatal Mortality Annual Review 2023	AGENDA REF:	BM/24/06/040 – Appendix 4a

1. BACKGROUND/CONTEXT

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

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 5standards 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 annual report presents WHH PMRT audit data for 2023 and highlights good practice and lessons learned during the mortality reviews.

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.

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

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. During 2023 reporting period 14 cases were reported to MBRRACE-UK. This comprised of four late fetal losses (gestation 22-24 weeks) seven stillbirths and three neonatal deaths. The three neonatal deaths comprised two babies born alive but at early gestation (before 24 weeks) and one baby born at term.

MBBRACE data does not include neonatal deaths before 24 weeks gestation. Where criteria for review using the PMRT tool was not met the deaths were notified and surveillance completed.

2.1 WHH Stillbirth Rate

- WHH stillbirth rate for 2023 is 2.02 per 1000 births.
- The most recent UK national stillbirth rate (2022) is 4.0 per 1000 births
- WHH had 7 stillbirths >24 weeks
- WHH had 0 intrapartum stillbirths
- WHH had no term stillbirths (babies born from 37 weeks gestation)

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 WHH Neonatal deaths

During 2023 three neonatal deaths were reported. Of these two were babies born alive before 24 weeks gestation. MBBRACE data does not include neonatal deaths before 24 weeks gestation.

The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate for 2023 (non NICU providers) across the ODN of 0.8 per

1000 live births, the same measure for Cheshire & Merseyside is 0.9 per 1000 live births. The WHH rate for 2023 was 1.2 per 1000 live births. The NWODN will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier.

2.3 2023 PMRT Review Panel Key Findings

13 PMRT panels took place during 2023 reviewing 15 cases of stillbirth or neonatal death.

Table 3: 2023 PMRT Grading of 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	7
PMRT grade B - The review group identified care issues which they considered would have made no difference to the outcome	4	4
PMRT grade C - The review group identified care issues which they considered may have made a difference to the outcome	6	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	Twelve cases	Twelve cases

Table 4: 2023 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	-	-	2
PMRT grade B - The review group identified care issues which they considered would have made no difference to the outcome	3	3	-
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	Three cases	Three cases	Three cases

2.3.1 Key learning and good practice

Learning and actions:

In the majority of cases care was graded as A or B, however learning is collated in all cases. 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. As at 31st December 2023, there were no outstanding actions.

Care of women with diabetes has been identified as a theme through learning from PMRT. A quality improvement piece of work has been commenced and a Specialist Midwife – Diabetes appointed who will work as part of a wider MDT caring for this cohort of women. In addition, a thematic review of all cases where diabetes was a feature is underway coordinated by the Trust Patient Safety Manager.

Good Practice:

- The cases have all been notified and surveillance completed within the required timescale.
- Parental involvement was sought in all cases as part of PMRT panel review.
- In one case a family requested to be able to take their baby for a walk in their pram and this was facilitated. This learning has been shared with the national bereavement care steering group as evidence of good practice and has been adopted by other trusts.
- The quality of individual care from specialist Bereavement Midwives, Obstetricians, community based midwives and wider multidisciplinary team was commended in a number of cases.
- WHH is compliant with all measures included as part of Maternity Incentive Scheme Safety Action 1 (MIS Year 6 standards).

3. MBRRACE 2022 REPORT

Since 2013 "Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) produces an annual "Perinatal Mortality Surveillance Report". This report provides rates for stillbirths and neonatal deaths for each provider as well as reporting the national picture. Warrington and Halton NHS Foundation Trust (WHH) participates in reporting data into the Perinatal Mortality Review Tool (PMRT) which allows the analysis to take place. The timelines for submissions of deaths and the analysis of these means that when the reports are published by MBRRACE that they are based on deaths that occurred two years previously.

The MBRRACE annual report for 2022 births has been published. This reports notes:

- The stabilised and adjusted stillbirth rate for WHH for 2022 was 2.69 per 1000 total birth. This is around average for similar trusts and health Boards.
- The stabilised and adjusted neonatal mortality rate (neonatal mortality rate refers to the number of babies which have died within the first 28 days of life) was 1.12 per 1000 live births. This is more than 5% higher than the average for similar Trusts and Health Boards.
- The stabilised and adjusted extended perinatal mortality rate is 3.81 per 1000 total birth. This is around average for similar trusts and health Boards.

Excluding deaths due to congenital anomalies:

- The stabilised and adjusted stillbirth rate for WHH for 2022 was 2.49 per 1000 total birth. This is around average for similar trusts and Health Boards.
- The stabilised and adjusted neonatal mortality rate was 0.9 per 1000 live births. This is more than 5% higher than the average for similar Trusts and Health Boards.
- The stabilised and adjusted extended perinatal mortality rate is 3.39 per 1000 total birth. This is around average for similar trusts and Health Boards.

In light of the neonatal mortality rate (rate for all deaths and rate excluding deaths due to congenital anomalies) being more than 5% higher than the average for similar Trusts and Health Boards MBRRACE recommends the following:

- Review the data that was entered locally about the trust to ensure it is accurate and complete
- Ensure that a review using the PMRT tool has been carried out for all deaths to assess care and implement service improvement.

All cases have been reviewed using the PMRT tool. The recommendations have been shared with Trust Governance team who have confirmed a process of reviewing the data submitted has been completed. The full report is included as appendix 4b.

4. SUMMARY

- WHH stillbirth rate for 2023 is 2.02 per 1000 births.
- The most recent UK national stillbirth rate (2022) is 4.0 per 1000 births
- The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate for 2023 (non NICU providers) across the ODN of 0.8 per 1000 live births, the same measure for Cheshire & Merseyside is 0.9 per 1000 live births.
- WHH rate for 2023 was 1.2 per 1000 live births.
- The NWODN will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier.

- 13 PMRT panels took place during 2023 reviewing 15 cases of stillbirth or neonatal death. Good practice and learning from this review process has been shared and an ongoing action plan is in place. As at 31st December 2023, there were no outstanding actions.
- The MBRRACE annual report for 2022 births notes a stabilised and adjusted neonatal mortality rate of 1.12 per 1000 live births. This is more than 5% higher than the average for similar Trusts and Health Boards.
- The MBRRACE annual report for 2022 births notes a stabilised and adjusted neonatal mortality rate excluding deaths due to congenital anomalies of 0.9 per 1000 live births. This is more than 5% higher than the average for similar Trusts and Health Boards.
- Recommendations from the MBRRACE annual report for 2022 have been implemented.

5. ASSURANCE COMMITTEE

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

6. RECOMMENDATIONS

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

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Warrington and Halton Teaching Hospitals NHS Foundation Trust

MBRRACE-UK perinatal mortality report: 2022 births

This report concerns stillbirths and neonatal deaths among the 2,538 babies born within your Trust in 2022. It includes details of the stillbirths and neonatal deaths for births that occurred in your Trust in 2022, as well as background information on all births.

- Birth numbers are obtained from routine data sources and may not match locally recorded numbers.
- Births before 24 completed weeks gestational age and all terminations of pregnancy are EXCLUDED.
- Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **2.69 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **1.12 per 1,000 live births**. This is more than 5% higher than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **3.81 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **2.49 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.90 per 1,000 live births**. This is more than 5% higher than the average for similar Trusts & Health Boards. Your stabilised & adjusted neonatal mortality rate has worsened by two RAG categories since the previous MBRRACE-UK report.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.39 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Recommended actions

● As the neonatal mortality rate calculated excluding deaths due to congenital anomalies has been highlighted above, it is important to: a) review the data that was entered locally about your Trust to ensure it is accurate and complete; and b) ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths. In line with MBRRACE-UK processes, this information has been escalated to NHS England.

Definitions

Late fetal loss:	A baby born between 22 and 23 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby born at or after 24 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died up to 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

1. Your perinatal mortality rates

The mortality rates are reported for babies born within your Trust at 24 completed weeks gestational age or later, excluding terminations of pregnancy. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2022. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies. The **stabilised & adjusted mortality rate** provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Trust in 2022.

To account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision; (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 22 weeks or later; (iv) 2,000-3,999 births per annum at 22 weeks or later; (v) under 2,000 births per annum at 22 weeks or later.

Your Trust has been included in the comparator group with 2,000-3,999 births per annum.

Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**7**	**2.76**	**2.69**	**(2.26 to 3.14)**	**Up to 5% higher or up to 5% lower**
Neonatal	**3**	**1.19**	**1.12**	**(0.63 to 1.92)**	**More than 5% higher**
Extended perinatal	**10**	**3.94**	**3.81**	**(3.15 to 4.85)**	**Up to 5% higher or up to 5% lower**

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**6**	**2.36**	**2.49**	**(2.24 to 2.81)**	**Up to 5% higher or up to 5% lower**
Neonatal	**3**	**1.19**	**0.90**	**(0.51 to 1.57)**	**More than 5% higher**
Extended perinatal	**9**	**3.55**	**3.39**	**(2.99 to 4.27)**	**Up to 5% higher or up to 5% lower**

Comparisons with similar Trusts and Health Boards

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a coloured circle:

- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

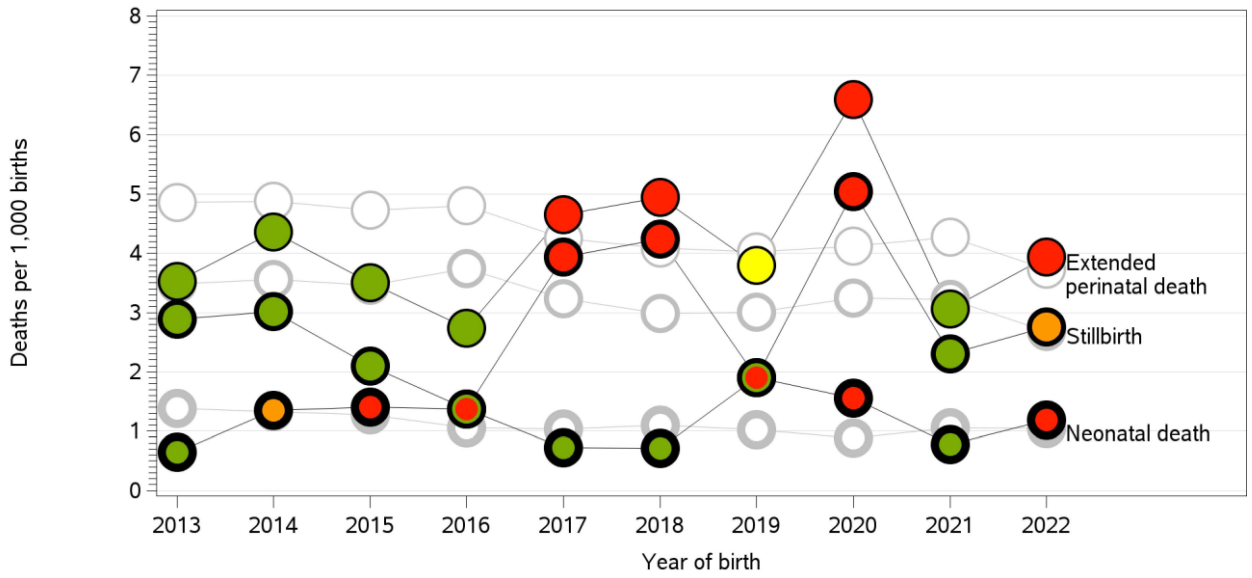
Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

2. Mortality rates over time

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

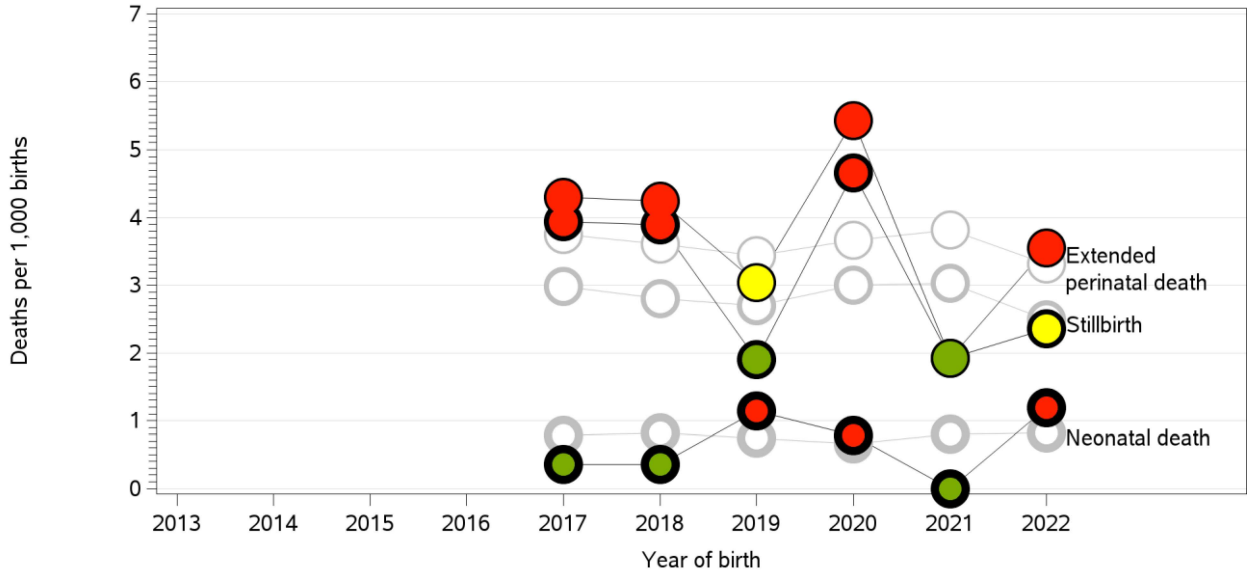
Due to updates to the data, these results might differ slightly from those in previous reports.



Crude mortality by year of birth (excluding deaths due to congenital anomalies)

Crude mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data, these results might differ slightly from those in previous reports.

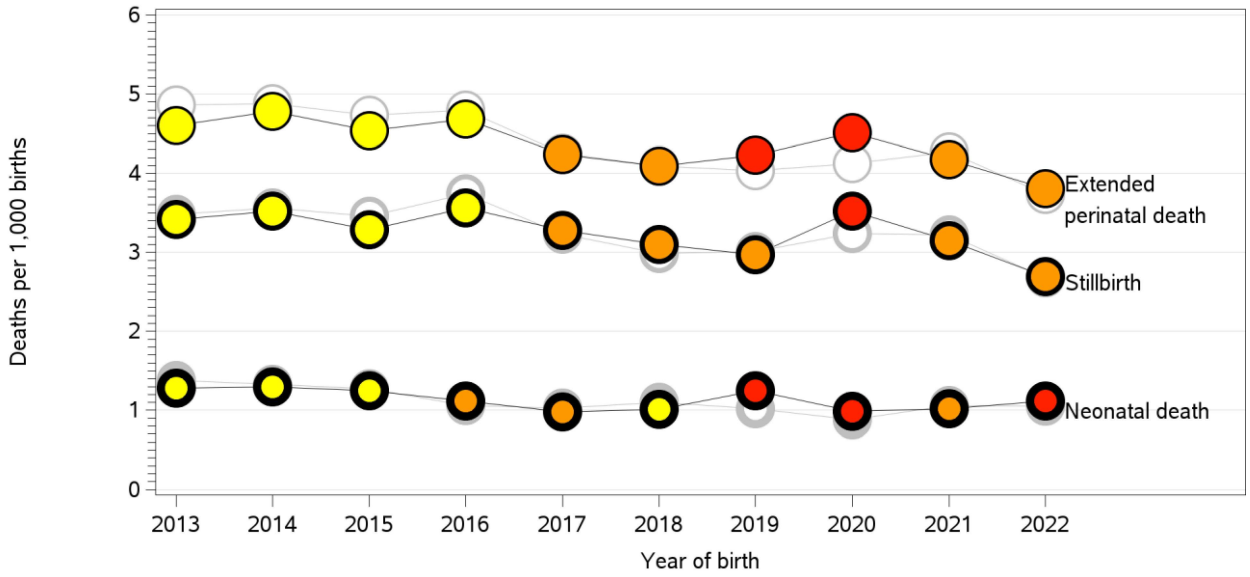


Mortality rates over time *continued*

Stabilised & adjusted mortality by year of birth (all deaths)

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

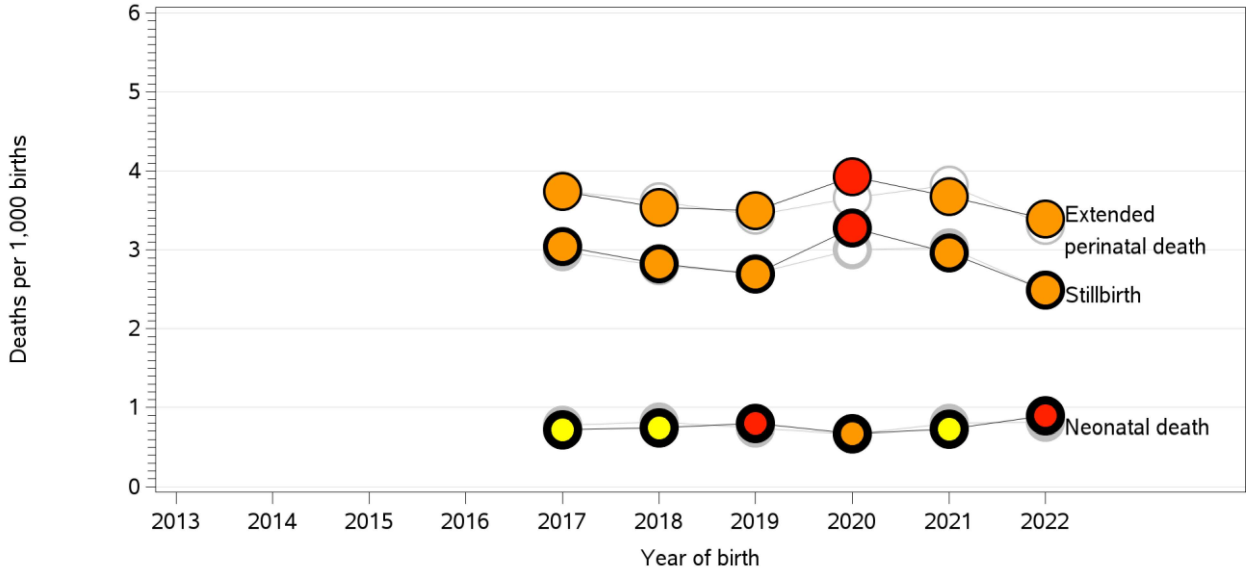
Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth (excluding deaths due to congenital anomalies)

Stabilised & adjusted mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



3. Your perinatal deaths

Deaths of babies born within your Trust

The crude mortality rates reported here are for babies born within your Trust, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 2 which provide more reliable estimates of the underlying (long-term) mortality rates for your Trust.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your Trust	*Rate (N)*	2.8	(7)	0.0	(0)	0.0	(0)	0.8	(2)	0.4	(1)	3.9	(10)
UK-wide	*Rate*	2.9		0.3		0.1		1.1		0.6		5.0	

The rates of extended perinatal death for your Trust, by gestational age at delivery, are shown below. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Your Trust	*Rate (N)*	714.3	(5)	55.6	(1)	12.1	(2)	0.9	(2)	0.0	(0)
UK-wide	*Rate*	325.7		101.7		19.2		1.7		1.3	

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of live born babies who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Within your Trust	*% (N)*		(0)	100%	(1)	100%	(2)		(0)		(0)
Outside your Trust	*% (N)*		(0)	0%	(0)	0%	(0)		(0)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere.

For births within your Trust, a post-mortem was offered for 100% of stillbirths and 100% of neonatal deaths, compared with 98% and 91% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your Trust	*% (n/N)*	100%	(7/7)	100%	(3/3)
Outside your Trust	*% (n/N)*	Not applicable			(0/0)
UK-wide	%	98%		91%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You should ensure that the cause of death on the MBRRACE-UK data reporting system is updated once the post-mortem results are known.

Cause of death		Post-mortem			
		Offered		Consent obtained	
Unknown	*% (N)*	100%	(1/1)	100%	(1/1)

Your perinatal deaths *continued*

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Trust and for neonatal deaths of babies who were born in your Trust. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.

			Infection		Neonatal		Intrapartum		Congenital anomaly		Fetal	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	14.3%	(1)	0.0%	(0)
	UK-wide	%	3.2%		1.4%		1.3%		8.3%		3.8%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	33.3%	(1)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	6.6%		42.8%		1.8%		33.7%		3.9%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your Trust	*% (N)*	14.3%	(1)	71.4%	(5)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	5.3%		36.3%		3.2%		33.9%		3.4%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	33.3%	(1)	0.0%	(0)	33.3%	(1)	0.0%	(0)
	UK-wide	%	0.3%		3.0%		0.3%		5.8%		1.9%	

Babies born at 22 to 23 weeks gestational age

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is essential that your Trust ensures that there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Trust for babies born in 2022 was 1. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

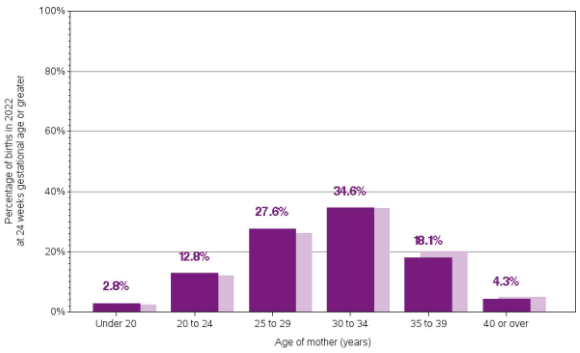
		Deaths of babies born at 22 to 23 weeks gestational age	
		Late fetal losses	Neonatal deaths
Your Trust	*N*	1	2

4. Your births

Age of mother

The proportion of mothers aged 35 years old or older was lower than that of the UK as a whole: 22.3% versus 25.1%.

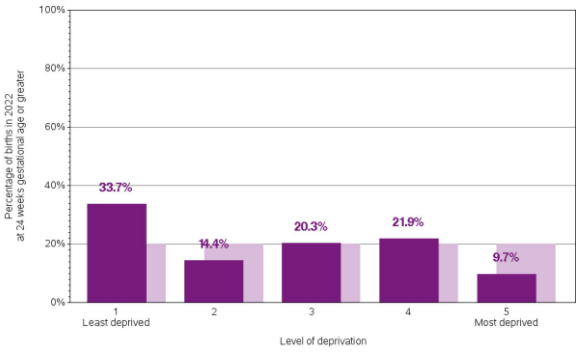
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

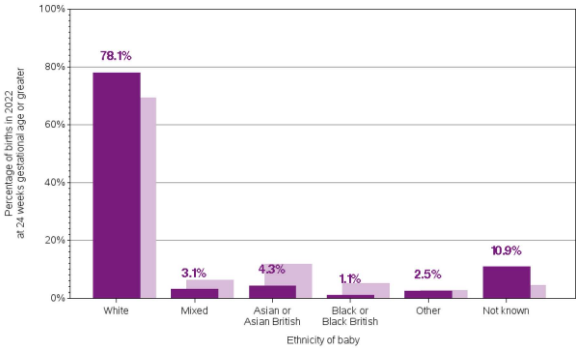
The mothers giving birth in your Trust were considerably less likely to live in areas of high deprivation than those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 11.0% versus 26.2%.

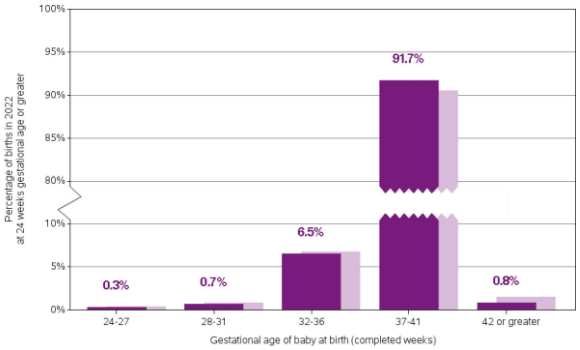
However, for 10.9% of your births the baby's ethnicity was reported as not known. This information is dependent on the accurate coding of babies' ethnicity within the routine reporting of all births.



Gestational age

In your Trust, 7 babies (0.3%) were born at 24 to 27 weeks gestational age, lower than the 0.4% seen in the UK as a whole. However, the percentage of babies born at 28 to 31 weeks was similar to the national average: 0.7% versus 0.8%.

In addition, 21 babies (0.8%) were born post-term (42 weeks or greater), a lower percentage than the UK average of 1.5%.

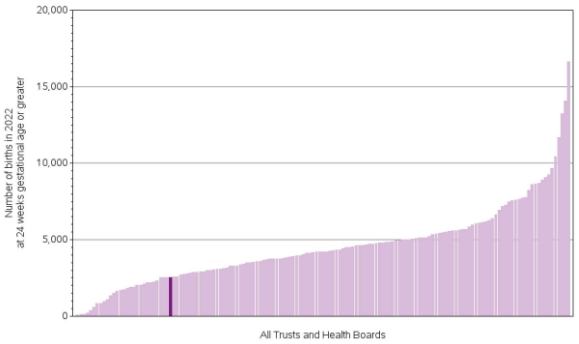


Your births *continued*

Number of births

There were 2,538 births in your Trust at 24 weeks gestational age or later, excluding terminations of pregnancy.

The purple line in the graph opposite shows that the number of births in your Trust puts you in the lowest third of all Trusts and Health Boards in the UK.



Percentage of births taking place in your Trust by commissioning organisation

The table below provides the percentage and number of births in your Trust at 24 weeks gestational age or later from each of the commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Trust. These organisations are Sub-Integrated Care Boards (Sub-ICBs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

In total, the births from these organisations accounted for 96.9% of your births at 24 weeks gestational age or later in 2022.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. NHS Cheshire and Merseyside ICB - 02E	89.6% (1715)	2. NHS Cheshire and Merseyside ICB - 01F	24.7% (294)
3. NHS Cheshire and Merseyside ICB - 01X	9.6% (178)	4. NHS Greater Manchester ICB - 02H	5.2% (176)
5. NHS Greater Manchester ICB - 01G	2.7% (96)		

5. Data reporting

Completeness of key data items for DEATHS AT YOUR TRUST

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2022, we received 100% of information on key data items for the deaths which occurred within your Trust.

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Trust, these tables show the overall completeness of data for **deaths at your Trust no matter where they were born**. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- ♦ less than 70.0% complete
- ♦ 70.0% to 84.9% complete
- ♦ 85.0% to 96.9% complete
- ♦ 97.0% to 99.9% complete
- ♦ 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Trust. We are pleased to report that 100% of the data items were completed for deaths reported by your Trust. Thank you for help and support.

Mother's details	Completeness	
Name	100.0%	♦
UK-wide	100.0%	
Postcode of residence	100.0%	♦
UK-wide	99.9%	
Ethnicity	100.0%	♦
UK-wide	96.3%	
Age	100.0%	♦
UK-wide	99.9%	

Birth	Completeness	
Type of onset of labour	100.0%	♦
UK-wide	98.8%	
Actual place of birth	100.0%	♦
UK-wide	99.6%	
Date and time of birth	100.0%	♦
UK-wide	97.7%	
Final mode of birth	100.0%	♦
UK-wide	99.5%	

Booking and antenatal care [note 1]	Completeness	
Smoking	100.0%	♦
UK-wide	97.7%	
Body mass index	100.0%	♦
UK-wide	100.0%	
Intended type of care at booking	100.0%	♦
UK-wide	95.5%	
Estimated date of delivery	100.0%	♦
UK-wide	97.0%	

Baby's outcome	Completeness	
Date death confirmed [note 2]	100.0%	♦
UK-wide	99.8%	
Whether alive at onset of care [note 2]	100.0%	♦
UK-wide	95.6%	
Whether admitted to NNU [note 3]	100.0%	♦
UK-wide	99.6%	
Main cause of death	100.0%	♦
UK-wide	97.0%	

Baby's characteristics	Completeness	
Birth weight	100.0%	♦
UK-wide	98.7%	
Gestational age at birth	100.0%	♦
UK-wide	99.0%	

Note 1: Excluding mothers reported as never booked.
Note 2: This data item is collected for stillbirths only.
Note 3: This data item is collected for neonatal deaths only.

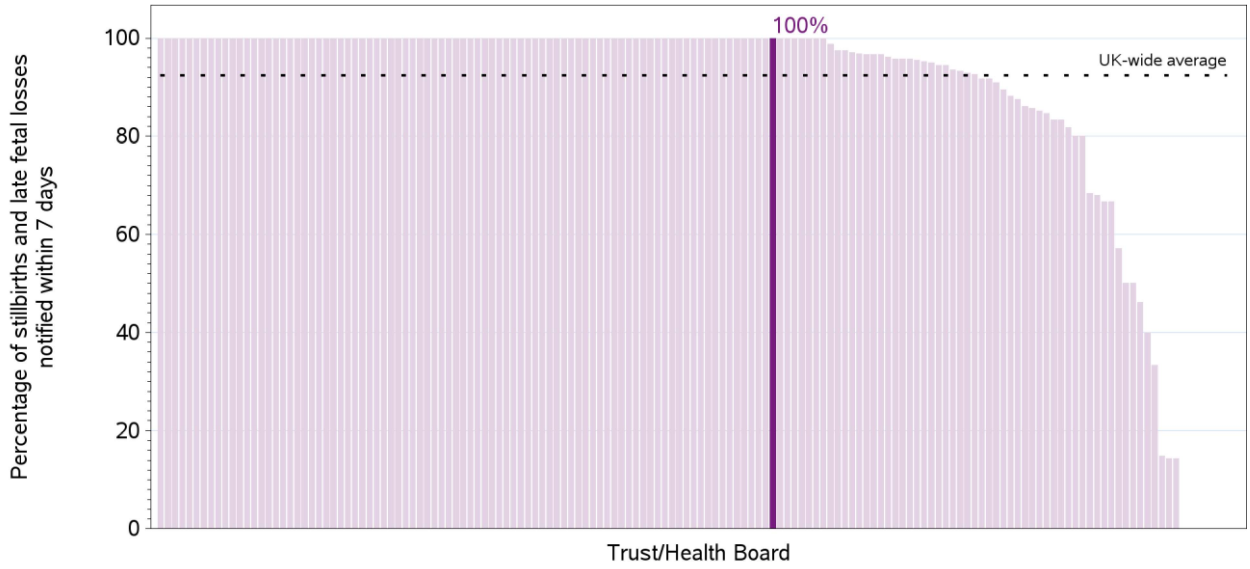
Percentage of deaths notified by your Trust within 7 days

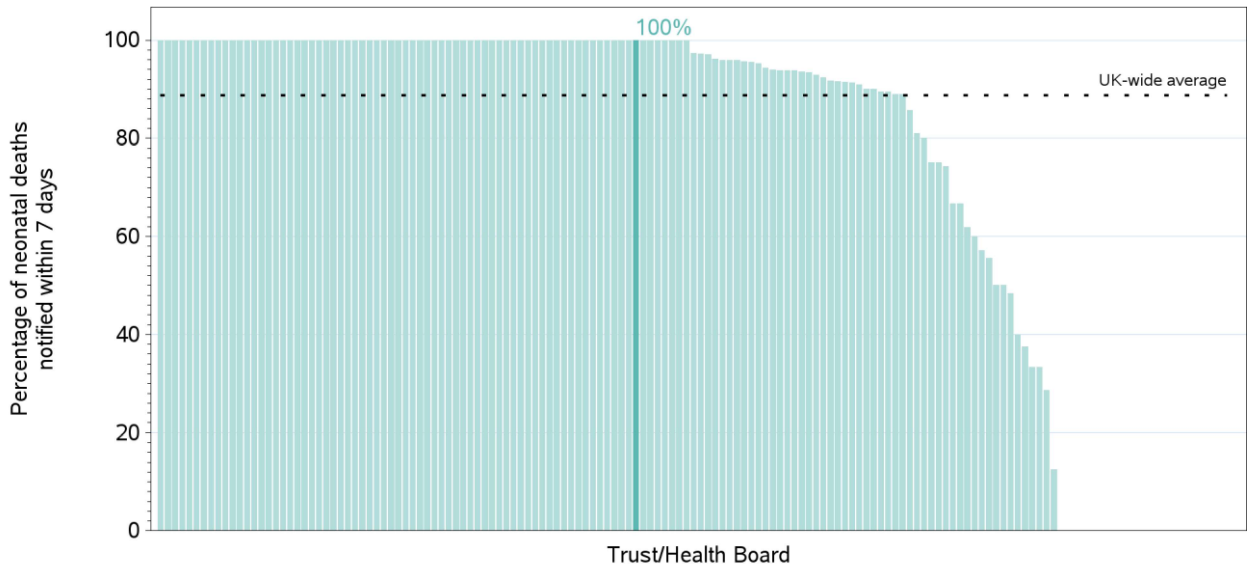
The MBRRACE-UK timeliness benchmarks for the notification of deaths and completion of surveillance data are:

1) All deaths should be **notified** to MBRRACE-UK within 7 days of the death occurring. The full surveillance data does not have to be complete at this point.

2) Trusts and Health Boards should aim to **complete** surveillance data entry for each death within 90 days of the death occurring. The final cause of death can be updated at a later date, if necessary.

The graphs below show the percentage of stillbirths & late fetal losses and neonatal deaths notified by your Trust within the 7-day benchmark period.





About this report

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford, with members from the University of Leicester (who lead the perinatal aspects of the work), University of Birmingham, Chelsea and Westminster Hospital NHS Foundation Trust, The Newcastle upon Tyne Hospitals NHS Foundation Trust, National Maternity Voices and Sands.

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England, the Welsh Government and, with some individual projects, other devolved administrations and Crown Dependencies.

Data sources

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics, Personal Demographics Service, National Records of Scotland, Public Health Scotland, Northern Ireland Maternal and Child Health, States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2023.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other locally or nationally reported rates, as births before 24 weeks gestational age have been excluded from most tables due to differences in reporting by Trusts and Health Boards. Further details on the methods we have used are included in the Technical Manual.

Data viewer

The MBRRACE-UK Data Viewer can be used to view data on a map and compare perinatal mortality rates for the organisations responsible for the commissioning and provision of care.

MBRRACE-UK, Department of Health Sciences, University of Leicester, George Davies Centre, Leicester, LE1 7RH.

Tel: +44 (0)116 252 5425 **Email:** mbrracele@npeu.ox.ac.uk **Web:** http://www.npeu.ox.ac.uk/mbrrace-uk

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/040 - Appendix 5**			
SUBJECT:	**Quarter 4 2023-24 Perinatal Mortality Review/Audit**			
DATE OF MEETING:	5 June 2024			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** **X**	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** **X**	**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** **X**
	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 6) 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 4 (Q4) PMRT report for the period covering 01/01/2024 – 31/03/2024. During Q4, WHH reported six babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): **Five Stillbirth:** • One baby born at 23+4 weeks • One baby born at 39+4 weeks • One baby born at 40+5 weeks • One baby born at 29+0 weeks • One baby born at 40+0 weeks **One Neonatal Death:** • One baby born at 38+6 weeks The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 1 2024/25 QAC following a PMRT review panel. WHH stillbirth rate for Q4 2023/24 was 8.50 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births. WHH Neonatal mortality rate during Q4 2023/2024 was 1.59 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

	During Q4, WHH undertook three PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed: One stillbirth: • One baby born at 26+4 weeks Two neonatal deaths: • One baby born at 38+0 weeks • One baby born at 38+5 weeks In two cases, there were no issues with care identified for the mother and baby up to the point that the baby was born. In two of the cases, there were no issues with care identified for the mother and baby up to the point that the baby was confirmed to have died. 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. In three of the cases, there were no issues identified with the care of the mother following confirmation of the death of her baby. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/24/05/34ii		
	Date of meeting	7 May 2024		
	Summary of Outcome	Noted		

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 4 2023-24 Perinatal Mortality Review/Audit	AGENDA REF:	BM/24/06/040 - Appendix 5

1. BACKGROUND/CONTEXT

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

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 6 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 4 PMRT audit data for 2023/2024 and highlights good practice and lessons learned during the mortality reviews. Q4 covers the reporting period from 01/01/2024 to 31/03/2024.

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 Q4 reporting period six cases were reported to MBRRACE-UK:

Five Stillbirth:
One baby born at 23+4 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 29th April 2024 and will be included in the Q1 2024/25 Perinatal Mortality Review Audit report to QAC.

One baby born at 39+4 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 29th April 2024 and will be included in the Q1 2024/25 Perinatal Mortality Review Audit report to QAC.

One baby born at 40+5 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 29th April 2024 and will be included in the Q1 2024/25 Perinatal Mortality Review Audit report to QAC.

One baby born at 29+0 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 20th May 2024 and will be included in the Q1 2024/25 Perinatal Mortality Review Audit report to QAC.

One baby born at 40+0 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 20th May 2024 and will be included in the Q1 2024/25 Perinatal Mortality Review Audit report to QAC.

One Neonatal Death:
One baby born at 38+6 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case took place on 18th March 2024 and is included in this Q4 2023/24 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 4. WHH Stillbirth Rate:

- WHH Q4 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 one intrapartum stillbirth.
- WHH had two 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 2023/24 is 3.71 per 1000 births. The MBRRACE-UK national rate is 4.1 per 1000 births.

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

Metric	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	12-month total
Number of live births	603	600	627	591	2421
Total number of stillbirths >24 weeks	1	2	1	5	9
Total Stillbirth Rate >24 weeks (per 1000 births)	**1.65**	**3.32**	**1.59**	**8.50**	**3.71**
Number of intrapartum still birth rate	0	0	0	1	1
Number of stillbirths >37 weeks	0	0	0	2	2

2.2 Q3. WHH Neonatal Mortality Rate:

There was one early neonatal death reported in Q4 2023/2024. This baby was known Anencephaly and was transferred from WHH following birth to Claire House for palliative care and died at 10 days.

WHH Neonatal mortality rate during Q4 2023/2024 was 1.67 per 1000 live births. The MBRRACE-UK national rate is 2.7/1000 live births.

2.3 Quarter 4 PMRT Review Panel Key Findings

2.3.1 Synopsis of Findings

One baby born at 26+4 weeks gestation was a stillbirth. The cause of death identified at post-mortem was determined to be severe hepatic hemosiderosis in keeping with fetal haemochromatosis.

One baby born at 38+0 weeks gestation was a neonatal death. The cause of death was confirmed as Anencephaly.

One baby born at 37+3 weeks gestation was a neonatal death. The cause of death identified at coronial post-mortem was haemolytic anaemia and intracranial haemorrhage. This case was a death recorded in April 2023 and the review was on hold until the coroners report was available as per the advice from MBRRACE-UK.

2.3.2 Surveillance Findings:

- All the babies were of a singleton pregnancy.

- One woman was aged between 22-26.
  Two of the women were aged between 30-34.

- All the women were identified as white ethnicity.

- Two of the women spoke English as their first language. One woman was Latvian, with little understanding of English. 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.

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

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

- None of the woman booked late in the pregnancy.

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

2.3.3 PMRT Review and 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.

2.3.3.1 PMRT Grading of Care - Stillbirth

During Q4 one PMRT stillbirth review panel took place. Parental perspective of the care they received were sought.

There were no issues with care identified for the mother and her baby up to the point that the baby was confirmed as having died.

There were no issues with the care identified for the mother following confirmation of the death of her baby.

Table 3: Q4 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	1	1
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	-	-
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	-	-
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-
Not Graded	-	-
Total Cases	One case	One case

2.3.3.2 PMRT Grading of Care – Neonatal Death

During Q4 there were two neonatal death PMRT review panels which were undertaken. In both cases, there were no issues with care identified for the mother and baby up to the point of the birth of the baby.

In one of the cases, issues with care were identified for the mother up to point that the baby was confirmed as having died that would not have made a difference to the outcome for the mother.

In one of the cases, there were no issues with care identified for the mother up to point that the baby was confirmed as having died.

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

The learning from this is included in an action plan (Table 8).

Table 4: Q4 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	2	1	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	-	-	-
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	Two cases

2.3.3 PMRT reporting for Saving Babies Lives Care Bundle v3- Q4 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%

2.3.4 Q4. WHH PMRT Panel Attendance

There have been three PMRT panel reviews in Q4 which were attended by multidisciplinary internal and external panel members.

Table 6: Q4 WHH PMRT Panel Attendance

	Number of participants involved in PMRT reviews. Total number of reviews from 01/01/2024 – 31/03/2024 = 3		
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	1	2	3
Admin/Clerical	0	0	0
Bereavement Midwife	1	2	3
External Rep	1	2	3
Management Team	0	0	0
Midwife	1	2	3
Neonatal Nurse	0	0	0
Neonatologist/Paediatrician	0	2	2
Obstetrician	1	2	3
Other	1	2	3
Governance Manager	1	2	3
Safety Champion	0	0	0

2.3.5 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 6 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 8 December 2023 to 30 November 2024.	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 8 December 2023.	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 8 December 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 within six months.	Assessed as compliant
d)	Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Assessed as compliant

2.3.6 Learning and Good Practice

- The six cases have been notified to MBRRACE and surveillance completed within the required timescale.
- Antenatal care was graded A in all the PMRT panel meetings which included feedback from the parents.
- Postnatal care was graded B in all the PMRT panel meetings, which included feedback from the parents. Learning from this case is included in the 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 was one action recorded from the Q4 2023/24 PMRT review panels and all actions are complete:

Table 8: PMRT Action Plan

Action	Lead	Start date	Due Date	RAG rating
Share the learning to ensure all women whose first language is not English have access to an NHS provider translation service during antenatal, intrapartum and postnatal care.	Sam Emery, Antenatal & Postnatal Matron	18.03.24	Complete	

2.3.7 Summary

- WHH Q4 PMRT audit recorded one baby reported to MBRRACE who was born between 01/01/2024 and 31/03/2024.
- The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 1 2024/25 QAC report following the PMRT review panels due to be held on 20th May 2024.
- WHH stillbirth rate for Q3 2023/24 was 8.50 per 1000 births. WHH annual Mean stillbirth rate is 2.71 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. The MBRRACE-UK national rate is 2.7 per 1000 births.
- Three PMRT review panels were held in Q4 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 two cases, there were no issues with care identified for the mother and baby up to the point that the baby was born.
- In two cases, there were no issues with care identified for the mother and baby up to the point that the baby was confirmed to have died.
- 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.
- In three 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 Q4 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 7 May 2024.

5. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="2">BM/24/06/040 - Appendix 6</td></tr>
<tr><td>SUBJECT:</td><td colspan="2">Maternity Self-Assessment Tool</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="2">5 June 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="2">Ailsa Gaskill-Jones, Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="2">Ali Kennah - Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td>SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>X</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="2"></td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="2">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
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<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes
X</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes
X</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A
X</td></tr>
<tr><td colspan="4">Further Information: This paper provides findings following completion of the NHS Maternity self-assessment tool, self-assess whether their operational service delivery meets national standards, guidance and regulatory requirements to ensure a safe, effective maternity service. The paper relates to care of pregnant</td></tr>
</table></td></tr>
</table>

	people/those on the pregnancy continuum. The principles within the self-assessment tool are to ensure safer care for this cohort. Achieving the principles within the tool will have a positive impact on this group.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The revised Maternity self-assessment tool is a national assurance tool introduced to maternity providers in response to the Kirkup Report (2015) and Ockenden Report (2020) and findings of outstanding Care Quality Commissioners (CQC) to support trusts to benchmark their services against national standards and best practice guidance. The WHH benchmarking update aligns to the key themes identified within the recommended tool: • Directorate infrastructure and leadership • Multidisciplinary team dynamics • Governance infrastructure and ward-to-board accountability • Application of national standards and guidance • Safety culture across the Care Group and Trust • Comprehension of business and impact on quality The Maternity self-assessment tool identifies 159 criteria. As at 31st March 2024, WHH is fully compliant with 117/159 criteria. This equates to 73.6% of the criteria, an improvement from 63.5% when the last assessment was completed. This paper is asked to be noted for information.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/24/05/34v		
	Date of meeting	7 May 2024		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Self-Assessment Tool	AGENDA REF:	BM/24/06/040 Appendix 6

1. BACKGROUND/CONTEXT

The Maternity self-assessment tool has been developed in response to national maternity review findings, including the Kirkup Report (2015) and recommendations for good safety principles within maternity services. The current tool has been further influenced by the findings of the Ockenden review (2020), 7 features of safety culture and the emerging themes from services on the safety support programme, and the trusts found to be outstanding following Care Quality Commissioners (CQC) reviews in other maternity services across England.

The tool has been designed for NHS maternity service providers to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

The tool is underpinned with a philosophy of promoting a positive leadership and safety culture and to inform the Trust Board and Commissioners of the current maternity quality improvement and safety programme.

2. KEY ELEMENTS

The Maternity self-assessment tool has been structured according to the six key areas important for the leadership and quality of maternity services that emerged in the diagnostic phase (year 1) of the Maternity Safety Support Programme (2018). These were:

- Directorate infrastructure and leadership
- Multidisciplinary team dynamics
- Governance infrastructure and ward-to-board accountability
- Application of national standards and guidance
- Safety culture across the division and trust
- Comprehension of business and impact on quality

3. MEASUREMENTS/EVALUATIONS

The Maternity self-assessment tool identifies 159 criteria to be evidenced against. As at 31st March 2024, WHH is fully compliant with 117, which equates to 73.6% of all actions. This is an improvement from the position when the assessment was last completed when compliance was noted against 63.5% of the criteria.

The 159 criteria have been RAG rated as follows:-

- Red 18 (11.3%)
- Amber 38 (23.9%)
- Green 101 (63.6%)
- N/A 2 (1.2%)

Those criteria identified as red can be themed within the following:

- Establishment of a formal maternity safety improvement plan
- Collaborative multiprofessional input to service development and improvement
- Safety huddles and Schwarz rounds
- Involvement of maternity and neonatal services in Trust-wide safety and learning events

A maternity strategy and transformation action plan has been developed to support the implementation of the new Maternity and Neonatal Strategy 2024-26 alongside areas for development identified within the maternity self-assessment tool and with regard to wider work being undertaken in relation to equity and equality. Activity is underway in relation to all red and amber actions with completion planned as part of the 2024/25 workplan.

4. MONITORING/REPORTING ROUTES

The content of this report has previously been noted and discussed at Quality Assurance Committee on 7 May 2024.

Progress against the action plan will be monitored via the Quadrumvirate and through the Women's and Children's monthly governance meeting.

Best practice requires the self-assessment tool be completed every six months with a report to Quality Assurance Committee for discussion and for the report to then be shared with the Trust Board. Accordingly a reviewed position will be brought to Quality Assurance Committee in October 2024.

5. CONCLUSION

The Maternity self-assessment tool has been undertaken and the 159 criteria have been RAG rated. 117/159 of the criteria are compliant, which equates to 73.6% of all actions. An action plan is in place to achieve full compliance. This has been developed in conjunction with the wider maternity strategy and transformation action plan and service equity and equality plans

6. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/040 - Appendix 7**	
SUBJECT:	**Maternity Update – Ockenden Report**	
DATE OF MEETING:	5 June 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	*x*		
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			
The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.			

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

	Ockenden recommendations, and the report will also be noted at Trust Board. In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 31st March 2024 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 100% compliant. • **Ockenden 2**: WHH is 98.55% compliant. The remaining one amber action is on track to be completed by 30 June 2024.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	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/24/05/34i		
	Date of meeting	7 May 2024		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/24/06/040 Appendix 7

1. BACKGROUND/CONTEXT

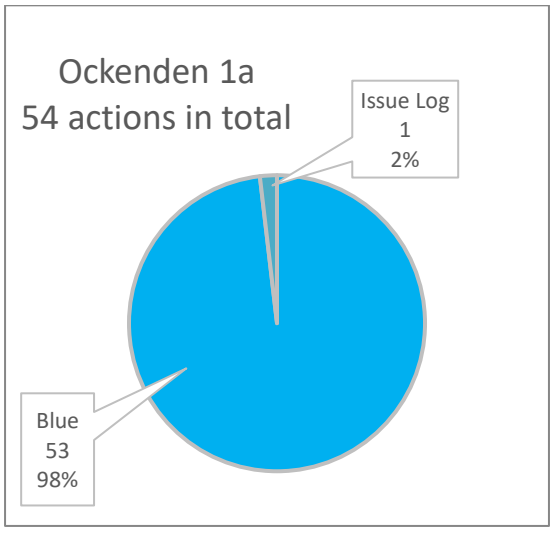
1.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

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

1.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

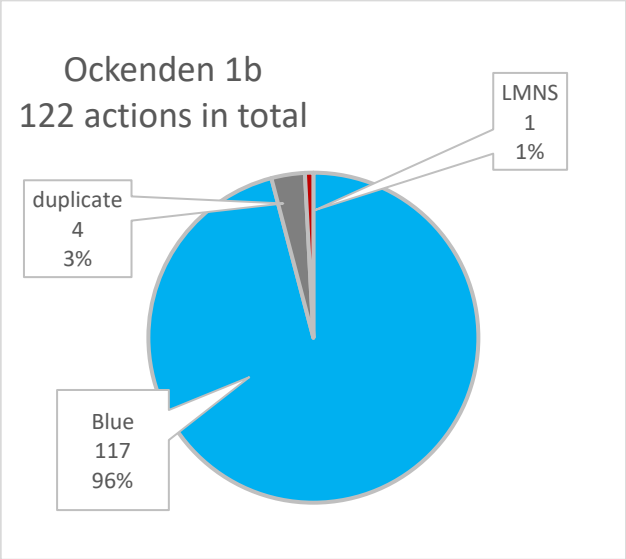
No change from previous month.

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

1.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



Update

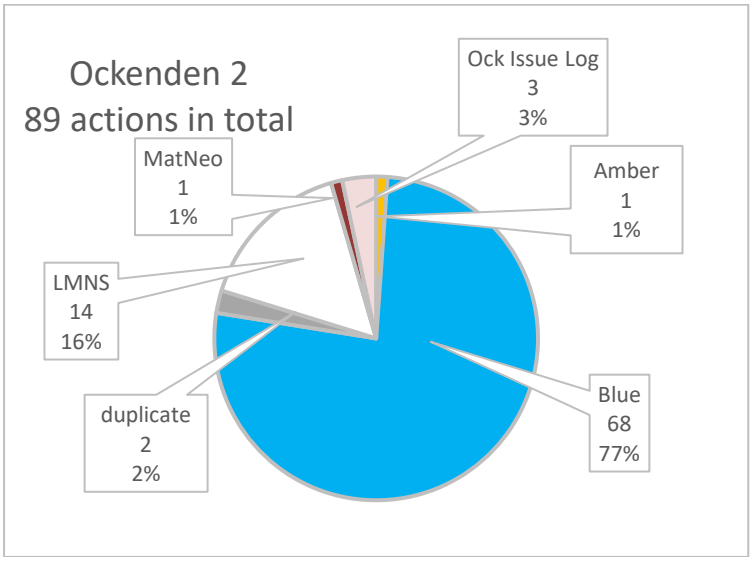
0 Outstanding Actions (previously 1)

Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is now 100% compliant at 31 March 2024 (previously 99%).

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



1 Outstanding Action (previously 1)

1 Amber Action due to be completed by 30 June 2024.

Excluding the following 20 actions from the initial 89:

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

The Ockenden 2 action plan is 98.55% compliant (68/69) at 31st March 2024 (no change from previously reported). The remaining one Amber action is on track to be completed by 30 June 2024.

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. This is awaiting the issue of her CCT which is expected in June/July 2024. In the interim other obstetric colleagues are supporting this activity.

a. Ockenden Summary

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

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

- Ockenden 2 Action Plan is 98.55% compliant.

1 Ockenden action remains outstanding and is on track to be completed by 30 June 2024.
4 actions have been transferred to an Issues Log for continued monitoring.

2. MONITORING/REPORTING ROUTES

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

3. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 7th May 2024.

4. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/040 - Appendix 8**			
SUBJECT:	**Midwifery Summary Safe Staffing Report – May 2024**			
DATE OF MEETING:	5 June 2024			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
	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 March 2024 (the latest available data) and red flag position for the period January – March 2024 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 March 2024 was 125.36wte. The vacancy rate for registered staff as at 31st March 2024 is 5.66%. This is a slight increase from the end of Q3 2023/24 but remains an improved position. Midwifery retention rates remain good with turnover at 8% at the end of March 2024. Rates below the Trust target have been maintained since December 2023. Sickness rates for March 2024 for registered midwifery staff were 6.69%, this is a decrease from February 2024 when the rate was 7.64%. It is however a slight increase from end of March 2023 when the rate was 6.2%. 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 6 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 January 2024 – 31st March 2024 there are no episodes recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary. In the period 1st January 2024 – 31st March 2024 there are no episodes recorded in SafeCare where a woman in active labour is NOT receiving one-to-one care. A deep dive is underway to review all workforce and acuity related data and metrics, the findings and actions of which will be included in the next Midwifery Staffing Summary to Strategic People Committee in August and then to Trust Board.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	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/24/05/29**		
	Date of meeting	15 May 2024		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Midwifery Summary Safe Staffing Report – May 2024	AGENDA REF:	BM/24/06/040 Appendix 8

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 March 2024 and red flag position for the period January – March 2024 alongside other key workforce metrics.

2. MIDWIFERY ESTABLISHMENT

This report summarises the current funded and actual staffing establishment as of the 31st March 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 March 2024 is 125.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 31st March 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. All new posts have been funded within the service via reallocation of existing establishment or via external funding streams.

Review of the maternity workforce using the Birthrate Plus® workforce planning tool is required every three years. Accordingly a full review will be required to be completed by March 2025 in line with Maternity Incentive Scheme Year 6 - Safety Action 5. Work is underway to arrange this assessment and compliance will be monitored as part of the service's usual assurance processes for the Maternity Incentive Scheme.

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

Red Flag Reason	Number of Red Flags raised		
	Jan 2024	Feb 2024	Mar 2024
Delay in med review triage >30min	8	16	47
Delay in review of CTG	0	0	3
Delay in triage >15min	1	6	3
Delay in triage >30min	0	0	4
Delayed IOL	2	2	2
Delayed MEOWS	0	0	0
Delayed >30min Pain relief	0	0	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	0
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	1	3
Delay of 2 hours or more between admission for induction and beginning of process			
Shortfall in RM Time	31	43	42
Birth Suite Coordinator NOT supernumerary	0	0	0
NEST Divert – Staffing	0	2	0
NEST Divert - Acuity	0	3	1
AMBER Alert - Staffing	0	0	1
AMBER Alert - Acuity	0	0	0
Red Status (Deflect)	0	0	0
IOL Handover to C23	10	5	13
Time critical activity	0	0	0
Homebirth Service suspended	0	0	0
Unable to provide Transitional Care	0	0	0

Where a red flag is raised, this is escalated to the bleep holder and appropriate mitigation/support is provided to resolve the issue. There have been no harm events as a result of issues within the red flag escalation process.

3.3.1 Birth Suite Coordinator NOT Supernumerary

Monitoring of Safe Staffing levels is a requirement of the NHSLA 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 is recorded on SAFECARE.

In the period 1st January 2024 – 31st March 2024 there are 0 episodes recorded in SAFECARE/BR+ where the Birth Suite Coordinator is NOT supernumerary.

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 January 2024 – 31st March 2024 there were 0 episodes recorded in SafeCare where a woman in active labour is **NOT** receiving one-to-one care.

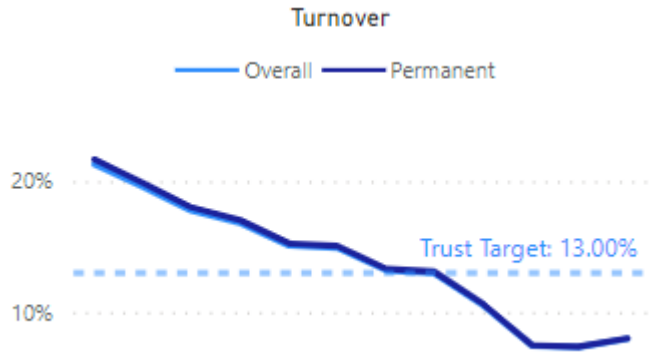
4. WORKFORCE METRICS

The vacancy rate for registered staff as at 31st March 2024 is 5.66%. This is a slight increase from the end of Q3 2023/24 but remains a significant improvement from the from end of January 2023 when the vacancy rate was 18.29%.

The vacancy rate excludes 1.0 wte registered staff in the recruitment pipeline and due to start in May 2024 which will further improve the position. Processes are underway to complete recruitment for all vacant posts.

4.2 Retention rate

Midwifery retention rates remain good with turnover at 8% at the end of March 2024. Rates below the Trust target have been maintained since December 2023.



4.3 Sickness absence

Sickness rates for March 2024 for registered midwifery staff were 6.69%, this is a decrease from February 2024 when the rate was 7.64%. It is however a slight increase when compared to March 2023 when the rate was 6.2%. The rolling 12 month rate is 7.19%.

Proactive management of matters relating to workforce are ongoing

6. OTHER WORKFORCE ACTIVITY

There have been significant improvement in workforce metrics since January 2023. Despite this improvement there still remains shortfall in RM time (116 red flags raised in quarter four) and a reliance on NHSP (including enhanced rates of NHSP) to maintain a safe service.

To understand this further, a deep dive is underway to review all workforce and acuity related data and metrics, this will include:

- Annual leave unavailability
- Training unavailability
- Sickness absence unavailability
- Maternity leave unavailability
- Impact of occupational health restrictions on deployment of staff
- Impact of flexible working agreements on deployment of staff
- Impact of secondments
- Learning from NHSE Workforce tool
- Birth rate+ Birth Suite acuity tool data/outputs
- Birth rate+ Maternity ward acuity tool data/outputs
- Induction of labour rates
- Caesarean section rates
- Length of stay data

- Triage acuity
- Caseload complexity
- Antenatal Day Unit activity

The findings and actions from this review, including opportunities for service improvement and development will be included in the next Midwifery Staffing Summary to Strategic People Committee.

7. ASSURANCE COMMITTEE

The content of this report has previously been noted at Strategic People Committee on 15 May 2024.

8. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MATERNITY REVIEW 2023/24

Trust Board
5 June 2024

Working Together | Excellence | Inclusive | Kind | Embracing Change

Workforce recruitment & retention

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ Three Year Delivery Plan for Maternity & Neonatal Services	Focussed workforce project to improve recruitment and retention of midwives implemented
	Improved workforce planning in place to monitor midwifery staffing on a daily, weekly basis alongside appropriate escalation processes
	Increased Consultant Obstetrician workforce
	Specialist Midwife – Retention in place
	Implementation of RCOG Compensatory Rest policy for Consultants
	Implementation of bespoke orientation package for new Birth Suite Coordinators
	Review of the Midwifery Continuity of Care model
	Review of processes to support locum medical colleagues
	NHSE Cultural leadership programme implemented

Workforce development

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report	Annual training plan refreshed to facilitate increased opportunity for MDT learning and ensuring significance of human factors feeds through all training
	Bespoke Human factors training implemented
	Robust programme of skills and drills implemented reflecting learning from incidents and best practice
	Focus on maintaining and improving compliance with mandatory training
	Refreshed preceptorship programme implemented including additional supernumerary skills and drills package for newly qualified midwives
	Introduction of MAMU3 training day for Midwives and MSWs to share local learning from safety events and population health updates e.g. smoking cessation, perinatal mental health, screening and transitional care workstreams

Workforce – outcomes #1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Sustained improvement in midwifery workforce metrics

- Vacancy rate for registered staff has reduced from a peak of 23.25% in June 2022 to 4% at the end of April 2024 (3.66% not recruited to)
- Midwifery retention rates remain good with turnover at 5.72% at the end of April 2024 , compared to 29.51% in January 2023 - Rates below the Trust target have been maintained since December 2023
- Excellent retention of newly qualified midwives

All requirements of Maternity Incentive Scheme Year 5 and Saving Babies Lives v3 in relation to workforce achieved

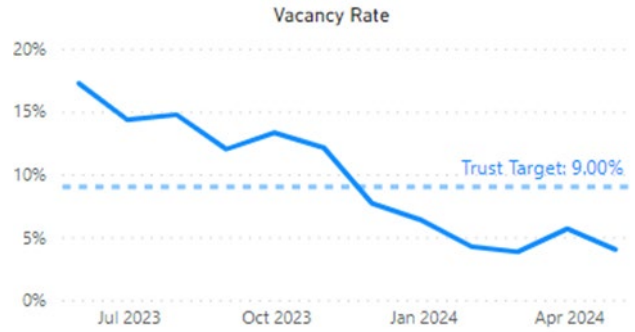
Robust staffing escalation processes in place including implementation of digital processes for monitor and recording escalation through Opel status

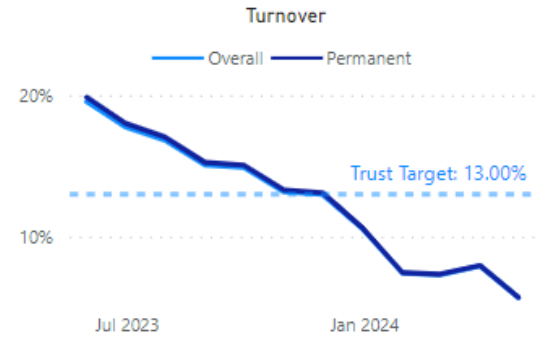
Review of Continuity of Carer delivery model completed, enabled release of 5.4fte registered midwives to Core Hospital establishment to support inpatient areas in particular a safer staffing model for Maternity Triage

Excellent performance against key 'red flag' measures Jan 2023-March 2024

- Provision of 1:1 care in labour – no episodes recorded in SafeCare
- Birth Suite Coordinator supernumerary - 9 episodes recorded in SafeCare – 0.99% shifts – occurs rarely

Midwifery workforce metrics



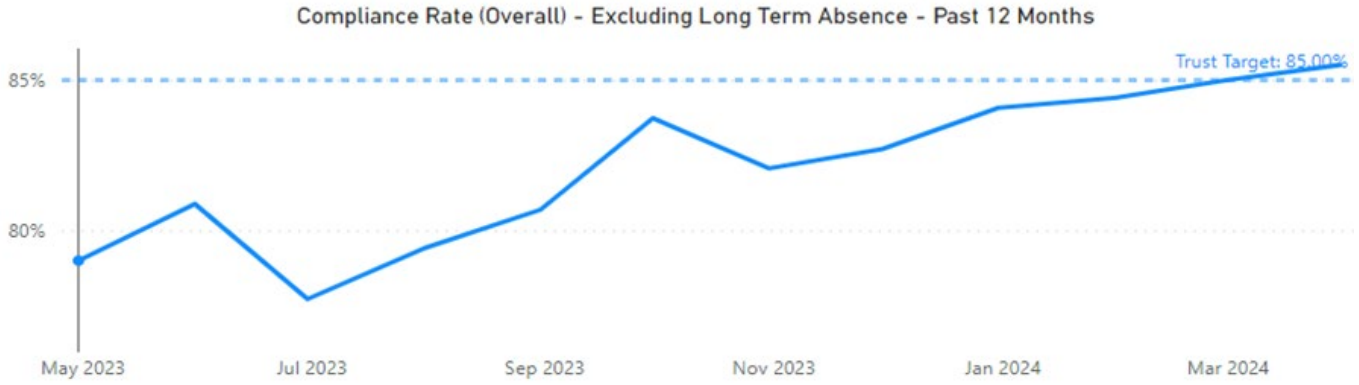


Workforce – outcomes #2

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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

Current position – Training compliance - maternity specific



Workforce – outcomes #3

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

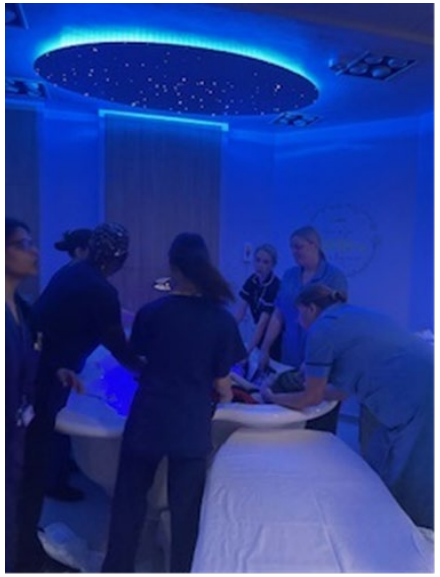
Obstetric workforce increased to a headcount of 12 including named Consultant for fetal surveillance, preterm birth, multiple pregnancy supporting development of specialist pathways and reduced frequency of on call to improve retention

Rated as 'Good' by the CQC in the well led domain

- "Staff felt respected, supported, and valued by the leadership team"
- "Leaders ran services well using reliable information systems and supported staff to develop their skills"

Programme of MDT skills and drill in place

- 10 simulations conducted so far in 2024
- Well received by the team and excellent learning identified and shared



Personalised Care

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ Three Year Delivery Plan for Maternity & Neonatal services	Robust process of debrief and birth reflection in place via Consultant Midwife led clinic
	Continued focus on reducing inequality and ensuring relevant specialist pathways are implemented and embedded
	MDT Perinatal Pelvic Health Service established including appointment of Specialist Midwife – Perinatal Mental Health
	Improved partnership working to provide holistic care provision and use of digital solutions to support pathway development
	Tailored midwifery service supporting families seeking asylum
	Recruitment of 3.0fte enhanced Maternity Support Workers working alongside midwifery teams as part of a model of enhanced care
	Appointment of Specialist Midwife – Perinatal Mental Health

Personalised care – outcomes/outputs

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Achieving 100% compliance against six national agreed criteria for Personalised Care Planning (externally reviewed via the LMNS)

Five day pelvic health service in place including services delivered from the Living Well hub to improve accessibility for women

Robust perinatal mental health pathways in place

Equality Delivery System assessment completed

- Achieving across six of eight domains and excellent feedback via external review panel

Optimisation of BadgerNet has increased referrals to partner organisations and facilitated holistic personalised care delivery

- E.g.. Referrals to Parents in Mind have increased four fold since creating the BadgerNet referral process.

Parent education reintroduced

- Led by community midwifery teams and developed including feedback from service users and the Maternity & Neonatal Voices Partnership

Package of resources developed to support families for who English is not first language alongside a series of 'Easy Read' leaflets

Personalised care – feedback from families

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

"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 A) 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. I would love to see obstetrics and other maternity professionals emulate that level of excellent communication that your team have"

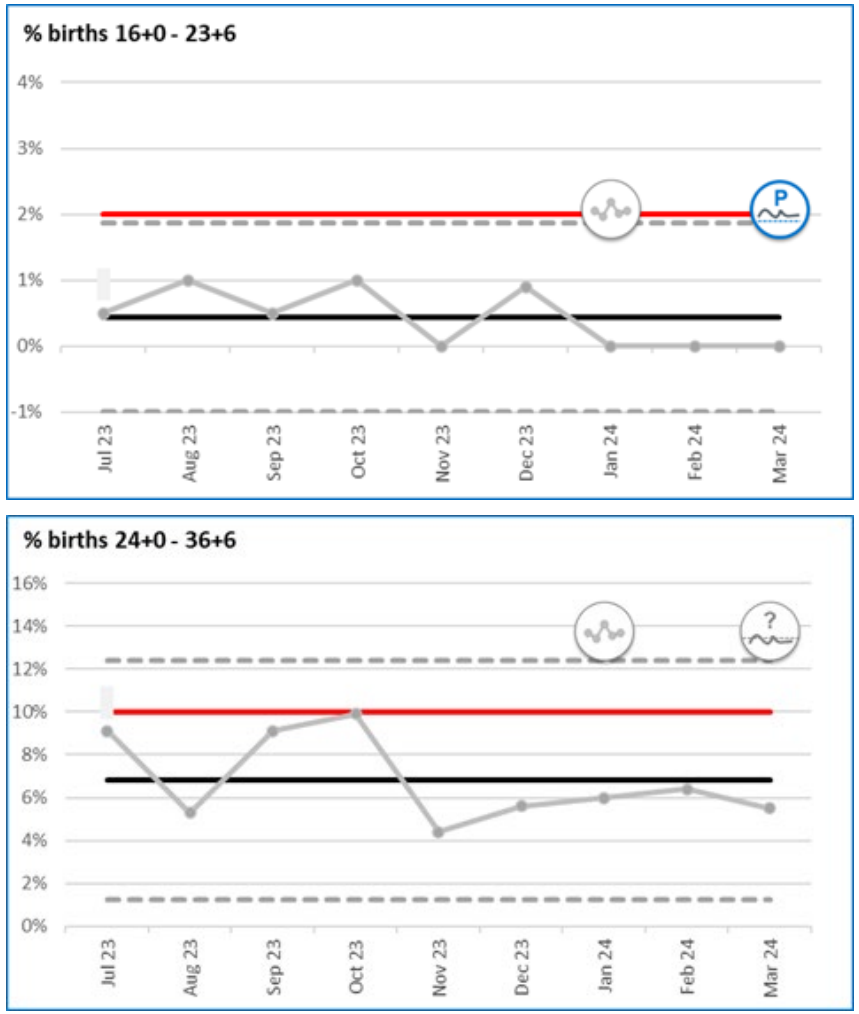
"My appointment was with the consultant midwife (I'm crying again) she is the most wonderful, caring, lovely person. I spent an hour with her asking all my questions along with my husband. She took me through my records, explained everything, answered my what ifs and whys. I hugged her at the end. That 1 hour completely changed my life. I felt this black cloud around my birth lift, and I felt there was a little piece of me missing but Sarah had given it back to me. I am no longer scared of birth and no longer have painful feelings towards what happened. After my appointment I didn't feel a counsellor was necessary either as Sarah had totally changed my perspective on it all. I want to thank Sarah from the bottom of my heart but also to thank Warrington hospital for the opportunity to have a debrief as I know that this is not the norm in other hospitals. Please do not take this service away as it is so important for women's mental health to get over birth trauma and to bond with their babies."

Care Pathways

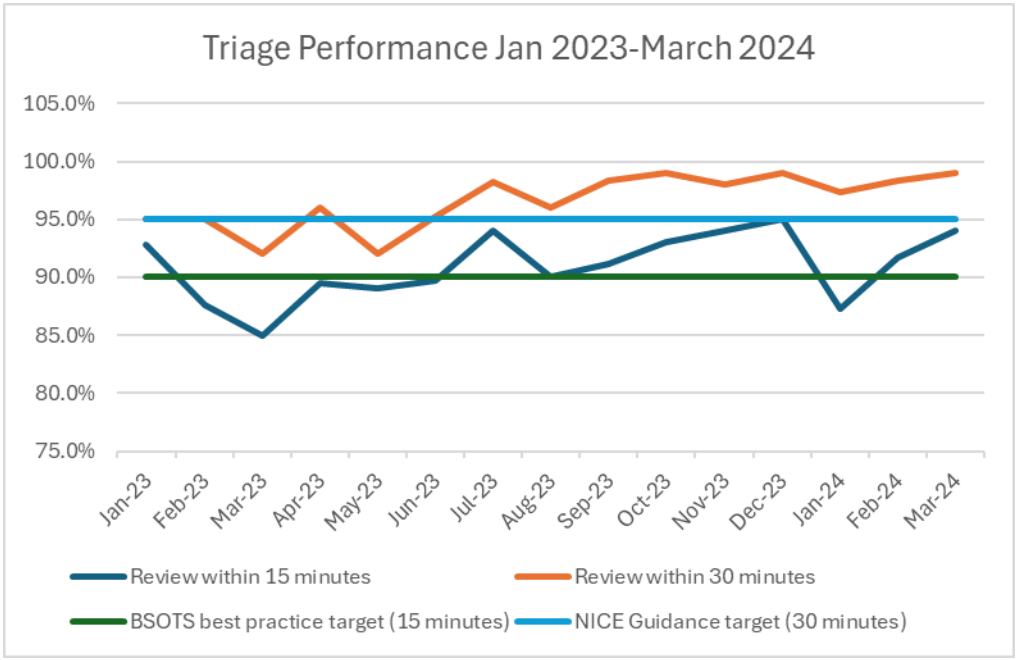
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report ❖ CQC Maternity Survey	Personalised care planning in place with regular audit of compliance against best practice
	Updated processes to ensure risk assessment at onset of labour to inform decision making and birth choices
	Refreshed processes to ensure ongoing risk assessment during intrapartum period
	MAMU 2 (fetal surveillance) training reviewed and refreshed
	Quality Improvement project registered to support improvement with fetal surveillance fresh eyes peer review
	Multidisciplinary pre-term birth clinic established including Specialist Midwife – Preterm Birth
	Relocation of Maternity Triage and reallocation of midwifery establishment to support Triage service
	Nest midwifery led unit reopened
	Homebirth team reestablished

Care pathways - outputs



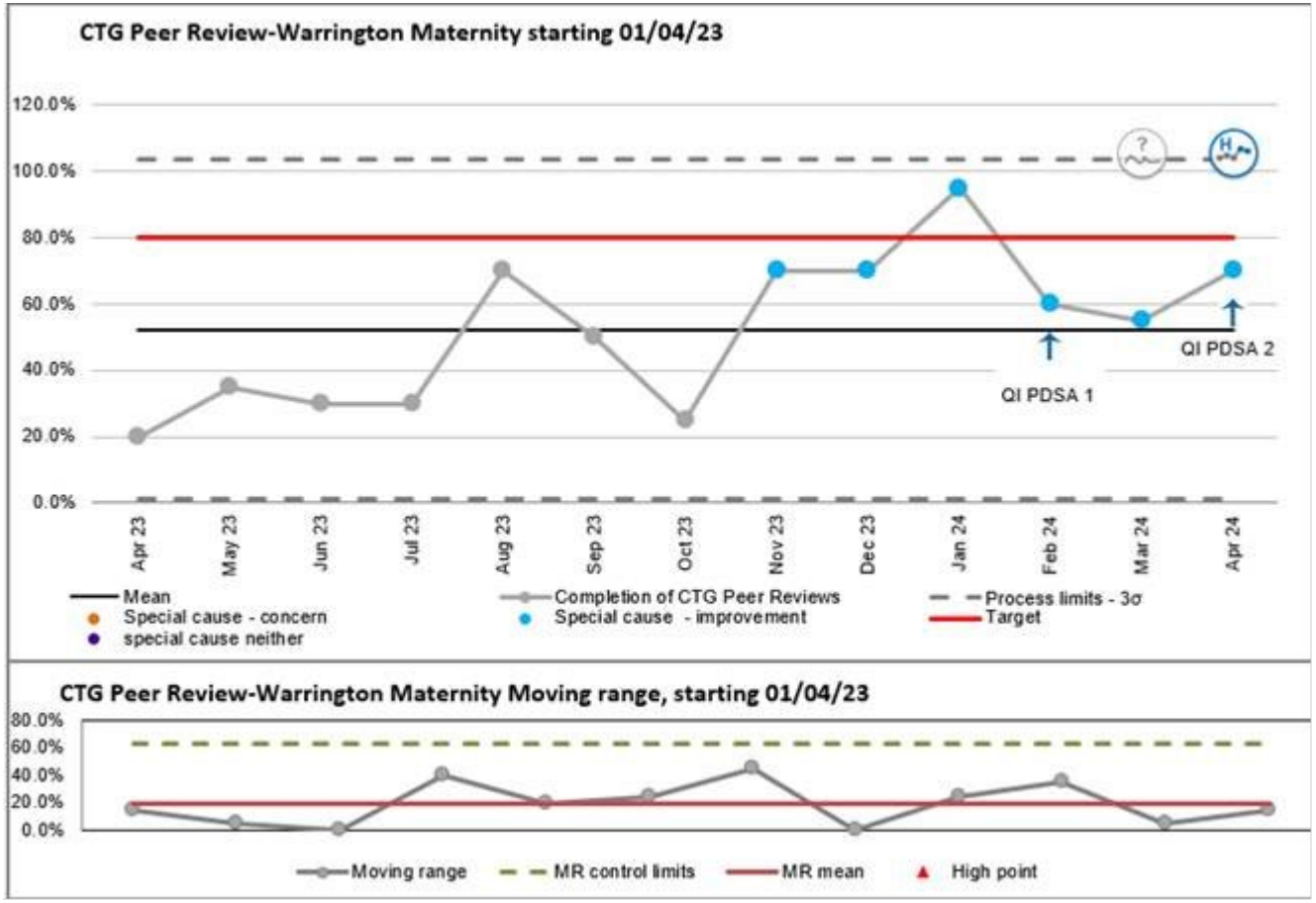
Consistently within target for preterm births between 16+0 and 23+6, and 24+0 – 36+6 as a percentage of all births.



Maternity Triage meeting NICE guidance and BSOTS best practice standards for initial triage assessment

Care pathways - outputs

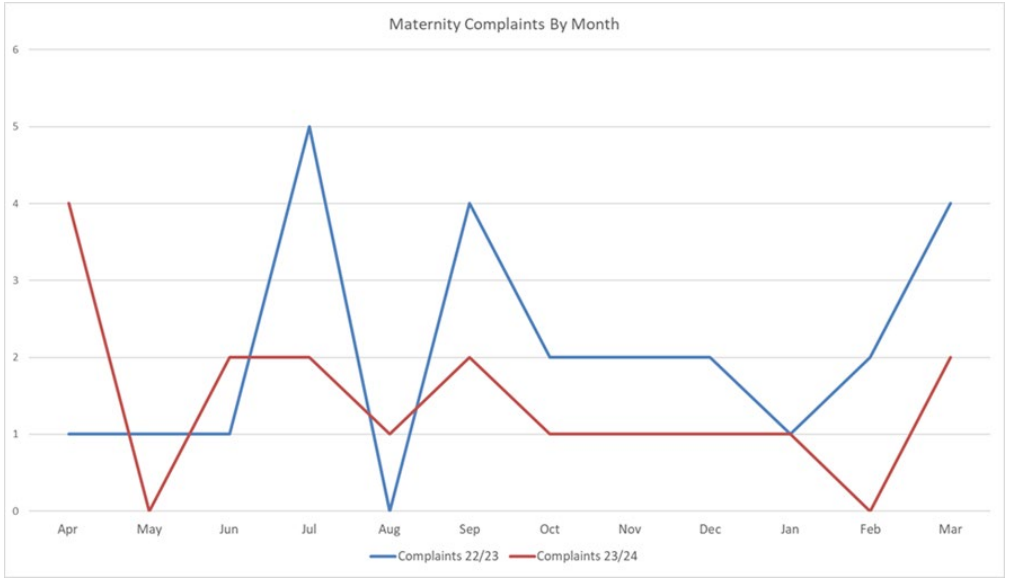
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



CTG peer review compliance quality improvement project

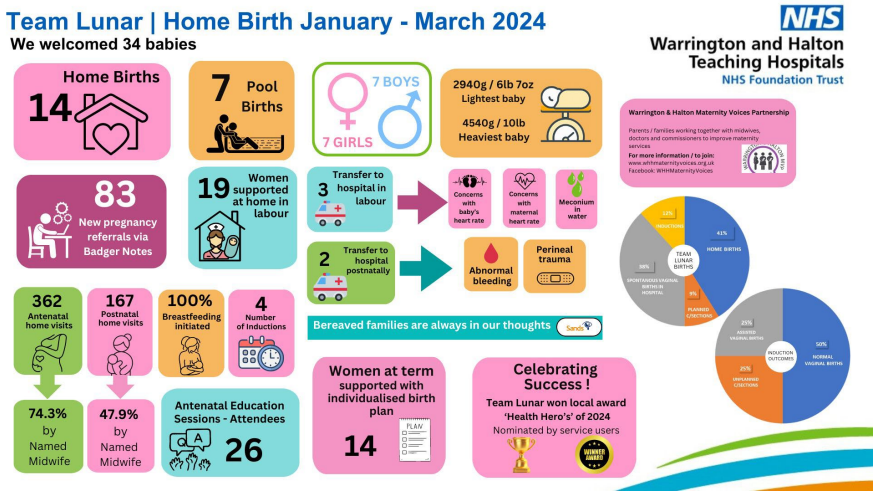
Care pathways - outputs

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Reduction in maternity care related complaints in 2023-24 (n=17) compared to 2022-23 (n = 23)

Team Lunar (home birth team) awarded Warrington Guardian Health Hero Award



Bereavement care

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme	Increased establishment for Specialist Midwife – Bereavement
	Programme of bespoke bereavement training in place
	Butterfly passes implemented

Bereavement care - outputs

Compliance with national requirements

- Fully compliant with national guidance in relation to reporting and PMRT review process in line with Maternity Incentive Scheme Year 5

Seven day bereavement service now in place

Bereavement champion roles created across all clinical areas

Butterfly bereavement study day delivered to 60 members of the team from across the CBU to date

Neonatal Care

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report	Introduced hybrid Consultant Paediatrician roles to support Tier 2 BAPM compliance
	Full review of Transitional Care pathways completed and action plan underway
	ATAIN review group embedded and robust action plan in place
	Focussed approach to recruitment and retention of neonatal nursing team
	Implementation of neonatal escalation policy for times of high acuity

Neonatal Care - outcomes

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Tier 2 BAPM compliance achieved in line with Saving Babies Lives v3

Excellent retention rate for neonatal nursing

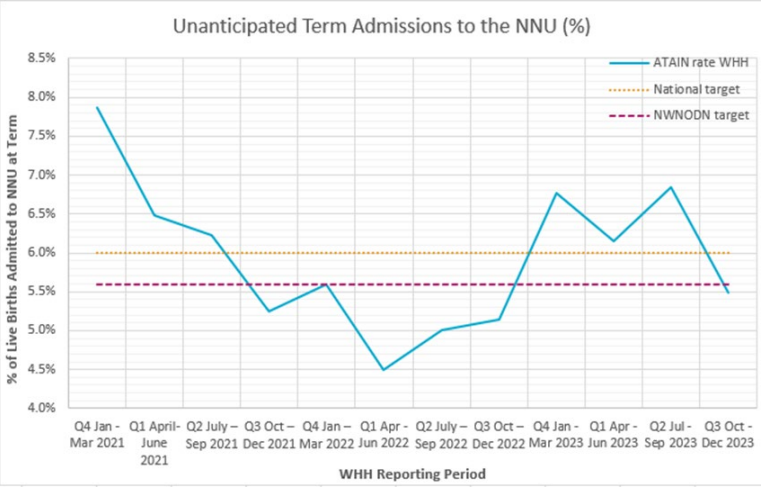
- No current vacancies

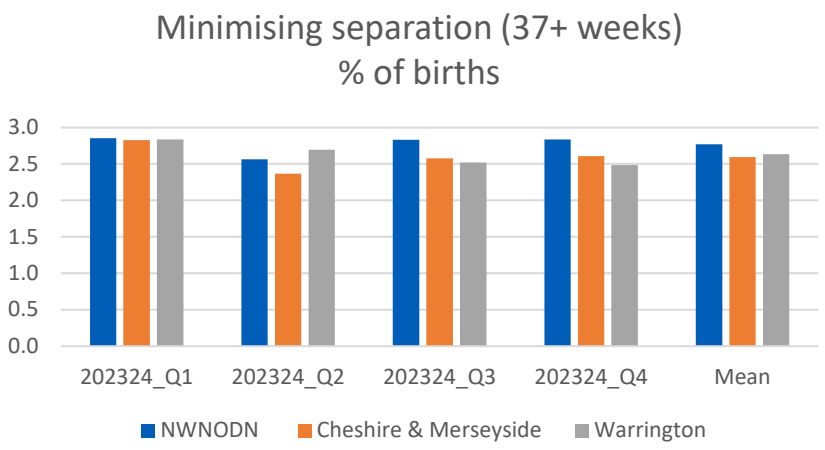
Positive feedback as part of NW Neonatal ODN annual assurance visit

- WHH commended for improvement in number of closure to external admission to NNU as part of

FiCare Gold accreditation achieved

Improvement seen in the early recognition of babies who can step down to transitional care





Clinical Governance

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report	Implementation of Quadrumvirate leadership model
	PSIRF processes fully implemented within maternity service
	Monthly programme of Maternity Safety Champion walkarounds in place
	Quarterly meetings of the ‘Quad’ and Non-Executive Director Safety Champion established
	Processes to ensure all policies and procedures are in place and reflect current evidence-based best revisited and updated
	Appointment of Specialist Midwife – Audit & Assurance
	Shared learning processes well embedded
	Creation of Maternity Guideline Review Group
	Compliance Manager appointed
	Robust peer and MDT review processes across all clinical areas
	Conflict of Opinion policy developed and implemented

Clinical Governance - outcomes

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Rated as 'Good' by the CQC in the safe domain

- Staff understood how to protect women and birthing people from abuse.
- The service was visibly clean and staff controlled infection risk well.
- Staff assessed risks to women and birthing people, acted on them and kept good care records.
- Medicines were managed well.
- The service identified, recorded, and responded to safety incidents well and learned lessons from them.

Maternity complaints processes well managed

- Breached complaints – 0
- Complaints over 6 months old - 0
- Reopened complaints 0

Good position achieved in relation to guidelines/policies and adherence to national guidance

- 147 Women's Health Guidelines/Policies – Maternity & Gynaecology - Currently 12 expired, three to May Governance, 9 in train

NICE guidance:

- 31 NICE Guidance documents across maternity and obstetrics - 28 full compliance in place (90.3%)
- 3 partial compliance – in train, relevant changes being implemented and updated internal guidance and SOPS processing through Trust governance systems

Requirements of Maternity Incentive Scheme Year 5 in relation to Board assurance achieved

- 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.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Any questions

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/040**
SUBJECT:	**Health and Wellbeing Guardian Report (Annual)**
DATE OF MEETING:	5th June 2024
AUTHOR(S):	Rebecca Patel, Associate Chief People Officer Rebecca Patel, Associate Chief People OfficerJennie Dwerryhouse, Deputy Chief People OfficerCaroline Eardley, Head of Occupational HealthAdam 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 RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)
#115 If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.
#134 If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton
#1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff

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: All schemes are reviewed to identify any equality considerations to ensure equality of access to all and to support the reduction in health inequalities across the workforce.			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
Further Information: All schemes supporting individuals within the workplace are equality impact assessed to enable equality of access irrespective of protected characteristic.			
	Yes	**No**	**N/A**

	3. Foster good relations between people who share a protected characteristic and those who do not	✓		
	Further Information: All schemes are reviewed to identify any equality considerations to ensure equality of access to all and to support the reduction in health inequalities across the workforce.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the activity undertaken in 2023-24 to provide assurance against the national Health and Wellbeing Guardian principles and refreshed responsibilities. The report details how the organisation is supporting the health and wellbeing of the workforce, with plans for enhancement of the offers into 2024-25.			
PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note progress against the Health and Wellbeing Guardian principles and the work undertaken to support the workforce from a health and wellbeing perspective.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/24/05/27**		
	Date of meeting	15th May 2024		
	Summary of Outcome	The Committee received substantial assurance on the governance processes implemented to support the health and wellbeing of the workforce. From a delivery perspective, the Committee received moderate assurance relating to the need to further understand the impact of interventions which will be reflected in bi-annual updates for 2024/25.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO TRUST BOARD

SUBJECT	Health and Wellbeing Guardian Report	AGENDA REF:	BM/24/06/040

1. BACKGROUND/CONTEXT

The NHS People Plan provides key actions to implement to support the workforce. One of the key promises focuses on the need to appoint a Health and Wellbeing (HWB) Guardian. The key purpose of the HWB Guardian is to seek assurance, independently challenge, and hold to account the Board/senior leadership team of their healthcare organisation for developing a compassionate and inclusive culture of health and wellbeing to ensure that all employees are cared for and enabled to deliver high quality of care to patients and service users. WHH has appointed a Non-Executive Director as the Trust's HWB Guardian.

From 2021 – Q2 2023, the Wellbeing Guardian worked within 9 principles, illustrated in **Table One**, which provided a framework to gain assurance on the work that has been undertaken operationally by the organisation to keep the workforce healthy and well.

Table One: Wellbeing Guardian Principles

No.	Principle
1.	The mental health and wellbeing of NHS staff and those learning in the NHS should not be compromised by the work they do for the NHS
2.	The Wellbeing Guardian will ensure where there is an individual or team exposure to a clinical event that is particularly distressing, time is made available to check the wellbeing impact on those NHS staff and learners
3.	The Wellbeing Guardian will ensure that wellbeing check-in meetings will be provided to all new staff on appointment and to all learners on placement in the NHS
4.	All NHS staff and those learning in the NHS will have ready access to a self-referral, proactive and confidential Occupational Health service that protects and promotes wellbeing
5.	The death by suicide of any members of staff or learner working in an NHS organisation will be independently examined and findings reported through the Wellbeing Guardian to Board
6.	The NHS will ensure that all staff and learners have an environment that is safe and supportive of their mental wellbeing
7.	The NHS will ensure that the cultural and spiritual needs of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS
8.	The NHS will ensure the wellbeing and make necessary adjustments for the nine groups protected under the Equality Act (2020)
9.	The Wellbeing Guardian working with system leaders and regulators will ensure that wellbeing is given equal weight in organisational performance assessment.

During 2023, a national review was undertaken of the Wellbeing Guardian role and associated principles, with updates to the role reflecting the language within the NHS People Plan. From Q3 2023-24, the Wellbeing Guardian role evolved to be a 'Health and Wellbeing Guardian'. In addition, the nine principles were replaced with a set of responsibilities as illustrated in **Table Two**.

Table Two: Health and Wellbeing Guardian Responsibilities from Q3 2023/24

Theme	Responsibilities
Championing a Health and Wellbeing Culture	Creating a proactive and preventative health and wellbeing culture
	A role model for health and wellbeing
	Networking and influencing across boundaries
Seeking Assurance	The organisation understands the diverse health and wellbeing needs of its employees
	There is a holistic strategy for improving health and wellbeing for all employees
	Senior leaders continually review and act on employee health and wellbeing data and metrics
	There is an inclusive approach to providing Occupational Health and wellbeing services and support to all employees
Holding to Account	All senior leadership decisions consider the impact on employee health and wellbeing
	Occupational Health and wellbeing are considered alongside other workforce, performance, quality and financial demands
	Work does not compromise the health and wellbeing of employees
	There is an adequately funded / resourced Occupational Health and wellbeing service / offer
	All leaders and managers are responsible for improving the health and wellbeing of their employees

Assurance of work aligned to the principles set out in Table One and the responsibilities set out in Table Two are provided to the Health and Wellbeing Guardian through a monthly meeting with the Health and Wellbeing Guardian, the Chief People Officer, and Associate Chief People Officer (Culture, Inclusion and Wellbeing). As part of these assurance meetings, the following topics have been discussed in 2023/24:

- Regular updates on health and wellbeing interventions and associated activity.
- WHH baseline assessment against the national Health and Wellbeing Framework[1].
- 2022 and 2023 Staff Survey analysis on themes relating to health and wellbeing.
- Regular updates on progress against the defined Health and Wellbeing Guardian principles and responsibilities.
- Regular updates on the Mental Wellbeing Hub and Occupational Health team activity to support the workforce.
- National recognition of health and wellbeing approach within the organisation.
- Links into wider place-based programmes of work such as the Warrington Together Health and Wellbeing project, and the regional working group on Occupational Health and Wellbeing services.

This annual report provides an overview of progress against the Health and Wellbeing Guardian principles and responsibilities for 2023-24, including information on wellbeing activity and next steps to continue to support health and wellbeing across the organisation.

2. KEY ELEMENTS

2.1 Approach to Health and Wellbeing at WHH

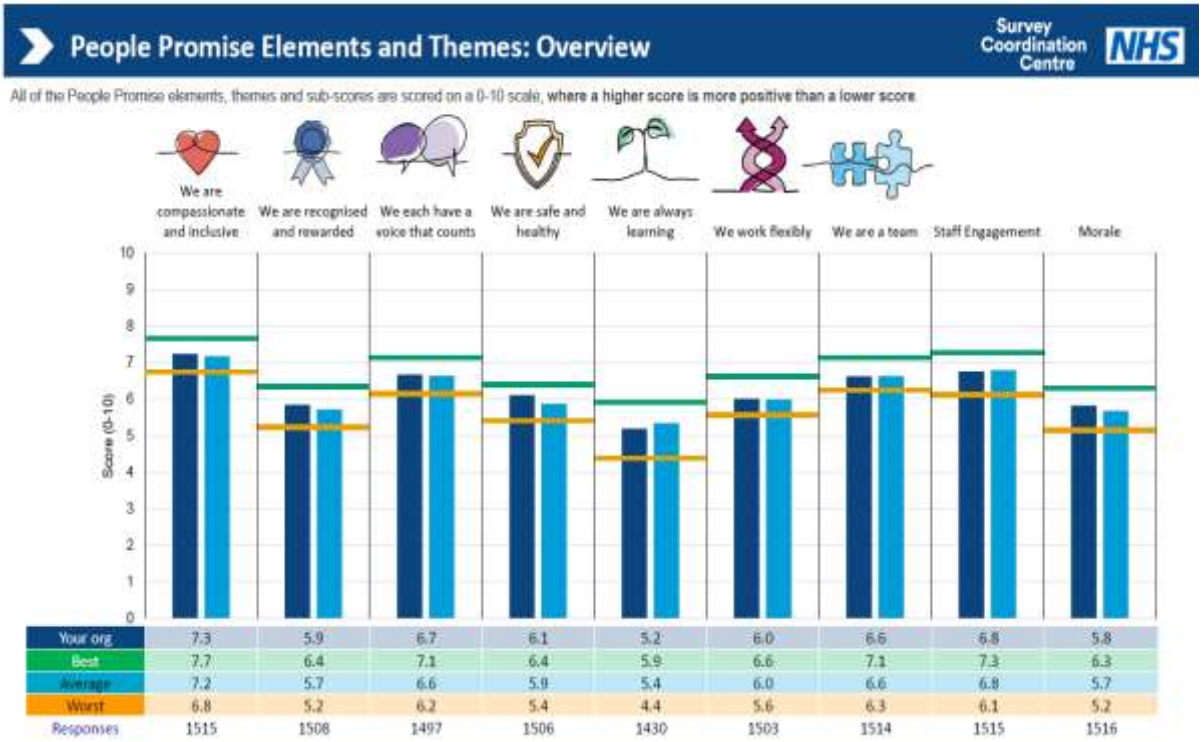
[1] National Health and Wellbeing Framework: www.england.nhs.uk/publication/nhs-health-and-wellbeing-framework

The approach to health and wellbeing at WHH is evidence-based and focuses on the contribution it can make to the wider population in terms of public health outcomes. The WHH approach is to equip the workforce with the skills, information and support they need to lead healthier lifestyles, and supporting individuals who may be at crisis point or need an intervention due to ill health.

The context for health and wellbeing within the organisation takes into consideration the principles and responsibilities from the Health and Wellbeing Guardian role, the baseline assessment from the national Health and Wellbeing Framework, and the annual Staff Survey results. The organisation's health and wellbeing activity aligns to the NHS People Plan promise of 'we are safe and healthy', including some of the free text analysis from the Staff Survey which provides a rich source of data.

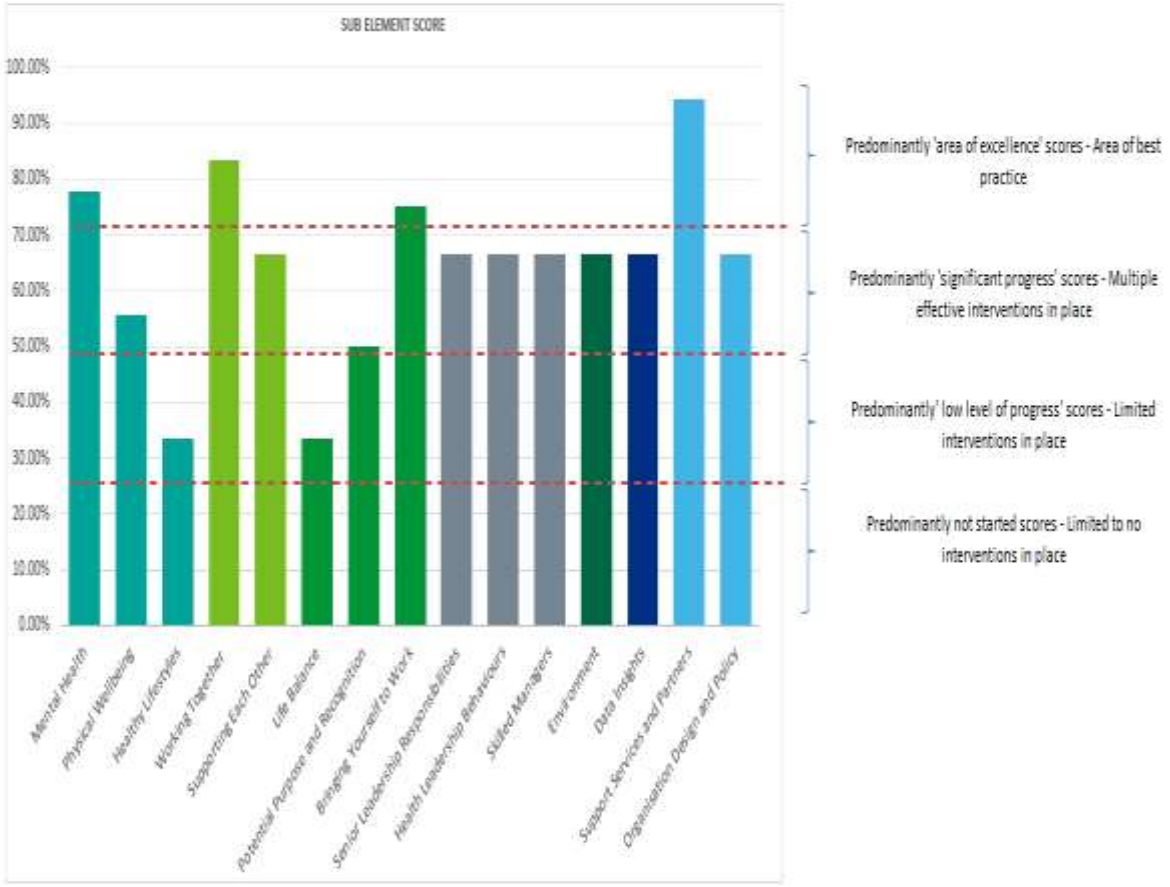
Our results from the 2022 Staff Survey, illustrated in Diagram One, demonstrate that although the organisation is better than the Acute Trust score in the 'we are safe and healthy' theme, the free text comments suggest that the impact of health and wellbeing interventions may not be felt across all staff groups which has resulted in a concerted effort to track and measure the impact of interventions under the banner of health and wellbeing during 2023/24.

Diagram One: NHS Staff Survey Results 2022



In addition to the Staff Survey, the baseline assessment undertaken in December 2021 with the national Health and Wellbeing Framework provides an overview of where the organisation excels and where there needs to be improvement from a health and wellbeing perspective. These results fed into the workplan for health and wellbeing in 2023-24. Diagram Two illustrates the findings which identify further work required on physical wellbeing and healthy lifestyles due to their low level of progress.

Diagram Two: Health and Wellbeing Framework December 2021



Appendix One provides a case study example of a targeted health and wellbeing intervention, utilising datasets to inform decision making, including the use of age profiling and social factors.

2.2. Wellbeing Guardian Principles Progress (End of Q2 2023/24)

A significant amount of work continues to be undertaken to support the health and wellbeing of the workforce in support of the Wellbeing Guardian principles that were in place until the end of Q2 2023/24:

The mental health and wellbeing of NHS staff and those learning in the NHS should not be compromised for the work they do for the NHS.

- Supporting counselling placements within the Mental Wellbeing Hub to help with further capacity and demand to support staff mental health and wellbeing.
- Implementation of group counselling sessions.
- Updated extranet pages with expanded resources on health and wellbeing activity.
- Delivery of 'Festival of Us' digital platform from January 2023 – January 2024 which provided a year of wellbeing topics that can be accessed digitally by the workforce.
- Implementation of bespoke interventions with partners such as Rugby League Cares and the Brathay Trust.

The Wellbeing Guardian will ensure where there is an individual or team exposure to a clinical event that is particularly distressing, time is made available to check the wellbeing impact on those NHS staff and learners.

- Crisis intervention process for staff refreshed and updated via Occupational Health and Mental Wellbeing Hub teams.
- Protocol for 'in-hours' and 'out-of-hours' support following violence and aggression refreshed and implemented.
- Continued access to facilitated conversations for individuals and teams to enable psychological safety in the workplace as a result of an incident, delivered by Wellbeing and Organisational Development teams.
- Therapeutic debriefing available via the Mental Wellbeing Hub for individuals and teams as a result of an incident within the workplace.
- Refreshed Stress Risk Assessment policy.
- Refreshed wellbeing support within people policies and procedures, particularly around investigations.

The Wellbeing Guardian will ensure that wellbeing check-in meetings will be provided to all new staff on appointment and to all learners on placement in the NHS.

- Refreshed and updated electronic appraisal documentation including a section regarding wellbeing conversation.
- Corporate induction includes a focus on health and wellbeing and the offers available to staff to support their health and wellbeing.
- New training package for mental health developed for line managers by the Mental Wellbeing Hub utilising feedback from existing workforce.
- Further development of local induction required to ensure the inclusion of wellbeing check-in meetings for new starters.

All NHS staff and those learning in the NHS will have ready access to a self-referral, proactive and confidential Occupational Health service that protects and promotes wellbeing.

- In-house Occupational Health service available to the workforce which they are able to self-refer to including fast-track physiotherapy service.
- Maintained SEQOSH accreditation for Occupational Health and Wellbeing service.
- Robust OH KPI monitoring through people governance routes and reflected in IPR to monitor performance and accessibility.
- Management referrals for advice, information and support as well as managing long term sickness outcomes.
- Continue to work in partnership with Staff Engagement and the Mental Wellbeing Hub to deliver interventions to support campaigns and wider public health outcomes i.e. blood pressure, sleep, active lifestyles.
- Enhanced holistic therapy offer to all staff through the provision of 'Holistic Fridays' campaign.
- Delivery of accelerated winter vaccination campaign and programme
- Respond to national outbreaks in a timely manner to protect patients and staff in relation to infections and communicable diseases i.e. measles.

The death by suicide of any members of staff or learner working in an NHS organisation will be independently examined and findings reported through the Wellbeing Guardian to Board

- Support of national campaigns linked to suicide and awareness of suicide.

- Range of suicide resources linked to bereavement available to all staff.
- WHH contribution to regional discussions around formal NHSE process.
- Individual support to members of the workforce and teams available as and when required.

The NHS will ensure that all staff and learners have an environment that is safe and supportive of their mental wellbeing.

- Staff Engagement and Mental Wellbeing Hub team continue to be deployed to support Trust's Ward of the Month programme.
- Staff Facilities Task and Finish Group in place to focus on enhancing staff facilities across the organisation. Membership is drawn from clinical and non-clinical colleagues.
- Annual audit of staff facilities undertaken to identify areas of priority such as breastfeeding spaces.
- People Champion information boards available in staff areas and are regularly updated in clinical and non-clinical areas in relation to additional wellbeing information or events.
- Funding secured for the building of a wellbeing space in the Cherry Tree Courtyard.

The NHS will ensure that the cultural and spiritual needs of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS.

- All wellbeing offers continue to be equality impact assessed and the team work in partnership with the Workforce Equality, Diversity and Inclusion team and Staff Networks to develop approaches as appropriate.
- Enhanced BorrowBox[2] offering with additional mental wellbeing resources and materials with a cultural lens.
- Peer cafes, enhanced induction and pastoral care established to support international staff.
- Calendar of events held to support various cultural and spiritual celebrations including additional support and guidance for Ramadan, events to celebrate Diwali and the celebration of Christmas.

The NHS will ensure the wellbeing and make necessary adjustments for the nine groups protected under the Equality Act (2020).

- Continued commitment to provision of Staff Networks within the organisation (Disability Awareness Network, Progress LGBTQ+ Staff Network, Multi-Ethnic Staff Network, Armed Forces and Veterans Community Staff Network)
- Continued support of Menopause Peer Café support group
- Development and implementation of new Women's Staff Network
- Recognising the significant disparities of the Staff Survey results in 2022 for those aged 16-30, in 2023/24 a Young Voices Group was developed. In addition to creating a safe space for engagement, this group allowed the opportunity to consider the experiences of our workforce in a wider capacity with the aim of making improvements to our workforce experience.

The Wellbeing Guardian working with system leaders and regulators will ensure that wellbeing is given equal weight in organisational performance assessment.

- WHH People Strategy objective 'We will prioritise the safety, health and wellbeing of our people to ensure work has a positive impact through the recognition and appreciation of our people, and by providing the best patient and staff experience'.

[2] BorrowBox is a digital library app available to all WHH colleagues.

- Wellbeing metrics and analysis are embedded into the Quality, People and Sustainability (QPS) meetings with Care Groups.
- Development of health and wellbeing strategy group with membership comprising clinical and non-clinical colleagues to share best practice regarding wellbeing initiatives and approaches to addressing sickness KPIs.

2.3. Health and Wellbeing Guardian Responsibilities (From Q3 2023/24)

Theme: Championing a Health and Wellbeing Culture

Creating a proactive and preventative health and wellbeing culture.

- Monthly assurance meeting continues with Health and Wellbeing Guardian, Chief People Officer and Associate Chief People Officer (Culture, Inclusion and Engagement).
- Development of preventative framework of activity within Occupational Health and Mental Wellbeing Hub aligned to Public Health outcomes.
- Development of Mental Wellbeing Impact Framework to understand impact of intervention.

A role model for health and wellbeing.

- Health and Wellbeing Guardian continues as Non-Executive Director with visibility within Trust Board governance processes.

Networking and influencing across boundaries.

- Health and Wellbeing Guardian part of regional and national network with updates shared through people governance processes and monthly assurance meeting.

Theme: Seeking Assurance

The organisation understands the diverse health and wellbeing needs of its employees.

- Focus during 2023-24 on health inequalities through the Equality Delivery System[3] (EDS) domain two which focuses on the health and wellbeing of the workforce. Reporting of the EDS is published annually following focus groups with the wider workforce which represent various protected characteristics to develop a series of actions for improvement.
- Further work has been embedded led by the Head of Culture and Inclusion, engaging with the Director of Strategy and Partnerships and Director of Population Health and Inequalities regarding the inclusion of health inequality analysis in the pre-existing equality analysis process. In 2023/24, this has supported the production of the health inequality annual reporting. This will continue into 2024/25 to develop and implement an improvement plan to address health inequalities within the workforce, linked to the NHS EDI improvement plan.
- Occupational Health pre-employment process updated to reflect needs of workforce aligned to the Workforce Equality, Diversity, and Inclusion strategy. This also has been shared with the Mersey and Cheshire Occupational Health group to support collaborative working across the region.
- Development of an equality, diversity and inclusion workforce dashboard to allow for enhanced monitoring of the workforce profile through an intersectional lens.

There is a holistic strategy for improving health and wellbeing for all employees.

[3] NHS England, Equality Delivery System: https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

- Baseline assessment against national 'Growing Occupational Health and Wellbeing: our roadmap for the future'[4] undertaken and activity for 2023/24 developed on basis of assessment.
- Baseline assessment undertaken against national Health and Wellbeing Framework[5] to identify gaps for improvement which formed part of the activity plan for Occupational Health and the Mental Wellbeing Hub
- The Growing Occupational Health and Wellbeing framework has been further developed within the Mersey and Cheshire Occupational Health group to support collaborative working.
- Appendix 2 details an example of a preventative intervention to support the wellbeing of the workforce following cardiac vascular disease being identified locally as a medical condition leading to an above average risk in increased mortality.

Senior leaders continually review and act on employee health and wellbeing data and metrics.

- Development of health and wellbeing IPR metrics which are reported through people governance processes and acted upon. Appendix one demonstrates the analysis of data and targeted interventions to address the data.
- Further enhancements to be developed in relation to a health and wellbeing impact framework.

There is an inclusive approach to providing Occupational Health and wellbeing services and support to for all employees.

- Service accessibility review has been undertaken with Occupational Health and Wellbeing and Mental Wellbeing Hub in partnership with Workforce Equality, Diversity, and Inclusion team and actions taken to ensure accessibility.
- Expansion of the Occupational Health and Wellbeing service to include signposting to local food bank provision.
- Signposting to Maximus[6] an Access to Work mental health provider to support individuals with long lasting mental health conditions to remain well in work.

Theme: Holding to Account

All senior leadership decisions consider the impact on employee health and wellbeing.

- Updated business case templates to include consideration of staff facilities to embed health and wellbeing of the workforce into business planning processes.
- Health and wellbeing conversation reflected in annual appraisal documentation with additional guides for line managers and individuals available.
- Development of Equality Impact Assessment (EIA) process and training for managers, with panel overview to ensure all programmes of work are supported by a robust EIA.

Occupational Health and wellbeing are considered alongside other workforce, performance, quality and financial demands.

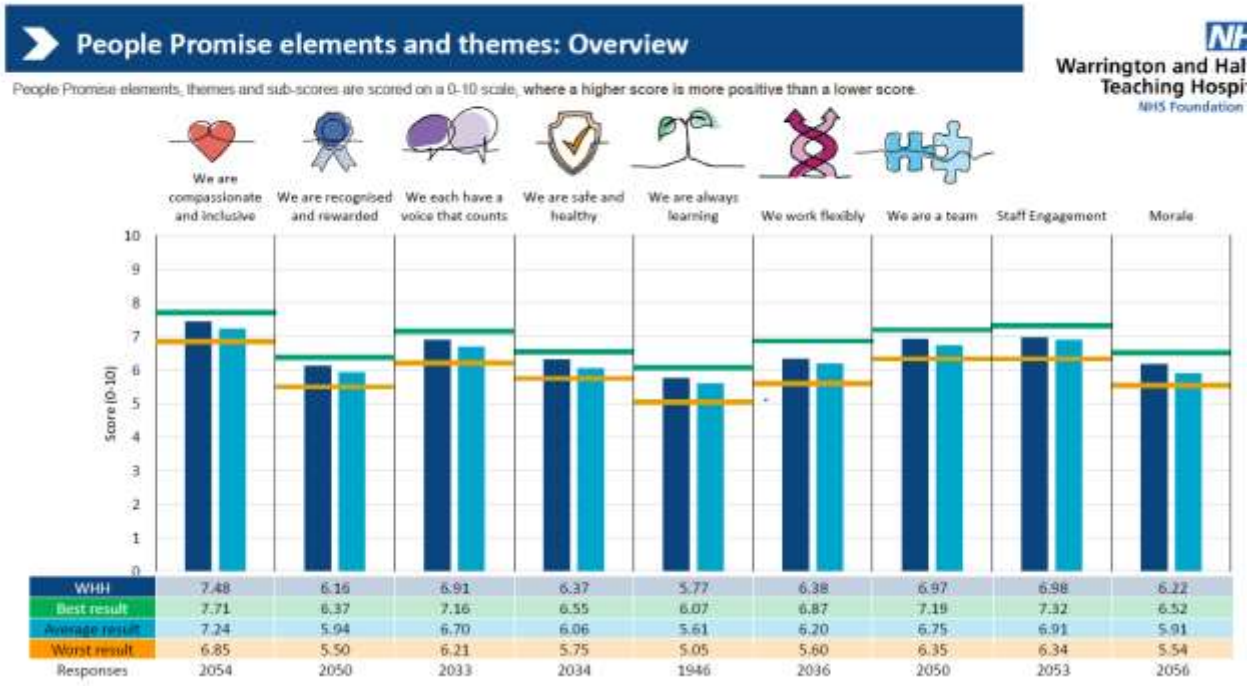
[4] Growing Occupational Health and Wellbeing Strategy: www.england.nhs.uk/wp-content/uploads/2023/01/Growing-occupational-health-and-wellbeing-together.pdf
[5] National Health and Wellbeing Framework: www.england.nhs.uk/publication/nhs-health-and-wellbeing-framework/
[6] Maximus Access to Work Mental Health programme: www.atw.maximusuk.co.uk

- Occupational Health and Mental Wellbeing Hub KPIs reflected in People IPR reported to SPC which reports into Trust Board alongside performance and finance data.
- Wellbeing metrics and analysis are embedded into the Quality, People and Sustainability (QPS) meetings with Care Groups.
- Wellbeing metrics reviewed at Operational People Committee.

Work does not compromise the health and wellbeing of employees.

- Improved health and wellbeing metrics in Staff Survey for 2023 as per Diagram Three demonstrate the improved impact of interventions on the health and wellbeing of the workforce.

Diagram Three: NHS Staff Survey Results 2023



- Aligned to the NHS employee suicide prevention toolkit[7], work has commenced to integrate this into existing processes in the health and wellbeing provisions of the Trust to support the workforce. This has also included where applicable, ensuring the ethos of this toolkit is embedded in responding to employee relations activity on a case-by-case basis. The development of a dedicated space on the extranet with access to training by the Zero Suicide Alliance[8] and signposting to external organisations has been completed in 2023/24. Further work will be embedded within the priorities plan for 2024/25.

There is an adequately funded / resourced Occupational Health and wellbeing service / offer.

- The Trust has an in-house SEQOSH accredited Occupational Health provision available to all, including fast-track physiotherapy service. It also has an in-house Mental Wellbeing

[7] NHS Confederation, NHS employee suicide: https://www.nhsconfed.org/system/files/2023-03/NHS-employee-suicide-postvention-toolkit.pdf
[8] Zero Suicide Alliance training: https://www.zerosuicidealliance.com/training

Hub which provides a range of therapeutic interventions, from holistic therapies to CBT and EDMR for Post Traumatic Stress Disorder.

- The Trust's Health and Wellbeing offer has been regionally cited as best practice by NHSE and provides both informal and formal interventions to support the workforce and provide a proactive approach to contribute to the wellbeing of the organisation.
- **Table Five** provides an overview of the WHH offer to support the workforce health and wellbeing.

Table Five: WHH Offer

• **Offer Name**	• **Overview**
• **Induction: WHH Values and Behaviours**	• Learning opportunity as part of Corporate Induction for all new starters to understand how our behaviours underpin our Trust values and how these can be demonstrated within the workplace.
• **In-house Occupational Health Service**	• SEQOSH accredited in-house Occupational Health and Wellbeing service supporting health promotion campaigns, needlestick injuries, advice, information, support and guidance on supporting attendance and management of long-term conditions, vaccinations and immunisations and pre-employment checks. Respond to National outbreaks in a timely manner to protect patients and staff in relation to infections and communicable diseases.
• **Fast-track Physiotherapy Service**	• In-house physiotherapy service available for individuals to self-refer or via management referral. Appointments with a specialist physio available (on average) within 5 working days.
• **Winter Vaccination Programme**	• Members of the workforce have access to flu vaccination and COVID-19 vaccinations as part of the accelerated Winter Vaccination campaign
• **WHH Mental Wellbeing Hub**	• In-house counselling team available to staff with access to 1:1 and group therapy, available on a self-referral basis. Crisis intervention service also available.
• **Access to Work: Maximus**	• Available via Occupational Health, the team can signpost to additional Access to Work resources if individuals are suffering from an ongoing mental health condition to enable individuals to remain well in work.
• **Referral to Food Banks**	• Available via Occupational Health, referrals available into local food bank provision for individuals.
• **All About You – Extranet Pages**	• Dedicated extranet pages on the following topics to support the workforce: 
• **Menopause Peer Support Group**	• Peer support group run on a monthly basis to support individuals who would like further information on the menopause.
• **NHS North West Games**	• The organisation participates in the NHS North West Games with teams supported from WHH to participate.

• **Wellbeing Wednesday**	• Weekly drop in to Warrington LiveWire service available on the main hospital site.
• **Holistic Fridays**	• Delivered by the Mental Wellbeing Hub team in partnership with complementary therapists, offering a range of complementary and holistic therapy to staff at Warrington and Halton sites. Appointment slots and information are released via 'The Week' publication
• **Cognitive Behaviour Therapy (CBT)**	• Delivered by the Mental Wellbeing Hub, CBT is offered as part of a psychotherapeutic treatment that helps individuals understand the thoughts and feelings that influence behaviours.
• **Single Session Therapy**	• Delivered by the Mental Wellbeing Hub, available to members of the workforce who may benefit from an intensive single session of counselling to support within the workplace or back into the workplace.
• **Facilitated Conversations**	• Available to teams and delivered by the Organisational Development team to guide staff in a facilitated discussion to enable them to feel psychologically safe to go home, rest and recuperate for their next shift. Can be used when processing any particular distressing incidents within teams both clinical and non-clinical.
• **Therapeutic Debriefing**	• Available to teams and delivered by the Mental Wellbeing Hub to debrief after incidents within the workplace utilising therapeutic models.
• **Hypnotherapy Sessions**	• Available through referral into the Mental Wellbeing Hub as a therapeutic intervention using hypnotic techniques.
• **EMDR Therapy for Trauma and PTSD**	• Eye Movement Desensitisation and Reprocessing (EMDR) therapy is delivered by the specialist team within the Mental Wellbeing Hub to support those suffering from trauma or Post-Traumatic Stress Disorder (PTSD).
• **Group Therapy**	• Delivered by the Mental Wellbeing Hub, group therapy to support mental health interventions is available to staff members.
• **Managing Stress Workshops**	• Delivered across both sites on a quarterly basis and ad-hoc with teams as required, the workshop provides an overview of stress, tools and techniques to spot signs of stress and also how to deal with these in the moment to support the workforce.
• **Relaxation Workshops**	• Delivered across both sites via a hybrid model and also deployed to support Ward of the Month recipients, the workshop provides an overview of key relaxation techniques to support individuals within the workplace.
• **Guided Meditation**	• As part of our approach to mindfulness, there are guided mediation videos available on our dedicated health and wellbeing extranet pages delivered by our Lead Counsellor.
• **Mental Health Workshops**	• A workshop to provide individuals with an overview of mental health, mental ill health and tools and techniques to support healthy mental health in the workplace.

• **Rugby League Cares**	• A bespoke programme delivered by the organisation, Rugby League Cares (made up of ex-professional rugby players and military veterans) to support mental health in the workplace. Topics available to staff include: o Mental fitness and GOAL setting o Sleep hygiene o Mindfulness o Stress and coping o Resilience training o Nutrition for mood
• **The WHH - Brathay Programme**	• Delivered in partnership with The Brathay Trust who are a not-for-profit organisation and have worked successfully with supporting military veterans and young people to transition to either civilian street or to maximise their own potential and support wellbeing. The bespoke WHH wellbeing programme is delivered in partnership with WHH at our Halton Education Centre and offers participants the following: • Share and process recent and current experiences, challenges and hopes with colleagues in a safe, supportive, and developmental environment. • Feel energised, empowered, and equipped to positively approach those experiences and challenges both in and out of the workplace. • Feel equipped with a range of techniques and ideas with which to support themselves and their colleagues • Gain insight into and reflect upon key pillars of individual health and wellbeing and how to develop those pillars moving forward • Development of personal plans to implement learning from the programme into individual life for health, wellbeing, and resilience.
• **Access to Headspace App**	• Free access to the following wellbeing apps: • Headspace – which provides access to mindfulness and meditation techniques • Calm – which is an award-winning app to support restful sleep using meditation and calming techniques • Stay Alive – which is a suicide prevention resource packed full of useful information and tools to help individuals to stay safe in a crisis • Trello – a list making app to support individuals in managing their day.
• **Compassionate Leadership Programme**	• Designed for leaders within WHH, this programme comprises of virtual workshops and facilitated by Dr Amanda Super (Chartered Occupational Psychologist). Amanda is a leading practitioner in the UK who exclusively focuses on the development of compassion in the workplace. The workshops cover the following topics: • Self-compassion at work, for ourselves, towards others and from others • Compassion in leadership • Building compassionate cultures

	• Leading with compassion and compassionate coaching conversations.
• **Self-Compassion at Work Programme**	• Online programme developed by Dr Amanda Super to enable participants to understand self-compassion and how to implement learning in the workplace. The programme takes place over 4 weeks and can be fitted around individual's busy work life.
• **WHH Choir**	• Supported by the Staff Engagement team, the WHH Choir meet every Friday evening to come together to practice mindfulness through the medium of music.
• **Leadership Circles**	• Delivered by the Organisational Development team on an ad-hoc request basis, Leadership Circles are a peer support methodology to support leaders on a challenging problem or topic.
• **WHH Staff Networks**	• The organisation supports a number of Staff Networks who are peer support groups to facilitate staff voice on a range of topics, including access to wellbeing opportunities and workshops. Current WHH Staff Networks include: • D.A.N (Disability Awareness Network) • Multi Ethnic Staff Network • PROGRESS Network (LGBTQA+) • Armed Forces and Veterans Community Staff Network • Women's Network
• **Wagestream**	• Programme to support financial wellbeing which allows staff members to track and instantly stream a percentage of their substantive salary whenever they need to, save directly from their pay or access financial education to support financial wellbeing.
• **Financial Wellbeing**	• Dedicated resources on the extranet pages regarding financial wellbeing, including a handy booklet and guide for access to external partners who can support members of the workforce with any financial issues.
• **Barclays Financial platform**	• Digital platform available to all staff members (they do not need to be a customer of Barclays to access the platform). Staff can book an appointment with a Money Mentor and access financial resources and tools to support their financial wellbeing.
• **Festival of Us Digital Wellbeing Platform**	• Digital wellbeing platform available for free to staff with a monthly focus on different topics: • Relationships • Sleep • Priorities • Purpose • Nutrition • Burnout • Reset • Stress • Loneliness • Resilience • Self-compassion.

• **Access to Borrow Box Library App**	• Borrow Box is a free app for all WHH staff to utilise with access to a range of books including wellbeing and self-help titles.
• **WHH Looking After You: Health and Wellbeing Leaflet**	• Annual health and wellbeing leaflet published to capture the core offer for all WHH staff and distributed through People Champion networks, induction and events across all sites.
• **Supporting National Campaigns**	• Commitment to celebrate and support national campaigns, including but not limited to the following: • World Mental Health Day • Stress Awareness Week / Month • Menopause Awareness Week • Random Acts of Kindness Day • Suicide Awareness and Prevention • Know Your Numbers / Smart Heart health promotion • Smoking Cessation • Back Care Week • Bullying and Harassment awareness • Annual Day of Reflection • Bereavement Awareness
• **Introduction to WHH Health and Wellbeing**	• Staff Engagement and Mental Wellbeing Hub team are embedded into the marketplace for Corporate Induction enabling all new starters to be given an overview of the health and wellbeing offers available to all members of Team WHH.

All leaders and managers are responsible for improving the health and wellbeing of their employees.

- Updated expectations within refreshed line manager training available for line managers to book onto via ESR and delivered by the OD team which are well attended.
- Responsibilities reflected as part of updated appraisal documentation process and associated guidance requiring wellbeing conversations.
- Refreshed People policies to support managers and the workforce including Supporting Attendance.

2.4. Next Steps

In order to further enhance the health and wellbeing for the organisation and continuing to deliver the activity articulated in **Table Five**, work will continue on delivering bespoke interventions based on workforce need to contribute to Public Health outcomes, and also to identify the impact of interventions to ensure resources are deployed most effectively to make the biggest impact. Results from the impact framework that has been developed and piloted in 2023-24 will form part of regular reporting and monitoring through people governance processes and as part of the monthly assurance meeting with the Health and Wellbeing Guardian.

In addition, an updated baseline assessment against the national health and wellbeing framework and the 2023 Staff Survey results will be undertaken in Q1 2024/25 to further enhance the wellbeing offer, with plans for a bespoke long term sickness pilot in partnership with Rugby League Cares and Occupational Health.

Significant progress continues to be made against the Wellbeing Guardian principles and updated Health and Wellbeing Guardian responsibilities which have been recognised by NHSE, with further developments to be implemented in relation to decision making processes to support wellbeing as equal to quality or financial considerations.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Detailed in Section 2. Responsible Officer is the Chief People Officer.

4. IMPACT ON QPS?

The activities outlined in this report and the Wellbeing Guardian principles focus on the People element of QPS ensuring that the workforce is fit for now and for the future, supporting health and wellbeing to build the conditions where the workforce can thrive and have a positive impact on patient care.

5. MEASUREMENTS/EVALUATIONS

Measures and evaluation for specific projects and principles can be found in Section 2 of this report.

6. TRAJECTORIES/OBJECTIVES AGREED

The objectives within the WHH People and Workforce Equality, Diversity and Inclusion Strategy are aligned to People Promises and are available on both the external WHH website and internal extranet.

7. MONITORING/REPORTING ROUTES

Monitoring of the WHH People and Workforce Equality, Diversity and Inclusion Strategy is through internal People Directorate governance processes and the Strategic People Committee on a bi-annual basis.

8. TIMELINES

As detailed in Section 2.

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

The Trust Board are asked to note the update provided on the progress of activity aligned to both the Wellbeing Guardian principles and the refreshed Health and Wellbeing Guardian responsibilities in order to provide assurance on how the organisation is supporting the workforce from a health and wellbeing perspective.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Case Study – Domestic Services Health & Wellbeing Pilot Project

Once upon a time

Where Our Story Began…….

Back in July 2022 absence figures for Estates & Facilities were running 10.07% against a Trust overall sickness absence of 7.48%, with E&F being one of the highest % for absences across the Trust.

The HRBP Team carried out a deep dive exercise into the data to see if we could identify any specific areas or themes together with a age profile review.

What issues did we identify?

- Highest absence reasons throughout the period (Jan to June) were for Anxiety/Depression/Stress and MSK Issues.
- Domestics at Warrington was identified as a hot spot area.

Anxiety, Stress & Depression

Departments	Nos.
370 COR EST Telecommunications - 536402	1
370 COR EST Warrington Catering Servi… 536400	6
370 COR EST Works Manager - 536303	1
370 COR FAC Car Parking and Security - 536414	2
370 COR FAC Halton Domestics - 536411	5
370 COR FAC Warrington Domestics - 536404	13
370 COR FAC Warrington Portering - 536415	2
(blank)	
Grand Total	**30**

S12 Other musculoskeletal problems	19
370 COR EST Warrington Catering Services - 536400	1
370 COR EST Warrington Medical Engineering - 536302	1
370 COR EST Works Manager - 536303	2
370 COR FAC Car Parking and Security - 536414	1
370 COR FAC Halton Catering Services - 536408	1
370 COR FAC Halton Domestics - 536411	2
370 COR FAC Post - 536416	1
370 COR FAC Warrington Domestics - 536404	9
370 COR FAC Warrington Portering - 536415	1

S28 Injury, fracture

Department	Nos.
370 COR EST Works Manager - 536303	3
370 COR FAC Halton Domestics - 536411	1
370 COR FAC Halton Portering - 536417	1
370 COR FAC Warrington Domestics - 536404	9
Grand Total	**14**

Age Profiling of our Domestic Team

Our data identified that our Domestic Team staff are predominately over the age of 40. (84%)

Science tells us that middle age falls between the ages of 45-65 and unfortunately this phase of life is marked by gradual physical, cognitive, and social changes in the human body. These natural changes together with the physical nature of the Domestic Role means we see an impact on the overall health & wellbeing of our staff.

Age Ranges		
<=20 Years	0	0%
21-25	3	1%
26-31	9	4%
31-35	15	7%
36-40	7	3%
41-45	14	7%
46-50	31	15%
51-55	38	18%
56-60	42	20%
61-65	37	18%
66-70	9	4%
>=71	6	3%

What happened next?

As at Senior Management Team we discussed the concerns we had for the Health & Wellbeing of our Estates & Facilities Staff overall and were all in agreement that we needed to look at some interventions to help support our most valuable asset

Based on our data we decided it was time to do something different and reach out to our staff. Unfortunately science tells us we cannot eradicate ill health but what we could do is:-

- Ensure our staff are aware of the support services we as trust offer and how these can be accessed.
- Educate our staff to put their health & wellbeing first and look at preventative measures to ensure a long and healthy life.

So this is what we did!!!

- We gathered together an amazing group of Specialists to work on a plan to run a Pilot Health & Wellbeing Event which would focus on our Domestic Staff at Warrington Hospital. Our Specialists came from both within the Trust and from external partners.
- Our journey commenced on 4th November 2022 with the first of our fortnightly planning meetings.
- We booked our date 7th February 2023, agreed the format and what information/activities would be included as part of the day
- We offered an incentive to our staff to be included in our free prize draw for an amazing H&WB Hamper
- We prepared our Comms and reached out to our Domestic Staff.

Our Specialists

Our amazing team were made up of:-

- Physios
- Mental Health & Staff Engagement Representatives
- Occupational Health Nurses
- Rugby League Cares Representatives
- Livewire Lifestyle & Smoking Cessation Specialists
- MacMillan Cancer Support Services
- HR BP Team
- Facilities Management Team

Before we knew it the Big Day was here!!!!

An amazing 86% of all Domestics rostered to be on shift attended the event

Activity on the Day

- There were 36 Health Checks Performed including Blood Pressure Checks and Health Fitness Checks
- 18 Referrals made to various services including GPs, Counselling & Reflexology
- Tailored advice offered on a number of H&WB topics such as Smoking Cessation, Weight Management and Menopause
- Over 99 points of contact made around Services Provided and how to access these
- Information handouts provided on Financial Wellbeing
- Free day gym passes provided
- Our O/H team even managed to squeeze in a Flu Vaccine

Feedback from our Domestic Staff

Feedback has been great with staff saying they found the event

- Very informative
- Great atmosphere
- Fantastic team
- Left them feeling valued

This is not the end of our Story, just the first Chapter!

The next Chapter ……

Roll out similar events to other departments within Estates & Facilities

Release staff to take part in the Smartheart campaign to be run by Mr Farag, our Consultant Cardiologist

Look at providing bespoke H&WB sessions

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Cardiac Intervention to Support WHH Workforce

Overview

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Cardiac vascular disease has been identified locally as a medical condition leading to an above average risk in increased mortality.

Intervention

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Occupational Health and Wellbeing department working in collaboration with Trust Cardiac Consultants and Livewire, a community-based council run facility, providing support to the Warrington community to enable then to lead happier healthier lives.

- The purpose of this event was to assess staff working in the Trust for undiagnosed Cardiac issues. Over 50 staff who are employed by the Trust in numerous areas and roles attended this event to have screening undertaken for blood pressure and atrial fibrillation.

Evaluation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- It was identified from this event that the Occupational Health and Wellbeing team referred five staff members to their general practitioner with raised blood pressure. A further four staff members working in the Trust were identified as having undiagnosed atrial fibrillation and referred to their general practitioner for further monitoring and assessment.

- Evaluation of the event shows the importance of this early screening intervention. If left untreated further complications may occur, such as, a cerebral vascular accident. This Occupational Health and Wellbeing event engaged staff members to lead a happier and healthier life, and also offered staff the opportunity to speak with specialist and support their health and wellbeing.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/041**			
SUBJECT:	**Gender Pay Gap – Annual Report 2023/24**			
DATE OF MEETING:	5 June 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 RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	Not applicable			
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: This report and action plan works towards the Trust zero tolerance approach, advancing equality of opportunity and providing a shared ambition of equality.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information: This report has been written through the context of improving equality of access for females by reducing the gender pay gap at Warrington and Halton Teaching Hospitals.			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information: The action plan of this report aims to foster good relations between protected characteristics – particularly sex.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report presents the findings of the Gender Pay Gap for the financial year 2023/24. The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires all public sector organisations with over 250 employees to report			

<table>
<tr><td></td><td colspan="3">and publish their Gender Pay Gap on their website on an annual basis.

A copy of the report can be found as Appendix One, a highlight update is as follows:
The workforce profile split for male, and female remains consistent with previous years at 80% female and 20% male.
There has been a positive improvement in the mean and median hourly rate in 2023/24 in comparison with previous years.
It is noted that the median hourly rate is at its lowest since pre-2019/20 where the Trust had seen a steady increase. This demonstrates actions for improvement have potentially made an impact on datasets.
Although there remains work to do, again an improvement has been noted in the quartile splits, found on page 4 of the report in Appendix One.
Bonus payments have been included in the report, alike the previous three years, the median bonus payment remains the same for males and females.
The mean bonus pay continues to show that although less females receive a bonus payment compared to males when they do they receive a proportionately higher bonus payment.
The Gender Pay Gap annual report is required to be submitted via the UK Government portal by 30 March 2025. An action plan for further improvement can be found as Appendix Two.</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 receive and note the analysis, data and action plan included within this paper, post approval by the Strategic People Committee in May 2024.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Strategic People Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">SPC/24/05/26</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">15 May 2024</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Approved with high assurance</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>

REPORT TO TRUST BOARD

SUBJECT	Gender Pay Gap – Annual Report 2023/24	AGENDA REF:	BM/24/01/041

1. BACKGROUND/CONTEXT

1.1. Context

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is committed to promoting, championing and advancing equality, diversity and human rights, making WHH the best place to work and creating a culture of belonging for all.

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires all public sector organisations with over 250 employees to report and publish their Gender Pay Gap on their website on an annual basis. This report captures data effective 31st March 2024 – found as **Appendix One**.

WHH employs staff in several disciplines across a range of staffing groups including:

- Additional Clinical Services
- Administrative and Clerical
- Allied Health Professionals
- Estates and Facilities
- Healthcare Scientists
- Medical and Dental
- Nursing and Midwifery Registered

All staff employed at the Trust are on either the Very Senior Managers (VSMs), Agenda for Change or medical and dental pay-scales, which provide a clear process of paying employees equally, irrespective of their gender.

1.2. Background

The gender pay gap is defined in the Equality Act 2010 as 'the difference between the average hourly earnings of men and those of women'. This is not the same as equal pay, which is concerned with men and women earning equal pay for the same jobs, similar jobs or work of equal value.

Gender pay reporting highlights any imbalance of average pay across an organisation. For example, if an organisation's workforce is predominantly female yet most senior positions are held by men, the average female salary would be lower than the average male salary.

2. KEY ELEMENTS

2.1. Reporting Requirements

The reporting regulations require that each public sector organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band

- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment.

Alongside the calculations, if the organisation is a business or charity, it must also publish a 'written statement' that confirms that the published information is accurate.

The data and written statement must be published within a year of the 'snapshot date' (31st March) and must be submitted on the Government portal and published by 30th March each year.

Reporting outcomes effective 31 March 2024 can be found at **Appendix One** of this report. An action plan to address the findings of this data and previous years reporting can be found at **Appendix Two**.

It is noted that the action plan produced for the 2023/24 pay gap reporting period has followed suit with the Workforce Race and Disability Equality Standard reports to go beyond a 12-month period. This allows for greater improvements and triangulation against the Workforce Equality, Diversity and Inclusion Strategy 2022-2025.

2.2. Definitions of the Gender Pay Gap

The gender pay gap is a figure that shows the difference in the average pay between all men and women in a workforce. It is a measure of women's overall position in the paid workforce and does not compare like roles.

The mean pay gap is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females employed in the workforce.

The median pay gap is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

2.3. Scope of Analysis

The report (found as **Appendix One**) includes all staff who were employed by WHH on full pay on the snapshot date of 31 March 2024.

Ordinary pay calculations include:

- Basic pay
- Paid leave including annual leave, sick, maternity, paternity, adoption, or parental leave (except where an employee is being paid statutory)
- Shift premium pay.

It does not include overtime pay, redundancy pay, or termination payments and expenses. Employees who are on half or nil pay for sickness absence or maternity leave, hosted staff and agency staff are not included in the results.

Bonus pay calculations include any pay related to performance, including Clinical Excellence Awards, made in the 12-month period directly before 31 March 2024.

Clinical Excellence Awards are financial incentives to Consultant Doctors, Consultant Dentists and Clinical Academics. Their purpose is to recognise senior clinicians' achievements beyond what is expected as part of their job plan.

3. IMPACT ON QPS

The Gender Pay Gap is a mandated report as per the Equality Act 2010 and is a contributing intelligence source for the People aim of the Trust Strategy 2023-2025.

4. MONITORING/REPORTING ROUTES

Monitoring of the action plan for the Gender Pay Gap is completed by the Workforce Inclusion and Culture Sub-Committee (formally known as the Workforce Equality, Diversity and Inclusion Sub-Committee) through the workplan of the Workforce Equality, Diversity and Inclusion Strategy 2022-2025.

5. TIMELINES

The Gender Pay Gap is analysed at a snapshot date of the 31 March 2024. Reporting of the data analysis and action plan is completed in May 2024 to support actions to be undertaken in the 2024/25 financial year.

The Gender Pay Gap must be published on the UK Government website by 30 March 2025.

6. ASSURANCE COMMITTEE

Reporting of progress and escalation for the Gender Pay Gap is completed through the Workforce Equality, Diversity and Inclusion Strategy updates to Strategic People Committee on a bi-annual basis.

7. RECOMMENDATIONS

The Trust Board is asked to receive and note the analysis, data and action plan included within this paper, post approval by the Strategic People Committee in May 2024.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Gender Pay Gap Annual Report

2023-2024

Working Together | Excellence | Inclusive | Kind | Embracing Change

Introduction

Background to the report

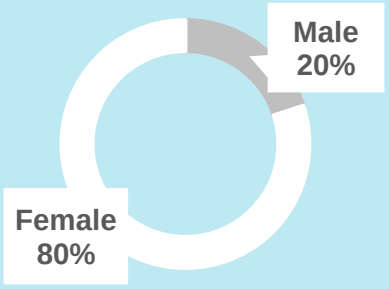
Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is committed to promoting, championing and advancing equality, diversity and human rights. We aim to make WHH the best place to work, creating a culture of belonging for all.

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, requires all public sector organisations with over 250 employees to report and publish their Gender Pay Gap annually.

The gender pay gap is defined in the Act as the difference between the average hourly earnings of males and that of females.

Gender pay reporting highlights any imbalance of average pay across the Trust. For example, if the Trust's workforce is predominantly female yet the majority of senior positions are held by males, the average female salary would be lower than the average male salary.

WHH Gender Profile



What does this tell us?

Of the **4,612-workforce** included in the gender pay gap reporting, effective 31 March 2024, 3,682 were female compared to 930 males.

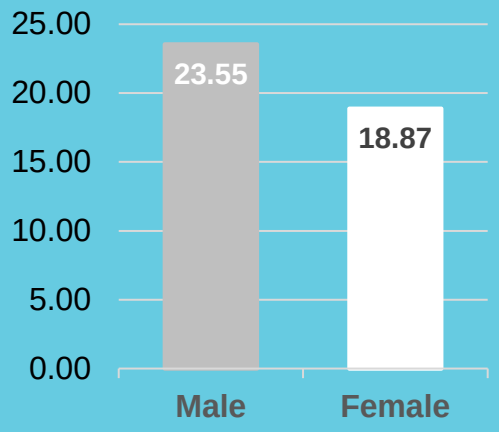
This shows a consistent gender split across the workforce in comparison to reporting in 2022/23. This is reflected nationally in NHS workforce profiles.

Gender Pay Gap 2023/24

Mean Pay Gap

Mean is the sum of the values divided by the number of values. In this context, the mean is the difference between the mean hourly rate for female and male employees.

Mean Hourly Rate



What does this tell us?

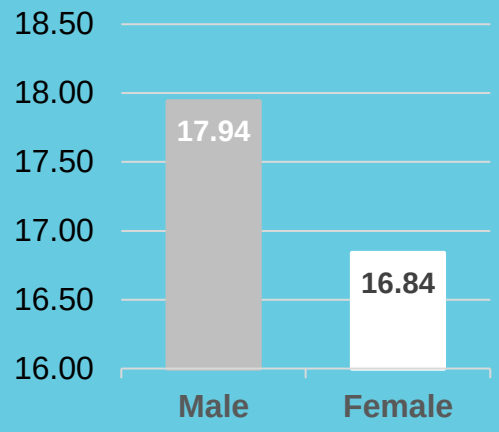
This highlights that the mean hourly pay for males is **£4.68 higher** than that of females, a gender **pay gap of 19.89%**.

This is a **decrease** in the mean pay gap from 21.94% reported in 2022/23.

Median Pay Gap

Median is the middle value in a sorted list of values. It is the middle value of the pay distribution, such that 50% of people earn more than this and 50% earn less than the median.

Median Hourly Rate



What does this tell us?

This highlights that the median pay for males is **£1.10 higher** than females, a gender **pay gap of 6.13%**.

This is a **decrease** in the median pay gap from 9.38% reported in 2022/23.

The median pay gap is the representative gender pay gap across the Trust. This does not take account of the highest paid employees which although a small number, may distort the data at the mean (average) level.

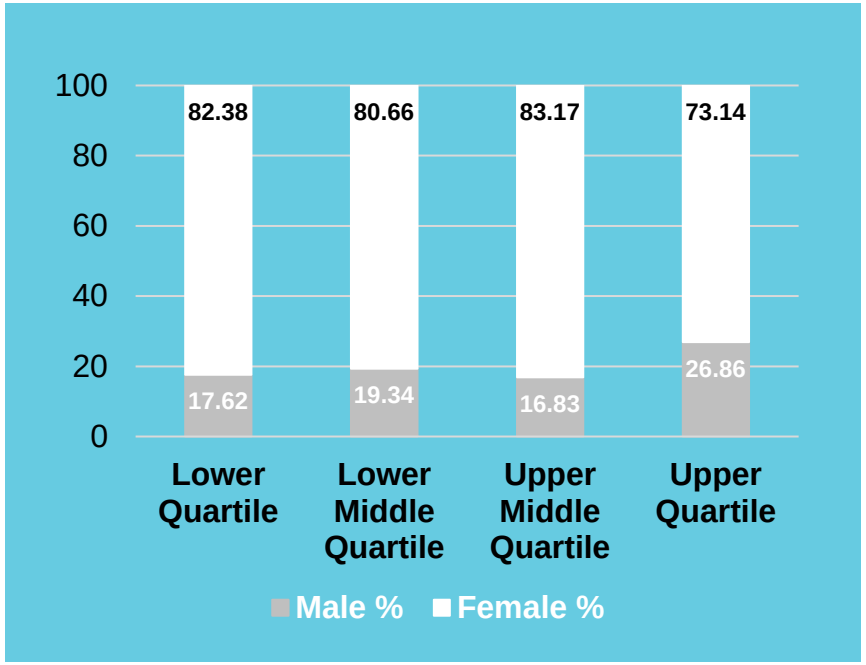
Although there has been a steady decrease in the mean pay gap since 2021/22, there had been an increase of the median pay gap since 2019/20 – reporting for 2023/24 now highlights that the **median pay gap is the lowest since 2019/20 (7.78%) at 6.13%.**

Further work to reduce this, including actions can be found in the WHH Gender Pay Gap action plan.

Gender Pay Gap 2023/24

Quartile Split

The Trust is required to split the workforce into quartiles (blocks of 25%) split by pay, showing the proportion of males and females in each quartile.



Analysis

This shows that compared to the gender split across the workforce, where males represent 20% of the workforce there are more males in the highest pay quartile (26.86%). This however is a reduction of 1.46% in comparison with 2022/23 highlighting a positive trajectory.

Although females make up 80% of the overall workforce, there are fewer females in the upper pay quartile (73.14%). Females are representative across all other pay quartiles above 80%.

In comparison to 2022/23 the largest shift in growth remains in the ‘lower middle quartile’ where males have increased, and females have decreased by 1.41%. This presents a more accurate split in comparison to the workforce gender profile.

Enhanced work is required in the ‘upper middle quartile’ and ‘upper quartile’ to ensure work is completed to remove the pay gap identified.

This will be supported through the Trust action plan.

Gender Pay Gap 2023/24

Bonus pay

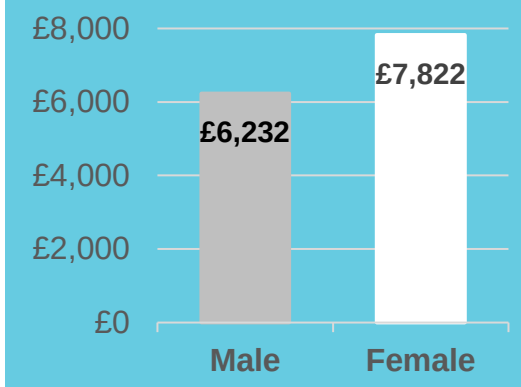
Bonus pay for the Trust refers to Clinical Excellence Awards, a scheme that recognises and rewards consultants who contribute to the delivery of safe and high-quality care to patients, and to continuous improvement of NHS services.

Clinical Excellence Awards are split by national and local awards, the data in this report provides a combined bonus ‘mean’ and ‘median’ calculation.

Data for bonuses are calculated for the 2023/24 financial year period (1 April 2023 to 31 March 2024), of which 153 of the Trust workforce received a local award and 41 received a national award in this snapshot period.

This relates to 1.5% of females and 13.6% of males in the workforce awarded a bonus.

Mean Bonus Pay

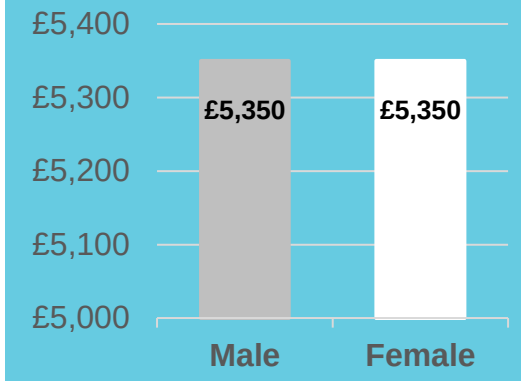


What does this tell us?

This highlights that females **received 25.5% higher** mean bonus pay compared to males.

This is alike the results of 2022/23, where although less females received a bonus, when they did, they proportionately received a higher bonus payment.

Median Bonus Pay



What does this tell us?

This highlights that the median bonus pay for females and males was the same in 2023/24.

This is reflective of previous years reporting.

Appendix Two: Gender Pay Gap Action Plan 2024-25 – Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Name:	Warrington and Halton Teaching Hospitals NHS Foundation Trust	**Trust Chief People Officer:**	Michelle Cloney	**Trust EDI Lead:**	Adam Harrison-Moran, Head of Culture and Inclusion

The Gender Pay Gap report for 2022/23 included a Trust wide Gender Pay Gap Action Plan for 2023/24. This has been enhanced by the data sets analysed in the 2023/24 financial year and updated actions can be found below:

#	Key Action	Steps to achieve action	Progress Updates Due by
1.	Continue the implementation of the inclusive recruitment programme, aligned to the Workforce Equality, Diversity and Inclusion Strategy people promises, taking account of ED&I considerations and be responsive to individual circumstances.	• Enhance, monitor, redesign and initiate training and support packages for recruiting managers that focus on equality, diversity and inclusion, unconscious bias and the Trust Values: ○ Include specific references to and mitigations against gender inequalities. • Complete an audit review for advertising jobs as flexible, by default – linked to the NHS EDI improvement plan. • Review Trust approach to recruiting returners – those who have been off work for caring responsibilities, etc. • Review opportunities to support staff absent from work for long periods of time, e.g. family leave to support them in accessing recruitment opportunities.	December 2024

2.	Triangulate data from the Gender pay gap and Ethnicity / Disability pay gap reporting to identify opportunities for best practice improvements.	• Split data by gender and grade and review against other protected groups:
		  ○ Determine if differences in scores by gender within grades.
		  ○ Cross-reference with self-assessment scores.
		• Review professional development support offered to assess if men and women have equal access to support.
			March 2025

#	Key Action	Steps to achieve action	Progress Updates Due by
3.	Review opportunities to identify and remove barriers to career progression for females in our workforce.	• Encourage up take of aspiring individuals to attend the Trust Reciprocal Mentoring programme – launching September 2024. • Enhance the support provided by the Women's Staff Network in relation to women's health – reviewing scope for the introduction of Culture Retention Champion support. • Complete a review of equality, diversity and inclusion training programmes to promote gender inclusivity and apply learnings from lived experience into practice.	September 2024

4.	Promote flexible working for men and women who have caring responsibilities.	• Trust wide review for the take up of shared parental leave by men and women at WHH – linked to the national policy best practice review.
		• Promote shared parental leave and other policies that support caring responsibilities as part of Culture Corners programme.
		• Annually review part time working in the Trust, aligned to the "We work flexibly" People Promise to identify:
		  ○ any actual or perceived barriers to part time working at senior levels.
		  ○ any actual or perceived barriers to part time workers progressing through the Trust.
			July 2024 – aligned to recruitment of the People Promise Manager

5.	Work with the Women's Staff Network to develop specific plans associated with analysis of the 2023 Staff Survey results.	• Assess data to determine specific inequalities for women. • Assess data to identify any barriers to promotion or appointment at a senior level. • Publish a network improvement plan based on findings.	June 2024
6.	Development of the Bumps and Babies programme	• Develop a family friendly networking programme focused on supporting career progression on return of family friendly leave. • Develop learning opportunities to engage with the workforce during periods of absence, supporting retention in roles. • Align the return of flexible working to "stay" conversations across the Trust – linked to professional legacy programmes.	To launch July 2024

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/042**	
SUBJECT:	**Estate Strategy 2024-2029**	
DATE OF MEETING:	5 June 2024	
AUTHOR(S):	Ian Wright, Associate Director Estates and Facilities Management	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	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)***	**#1898** If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions. **#125** If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation, and financial position.	
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:			
	Yes	**No**	**N/A**

	3. Foster good relations between people who share a protected characteristic and those who do not			***x***
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	All NHS Trusts have a statutory responsibility for the management of their assets. A well devised Estate Strategy is an essential element of that management. There is a pressing need for rationalisation, modernisation, and reconfiguration on both the Warrington and Halton sites. At Warrington, some services are still delivered in Victorian buildings and other buildings are outmoded and inefficient. While the Halton site is generally more modern, there is an urgent need for infrastructure renewal to enable the enhancement and growth of future clinical services. The Warrington and Halton estate comprises of several sites across a footprint of 21 hectares and with an internal floor area of 95,200m^2. The strategy sets out the Trust current position, and the ambition for the next 5 years whilst remaining aligned to trust business and clinical strategies. Further to the above, the Estate Strategy was approved at FSC Wednesday, 22 May 2024. In relation to the Bridgewater transaction, the Estate Strategy remains relevant and will be amended in accordance with any progress in relation to Bridgewater. Quarterly updates will be provided to FSC to ensure any amendments and updates are addressed.			
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**	
RECOMMENDATION:	The Trust Board is asked to approve the 2024-2029 Estate Strategy.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	**FSC/24/05/39**		
	Date of meeting	22 May 2024		
	Summary of Outcome	approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

ESTATE STRATEGY

'Enabling a safe, secure, fit for purpose hospital and workplace'

Hello and welcome.

About Us

I am delighted to share our 2024-2029 Estate Strategy with you.

Our goals and priorities for the next 5 years build on the significant development undertaken across our estate to realise our vision of being a great place to receive healthcare, work and learn. In the past two years alone, some significant developments have been to open the Halton Health Hub in Runcorn Shopping City, completed two out of three phases of a Community Diagnostic Centre programme, and created a Same Day Emergency Care centre.

As a Trust we are committed to working in partnership across Cheshire & Merseyside to utilise estate even more effectively and look at how we can move care closer to our patients. This strategy sets out our roadmap to continue to develop our estate to reflect the needs of our population, and ensure we continue to deliver outstanding care to our patients.

We have considered the ongoing impact of the COVID-19 pandemic, including its impact in widening the gap in health inequalities, and recovery of the elective backlogs; changes to the local health and social care system structures;

increased demand and an ageing population; a move away from competition to collaboration; and a greater focus on preventing ill health. As our healthcare landscape evolves, we must continue to assess and transform our estate to build robust foundations to meet the needs of the future.

Dan Moore Chief Operating Officer

All NHS Trusts have a statutory responsibility for the management of their assets. A well devised Estate strategy is an essential element of that management.

There is a pressing need for rationalisation, modernisation, and reconfiguration on both the Warrington and Halton sites.

At Warrington, some services are still delivered in Victorian buildings and other buildings are outmoded and inefficient. While the Halton site is generally more modern, there is an urgent need for infrastructure renewal to enable the enhancement and growth of future clinical services.

The Warrington and Halton estate comprises of several sites across a footprint of 21 hectares and with an internal floor area of 95,200m^2. Hospital services are delivered from Warrington Hospital, Halton Hospital, Halton Health Hub and at Bath Street, Warrington.

OUR HOSPITAL SITES

WARRINGTON HOSPITAL

HALTON HOSPITAL

COMMUNITY SITES

In addition to the two core hospital sites, the Trust operates from two community locations, with more in development.

Halton Health Hub

Operating from Runcorn Shopping City, the Halton Health Hub is a refurbishment of a vacant retail unit to create high quality, clinical space in the core of the Halton and Runcorn community.

Bath Street Breast Screening Centre – Warrington

Breast screening services were relocated from aging estate in Kendrick Wing, Warrington Hospital, to refurbished space within the Bath Street Health and Wellbeing Centre.

WHERE ARE WE NOW?

There are several key drivers behind our Estate Strategy including the development of effective care pathways, achievement of statutory compliance, and ensuring value for money.

In recent years there has been several local service reviews, spanning back to 2016 which sought to identify how more sustainable care pathways can be developed, to support a greater level of services. Reconfiguration of the Trust's estate is fundamental to ensuring that care pathways can be changed to meet the needs of patients and services.

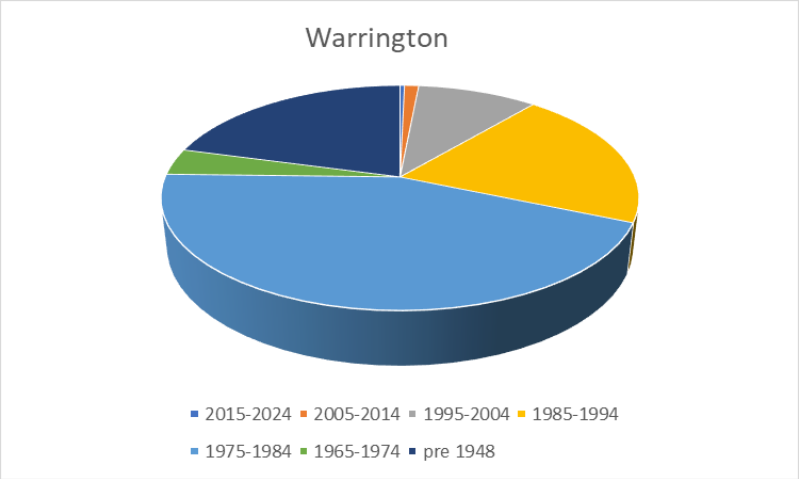
Assessments of the Trust's estate performance have considered factors including: -

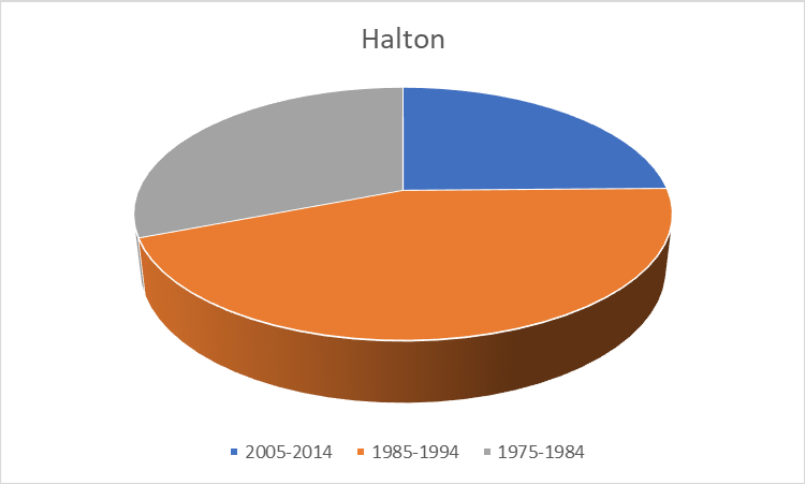
- Physical condition
- Functional suitability
- Space utilisation
- Quality
- Statutory compliance
- Environmental management

The outcome of these assessments informs our investment priorities and estate masterplan, to ensure that we can provide great places for our people.

Age and Condition

Our buildings vary in age, and we can compare with NHS England age data.





Backlog Maintenance

Backlog maintenance cost (backlog) is the cost to bring estate assets that are below a standard, to make them operationally sound in terms of their physical condition, and/or compliance with mandatory fire safety requirements and statutory safety legislation.

Backlog Maintenance and Statutory Compliance costs are graded as Low, Moderate, Significant and High Risk.

The NHS Estates Guide 'A Risk-Based Methodology for Establishing & Managing Backlog' is used to calculate the risks for each defect highlighted within the Physical Condition and Statutory Compliance.

Table 1 below shows a breakdown of the backlog costs (i.e., costs required to bring elements currently below condition grade 'B' up to condition grade 'B' immediately) by risk.

Backlog by Site	Low	Moderate	Significant	High	Total
Halton Hospital	**£859,220**	**£3,804,577**	**£7,128,101**	**£674,142**	**£12,466,040**
Warrington Hospital	**£3,437,657**	**£8,491,568**	**£13,968,118**	**£1,439,865**	**£27,337,208**
Total	**£4,296,877**	**£12,296,145**	**£21,096,219**	**£2,114,007**	**£39,803,248**

In November 2023, the total Backlog cost in relation to physical condition and statutory compliance is £39,803,248.

Warrington Impending Backlog Maintenance Costs

Impending backlog relates to elements of the estate currently in Condition B that will fall below B **within 5 years**, assuming no major investment in the interim.

The total Impending Backlog costs, for Condition (including costs for site infrastructure) are shown below: -

Total Impending Backlog	**£12,638,790**

Halton Impending Backlog Maintenance Costs

Impending backlog relates to elements of the estate currently in Condition B that will fall below B **within 5 years**, assuming no major investment in the interim.

The total Impending Backlog costs, for Condition (including costs for site infrastructure) are shown in below: -

Total Impending Backlog	**£11,791,949**

In addition to backlog costs relating to physical condition and statutory compliance, we also calculate costs relating to the following facets. These are updated annually.

- Functional suitability
- Space utilisation
- Quality of the environment
- Environmental management
- Equality Act

Some of these facets are difficult to address due to the nature of a building, the historical design and layout of rooms and wards, or the infrastructure unable to support new methods of building. It's therefore less likely that the costs will be addressed, and we focus primarily on the physical condition and statutory compliance. These are what we are measured on nationally.

The estimated costs to address these facets of backlog is currently £25.5m at Warrington Hospital and £4m at Halton Hospital.

Works identified include: -

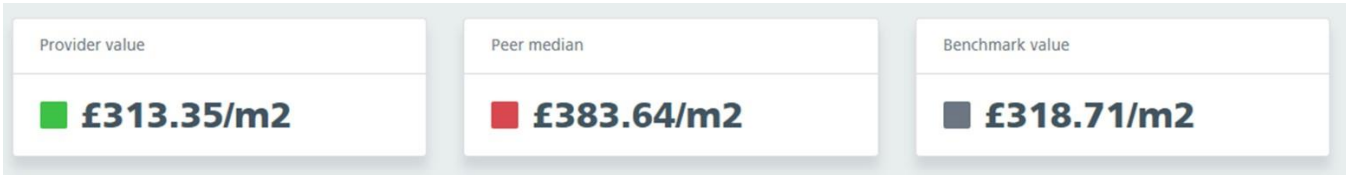
- Replacements to infrastructure including replacement windows.
- Aged site drainage.
- Building Management System
- Ventilation systems.
- Water distribution.
- Electrical systems.

To effectively address backlog we will need to spend **£101,850,678** over the next 10 years.

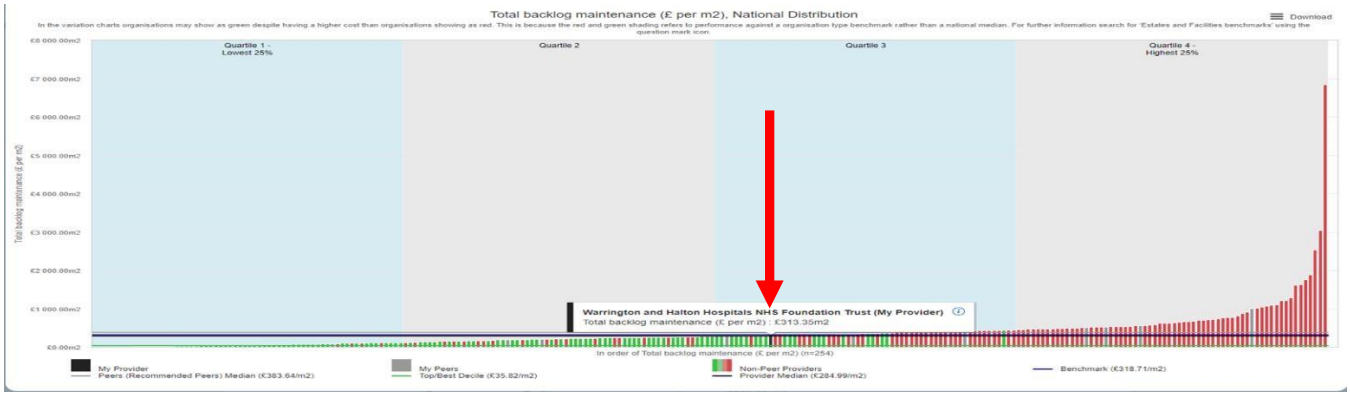
Whilst addressing backlog can limit development and growth elsewhere, Statutory Compliance items will be addressed first, followed by high-risk backlog items under Physical Condition, followed by significant then moderate and low risk items. Future costs should be addressed as appropriate by risk as described for backlog items above.

How we compare Nationally

Warrington and Halton **Recommended Peers** National **benchmark**



Model Health data suggests we are below both our recommended peer median (£384/m^2), and national benchmark median (£319/m^2) when it comes to backlog maintenance costs.



THE STRATEGY

The Estate Strategy is a medium term 5-year plan for managing the estate in an optimum way in relation to the service and business needs of the Trust and the local health economy. In doing so it aims to meet the Trust's strategic objectives of Quality, People and Sustainability and align itself with the Trust's other strategies.

The Estates Strategy aims to:

- Support a place-based strategy for our estate.
- Respond to care requirements and changes in demand.
- Support the delivery of high-quality inpatient and outpatient facilities.
- Increase the operational efficiency and enhance delivery capability.
- Support our ambitions for a new hospital estate.
- Improve capability and capacity to support national and local planning and transformation projects.

Development of the Strategy

Several workshops and discussions with internal, and external stakeholders have taken place to discuss the direction an estates strategy for Warrington and Halton should take. The common theme is that although we were unfortunate not to be included in the current new hospitals programme, we should still maintain a watching brief and do everything we can to be ready should another round of allocations be published. Whilst we maintain an element of focus in new hospitals, we cannot sit idly and fail to address some of the issues we are aware of on both our hospital sites. For example, car parking; limitations of the emergency department due to size; the potential for an urgent care treatment centre in Warrington; lack of space within the Warrington site footprint to develop clinical services for the future and backlog maintenance.

In delivering the strategy we will focus on key aims and objectives.

Our Estate Strategy Objectives

To support the aims of the strategy, the delivery of the estates objectives below will support the strategic aims which collectively underpin achievement of the Trust's strategic objectives focused on Quality, People and Sustainability to: -

- Align the estate to the clinical strategies and underpin the Trust's values and objectives.
- Support the ambitions of Warrington and Runcorn as growing towns, focussing on regenerating built and natural environment and reducing health inequities.
- Improve compliance with Health Building Notes and Health Technical Memorandums.
- Provide a solid platform to prioritise investment and prepare for future opportunities.
- Reduce Backlog Maintenance and Critical Infrastructure Risks.
- Enable the delivery of clinical and operational services and sustainability.
- Improve functional suitability and net zero target.
- Improve utilisation.

Who will help to make this happen?

Our Estates and Facilities team will work with a range of internal and external resources to deliver our strategy.

INTERNAL - our clinicians, people, and key stakeholders (infection control, IT etc), help shape the needs of the environment we provide and will be directly involved in design development and project delivery, to ensure we have a well thought out plan that maintains business as usual whilst we transition from old, to new facilities.

PARTNERS - working with our partners will ensure we have the capacity and skills to deliver a fully joined strategy. We take the views of our patients when developing proposals to ensure we take account of their thoughts on specific things like accessibility and environment.

PATIENTS - we take the views of our patients when developing proposals to ensure we take account of their thoughts on specific things like accessibility and environment.

EXTERNAL - we will work with a range of external organisations to develop our proposals and deliver our strategy projects, these include professional services like architects, engineers, and cost advisors as well as contractors, sub-contractors, and specialists.

We will procure the services of the external organisations through a range of procurement routes including the Department of Health's Procure 23 Framework and ensure we use the services of local companies where we can.

A GREEN STRATEGY

Sustainability and Net Zero

We understand that climate change plays a huge part in the future of our estate. To achieve Net Zero, the Trust has developed a Green Plan, which will outline our objectives and goals to help us achieve this ambition. We are committed to reducing our carbon footprint and are pursuing a wide range of projects and initiatives to make this happen.

The key areas of focus for us are Energy, Water, Biodiversity and Buildings.

These areas play a huge part in the future of our estate.

It is important that we futureproof our buildings and our green spaces to ensure that we are prepared for future patient care, and the inevitable changes in our climate.

We understand that our buildings need to be more sustainable, resilient, and adaptable and we are taking steps to make this happen, with the full adoption of sustainable buildings accreditations across all our major capital buildings projects such as BREEAM.

Energy Management is also a significant area of focus as we commit to Net Zero by 2045.

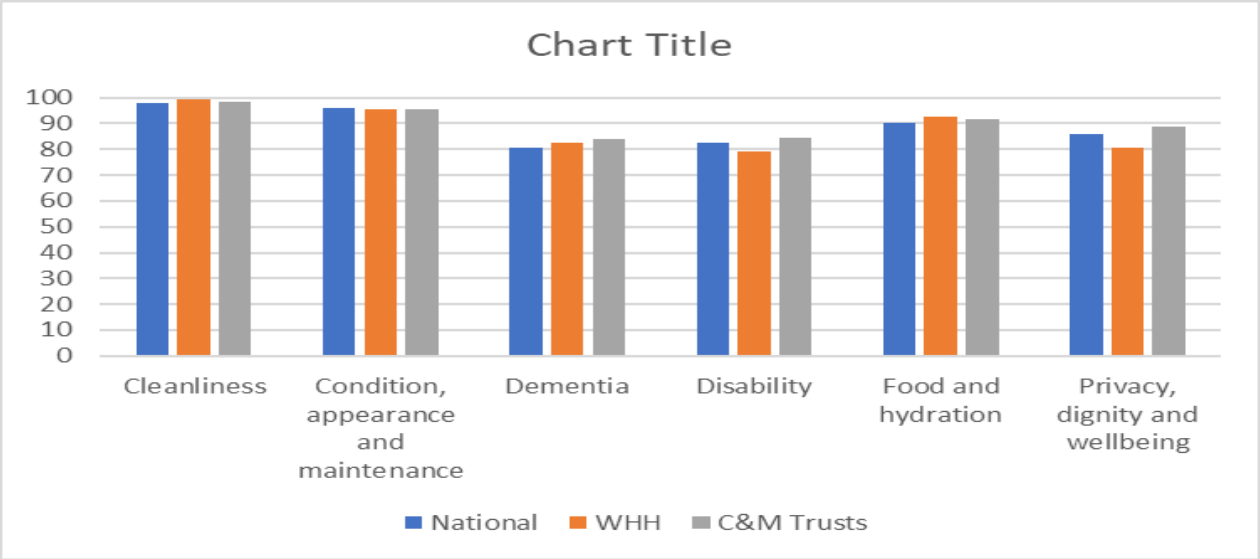
We will aim to reduce our energy consumption through basic employee engagement and change management approaches.

The estate team will support the Trust Green Plan.

Customer Satisfaction

Annual Patient Led Assessment of the Care Environment (PLACE), across all our sites is a framework for assessing quality against common standards and guidelines.

PLACE quantifies environmental cleanliness and maintenance of estates standards, food, and hydration, and assesses whether the premises are equipped to meet the needs of people with dementia or a disability.



Our position in comparison to the national backlog data is reflected in our most recent PLACE results. Falling short on provision for patients with disabilities and providing the very best in privacy, dignity and wellbeing are a measure of our current backlog maintenance costs.

Where we have come from…

New Hospital

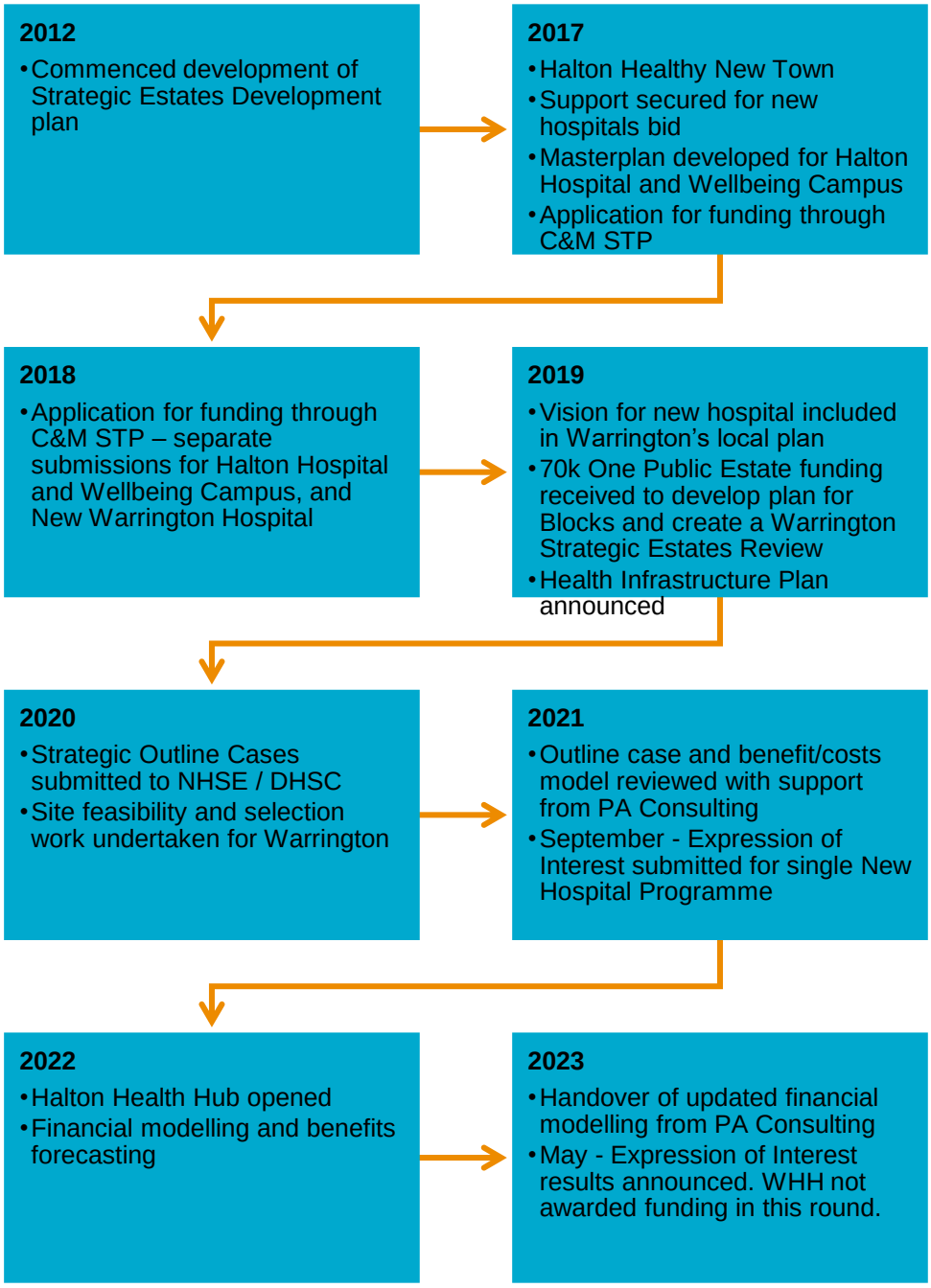
In September 2021, the Trust submitted an expression of interest (EOI), to be considered for one of the 8 remaining spaces on the Government's New Hospitals Programme. This was supported by commissioners, local government, educators including the University of Chester, social care, third sector partners and MPs. The EOI set out a compelling and cost-efficient case for the investment required to build a new hospital in Warrington and redevelop the Halton hospital site (through an extension to the newest estate, Captain Sir Tom Moore Building). The vision for futureproofed, adaptable, and appropriate healthcare facilities has been well embedded since the previous Estate Strategy and had strong support.

In May 2023 we learned that we had not been included in the latest funding round of the Government's New Hospitals Programme. Hospital trusts in urgent need of redevelopment due to health and safety risks associated with RAAC (reinforced autoclaved aerated concrete) roofing had been prioritised in this funding round.

The pressing need remains to create modern, sustainable, and compliant estate which is fit for purpose and can deliver the best healthcare for our local population.

WHH are no longer part of DHSCC New Hospital Programme and whilst it remains a goal to see two new hospitals that best serve our patient population, there is currently no identified funding to realise this. Therefore, the reality is, if the estate is to meet the goals of this strategy, a redevelopment of the existing sites approach is required.

Timeline of work undertaken to date: -

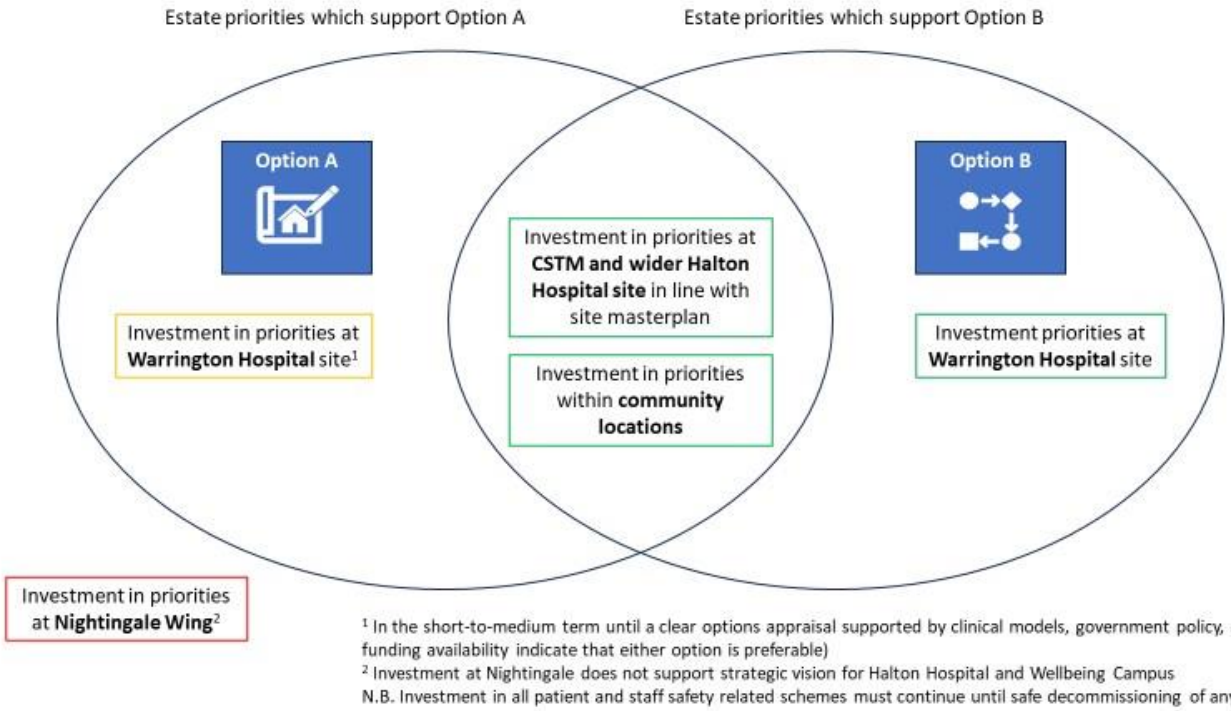


Delivering new hospitals – what are our options?

Option	Warrington Site	Halton Site	Community	Comments
Option A	Total re-build of Warrington hospital at a new site.	Extend CSTM at Halton and demolish Nightingale building and 'the blocks'.	Relocation of services into the community.	**Risks:** Sites not in Trust control Funding unlikely in current climate **Opportunities:** Funding conversations ongoing nationally Easier to deliver new hospital off site Supports town centre regeneration
Option B	Phased re-build of the Warrington estate, on site.	Extend CSTM at Halton and demolish Nightingale building and 'the blocks'.	Relocation of services into the community.	**Risks:** Complex and potentially more costly building programme Clinical risk of continuing BAU during construction Funding unlikely in current climate **Opportunities:** Own the site Funding conversations ongoing nationally Funding potentially more likely in piecemeal sections

Estates priorities alignment to new hospitals options

Investment at Warrington in the short-to-medium term aligns to Option B, until a clear options appraisal supported by clinical models, government policy, and funding availability indicate that either option is preferable



[1] In the short-to-medium term until a clear options appraisal supported by clinical models, government policy, and funding availability indicate that either option is preferable)
[2] Investment at Nightingale does not support strategic vision for Halton Hospital and Wellbeing Campus
N.B. Investment in all patient and staff safety related schemes must continue until safe decommissioning of any site

New Hospital Programme Next Steps

- Undertake revised appraisal, including updated costings, phasing, and feasibility for same site delivery of new hospital (Warrington)
- Investigate all future funding options

Where we are going…

Aligning our strategy with the Integrated Care Board; Cheshire and Mersey ICB are required to submit a draft strategic estate plan by January 2024. At the time of writing there is no PLACE estate strategy to align to, although our strategic estates leads are engaged across Cheshire and Merseyside ICB as it is its developed.

What we have achieved so far…

Same Day Emergency Care

Provides same day care for emergency patients who would otherwise be admitted to hospital.

Halton Health Hub

High quality clinical space for outpatient services in Runcorn Shopping City.

Breast Screening Services

Centre of Excellence at CSTM and relocation of services in Kendrick Wing to Bath Street Health Centre.

Therapies estate redesign

Staff rest area, redevelopment of gym area & women's health areas redesign for privacy.

Clinical treatment suite*

Designated area for pain services in Nightingale Building.

Ophthalmology Clinical Treatment Rooms (Phase 1)

Provision of additional clinic rooms in Daresbury Wing.

Post-anaesthetic care unit*

A recovery area within CSTM theatres, to enable the provision of higher-risk surgery at Halton.

Respiratory Enhanced Care Unit*

28 bedded respiratory ward which is co-located next to critical care, and provides opportunity to expand ITU capacity by 11 beds =7 enhanced care beds and 4 flexible bioquell pods.

Relocation of maternity triage unit.

CDC Phase 1 - Nightingale Building

MRI at Warrington Hospital

New MRI unit at Warrington hospital, replacing the mobile scanning unit.

What we are currently developing…

Warrington Living Well Hub (Winter 2023)
Refurbishment of the Contact Centre in Warrington town centre, to target and addresshealth inequalities in Warrington by providing a range of services focused on prevention, and early intervention.

Community Diagnostic Centre (2023 / 24)*
3 phase programme comprising redevelopment of estate in the Nightingale Building and fallow space in Halton Health Hub, plus a new build diagnostics centre at CSTM.

TIF (2023 / 2024)
CSTM - creation of a new Day Case Unit and a new theatre.
Nightingale Building: - creation of a third Endoscopy room; relocation of the Endoscopy Decontamination Unit;
creation of a new theatre; refurbishment of one ward.

ED Minors (Spring 2024)*
Relocation of Minors into emergency department.

Redevelop the Induction of Labour Bay (Spring 2024)*
To become compliant with a CQC requirement (phase 2 development).

Catering (Spring 2024)*
Refurbishment of Warrington Catering Department.

Ultrasound extension at Warrington (Spring 2024)*
Scheme to redevelop the department by increasing number of scan rooms by 3 or 4. Externally funded with allocation of £500K.

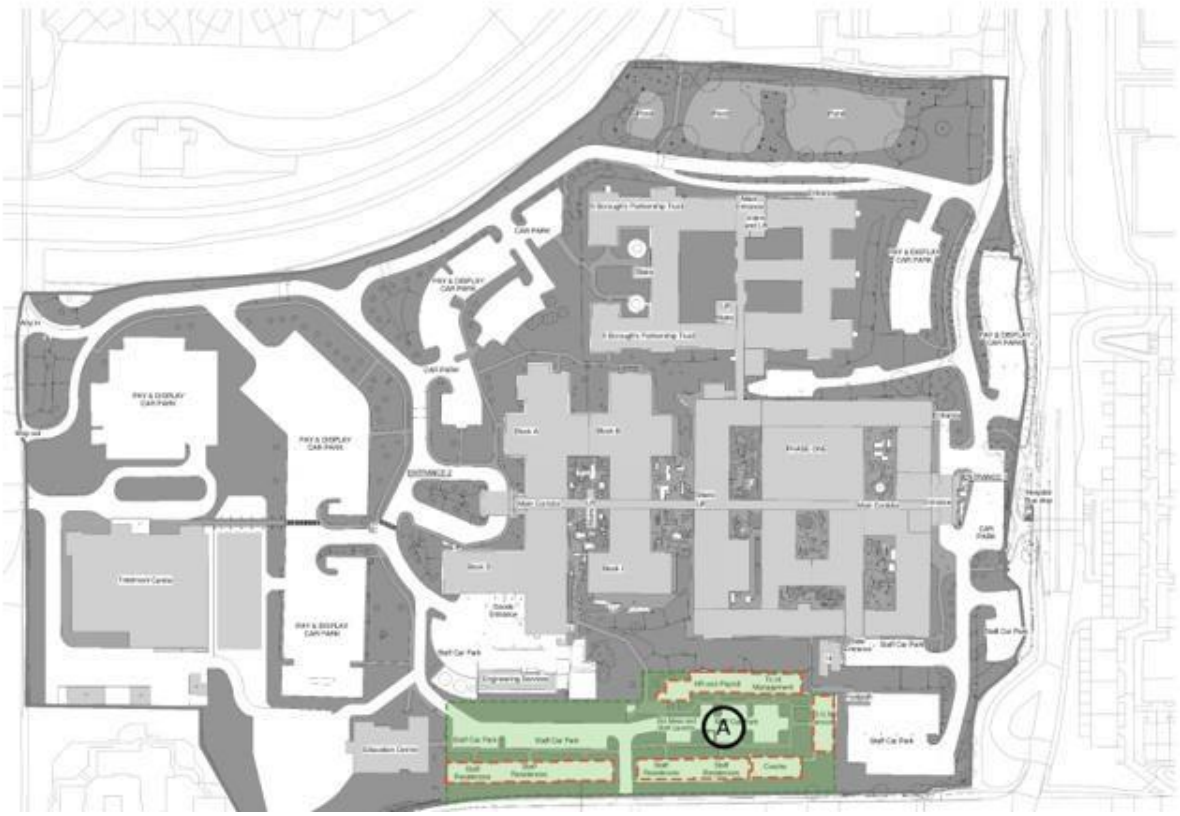
Runcorn Health & Education Hub (Winter 2024 / 2025)
Refurbishment of Runcorn Library will deliver services focused on prevention; women and children, and long term conditions. To provide flexible education facilities to support the growth of the future workforce.

Halton Endoscopy Development (Spring 2024)*
Scheme to create additional Endoscopy rooms at Halton, to deliver capacity for Cheshire and Merseyside; externally funded.

Land development opportunities

The element of the Halton site known as “The Blocks” forms an area of 0.89 hectares on the southeast boundary of the Halton General Hospital site adjacent to Palace Fields Avenue, as illustrated below in the red hatched area. The Blocks were originally used as staff accommodation but have predominantly been repurposed as office and clinical space. However, the buildings are reaching the end of their usable life and are falling into disrepair.

In August 2023 the trust Executive Team agreed to vacate the blocks, excluding Block 1 (that houses the Trust’s education facilities), which gives way to the opportunity of repurposing the land with a private sale, or otherwise.



Development Opportunities

As a result of several internal stakeholder engagement sessions the following development opportunities have been identified. Further work will be required to develop plans, engage, and consult with stakeholders and secure funding.

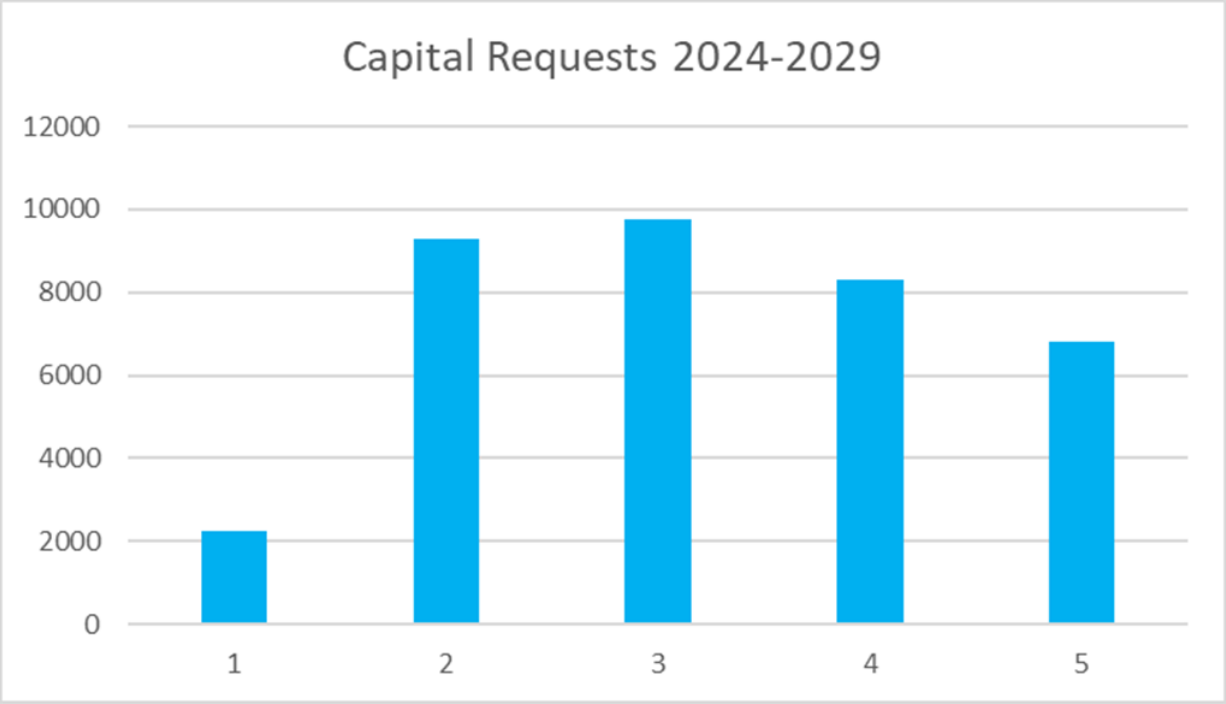
- Warrington Urgent Treatment Centre
- Urgent Care Village
- Relocate Warrington Outpatient to community premises.
- Demolition of Kendrick Wing – relocate remaining clinical services.
- Demolition of Halton Blocks
- Development of Additional Community Hubs
- Development of Shared Education Facilities
- Relocate Corporate Services Off-Site
- Development of Paediatric Surgical Hub
- Bed Reconfiguration
- Car Parking improvements.
- Development of Paediatric Surgical Hub

Our Estates Roadmap

Our estate strategy provides a 5-year roadmap to both address backlog maintenance, develop key clinical services, meet the aims and objectives of this strategy, and develop several of the opportunities that have arisen from stakeholder engagement.

Backlog Maintenance plan years 1 – 5.

Using data from the 7-facet survey of both sites, on the ground knowledge and real-time site surveys by our estates and capital team, an assessment of backlog we need most urgently over the next 5 years is below. The assessment considers the limitation of capital funding and a risk-based approach.



The estates and capital teams have been able to project backlog maintenance costs onto a rolling programmer across 10 years.

Key elements of backlog maintenance over the next 5 years, in a phased approach, include: -

- Ward refurbishment.
- Theatre refurbishments.
- Lift replacements.
- Electrical infrastructure upgrading.
- Roof repairs.

- New substations.
- Environmental improvements.
- Internal drainage upgrades.
- Window replacement.
- Fire precaution works.
- Ventilation plant replacement.
- Emergency generator replacement.

The 2024 – 2029 Roadmap

Our Estate Roadmap

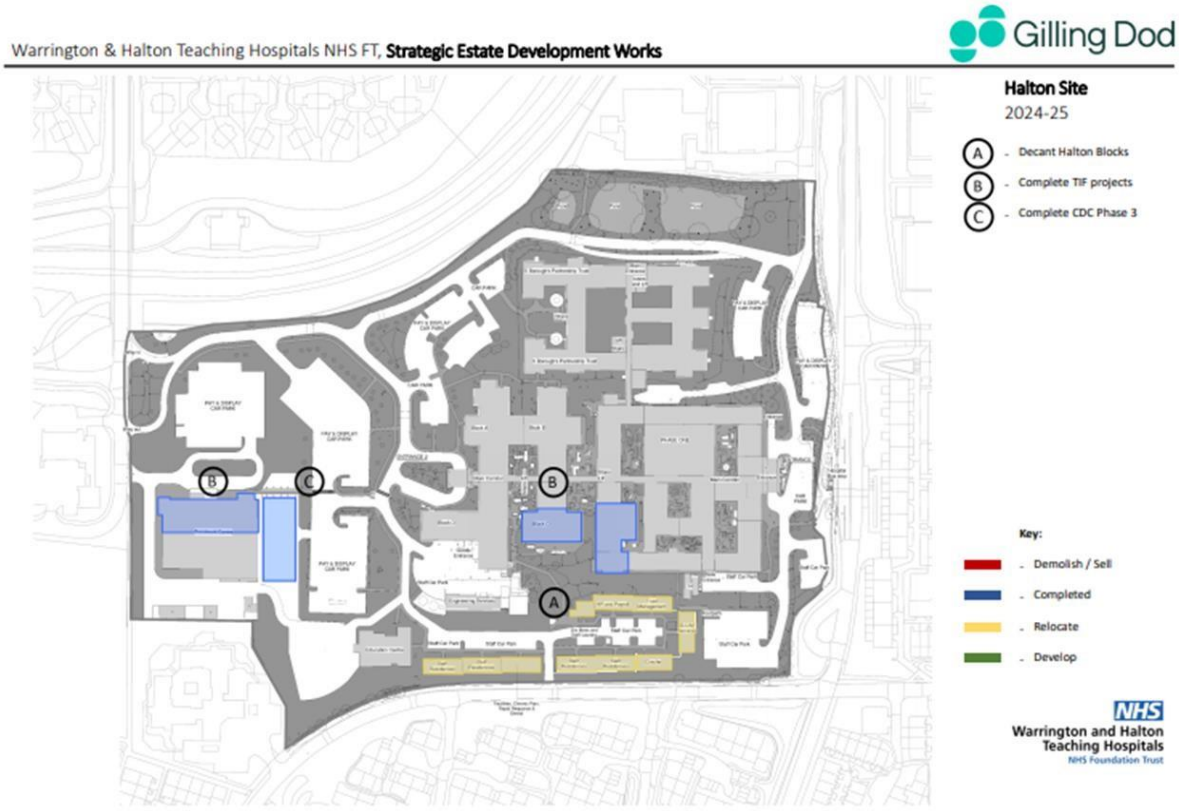
2024 - 2025	2025 - 2026
• Backlog Maintenance as per plan • Decant Halton Blocks • Complete TIF projects • Complete CDC Phase 2 • Agree option appraisal for use of space currently occupied by A10 to enable relocation of Clinical Services from Kendrick Wing • Scope OPD moving to community premises • Develop new hospitals Option B • Complete Living Well Hub	• Backlog Maintenance as per plan • Relocate Corporate Services from Kendrick Wing • Relocate Warrington OPD to community premises • Sell Halton Blocks land • Develop Urgent Care Village and ED expansion at Warrington to RIBA Stage 4 (technical design) using vacated OPD space and new build (in place of A10) • Complete Runcorn Health Education Hub

2026 - 2027	2027 - 2028
• Backlog Maintenance as per plan • Develop Urgent Care Village to RIBA 7 (in use) • Relocate clinical services (cardio respiratory), to vacated OPD or new build	• Backlog Maintenance as per plan • Demolish Kendrick Wing • Develop plans for replacement Appleton Wing Ward Block to RIBA 2 (concept design)

2028 - 2029

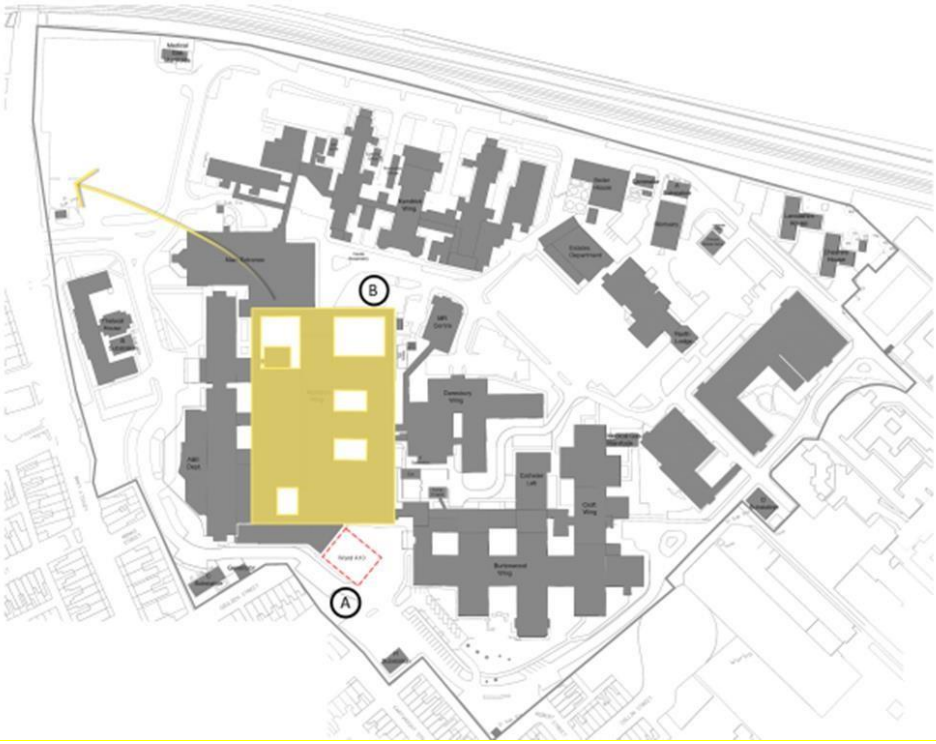
- Backlog Maintenance as per plan
- Develop Ward Block to RIBA 4
- Develop MSCP to RIBA 4

2024-2025


Warrington & Halton Teaching Hospitals NHS FT, Strategic Estate Development Works
Gilling Dod
Halton Site
2024-25
A . Decant Halton Blocks
B . Complete TIF projects
C . Complete CDC Phase 3
Key:
. Demolish / Sell
. Completed
. Relocate
. Develop
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington & Halton Teaching Hospitals NHS FT, **Strategic Estate Development Works**

Gilling Dod



Warrington Site

2024-25

(A) - Agree option appraisal for use of space currently occupied by A10 to enable relocation of clinical services from Kendrick Wing

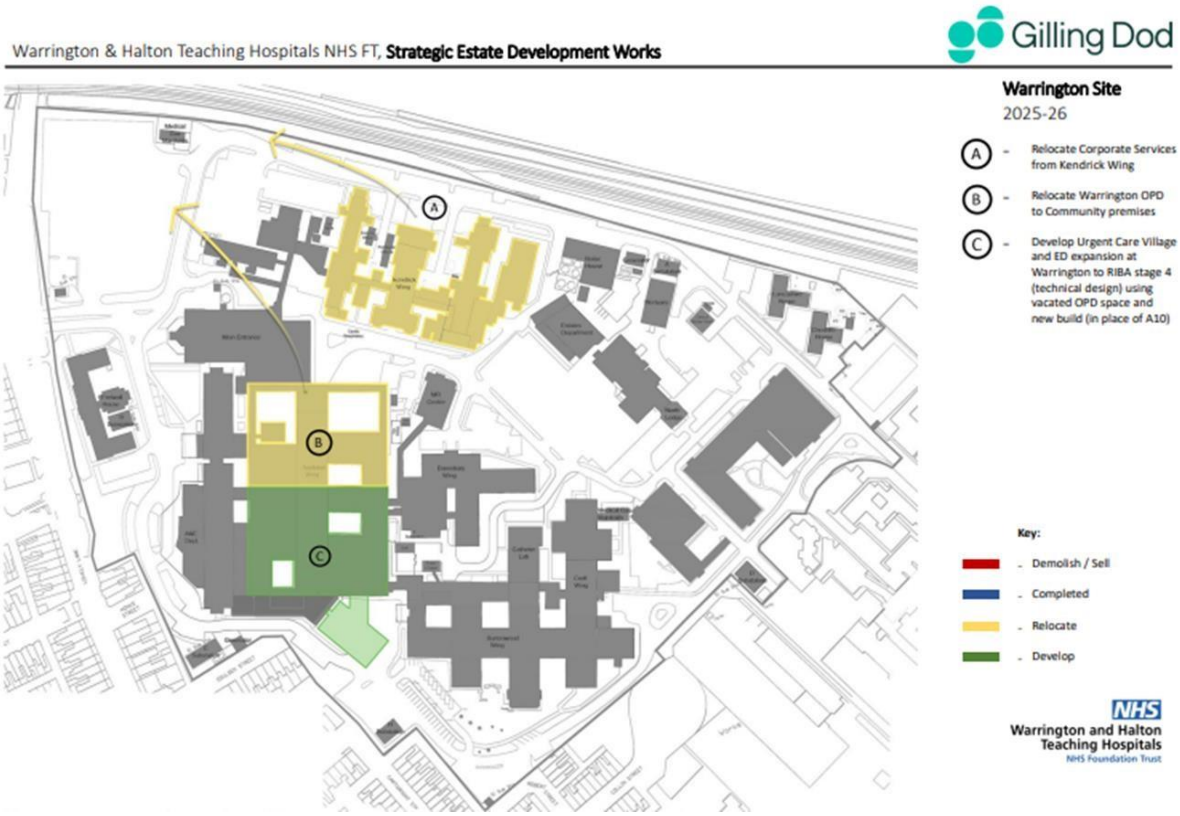
(B) - Scope OPD moving to community premises

Key:

- Demolish / Sell
- Completed
- Relocate
- Develop

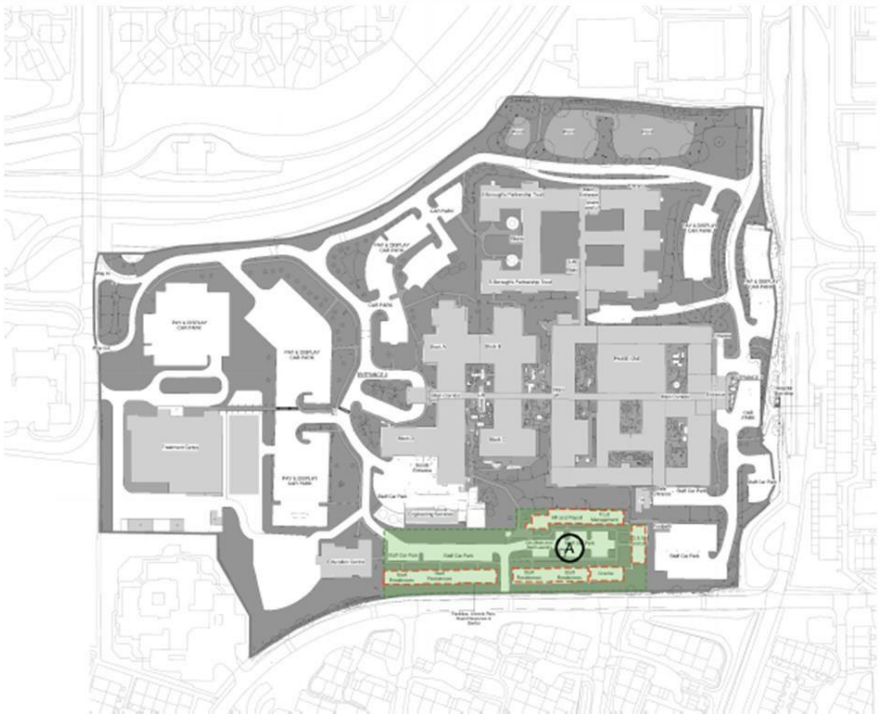
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

2025-2026


Warrington & Halton Teaching Hospitals NHS FT, Strategic Estate Development Works
Gilling Dod
Warrington Site
2025-26
A - Relocate Corporate Services from Kendrick Wing
B - Relocate Warrington OPD to Community premises
C - Develop Urgent Care Village and ED expansion at Warrington to RIBA stage 4 (technical design) using vacated OPD space and new build (in place of A10)
Key:
Demolish / Sell
Completed
Relocate
Develop
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington & Halton Teaching Hospitals NHS FT, Strategic Estate Development Works

Gilling Dod



Halton Site
2025-26

(A) - Sell Halton Land

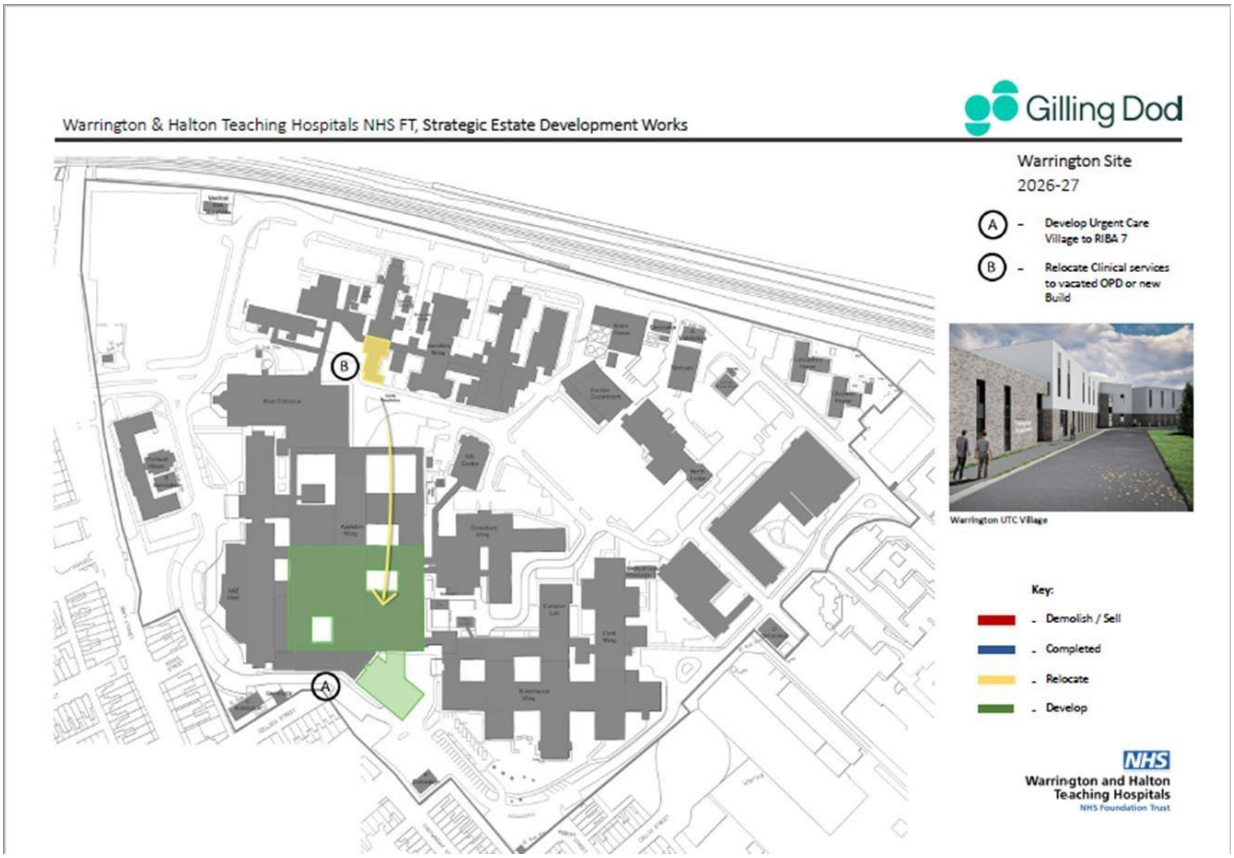
Potential Social housing development

Key:

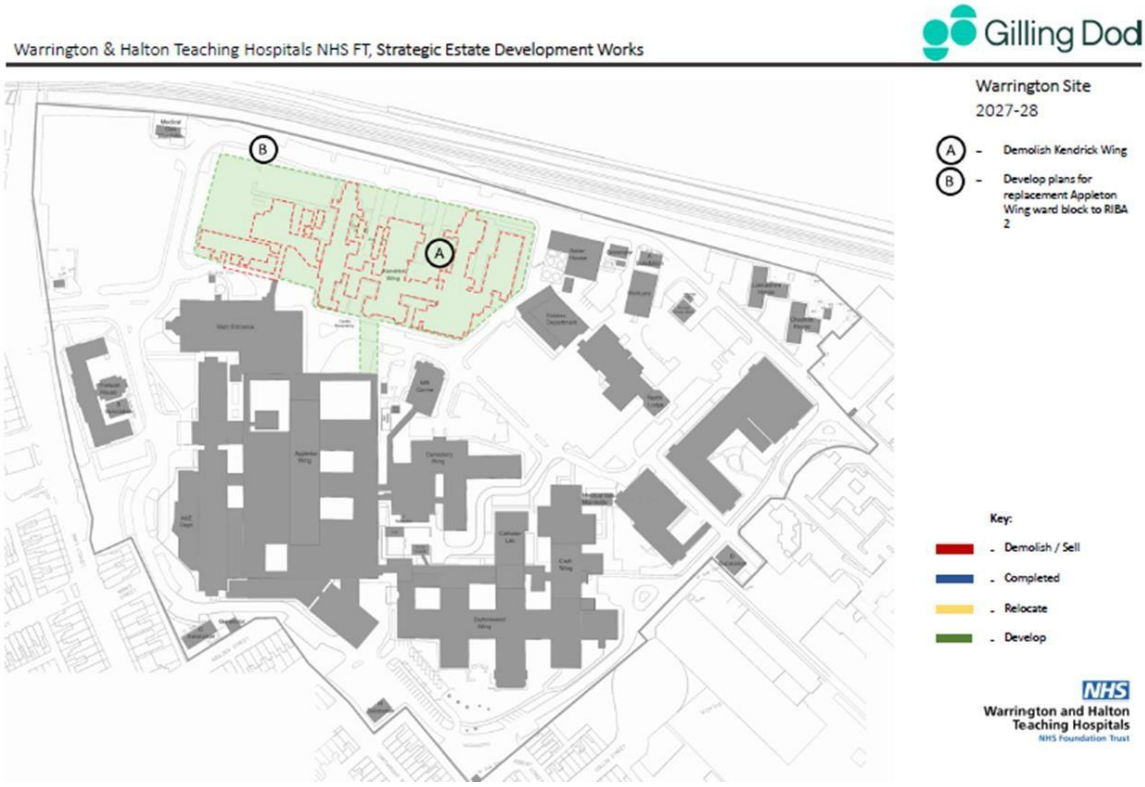
- Demolish / Sell
- Completed
- Relocate
- Develop

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

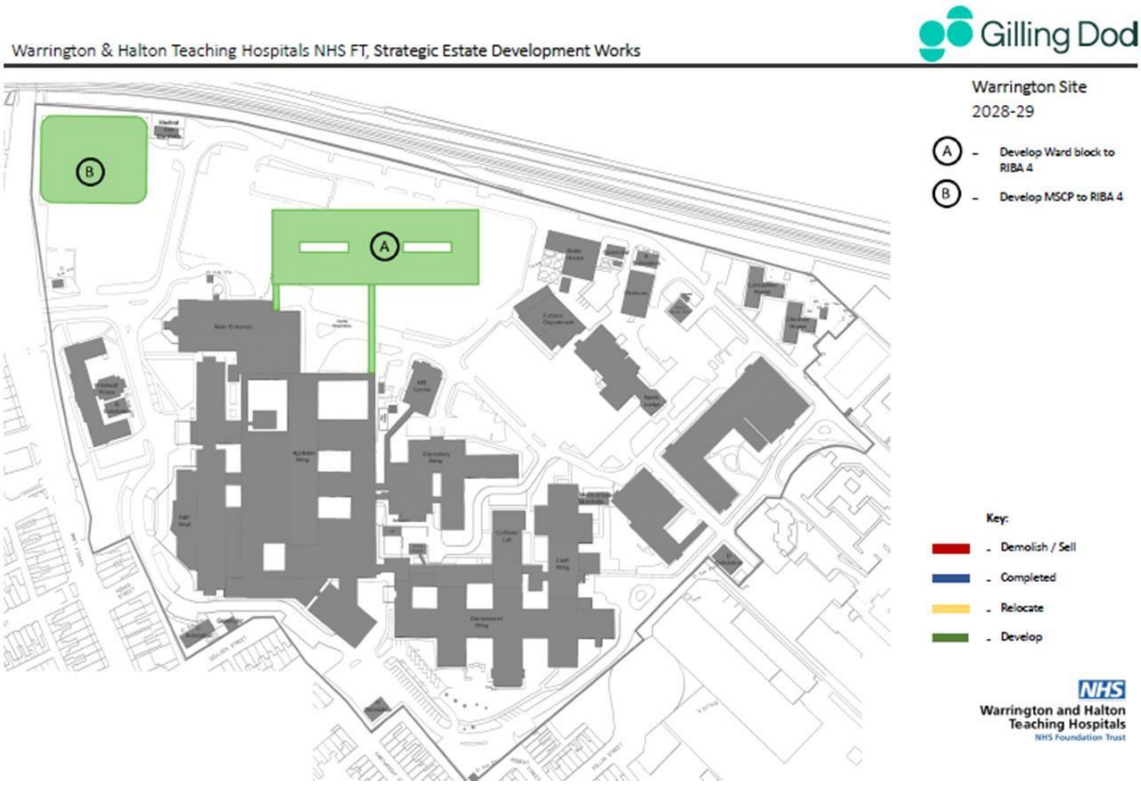
2026-2027


Warrington & Halton Teaching Hospitals NHS FT, Strategic Estate Development Works
Gilling Dod
Warrington Site
2026-27
A - Develop Urgent Care Village to RIBA 7
B - Relocate Clinical services to vacated OPD or new Build
Warrington UTC Village
Key:
- Demolish / Sell
- Completed
- Relocate
- Develop
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

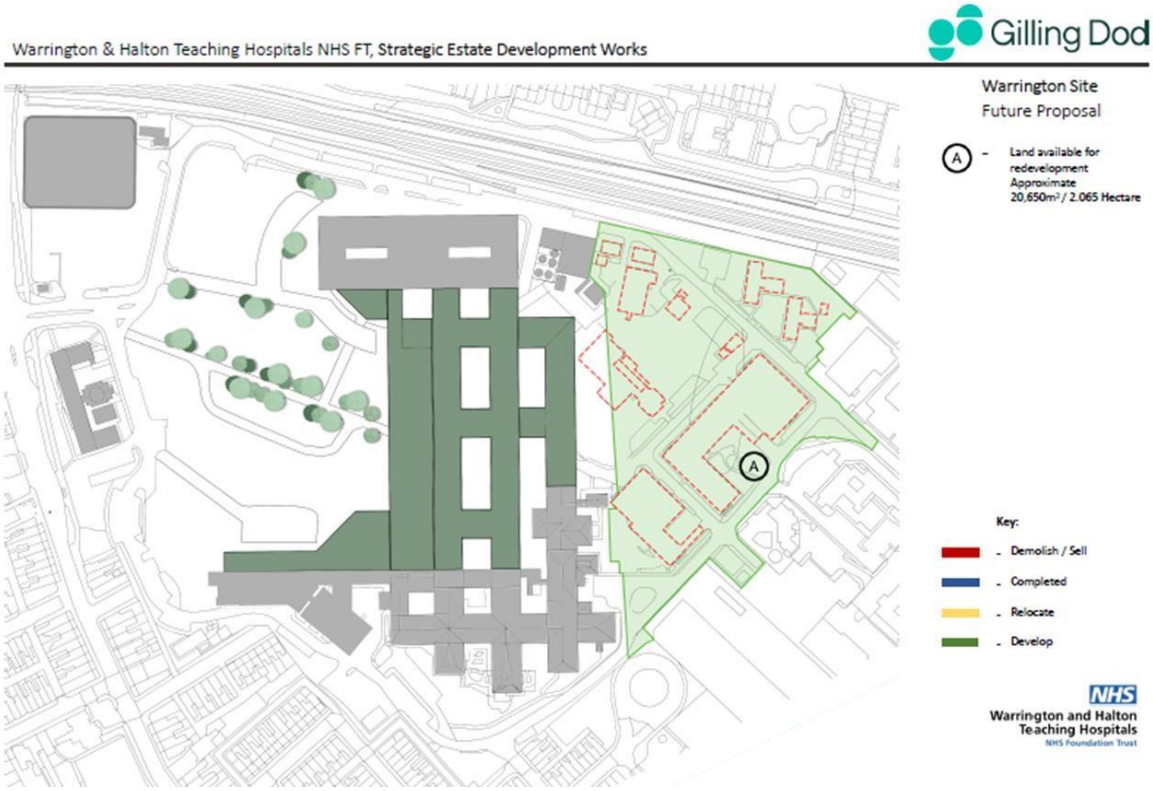
2027-2028


Warrington & Halton Teaching Hospitals NHS FT, Strategic Estate Development Works
Gilling Dod
Warrington Site
2027-28
A - Demolish Kendrick Wing
B - Develop plans for replacement Appleton Wing ward block to RIBA 2
Key:
- Demolish / Sell
- Completed
- Relocate
- Develop
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

2028-2029


Warrington & Halton Teaching Hospitals NHS FT, Strategic Estate Development Works
Gilling Dod
Warrington Site
2028-29
A - Develop Ward block to RIBA 4
B - Develop MSCP to RIBA 4
Key:
- Demolish / Sell
- Completed
- Relocate
- Develop
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Proposed 2029-2034



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Please contact the Communications Team on 01925 662710

Polish: Niniejsza publikacja jest dostępna w alternatywnych językach lub formatach na życzenie

Punjabi: ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਬੇਨਤੀ 'ਤੇ ਵਿਕਲਪਕ ਭਾਸ਼ਾਵਾਂ ਜਾਂ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ

Urdu: یہاشاعتدرخواست پر متبادل زبانوں یا وضعوں میں دستیاب ہے

Bengali: এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে উপলব্ধ

Gujurati: આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા ફોર્મેટમાં ઉપલબ્ધ છે

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Working Together | Excellence | Inclusive | Kind | Embracing Change

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/043**			
SUBJECT:	**Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence**			
DATE OF MEETING:	5th June 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):*	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.			

PURPOSE: *(please select as appropriate)*	Approval ✓	To note	Decision
RECOMMENDATION:	The Board is asked to note compliance with NHS Conditions G6 and CoS7 and approve the self-certification.		
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		

Worksheet "G6 & CoS7" Financial Year to which self-certification relates: 2023/24

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust recorded an adjusted deficit of £27.5m which is £11.8m away from the £15.7m deficit plan (revised to £21.2m excluding industrial action). This adjusted deficit is the value which NHSE monitors the Trust against and was not achieved.
The annual capital programme was £28.7m and the actual spend for the year was £29.1m (excluding IFRS16), delivering an overspend of £0.4m.
The cash balance at the end of the year was £17.6m which includes £7.4m cash support. The cash balance will be utilised to manage the position in April and pay circa £11m capital creditors.
There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on a regular basis.
Capital has been monitored through the year via the Capital Planning Group and Finance and Sustainability Committee, with a particular focus on schemes over £0.5m.
Over the past 12 months the Trust has continued to have regular meetings with the ICS where the financial position, forecast and capital have been discussed, reviewed and challenged.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		Signature	
Name	Steve McGuirk	Name	Simon Constable
Capacity	Chair	Capacity	Chief Executive
Date		Date	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/06/044**			
SUBJECT:	Updates to the WHH Constitution			
DATE OF MEETING:	5 June 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 Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* Following approval by the council of Governors at its meeting 16 May 2024, the paper sets out the recommendation to make the following three key changes to the WHH constitution (as detailed within the paper)			

	1. ANNEX 1 – The Public Constituency – minimum number of members required. Code of Governance updates 2. Non-NHS income 3. Significant transactions		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	The Trust Board is asked to approve the amendments to the Constitution as outlined in the paper to support: • The Public Constituency – minimum number of members required, 50 per constituency. • Code of Governance updates, in regard to: o Non-NHS income o Significant transactions		
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors	
	Agenda Ref.	**COG/24/05/08**	
	Date of meeting	16.05.2024	
	Summary of Outcome	Recommended for approval by Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Updates to the WHH Constitution	AGENDA REF:	BM/24/06/044

1. Background/Context

In regard to amendments to the Trust's Constitution, the current WHH Constitution states:

The Trust's Constitution states:

45. Amendment of the constitution
45.1. The Trust may make amendments to its constitution if:
45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and
45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

This paper provides details of the recommendations being made to amend the Trusts Constitution; the three changes are:

1. ANNEX 1 – The Public Constituency – minimum number of members required.

Code of Governance updates

2. Non-NHS income
3. Significant transactions

2. Updates to the WHH Constitution

Following a Governor Working Group that took place on 15th April 2024, the recommended changes to the constitution are proposed and include some minor formatting amendments and the following three notable amendments:

1. Minimum Public Membership numbers

The minimum number of members required for each public constituency this has been benchmarked against other comparable FTs in the Cheshire and Merseyside ICS.

The proposal is:

ANNEX 1 – THE PUBLIC CONSTITUENCY

(Paragraphs 6.1 and 6.3)

The Public Constituency consists of the three areas specified in the table below:

Area	Constituency	
1	Warrington North	50
2	Warrington South	50
3	Halton	50
4	Rest of England	50
	Total	**200**

The minimum number of members required for each area of the Public Constituency is 50.

Code of Governance Updates

2. Non-NHS Income

On reviewing our compliance with the latest Code of Governance, the Trust is required to update section 40.7 of the Constitution (page 27) which currently states:

> *40.7 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England it may implement the proposal only if more than half of the members of the council of governors of the Trust voting approve its implementation.*

The updated requirement in the Code of Governance is as follows: More than half the Governors who vote to approve any proposal to increase the proportion of the Trust's income earned from non-NHS work by 5% a year or more.

For example, Governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the Trust's total income.

The proposed updated wording is as follows:

> 40.7 Where the Trust proposes to increase the proportion of its income earned from non-NHS work by 5% a year or more, it may implement the proposal only if more than half of the Governors vote to approve.

3. Significant Transactions

In addition, the updated Code of Governance provides a revision in relation to Governors taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions. This is also reflected in the recent Addendum to your statutory duties – reference guide for NHS foundation trust governors.

The **Code of Governance** states: A Council may disagree with the merits of a particular decision of the Board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the Council of Governors would need to provide evidence that due diligence was not undertaken.

On reviewing our compliance with the latest Code of Governance, the Trust is required to update section 42.2 of the Constitution, which currently states:

> *44.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust approve entering into the transaction.*

The proposed revision to the constitution (pages 29) is as follows:

> 44.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust approve entering into the transaction. A Council may disagree with the merits of a particular decision of the Board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the Council of Governors would need to provide evidence that due diligence was not undertaken.

3. Recommendations

As recommended by the Council of Governors following the meeting 16 May 2025, The Trust Board is asked to ratify the amendments to the Constitution as outlined in the paper:

- The Public Constituency – minimum number of members required, 50 per constituency.
- Code of Governance updates, in regard to:
  - Non-NHS income
  - Significant transactions

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION (v4.32)

Commencement Date: 529 June March 20243

Version Control Schedule

Version	Date	Section	Page	Amendment
2	21.3.13			Amendments arising from Health and Social Care Act that came into force on 1 April 2013. Constitution was approved by both the Board and Council to come into force on 1 April 2013 to coincide with requirements of the Health and Social Care Act 2012.
3.0	25/09/2014			Amendment to clarify requirement that the Non-Executive Chair need not be a member of a Public constituency and therefore can be appointed outside of the public constituent areas.
3.1	28.1.16	28.5	17	Clause amended to remove the disqualification criterion for a person becoming or continuing as a director on account of being a director of another NHS FT or NHS Body. (Any such appointment would remain subject to consideration by the relevant nomination committee and for NED appointments, the CoG in addition). Approved by the Board 27.1.16 and the Council on 28.1.16.
3.1	28.1.16	4.14	94	Insertion of a new clause 4.14a. The effect of the insertion to clarify that directors may join meetings of the Board by electronic means. Approved by the Board 27.1.16 and the Council on 28.1.16.
3.2	20.10.16	Annex 1	26	Public Constituency no. 16 renamed as 'Rest of England and Wales' excluding the areas listed in 1-15 (defined as having an England or Wales postcode) approved 20.10.17 by Council
3.3	19.1.17	Annex 9	106	Creation of new Lead Governor Role approved by Council 19 Jan 2017
3.4	20.7.17	4	6	Changes to Register of Members approved 20.7.17 by Council
	20.7.17		0	Change to front cover to incorporate branding
	20.7.17	34	20	Change to Registers to reflect the non-publication of members' details on register – in accordance with new General Data Protection Legislation effective May 2018 approved by Council on 20.7.17
3.5	28.03.2018	Annex 1	29	Merge Area 15 with the 'Rest of England and Wales' and correspondingly increase the number of Governors affiliated with the 'Rest of England and Wales' from one to two Governors. Approved by the Council 15.02.2018 and by the Board 28.03.2018
3.5	28.03.2018	Annex 3	33	Change to the existing public partners. Approved by the Council 15.02.2018 and by the Board 28.03.2018
3.5	28.03.2018	Annex 3	34	Amendment to the table to the table of Elected Governors to reflect merger of area 15 with Rest of England Approved by the Council 15.02.2018 and by the Board 28.03.2018
3.6	27.03.2019	12.1-12.6	14	Amendment to Council of Governors Tenure

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3.6	27.03.2019	25,5	17 + 18	Amendment to Non-Executive Directors Tenure
3.6	27.03.2019	Annex 5	63	Amendment to Annex 5, Section 12 – Eligibility to be a Governor
3.6	27.03.2019	Annex 5	64	Amendment to Termination of Office and removal of Governors
3.6	27.03.2019			Replacement of pronouns replacing s/he or his/her with they or their
3.7	30.05.2019	Annex 7	98	Amendment to Board of Directors Standing Orders (section 6.1) Appointment of Committees
3.8	14.11.2019		2	Interpretations and definitions- amendment to name
3.8	14.11.2019	Section 2		Name – amendment to name
3.8	14.11.2019	Section 4		Membership – amendment to name
3.8	14.11.2019	Part 7		Elections – amendment to name
3.8	14.11.2019	Annex 5B		Governors – amendment to name
3.8	14.11.2019	Cover		Amendment to name, replacement of brand
3.9	25.11.2020	25.5		Amendment to Non-Executive Directors Tenure
3.10	27.01.2021	21.6	17	Board of Directors – composition
3.10	27.01.2021	Annex 5B	72	ANNEX 5B – Governors' Code of Conduct
3.11	31.03.2021	Annex 1	30	ANNEX 1 Public Constituency
3.11	31.03.2021	Annex 3	33	Composition of the Council of Governors
3.12	29.09.2021	Annex 8	110	Amendment to the description of Lead Governor Role & addition to the role of Deputy Lead Governor.
4.0	24.11.2021	Section 14, Annex 5, Annex 5B	16, 63, 64, 67, 75	Amendments to the description of Governor responsibilities
4.1	18.11.2022	25.5	19	Amendment to Non-Executive Directors Tenure excluding Chair from 9-year limit
4.1	18.11.2022	25.6 (New)	19	Additional of section 25.6 allowing Chair to serve for a maximum 12 years in exceptional circumstances
4.2	16.02.2023	Annex 1 & Annex 3	31, 35	Amendments to names of public constituencies and number of positions to be elected
4.2	16.02.2023	Annex 5	64 - 68	Eligibility to be a Governor - addition of sections 12, 13 & 19 Termination of office and removal of Governors – removal section 8d, addition of 8d(new), e and 9.
4.3	16.05.24	40.7	27	Updated in line with Code of Governance for NHS provider Trusts around non-NHS income
4.3	16.05.24	44.2	28-29	Updated in line with Code of Governance for NHS provider Trusts around Significant transactions
4.3	05.2024	Annex 1	31	The Public Constituency – minimum members changed to 50 from each public constituency

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Document owner

~~Company~~ Trust Secretary
Warrington & Halton Teaching Hospitals NHS FT
Warrington Teaching Hospital
Lovely Lane, Warrington, WA5 1QG

WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CONSTITUTION

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WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the National Health Service Act 2006 As amended by the Health and Social Care Act 2012.

References in this Constitution to legislation include all amendments, replacements, or re-enactments made.

References to legislation include all regulations, statutory guidance or directions.

Headings are for ease of reference only and are not to affect interpretation.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1. **Interpretation and Definitions**

1.1 In this Constitution:

"the 2006 Act"	Means the National Health Service Act 2006.
~~"the 1977 Act"~~	~~Means the National Health Service Act 1977.~~
"the 2012 Act"	Means the Health and Social Care Act 2012.
"applicant NHS Trust"	Means the North Cheshire Hospitals NHS Trust which made the application to become an NHS Foundation Trust.
"area of the Trust"	Means the totality of all the areas specified in Annex 1 as areas for a public constituency.
"Board of Directors"	Means the Board of Directors as constituted in accordance with this Constitution.
"The Council of Governors"	Means the Council of Governors as constituted in accordance with this Constitution.
"Accounting Officer"	Is the person who from time to time discharges the functions specified in

	paragraph 25(5) of Schedule 7 to the 2006 Act.	
"financial year"	a)	the period beginning with the date on which the Trust was authorised under the 2006 Act and ending with the next 31st March; and
	b)	each successive period of twelve months beginning with 1st April.
"Governors Code of Conduct"	Means the members of the Governors' Council code of conduct set out in Annex 5B.	
"Monitor"	Means the body corporate known as Monitor as provided by Section 61of the 2012 Act.	
"Local Authority Governor"	Means a member of the Council of Governors appointed by one or more of the local authorities specified in Annex 3.	
"Member"	Means a member of the Trust.	
"NHS Body"	means an NHS body as defined by Section 275 of the 2006 Act.	
"Partnership Governor"	Means a member of the Council of Governors appointed by a partnership organisation specified in Annex 3.	
"Public Governor"	Means a member of the Council of Governors elected by the members of the Public Constituency.	
"Trust Secretary"	Means the secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary.	
"Secretary of State"	Means the Secretary of State for Health	
"Staff Governor"	Means a member of the Council of Governors elected by the members of the staff constituency.	
"the Trust"	Means the Warrington and Halton Teaching Hospitals	

or "the Foundation Trust"	NHS Foundation Trust.
"voluntary organisation"	Means a body, other than a public or local authority, the activities of which are not carried out for profit.

1. **Name**

1.1 The name of the Foundation Trust is **Warrington and Halton Teaching Hospitals NHS Foundation Trust.**

2. **Principal purpose**

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.3 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to: -

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

2.3.2 the promotion and protection of public health.

2.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3. **Powers**

3.1 The powers of the t~~T~~rust are set out in the 2006 Act.

3.2 All the powers of the t~~T~~rust shall be exercised by the Board of Directors on behalf of the t~~T~~rust.

3.3 Any of these powers may be delegated to a committee of d~~D~~irectors or to an e~~E~~xecutive d~~D~~irector.

4. **Membership and constituencies**

4.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1.1 A Public Constituency.

4.1.2 A Staff Constituency.

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4.2 Members' Data and Rights

4.2.24.2.2.1 The names of members shall be entered in the register of members and the member shall be asked to give their consent at time of registration for their personal data to be entered onto this register.

4.2.34.2.2.2 The Trust is a Foundation Trust, the Constitution of which specifies that the Trust must have a membership. Warrington and Halton Teaching Hospitals NHS Foundation Trust has a membership that comprises two constituencies: The Public constituency and the Staff constituency. The Trust will enter your information into a secure database and will only use your data for the following purposes:

- 4.2.2.2..1 To conduct elections to our Council of Governors, which are elected by either public or staff members
- 4.2.2.2..2 To produce and annual membership report as prescribed by Monitor, our Regulator, under the Annual Reporting Manual. This report describes the membership database in its entirety and does not identify individuals.

4.2.44.2.3 We will not share your data with any person or organisation beyond secure transfer to our independent database provider which will, in turn, not share any data without specific authority from the Foundation Trust.

4.3 **Members Individual Rights**

The Foundation Trust commits that members:

- Have the right to be informed
- Have the right of access to their information
- Have the right to rectify any personal data held in the membership database
- Have the right to request that their record is deleted from the membership database
- Have the right to request exclusion from processing, such as for the election of governors, the receipt of correspondence or the production of the annual membership report
- Have the right to object to any element of how we hold and process individual data
- Have the right not to be subject to automated decision-making including profiling.

4.3.1 Lawful basis for processing personal data

The Foundation Trust is required, under its Constitution, to have a membership. Members will be recruited through multiple means and will be advised during recruitment about the processing of their data. Members' data will be processed securely and only for the purposes described above.

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4.3.2 Consent

Upon membership application members will be asked to give their consent to have their data processed as described. If members do not give their consent then their application will be processed for subscription as requested but their data will not be further accessed for elections, correspondence or for membership reports.

4.3.3 Children

To become a Foundation Trust member the minimum age is 12. Young people aged between 12 and 16 applying for membership will be required to indicate that they have the consent of their parent or guardian to join the membership and provide the parent/guardian contact details. The young person's membership will not be processed until written consent has been received by the parent/guardian giving consent.

4.4 Members may attend and participate in members meetings, vote in elections to, and stand for election to, the Council of Governors (members aged 16 and above only), and take such other part in the affairs of the Trust as is provided for in this Constitution.

4.5 Eligibility for membership

Members shall:

4.5.1 Be 12 years of age or over; and

4.5.2 Meet the criteria for membership of the Public Constituency or the Staff Constituency.

~~4.5.2~~4.5.3

4.6 **Representative membership**

4.6.1 The Trust shall at all times take steps to ensure that its membership is representative of those eligible for membership. To this end, the Trust shall comply with its Membership Strategy.

4.6.2 The Membership Strategy shall be reviewed from time to time by the Council of Governors, and at least every three years.

4.7 The Council of Governors shall present to each Annual Members Meeting:

4.7.1 a report on steps taken to ensure that the Trust's membership is representative of those eligible for membership;

4.7.2 any changes to the Membership Strategy.

4.8 The Board of Directors will prepare and approve the first membership strategy.

Conditions of membership

4.9 Members:

4.9.1 Will not receive payment, or any fees associated with becoming or remaining a member of the Trust;

4.9.2 Will not receive any preferential care or treatment as a consequence of being a member;

4.9.3 Can resign their membership at any time;

4.9.4 Can be members of more than one Trust.

5. **Application for membership**

An individual who is eligible to become a member of the Trust may do so on application to the Trust, subject to the provisions of paragraph 7.5 below.

6. **Public Constituency**

6.1 An individual aged 12 years or above who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust, unless otherwise disqualified in accordance with this Constitution.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

7. **Staff Constituency**

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

7.1.1 They are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 They have been continuously employed by the Trust under a contract of employment for at least 12 months.

7.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.3 The Staff Constituency shall be divided into five descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.5 An individual who is:

7.5.1 Eligible to become a member of the Staff Constituency, and

7.5.2 Invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so in writing.

8. **Restriction on membership**

8.1 An individual who is a member of a Constituency, or of a class within a Constituency, may not, while membership of that Constituency or class continues, be a member of any other Constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any Constituency other than the Staff Constituency.

8.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8.

9. Annual **Members' Meeting~~s~~**

9.1 The Trust is to hold a members meeting (the "Annual Members Meeting") within nine months of the end of each financial year. Members meetings may also be convened at other times in accordance with paragraph 9.3 below.

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9.2 Members meetings are open to all members of the Trust, Governors, Directors, representatives of the Trust's financial auditor and members of the public.

9.3 All members meetings, including the Annual Members Meeting shall be convened by the Trust Secretary by order of the Council of Governors.

9.4 The Council of Governors shall decide where members meetings are to be held and may also for the benefit of members arrange for the Annual Members Meeting to be held in different venues each year.

9.5 At the Annual Members Meeting:

a) The Board of Directors shall present to members:

i) The annual accounts.

ii) Any report of the financial auditor.

iii) Any report of any other external auditor of the Trust's affairs.

iv) Forward planning information for the next financial year.

b) The Council of Governors shall present to the members:

i) a report on steps taken to secure that (taken as a whole) the actual membership of its Public Constituency and of the classes of the Staff Constituency are representative of those eligible for such membership.

ii) The progress of the Membership Strategy.

iii) Any proposed changes to the policy for the composition of the Council of Governors and of the Non-Executive Directors.

c) The results of the election and appointment of Governors and the appointment of Non-Executive Directors will be announced.

9.6 Notice of members meetings is to be given:

a) By notice to all members.

b) By notice prominently displayed at the head office and at all of the Trust's places of business; and

c) By notice on the Trust's website,

at least 14 clear days before the date of the meeting. The notice must:

d) Be given to the Council of Governors and the Board of Directors and to the financial auditor.

e) Give the time, date and place of the meeting; and

f) Indicate the business to be dealt with at the meeting.

9.7 Before a members meeting can do business there must be a quorum present. Except where this Constitution says otherwise a quorum is one member present from each of the Trust's Constituencies.

9.8 The Trust may make arrangements for members to vote by post, or by using electronic communications.

9.9 It is the responsibility of the Council of Governors, the Chair of the meeting and the Trust Secretary to ensure that at members meetings:

a) The issues to be decided are clearly explained.

b) Sufficient information is provided to members to enable rational discussion to take place.

9.10 The Chair of the Trust, or in his absence the Deputy Chair of the Trust, or in his absence one of the other Non-Executive Directors shall preside at all members' meetings of the Trust. If neither the Chair nor the Deputy Chair, nor any other Non-Executive Directors are present, the meeting shall stand adjourned.

9.11 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determines. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

9.12 A resolution put to the vote at a members' meeting shall be decided upon by a poll.

9.13 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting shall have a second or casting vote.

9.14 The result of any vote will be declared by the Chair and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

10. **Council of Governors - composition**

10.1 The Trust shall have a Council of Governors, which shall comprise both elected and appointed Governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their Constituency or, where there are classes within a Constituency, by their class within that Constituency. The number of Governors to be elected by each Constituency, or, where appropriate, by each class of each Constituency, is specified in Annex 3.

11. **Council of Governors – election of Governors**

11.1 Elections for elected members of the Council of Governors shall be conducted on a first past the post basis in accordance with the Model Rules for Elections, as may be varied from time to time.

11.2 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

11.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 45 of the Constitution (amendment of the constitution).

11.4 An election, if contested, shall be by secret ballot.

11.5 The Board of Directors shall approve a process for agreeing the appointment of Local Authority Governors and Partnership Governors. The approved process shall be adopted by the Trust Secretary so as to confirm the appointments.

12. **Council of Governors - tenure**

12.1 An elected ~~G~~governor~~s~~ may hold office for a period of up to three years. A Governor shall be eligible for re-election or re-appointment at the end of their initial term, for two further terms.

12.2 An e~~E~~lected g~~G~~overnor shall cease to hold office if he or she ceases to be a member of the constituency or class by which he or she was elected.

12.3 Subject to paragraph 12.5 below, an e~~E~~lected g~~G~~overnor shall be eligible for re-election at the end of their term.~~.~~

12.4 Subject to paragraph 12.5 below, an a~~A~~ppointed g~~G~~overnor shall be eligible for reappointment at the end of his or her term.

12.5 Elected g~~G~~overnors and a~~A~~ppointed g~~G~~overnors may hold office for a maximum of 9 consecutive years.

12.6 Subject to any provision in this Constitution in respect of eligibility or disqualification of g~~G~~overnors, once an elected g~~G~~overnor has reached their maximum term or has been removed under paragraph 13, they shall only be eligible for appointment again after a period of three (3) years.

13. **Council of Governors – disqualification and removal**

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 A person who has been adjudged bankrupt or whose estate has been sequestered and (in either case) has not been discharged.

13.1.2 A person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

13.1.3 A person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment

(whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3 Further provisions as to the circumstances in which an individual may not become, or continue as, a member of the Council of Governors are set out in Annex 5.

13.4 Provision for the removal of Governors is set out in Annex 5.

14. Council of Governors – duties of governors

14.1 The general duties of the Council of Governors are:

14.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

14.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

14.1.3 To undertake the Roles and Responsibilities required of Governors as set out in Annex 5.

14.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

15. **Council of Governors – Meeting of Governors**

15.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 24 or paragraph 25 below) or in his absence the Deputy Chair (appointed in accordance with the provisions of paragraph 24 or 25 below), shall preside at meetings of the Council of Governors.

15.2 Meetings of the Council of Governors shall be open to members of the public, subject to paragraph 15.3 and 15.4 below;

15.3 The Council of Governors may resolve to exclude members of the public from any meeting or part of a meeting for special reasons.

15.4 The special reasons referred to in paragraph 15.3 include, but are not limited to, where the Council of Governors considers that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

15.5 The Chair may exclude any member of the public from the meeting of the Council if they consider that they are interfering with or preventing any conduct of the meeting.

15.6 For the purposes of obtaining information about the Trust's performance of

its functions or the dDirectors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

16. **Council of Governors – Standing Orders**

The Standing Orders for the practice and procedure of the Council of Governors are attached at Annex 6.

17. Council of Governors – referral to the Panel

17.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of the Trust may refer a question as to whether the Trust has failed or is failing:

17.1.1 to act in accordance with its constitution; or

17.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

17.2 A gGovernor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve such referral.

18. **Council of Governors – conflicts of interest of Governors**

18.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration, or is to be considered, by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

19. **Council of Governors – travel expenses**

19.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

20. **Council of Governors – further provisions**

20.1 Further provisions with respect to the Council of Governors are set out in Annex 5.

21. **Board of Directors – composition**

21.1 The Trust is to have a Board of Directors, which shall comprise of both Executive and Non-Executive Directors.

21.2 The Board of Directors shall comprise as a minimum of:

21.2.1 a Non-Executive Chair.

21.2.2 five other Non-Executive Directors; and

21.2.3 five Executive Directors.

21.3 The number of members of the Board of Directors may be increased, provided always that at least half the Board, excluding the Chair, comprises Non-Executive Directors.

21.4 One of the Executive Directors shall be the Chief Executive.

21.5 The Chief Executive shall be the Accounting Officer.

21.6 One Non-Executive Director will be appointed from the Senior Management Team of the University of Chester in line with the Trust's strategy. The appointment would form part of a Memorandum of Understanding (MOU) with the University of Chester. In the event the MOU is disestablished, the role of the Non-Executive Director would also be disestablished.

21.7 One of the Executive Directors shall be the Finance Director.

21.8 One of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

21.9 One of the Executive Directors is to be a registered Nurse or a registered Midwife.

22. Board of Directors – general duty

22.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

23. Board of Directors – qualification for appointment as a Non-Executive Director

23.1 A person may be appointed as a Non-Executive Director only if:

23.1.1 With the exception of the Non-Executive Chair[1], they are a member of the Public Constituency and

[1] Approved by the Board of Directors on 4 September 2014 and by the Council of Governors on 25th September 2014.

23.1.2 They are not disqualified by virtue of paragraph 28 below.

24. **Board of Directors – appointment and removal of Chair, Deputy Chair and other Non-Executive Directors**

24.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors and shall appoint one of the Non-Executive Directors as the Deputy Chair of the Trust.

24.2 Removal of the Chair, Deputy Chair or another Non-Executive Director shall require the approval of three quarters of the members of the Council of Governors.

24.3 The initial Chair, Deputy Chair and the initial Non-Executive Directors are to be appointed in accordance with paragraph 25 below.

25. **Board of Directors – appointment of initial Chair, Deputy Chair and initial other Non-Executive Directors**

25.1 The Chair of the applicant NHS Trust shall be appointed as the initial Chair of the Trust if he wishes to be appointed.

25.2 The power of the Council of Governors to appoint the other Non-Executive Directors of the Trust is to be exercised, so far as possible, by appointing as the initial Non-Executive Directors of the Trust any of the Non-Executive Directors including the Deputy Chair of the applicant NHS Trust (other than the Chair) who wish to be appointed.

25.3 The criteria for qualification for appointment as a Non-Executive Director set out in paragraph 23 above (other than disqualification by virtue of paragraph 28 below) do not apply to the appointment of the initial Chair and the initial other Non-Executive Directors in accordance with the procedures set out in this paragraph.

25.4 An individual appointed as the initial Chair or as an initial Non-Executive Director including Deputy Chair in accordance with the provisions of this paragraph shall be appointed for the unexpired period of his term of office as Chair or (as the case may be) Non-Executive Director of the applicant NHS Trust; but if, on appointment, that period is less than twelve months, they shall be appointed for twelve months.

25.5 Non-Executives are appointed for an initial period of up to three years. Appointments may be renewed at the end of the period of office, subject to the recommendations of the Council of Governors Nomination and Remuneration Committee and approval of the Council of Governors, for a further period up to three years. Non-Executives (excluding the Chair) may serve up to a maximum of 9 years

25.6 The Chair shall be eligible for appointment for three three-year terms of office, and in exceptional circumstances a further term of three years.

The Chair shall not be appointed to that office for a total period which exceeds twelve years in aggregate.

26. **Board of Directors – appointment and removal of the Chief Executive and other Executive Directors**

26.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

26.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

26.3 The initial Chief Executive is to be appointed in accordance with paragraph 27 below.

26.4 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

27 **Board of Directors – appointment of initial Chief Executive**

27.1 The Chief Executive of the applicant NHS Trust shall be appointed as the initial Chief Executive of the Trust if s/he wishes to be appointed.

27.2 The appointment of the Chief Executive of the applicant NHS Trust as the initial Chief Executive of the Trust shall not require the approval of the Council of Governors.

28. **Board of Directors - disqualification**

28.1 A person may not become or continue as a member of the Board of Directors if:

28.1 They have been adjudged bankrupt or their estate has been sequestrated and (in either case) has not been discharged;

28.2 They are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

28.3 They have made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

28.4 They have within the preceding five years been convicted in the British Isles of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;

28.5 They are a member of the Council of Governors, or a Governor of another NHS Foundation Trust or any other NHS Body;

28.6 They have been removed from office as a Governor of the Trust in accordance with the procedure for removal set out in Annex 5;

28.7 They are a spouse, partner, parent or child of a member of the Council of Governors or Board of Directors;

28.8 They are a member of a local authority's scrutiny committee covering health matters;

28.9 On the basis of disclosures obtained through an application to the Criminal Records Bureau, they are not considered suitable by the Trust's Executive Director responsible for Human Resources;

28.10 They have or have been the subject of a Sexual Offences Prevention Order, a Foreign Travel Order or a Risk of Sexual Harm Order made under the provisions of the Sexual Offences Act 2003;

28.11 They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

28.12 They are incapable by reason of mental disorder, illness or injury of managing or administering their property and affairs;

28.13 They have had their name removed from any list maintained pursuant to Parts 4, 5, 6 or 7 of the NHS Act 2006 and/or Regulations made under those Parts, and has not subsequently had their name included on such a list, and due to the reason(s) for such removal, they are not considered suitable by the Trust's Executive Director responsible for Human Resources;

28.13 In the case of a Non-Executive Director, they have refused without reasonable cause to fulfil any training requirements established by the Board of Directors;

28.14 They have refused to sign and deliver to the ~~Trust~~ Secretary a statement in the form specified by the Board of Directors confirming acceptance of the Trusts' Code of Conduct for Directors.

28.15 In the case of a Non-Executive Director (excluding the Non-Executive Chair)[2], they are no longer a member of the Public Constituency;

28.16 They have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

[2] Approved by the Board of Directors on 4 September 2014 and by the Council of Governors on 25th September 2014.

28.17 They are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

29. Board of Directors – meetings

29.1 Meetings of the Board of Directors shall be held in public. Members of the public may be excluded from a meeting for special reasons in accordance with Annex 7.

30. Board of Directors – Standing Orders

30.1 The Standing Orders for the practice and procedure of the Board of Directors are in accordance with Annex 7.

31. Board of Directors – conflicts of interest of Directors

31.1 The duties that a director of the Trust has by virtue of being a director include:

31.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

31.1.2 a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

31.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if –

31.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

31.2.2 The matter has been authorised in accordance with the constitution.

31.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4 In sub-paragraph 31.1.2, “third party” means a person other than:

31.4.1 the Trust; or

31.4.2 a person acting on its behalf.

31.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director shall declare the nature and extent of that interest to the other directors.

31.6 If a declaration under this paragraph proves to be, or becomes,

inaccurate or incomplete, a further declaration must be made.

31.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

31.8 A director is not required to declare an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

31.9 A director need not declare an interest –

31.8.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

31.8.2 If, or to the extent that, the directors are already aware of it; or

31.8.3 It concerns terms of the director's appointment that have been or are to be considered:

31.8.3.1 by a meeting of the Board of Directors; or

31.8.3.2 by a committee of the directors appointed for the purpose under the Constitution.

32. Board of Directors – remuneration and terms of office

32.1 The Council of Governors at a meeting of the Council of Governors shall decide the remuneration and allowances and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

32.2 The Board of Directors shall establish a committee of Non-Executive Directors to decide the remuneration and allowances and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

33. Voting

33.1 All decisions of Governors; Directors and Committees shall be by a simple majority of those present at a quorate meeting unless stated otherwise in this Constitution.

34. Registers

34.1 The Trust shall have:

34.1.1 Where the member gives consent, upon registration, a register of members showing, in respect of each member, the Constituency to which he belongs and where there are Classes within it, the Class to which they ~~he~~ belongs;

34.1.2 a register of members of the Council of Governors;

34.1.3 a register of interests of Governors;

34.1.4 a register of Directors; and

34.1.5 a register of interests of the Directors.

35. **Registers – inspection and copies**

35.1 The Trust shall ~~*NOT*~~ make the registers specified in paragraph 34 above, available for inspection by members of the public except in the circumstances set out below or as otherwise prescribed by regulations:

The production of the annual membership report where the data to be published will be arranged by constituency population and the demographic diversity of the membership as an entirety.

36. **Documents available for public inspection**

36.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

36.1.1 a copy of the current Constitution;

36.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

36.1.3 a copy of the latest annual report.

36.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

36.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

36.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

36.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

36.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

36.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act;

36.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

36.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

36.2.8 a copy of any final report published under section 65I (administrator's final report);

36.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

36.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

36~~5~~.3 Any person who requests a copy of, or extract from, any of the above documents shall be provided with a copy.

36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. **Auditor**

37.1 The Trust shall have an auditor.

37.2 The Council of Governors shall appoint or remove the auditor at a meeting of the Council of Governors.

38. **Audit Committee**

38.1 The Board of Directors shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

39. **Accounts**

39.1 The Trust shall keep proper accounts and proper records in relation to the accounts.

39.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

39.2 The accounts are to be audited by the Trust's auditor.

39.3 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may, with the approval of the Secretary of State direct.

39.4 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40. Annual Report, forward plans and non-NHS work

40.1 The Trust shall prepare an Annual Report and send it to the Monitor.

40.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

40.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

40.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

40.5 Each forward plan must include information about:

40.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

40.5.2 the income it expects to receive from doing so.

40.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 40.5.1 the Council of Governors must:

40.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and

40.6.2 notify the directors of the Trust of its determination.

40.7 Where the Trust proposes to increase the proportion of its income earned from non-NHS work by 5% a year or more, it may implement the proposal only if more than half the Governors vote to approve. ~~Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England it may implement the proposal only if more than half of the members of the council of governors of the Trust voting approve its implementation.~~

41. Presentation of the annual accounts and reports to the Council of Governors and Members

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41.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors.

41.1.1 The annual accounts.

41.1.2 Any report of the auditor on them.

41.1.3 The annual report.

41.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

41.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 41.1 with the Annual Members' Meeting.

42 Trust Secretary

42.1 The Trust shall have a Trust Secretary who may be an employee. The Trust Secretary may not be a Governor, or the Chief Executive or the Finance Director.

42.2 The Trust Secretary's functions shall include:

42.2.1 Acting as Trust Secretary to the Council of Governors and the Board of Directors, and any committees;

42.2.2 Attending all members meetings, meetings of the Council of Governors and the Board of Directors and keeping the minutes at those meetings;

42.2.3 Maintaining and keeping up to date the register of members and other registers and books required by this Constitution;

42.2.4 Taking charge of the Trust's seal;

42.2.5 Publishing to members in an appropriate form relevant information about the Trust's affairs;

42.2.6 Preparing and sending to Monitor and any other statutory body all returns which are required to be made;

42.3 The Trust Secretary shall be appointed and removed by the Board of Directors in consultation with the Council of Governors.

42.4 The Board of Directors of the applicant NHS Trust shall appoint the first Trust Secretary of the Trust.

43 Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors.

44. Mergers, Acquisition, Separation, Dissolution and Significant Transactions

44.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

44.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust approve entering into the transaction. A Council may disagree with the merits of a particular decision of the Board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the Council of Governors would need to provide evidence that due diligence was not undertaken.

44.3 For the purposes of this paragraph:

44.3.1 "Transaction" may be either an investment or a divestment.

44.3.2 A transaction is "significant" if its value equates to 25% of either the Foundation Trust's Gross Assets, Income or Gross Capital (inclusive of the transaction), calculated with reference to the Foundation Trust's opening Balance Sheet for the Financial Year in which approval is being sought.

44.4 If more than half of the members of the Council of Governors voting at a meeting of the Council decline to approve a significant transaction or any part of it, the meeting must provide an agreed written Statement of Reasons for its rejection to the Board of Directors

45. Amendment of the constitution

45.1 The Trust may make amendments to its constitution if:

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

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

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45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 If an amendment is made to the Constitution in relation the powers or duties of the Council of Governors;

45.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

45.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

45.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

45.5 Amendments made to the Constitution shall be notified to Monitor in accordance with the 2012 Act.

46. Dispute resolution procedures

46.1 Every unresolved dispute which arises out of this Constitution between the Trust and:

46.1.1 a member;

46.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

46.1.3 any person bringing a claim under this Constitution

except where otherwise specified in this constitution or the standing orders the unresolved dispute shall be determined by the Trust Secretary. There will be a right of appeal to the Chair, and if the dispute remains unresolved there will be a right of appeal to the Senior Independent Director whose decision shall be final and binding.

46.2 In the event that a dispute is referred to the Chair under paragraph46.1 and the Chair considers that he has a perceived or real interest in the outcome of that dispute and that the dispute would be better resolved externally, then the Chair may refer the dispute for resolution by arbitration under the Arbitration Act 1996 (as amended or re-issued from time to time). The arbitrator's decision will be binding and conclusive on all parties.

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47. Indemnity

47.1 The Trust Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their duties for the Trust, save where they have acted recklessly, and the Trust shall take out and maintain appropriate insurance against such risks.

48 Dissolution of the Trust

The Trust may not be dissolved except by order of the Secretary of State, in accordance with the 2006 Act as amended by the 2012 Act.

ANNEX 1 – THE PUBLIC CONSTITUENCY
(Paragraphs 6.1 and 6.3)

The Public Constituency consists of the four areas ~~Local Government electoral wards specified~~specified in the table below:~~.~~

Area	Constituency	Minimum Members
1	Warrington North	50
2	Warrington South	50
3	Halton	50
4	Rest of England	50
	Total	**200**

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The minimum number of members required for each area of the Public Constituency is ~~in the table above, which is derived from 25% of the Trust's target membership for each area in the first year of its authorisation. Although the two areas in Widnes have a higher population, due to the proportion of patients using an adjacent acute trust the minimum membership has remained at the same level as other areas~~50
~~. The Trust will continue to take all reasonable steps to secure that (taken as a whole) the actual membership of any Public Constituency will be representative of those eligible for such membership.~~

ANNEX 2 – THE STAFF CONSTITUENCY
(Paragraphs 7.3 and 7.4)

The Staff Constituency is to be divided into 5 classes as follows:

a) Medical Staff.

b) Nursing & Midwifery Staff.

c) Support Staff.

d) Clinical Scientist or Allied Health Professionals.

e) Estates, administrative and managerial staff.

a) **Medical Staff**
The members of the Medical Staff Class are individuals who are members of the Staff Constituency who are fully registered persons within the meaning of the Medicines Act 1956, who hold a licence to practice and have a post practising within the Trust.

b) **Nursing & Midwifery Staff**
The members of the Nursing and Midwifery Staff Class are members of the Staff Constituency who hold a professional registration with the Nursing and Midwifery Council and who practise as a nurse or a midwife within the Trust.

c) **Support Staff**
The members of the Support Staff Class are members of the Staff Constituency who do not fall within paragraphs a), b) or d) but provide services in direct support of registered practitioners or work within Patient Services.

d) **Clinical Scientist or Allied Health Professionals**
The members of the Clinical Scientist or Allied Health Professional Class are individuals who are members of the Staff Constituency who are registered clinical or health professionals who practise as such within the Trust, and who do not fall within paragraphs a) or b).

e) **Estates, Administrative and Managerial Staff**
The members of the Estates, Administration and Managerial Class are any members of the Staff Constituency who do not come within paragraphs a), b), c) or d).

Members of the Trust who are members of the Staff Constituency are to be individuals:

a) Who are employed under a contract of employment by the Trust which has no fixed term, or has a fixed term of at least 12 months; or

b) Have been continuously employed by the Trust under a contract of employment for at least 12 months.

Below is the minimum membership of each class of the Staff Constituency:

Class	Minimum number of members
Class a) – Medical Staff	60
Class b) – Nursing and Midwifery Staff	60
Class c) – Support Staff	60
Class d) - Clinical Scientist or Allied Health Professionals	60
Class e) - Estates, administrative and managerial staff	60
Total	**300**

ANNEX 3 – COMPOSITION OF THE COUNCIL OF GOVERNORS

(Paragraphs 10.2 and 10.3)

The Council of Governors consists of:

1. Partnership Governors appointed by:
   a) Local Authorities for an area which includes the whole or part of an area of a public constituency;
   b) Partnership organisations, including local Universities and voluntary organisations;

2. Elected Governors elected by;
   a) Members of the Public Constituency;
   b) Individuals within each class of the Staff Constituency.

More than half of the members of the Council of Governors shall be elected by those in 2a above.

Composition

Partnership Governors

Partnership Organisations	**Number to be appointed**
Local Authorities:	
Warrington Borough Council	1
Halton Borough Council	1
Warrington & Vale Royal College	1
Warrington Sikh Gurdwara	1
Educational Sector:	1
Private Sector:	1
Total Partnership Governors	**6**

Elected Governors

Constituency/class electing	Number to be elected
Staff Constituency	
Class a) – Medical Staff	1
Class b) – Nursing and Midwifery Staff	1
Class c) – Support Staff	1
Class d) – Clinical Scientist or Allied Health Professionals	1
Class e) - Estates, administrative and managerial staff	1
Total	**5**

Public Constituency	
Area 1 Warrington North	5
Area 2 Warrington South	5
Area 3 Halton	5
Area 4 Rest of England	2
Total Elected Governors	**17**
Total Membership of Council of Governors	
Partnership Governors	**6**
Staff Governors	**5**
Elected Governors	**17**
Total	**28**

ANNEX 4 – THE MODEL RULES FOR ELECTIONS
(Paragraph 11.2)

Part 1 – Interpretation

1. Interpretation

Part 2 – Timetable for election

2. Timetable
3. Computation of time

Part 3 – Returning Officer

4. Returning Officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4 – Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's consent and particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5 – Contested Elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting documents
25. Ballot paper envelope and covering envelope

The poll

26. Eligibility to vote
27. Voting by persons who require assistance
28. Spoilt ballot papers

29. Lost ballot papers
30. Issue of replacement ballot paper
31. Declaration of identity for replacement ballot papers

Procedure for receipt of envelopes

32. Receipt of voting documents
33. Validity of ballot papers
34. Declaration of identity but no ballot paper
35. Sealing of packets

Part 6 – Counting the votes

36. Interpretation of Part 6
37. Arrangements for counting votes
38. The count
39. Rejected ballot papers
40. Equality of votes

Part 7 – Final proceedings in contested and uncontested elections

41. Declaration of result for contested elections
42. Declaration of result for uncontested elections

Part 8 – Disposal of documents

43. Sealing up of documents relating to the poll
44. Delivery of documents
45. Forwarding of documents received after close of the poll
46. Retention and public inspection of documents
47. Application for inspection of certain documents relating to election

Part 9 – Death of a candidate during a contested election

48. Countermand or abandonment of poll on death certificate

Part 10 – Election expenses and publicity

Expenses

49. Expenses incurred by candidates
50. Expenses incurred by other persons
51. Personal, travelling and administrative expenses

Publicity

52. Publicity about election by the corporation
53. Information about candidates for inclusion with voting documents
54. Meaning of “for the purposes of an election”

Part 11 – Questioning elections and irregularities

55. Application to question an election

Part 12 – Miscellaneous

56. Secrecy
57. Prohibition of disclosure to vote
58. Disqualification
59. Delay in postal service through industrial action or unforeseen event

PART 1 – INTERPRETATION

1. **Interpretation**

1.1 In these rules, unless the context otherwise requires:

"corporation"	Means the public benefit corporation subject to this Constitution.
"election"	Means an election by a Constituency, or by a Class within a Constituency, to fill a vacancy among one or more posts on the Council of Governors.
"the regulator"	Means Monitor.
"the 2006 Act"	Means the National Health Service Act 2006

1.2 Other expressions used in these rules and in Schedule 1 to the Health and Social Care (Community Health and Standards) Act 2003 have the same meaning in these rules as in that Schedule.

PART 2 - TIMETABLE FOR ELECTION

2. **Timetable**

The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election.	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to Returning Officer.	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates.	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election.	Not later than the twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.

Proceeding	Time
Close of the poll.	By 5.00pm on the final day of the election.

3. **Computation of time:**

3.1 In computing any period of time for the purposes of the timetable:

a) A Saturday or Sunday.

b) Christmas Day, Good Friday, or a bank holiday, or

c) A day appointed for public thanksgiving or mourning.

shall be disregarded and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the Returning Officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 - RETURNING OFFICER

4. **Returning Officer**

4.1 Subject to rule 58, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same Retuning Officer may be appointed for all those elections.

5. **Staff**

Subject to rule 58, the Returning Officer may appoint and pay such staff, including such technical advisers, as he considers necessary for the purposes of the election.

6. **Expenditure**

The corporation is to pay the Returning Officer:

a) Any expenses incurred by that Officer in the exercise of his functions under these rules.

b) Such remuneration and other expenses as the corporation may determine.

7. **Duty of co-operation**

The corporation is to co-operate with the Returning Officer in the exercise of his functions under these rules.

PART 4 – STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. **Notice of election**

The Returning Officer is to publish a notice of the election stating:

a) The Constituency, or Class within a Constituency, for which the election is being held.

b) The number of members of the Council of Governors to be elected from that Constituency, or Class within that Constituency.

c) The details of any nomination committee that has been established by the corporation.

d) The address and times at which nomination papers may be obtained.

e) The address for return of nomination papers and the date and time by which they must be received by the Returning Officer.

f) The date and time by which any notice of withdrawal must be received by the Returning Officer.

g) The contact details of the Returning Officer; and

h) The date and time of the close of the poll in the event of a contest.

9. **Nomination of Candidates**

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The Returning Officer:

a) Is to supply any member of the corporation with a nomination paper, and

b) Is to prepare a nomination paper for signature at the request of any member of the corporation.

but it is not necessary for a nomination to be on a form supplied by the Returning Officer.

10. **Candidate's particulars**

10.1 The nomination paper must state the candidate's:

a) Full name.

b) Contact address in full, and

c) Constituency, or Class within a Constituency, of which the candidate is a member.

11. **Declaration of Interests**

The nomination paper must state:

a) Any financial interest that the candidate has in the corporation, and

b) Whether the candidate is a member of a political party, and if so, which party.

and if the candidate has no such interests, the paper must include a statement to that effect.

12. **Declaration of eligibility**

The nomination paper must include a declaration made by the candidate:

a) That he is not prevented from being a member of the Council of Governors by the 2006 Act or by any provision of the Constitution; and,

b) For a member of the Public Constituency, of the particulars of his qualification to vote as a member of that Constituency, or Class within that Constituency, for which the election is being held.

13. **Signature of candidate**

The nomination paper must be signed by the candidate, indicating that:

a) They wish to stand as a candidate.

b) Their declaration of interests as required under rule 11, is true and correct, and

c) Their declaration of eligibility, as required under rule 12, is true and correct.

14. **Decisions as to the validity of nomination**

14.1 Where a nomination paper is received by the Returning Officer in accordance with these rules, the candidate is deemed to stand for election unless and until the Returning Officer:

a) Decides that the candidate is not eligible to stand.

b) Decides that the nomination paper is invalid.

c) Receives satisfactory proof that the candidate has died, or

d) Receives a written request by the candidate of their withdrawal from candidacy.

14.2 The Returning Officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

a) That the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election.

b) That the paper does not contain the candidate's particulars, as required by rule 10.

c) That the paper does not contain a declaration of the interests of the candidate, as required by rule 11.

d) That the paper does not include a declaration of eligibility as required by rule 12, or

e) That the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The Returning Officer is to examine each nomination paper as soon as is practicable after he has received it and decide whether the candidate has been validly nominated.

14.4 Where the Returning Officer decides that a nomination is invalid, the Returning Officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The Returning Officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. **Publication of statement of candidates**

15.1 The Returning Officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

a) The name, contact address, and Constituency or Class within a Constituency of each candidate standing, and

b) The declared interests of each candidate standing as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The Returning Officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. **Inspection of statement of nominated candidates and nomination papers**

16.1 The corporation is to make the statements of the candidates and the nomination papers supplied by the Returning Officer under rule 15.4 available for inspection by members of the public free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statements of candidates or their nomination papers, the corporation is to provide that person with the copy or extract free of charge.

17. **Withdrawal of candidates**

A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the Returning Officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. **Method of Election**

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to the Council of Governors, then:

a) The candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

b) The Returning Officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5 – CONTESTED ELECTIONS

19. **Poll to be taken by ballot**

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. **The ballot paper**

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

a) The name of the corporation.

b) The Constituency, or Class within a Constituency, for which the election is being held.

c) The number of members of the Council of Governors to be elected from that Constituency, or Class within that Constituency.

d) The names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates.

e) Instructions on how to vote.

f) If the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

g) The contact details of the Returning Officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. **The declaration of identity (Public Constituency)**

21.1 In respect of an election for a Public Constituency a declaration of identity must be issued with each ballot paper.

21.2 The declaration of identity is to include a declaration:

a) That the voter is the person to whom the ballot paper was addressed.

b) That the voter has not marked or returned any other voting paper in the election, and

c) For a member of the Public Constituency, of the particulars of that member's qualification to vote as a member of the Constituency or Class within a Constituency for which the election is being held.

21.3 The declaration of identity is to include space for:

a) The name of the voter.

b) The address of the voter.

c) The voter's signature, and

d) The date that the declaration was made by the voter.

21.4 The voter must be required to return the declaration of identity together with the ballot paper.

21.5 The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

ACTION TO BE TAKEN BEFORE THE POLL

22. **List of eligible voters**

22.1 The corporation is to provide the Returning Officer with a list of the members of the Constituency or Class within a Constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member, a mailing address where his ballot paper is to be sent.

23. **Notice of poll**

The Returning Officer is to publish a notice of the poll stating:

a) The name of the corporation.

b) The Constituency, or Class within a Constituency, for which the election is being held.

c) The number of members of the Council of Governors to be elected from that Constituency, or Class with that Constituency.

d) The names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates.

e) That the ballot papers for the election are to be issued and returned, if appropriate, by post.

f) The address for return of the ballot papers, and the date and time of the close of the poll.

g) The address and final dates for applications for replacement ballot papers, and

h) The contact details of the Returning Officer.

24. **Issue of voting documents by Returning Officer**

24.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the Returning Officer is to send the following documents to each member of the corporation named in the list of eligible voters:

a) A ballot paper and ballot paper envelope.

b) A declaration of identity (if required).

c) Information about each candidate standing for election, pursuant to rule 47 of these rules, and

d) A covering envelope.

24.2 The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25. **Ballot paper envelope and covering envelope**

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

a) The address for return of the ballot paper printed on it, and

b) Pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the Returning Officer:

a) The completed declaration of identity if required, and

b) The ballot paper envelope, with the ballot paper sealed inside it.

THE POLL

26. **Eligibility to vote**

An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. **Voting by persons who require assistance**

27.1 The Returning Officer is to put in place arrangements to enable requests for assistance to vote to be made.

27.2 Where the Returning Officer receives a request from a voter who requires assistance to vote, the Returning Officer is to make such arrangements as he considers necessary to enable that voter to vote.

28. **Spoilt ballot papers**

28.1 If a voter has dealt with his ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the Returning Officer for a replacement ballot paper.

28.2 On receiving an application, the Returning Officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he can obtain it.

28.3 The Returning Officer may not issue a replacement ballot paper for a spoilt ballot paper unless he:

a) Is satisfied as to the voter's identity, and

b) Has ensured that the declaration of identity, if required, has not been returned.

28.4 After issuing a replacement ballot paper for a spoilt ballot paper, the Returning Officer shall enter in a list ("the list of spoilt ballot papers"):

a) The name of the voter, and

b) The details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

c) The details of the unique identifier of the replacement ballot paper.

29. **Lost ballot papers**

29.1 Where a voter had not received his ballot paper by the fourth day before the close of the poll, that voter may apply to the Returning Officer for a replacement ballot paper.

29.2 The Returning Officer may not issue a replacement ballot paper for a lost ballot paper unless they:

a) Is satisfied as to the voter's identity.

b) Has no reason to doubt that the voter did not receive the original ballot paper, and

c) Has ensured that the declaration of identity if required has not been returned.

29.3 After issuing a replacement ballot paper, the Returning Officer shall enter in a list ("the list of lost ballot papers"):

a) The name of the voter, and

b) The details of the unique identifier of the replacement ballot paper.

30. **Issue of a replacement ballot paper**

30.1 If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the Returning Officer in the name of that voter, the Returning Officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28.3 or 29.2, he is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the Returning Officer in the name of that voter.

30.2 After issuing a replacement ballot paper under this rule, the Returning Officer shall enter in a list ("the list of tendered ballot papers"):

a) The name of the voter, and

b) The details of the unique identifier of the replacement ballot paper issued under this rule.

31. **Declaration of identity for replacement ballot papers (Public Constituency)**

31.1 In respect of an election for a Public Constituency a declaration of identity must be issued with each replacement ballot paper.

31.2 The declaration of identity is to include a declaration:

a) That the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and

b) Of the particulars of that member's qualification to vote as a member of the Public Constituency, or Class within a Constituency, for which the election is being held.

31.3 The declaration of identity is to include space for:

a) The name of the voter.

b) The address of the voter.

c) The voter's signature, and

d) The date that the declaration was made by the voter.

31.4 The voter must be required to return the declaration of identity together with the ballot paper.

31.5 The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

PROCEDURE FOR RECEIPT OF ENVELOPES

32. **Receipt of voting documents**

32.1 Where the Returning Officer receives a:

a) covering envelope, or

b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that Officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

32.2 The Returning Officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to:

a) The candidate for whom a voter has voted, or

b) The unique identifier on a ballot paper.

32.3 The Returning Officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. **Validity of ballot paper**

33.1 A ballot paper shall not be taken to be duly returned unless the Returning Officer is satisfied that it has been received by the Returning Officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

33.2 Where the Returning Officer is satisfied that paragraph 33.1 has been fulfilled, he is to:

a) Put the declaration of identity if required in a separate packet,

and

b) Put the ballot paper aside for counting after the close of the poll.

33.3 Where the Returning Officer is not satisfied that paragraph 33.1 has been fulfilled, he is to:

a) Mark the ballot paper “disqualified”.

b) If there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it to the ballot paper.

c) Record the unique identifier on the ballot paper in a list (the “list of disqualified documents”) and

d) Place the document or documents in a separate packet.

34. **Declaration of identity but no ballot paper (Public Constituency)**

Where the Returning Officer receives a declaration of identity if required but no ballot paper, the Returning Officer is to:

a) Mark the declaration of identity “disqualified”.

b) Record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper and

c) Place the declaration of identity in a separate packet.

35. **Sealing of packets**

As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the Returning Officer is to seal the packets containing:

a) The disqualified documents, together with the list of disqualified documents inside it.

b) The declarations of identity if required.

c) The list of spoilt ballot papers.

d) The list of lost ballot papers.

e) The list of eligible voters, and

f) The list of tendered ballot papers.

PART 6 – COUNTING THE VOTES

36. **Interpretation of Part 6** – In Part 6 of these rules –

37. **Arrangements for counting of the votes**

The Returning Officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. **The Count**

38.1 The Returning Officer is to:

a) Count and record the number of ballot papers that have been returned, and

b) Count the votes according to the provisions in this Part of the rules.

38.2 The Returning Officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

38.3 The Returning Officer is to proceed continuously with counting the votes as far as is practicable.

39. **Rejected ballot papers**

39.1 Any ballot paper:

a) Which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced.

b) On which votes are given for more candidates than the voter is entitled to vote.

c) On which anything is written or marked by which the voter can be identified except the unique identifier, or

d) Which is unmarked or rejected because of uncertainty.

Shall subject to paragraphs 39.2 and 39.3 below, be rejected and not counted.

39.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

39.3 A ballot paper on which a vote is marked:

a) Elsewhere than in the proper place.

b) Otherwise than by means of a clear mark.

c) By more than one mark.

Is not to be rejected for such a reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears and the way the paper is marked does not itself identify the voter and it is not shown that he can be identified by it.

39.4 The Returning Officer is to:

a) Endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

b) In the case of a ballot paper on which any vote is counted under paragraph 39.2 or 39.3 above, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

39.5 The Returning Officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

a) Does not bear proper features that have been incorporated into the ballot paper.

b) Voting for more candidates than the voter is entitled to.

c) Writing or mark by which voter could be identified, and

d) Unmarked or rejected because of uncertainty.

And, where applicable, each heading must record the number of ballot papers rejected in part.

a) According to the next available preference given on those papers for any continuing candidate, or

40. **Equality of votes**

Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the Returning Officer is to decide between those candidates by a lot and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 – FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

41**. Declaration of result for contested elections**

41.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

a) Declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the Council of Governors from the Constituency, or Class within a Constituency, for which the election is being held to be elected.

b) Give notice of the name of each candidate who he has declared elected:
   (i) Where the election is held under a proposed Constitution pursuant to powers conferred on the Warrington and Halton Teaching Hospitals NHS Foundation Trust by section 34 (4) of the 2006 Act, to the Chair of the NHS Trust, or

   (ii) In any other case, to the Chair of the corporation; and

c) Give public notice of the name of each candidate whom he has declared elected.

41.2 The Returning Officer is to make:

a) The total number of votes given for each candidate (whether elected or not), and

b) The number of rejected ballot papers under each of the headings in rule 39.5

Available on request.

42. Declaration of result for uncontested elections

In an uncontested election, the Returning Officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

a) declare the candidate or candidates remaining validly nominated to be elected,

b) give notice of the name of each candidate who they have declared elected to the Chair of the Corporation, and

c) give public notice of the name of each candidate who they have declared elected.

PART 8 – DISPOSAL OF DOCUMENTS

43. **Sealing up of documents relating to the poll**

43.1 On completion of the counting at a contested election, the Returning Officer is to seal up the following documents in separate packets:

a) The counted ballot papers.

b) The ballot papers endorsed with “rejected in part”.

c) The rejected ballot papers, and

d) The statement of rejected ballot papers.

43.2 The Returning Officer must not open the sealed packets of:

a) The disqualified documents, with the list of disqualified documents inside it.

b) The declarations of identity.

c) The list of spoilt ballot papers.

d) The list of lost ballot papers.

e) The list of eligible voters, and

f) The list of tendered ballot papers.

43.3 The Returning Officer must endorse on each packet a description of:

a) Its contents.

b) The date of the publication of notice of the election.

c) The name of the corporation to which the election relates, and

d) The Constituency, or Class within a Constituency, to which the election relates.

44. **Delivery of documents**

Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 43, the Returning Officer is to forward them to the Chair of the corporation.

45. **Forwarding of documents received after close of the poll**

Where:

a) Any voting documents are received by the Returning Officer after the close of the poll, or

b) Any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

c) Any applications for replacement ballot papers are made too late to enable new ballot papers to be issued.

The Returning Officer is to put them in a separate packet, seal it up, and endorse and forward it the Chair of the corporation.

46. **Retention and public inspection of documents**

46.1 The corporation is to retain the documents relating to an election that are forwarded to the Chair by the Returning Officer under these rules for one year and then, unless otherwise directed by the Regulator, cause them to be destroyed.

46.2 With the exception of the documents listed in rule 47.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

46.3 A person may request a copy or extract from the documents relating to an election that is held by the corporation, and the corporation is to provide it and may impose a reasonable charge for doing so.

47. **Application for inspection of certain documents relating to an election**

47.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing:

a) Any rejected ballot papers, including ballot papers rejected in part.

b) Any disqualified documents, or the list of disqualified documents.
c) Any counted ballot papers.

d) Any declarations of identity, or

e) The list of eligible voters.

by any person without the consent of the Regulator.

47.2 A person may apply to the Regulator to inspect any of the documents listed in 47.1 and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

47.3 The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

a) Persons.

b) Time.

c) Place and mode of inspection.

d) Production or opening.

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

On an application to inspect any of the documents listed in paragraph 47.1.

a) In giving its consent, the Regulator, and

b) And making the documents available for inspection, the corporation

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) That his vote was given, and

(ii) That the Regulator has declared that the vote was invalid.

PART 9 DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

48 Countermand or abandonment of poll on death of candidate

48.1 If, at a contested election, proof is given to the Returning Officer's satisfaction before the result of the election is declared that one of the persons named, or to be named, as a candidate has died, then the Returning Officer is to:

a) Countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that Constituency or Class, and

b) Order a new election, on a date to be appointed by him in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

48.2 Where a new election is ordered under paragraph 48.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that Constituency or Class.

48.3 Where a poll is abandoned under paragraph 48.1a) paragraphs 48.4 to 48.7 are to apply.

48.4 The Returning Officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 33 and 34 and is to make up separate sealed packets in accordance with rule 35.

48.5 The Returning Officer is to:

a) Count and record the number of ballot papers that have been received, and

b) Seal up the ballot papers into packets, along with the records of the number of ballot papers.

48.6 The Returning Officer is to endorse on each packet a description of:

a) Its contents.

b) The date of the publication of notice of the election.

c) The name of the corporation to which the election relates, and

d) The Constituency or Class within a Constituency, to which the election relates.

48.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs 48.4 to 48.6, the Returning Officer is to

deliver them to the Chair of the corporation and rules 46 and 47 are to apply.

PART 10 – ELECTION EXPENSES AND PUBLICITY

Election expenses

49. **Election expenses**

Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the Regulator under Part 11 of these rules.

50. **Expenses and payments by candidates**

A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

a) Personal expenses.

b) Travelling expenses and expenses incurred while living away from home, and

c) Expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

51. **Election expenses incurred by other persons**

51.1 No person may:

a) Incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

b) Give a candidate or his family any money or property (whether as a gift, donation, loan or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

51.2 Nothing in this rule is to prevent the corporation from incurring such expenses and making such payments, as it considers necessary pursuant to rules 52 and 53.

Publicity

52. **Publicity about election by the corporation**

52.1 The corporation may:

a) Compile and distribute such information about the candidates, and

b) Organise and hold such meetings to enable the candidates to speak and respond to questions.

as it considers necessary.

52.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 52, must be:

a) Objective, balanced and fair.

b) Equivalent in size and content for all candidates.

c) Compiled and distributed in consultation with all of the candidates standing for election, and

d) Must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more candidates.

52.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

53. **Information about candidates for inclusion with voting documents**

53.1 The corporation must compile information about the candidates standing for election, to be distributed by the Returning Officer pursuant to rule 24 of these rules.

53.2 The information must consist of:

a) A statement submitted by the candidate of no more than 250 words, and

b) A photograph of the candidate.

54. **Meaning of "for the purposes of an election"**

54.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

54.2 The provision by any individual of his own services voluntarily, on his own time and free of charge is not to be considered an expense for the purposes of this Part.

PART 11 – QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

55. **Application to question an election**

55.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the Regulator.

55.2 An application may only be made once the outcome of the election has been declared by the Returning Officer.

55.3 An application may only be made to the Regulator by:

a) A person who voted at the election or who claimed to have had the right to vote, or

b) A candidate, or a person claiming to have had a right to be elected at the election.

55.4 The application must:

a) Describe the alleged breach of the rules or electoral irregularity,

and

b) Be in such a form as the Regulator may require.

55.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

55.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

a) The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

b) The determination by the person or persons nominated in accordance with Rule 55.6 shall be binding on and shall be given

effect by the corporation, the applicant and the members of the Constituency (or Class within a Constituency) including all the candidates for the election to which the application relates.

c) The Regulator may prescribe rules of procedure for the determination of an application including costs.

PART 12 – MISCELLANEOUS

56. **Secrecy**

56.1 The following persons:

a) The Returning Officer.

b) The Returning Officer's staff.

Must maintain and aid in maintaining the secrecy of the voting and the counting of the votes and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) The name of any member of the corporation who has or has not been given a ballot paper or who has or has not voted.

(ii) The unique identifier on any ballot paper.

(iii) The candidate(s) for whom any member has voted.

56.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

56.3 The Returning Officer is to make such arrangements as he thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

57. **Prohibition of disclosure of vote**

No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he has voted.

58. **Disqualification**

A person may not be appointed as a Returning Officer, or as staff of the Returning Officer pursuant to these rules, if that person is:

a) A member of the corporation.

b) An employee of the corporation.

c) A Director of the corporation, or

d) Employed by or on behalf of a person who has been nominated for election.

59. **Delay in postal service through industrial action or unforeseen event**

If industrial action, or some other unforeseen event, results in delay in:

a) The delivery of the documents in rule 24, or

b) The return of the ballot papers and declarations of identity.

The Returning Officer may extend the time between the publication of the notice of the poll and the close of the poll with the agreement of the Regulator.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS
(Paragraphs 13.3, 13.4 and 18)

Compliance with Code of Conduct

Governors shall comply with the Trust's Code of Conduct for Governors at Annex 5B.

Training

The Membership Strategy outlines the details of the training programme for members and Governors. Governors shall comply in so far as is possible with any training requirements identified by the Trust. The training programme set out in the Membership Strategy shall be reviewed from time to time and amended as required.

Eligibility to be a Governor

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

1. They are a Director of the Trust or any other NHS Body as defined in this constitution;
2. They are a Governor of another NHS Foundation Trust, unless:
    a. They are a Local Authority Governor appointed by one of the local authorities specified in Annex 3; or
    b. They are a Partnership Governor appointed by an NHS Body specified as a partnership organisation in Annex 3;
3. They are the spouse, partner, parent or child of a member of the Council of Governors or Board of Directors of the Trust;
4. They are under sixteen years of age at the time are nominated for election or appointment;
5. They are a member of a local authority's scrutiny committee covering health matters;
6. Being a member of the public constituency, they fail to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;
7. They fail to agree to comply with the Trust's Code of Conduct for Governors.
8. They fail to demonstrate compliance with the Trust's Code of Conduct for Governors.

9. Their use of social media does not reflect Trust values or The Nolan principles.

10. They have or have been subject to a Sexual Offences Prevention Order, a Foreign Travel Order or a Risk of Sexual Harm Order made under the provisions of the Sexual Offences Act 2003;

11. On the basis of disclosures obtained through an application to the Disclosure and Barring Service (including any application to the Criminal Records Bureau made prior to the establishment of the Disclosure and Barring Service), they are not considered suitable by the Trust's Executive Director responsible for Human Resources;

12. They are a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13. They are a person to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986

14. They are incapable by reason of mental disorder, illness or injury of managing or administering their property and affairs;

15. They have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

16. They are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that his/her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

17. They have had their name removed from any list maintained pursuant to Parts 4, 5, 6 or 7 of the NHS Act 2006 and/or Regulations made under those Parts, and has not subsequently had their name included on such a list, and, due to the reason(s) for such removal, they are not considered suitable by the Trust's Executive Director responsible for Human Resources;

18. They have previously been removed from office as a Governor of any Trust in accordance with the provisions of paragraph 8 below under the section titled 'Termination of office and removal of Governors'.

19. They have been found to be a vexatious complainant, in that, the Board of Directors has unanimously agreed that he/she has persistently and without reasonable grounds, made any unjustified complaint or requests of the Trust (or any of its staff, agents, patients or carers) causing inconvenience, harassment or expense;

Requirement of Governor to notify Trust

Where a person has been elected or appointed to be a Governor and they become disqualified from office under the provisions of this Constitution, they shall notify the Trust Secretary in writing of such disqualification.

Termination of office and removal of Governors

A person holding office as a Governor shall immediately cease to do so if:

1. They resign by notice in writing to the Trust Secretary;

2. It otherwise comes to the notice of the Trust Secretary at the time the Governor takes office or later that the Governor is disqualified;

3. They fail to meet the expected responsibilities laid out in Annex 5 – Page 67.

4. If a Governor fails to adhere to the provisions laid out in paragraph 3, this will result in termination of office unless the other Governors are satisfied by a 75% majority that:

4.1 The absences were due to reasonable causes; and

4.2 The Governor will resume attendance at meetings of the Council of Governors again within such a period as it considers reasonable;

4.3 If a Governor has been subject to a decision in their favour under paragraph 4 above and subsequently fails to meet the attendance standards set out in paragraph 3, that Governor's tenure of office is to be terminated immediately.

4. In the case of an elected Governor, they cease to be a member of the Trust;

5. In the case of an appointed Governor, the appointing organisation terminates the appointment;

6. They have refused without reasonable cause to undertake any training, which the Council of Governors requires all Governors to undertake;

7. they have failed to sign and deliver to the Trust Secretary a statement in the form required by the Council of Governors confirming acceptance of the Trust's Code of Conduct for Governors;

8. They are removed from the Council of Governors by a resolution approved by a majority of the remaining Governors present and voting at a general meeting on the grounds that:

   a) They have committed a serious breach of the Trust's Code of Conduct; or

   b) They have failed to declare a relevant and material interest in accordance with the Council of Governors Standing Orders; or

   c) They have acted in a manner detrimental to the interests of the Trust

   d) They have caused harm to the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of services;

   e) They have failed to discharge his/her responsibilities as a Governor;

9. The Governor concerned will be eligible to make representation, in writing, to the Council of Governors but not to vote on any resolution relating to his/her removal or suspension

Suspension from office of Staff Governors

If a staff Governor is suspended from duties for any reason they will also be suspended from their role as Governor for the duration of their suspension. Whilst a staff Governor is under suspension, the staff Governor cannot attend meetings of the Council of Governors in any capacity, but missing any meetings of the Council of

Governors will not count as failure to attend for the purposes of paragraph 3 under termination of office and removal as Governor above.

Vacancies amongst Governors

1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

2. Where the vacancy arises amongst the appointed Governors, the Trust Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

3. Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

    - To call an election within three months to fill the seat for the remainder of that term of office, or

    - To invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat for any unexpired period of the term of office; or

To leave the vacancy outstanding until the next annual election, providing that the vacancy shall not be for more than nine months.**Roles and Responsibilities**

Roles

The Governors have three general roles:

- Advisory – to communicate to the Board the views and interests of members and the wider community;

- Guardianship – to ensure that the Trust is operating in accordance with its authorisation;

- Strategic – to advise on the Trust's strategy and deliverance of that strategy.

The Governors shall carry out their roles and responsibilities in accordance with this Constitution and the Trust's Terms of Authorisation.

The roles of the Governors shall include to:

1. Appoint or remove the Chair and the other Non-Executive Directors. The removal of a Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors;

2. Decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;

3. Appoint or remove any external auditor and the Trust's financial auditor;

4. Approve (by a majority of the Council of Governors voting) an appointment of the Chief Executive, other than the initial Chief Executive;

5. Give the views of the Council of Governors to the Board of Directors for the purposes of the preparation (by the Directors) of the document containing information as to the Trust's forward planning in respect of each financial year to be given to Monitor;

6. Consider the annual accounts, any report of the financial auditor on them, and the annual report;

7. Consult with the Board of Directors on future plans for the services provided by the Trust;

8. Work with the Board of Directors to ensure the Trust operates within the conditions of its licence issued by Monitor;

9. Respond to any matter as appropriate when consulted by the Directors;

10. Review the Trust's Membership Strategy from time to time and at least once every three years to develop the membership of the Trust and represent the interests of members, and to review from time to time the Trust's policy for the composition of the Council of Governors and of the Non-executive Directors;

11. Establish mechanisms for consulting with the members and partnership organisations they may represent, particularly on developments and significant changes to services provided by the Trust;

12. Act as a source of ideas about how the Trust can provide services which reflect the needs of patients and the wider community;

13. Ensure that the Trust follows its values, as set out in the Trust's Membership Strategy;

14. Monitor the success of the Trust in meeting its planned service objectives;

15. Undertake such functions as the Board of Directors shall from time to time request.

<u>Responsibilities</u>

The responsibilities of Governors shall include to:

1. Ensure that they do not miss two consecutive Council of Governors meetings in any financial year.

2. Attend at least two Governor constituency meetings in any financial year.

3. Attend at least two Constituency meetings in any financial year.

4. Attend at least one Governor observation visit in any financial year.

5. Use social media responsibly upholding Trust values in line with the Nolan Principles.

Appointment of Non-Executive Directors (including Chair and Deputy Chair)

The Council of Governors shall establish a Nominations and Remuneration Committee to identify the skills, knowledge and experience required for Non-Executive Director posts, including the Chair and Deputy Chair of the Trust, and to prepare a suitable job description(s) and personal profile(s), which may be revised from time to time as required.

The Nominations and Remuneration Committee will identify suitable candidates (taking into account the skills, knowledge and experience identified as required for such posts and the job description(s) and personal profile(s) prepared) to assist with the process of selection of Non-Executive Directors (including the Chair and Deputy Chair) by the Council of Governors. The Terms of Reference of the Nominations and Remuneration Committee are set out in Annex 5A.

Duties of Deputy Chair

Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair or the Non-Executive Director nominated by the Council of Governors to take on the duties of the Chair or Deputy Chair should both be absent from a meeting or otherwise unavailable or unable to perform their duties.

ANNEX 5A - COUNCIL OF GOVERNORS NOMINATIONS AND REMUNERATION COMMITTEE

1. Purpose

A Nominations and Remuneration Committee ("the Committee") is to be established for the purposes of identifying appropriate candidates for the posts of Non-Executive Directors (including the Chair and Deputy Chair of the Foundation Trust), for making recommendations to the Council of Governors as to suitable candidates to fill the posts and for making recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Non-Executive Directors. The Committee will, taking into account the views of the Board of Directors, identify a balance of individual skills, knowledge and experience that is required at the time a vacancy arises and accordingly draw up a job description and personal profile for each new appointment.

2. Membership

2.1 Membership of the Committee will consist of:

- The Chair of the Foundation Trust (or Deputy Chair when the appointment of the Chair or their remuneration and allowances and other terms and conditions of office are being discussed, or another Non-Executive Director if the Deputy Chair is standing for Chair);
- One Partnership Governor;
- One Staff Governor; and
- Two Elected Governors.

2.2 The Chair of another Foundation Trust may be invited to act as an independent assessor to the Committee to advise the Committee as and when required.

2.3 The Chief Executive of the Foundation Trust shall be entitled to attend meetings of the Committee unless the Committee decides otherwise. In carrying out its responsibilities under Section 5, the Committee shall take the Chief Executive's views into account.

2.4 Members of the Committee may be required to undertake training and development commensurate with their responsibilities outlined in Section 5.

3. Chair of the Committee

The Chair of the Committee will be the Chair of the Foundation Trust, unless the discussion relates to the appointment of the Chair or their remuneration and allowances and other terms and conditions of office, in which case the Deputy Chair will chair the Committee. In the event that the Deputy Chair wishes to stand for the appointment of Chair, the Committee will be chaired by another Non-Executive Director.

4. Support for the Committee

The Director of Human Resources will provide advice and support to the Committee as required to ensure that the nominations processes are managed in accordance with best practice and that the recommendations made to the Council of Governors on the Non-Executive Directors' remuneration and allowances and other terms and conditions of office are appropriate and relevant to local circumstances.

5. Responsibilities of the Committee

5.1 *To prepare information detailing the skills, knowledge and experience required for the posts of Non-Executive Directors and to prepare job descriptions and personal profiles for each post, as may be amended from time to time*.

5.2 Save for in the case of the appointment of the initial Chair and initial other Non-Executive Directors of the Foundation Trust, where such appointments take place in accordance with paragraph 24 of this Constitution, to undertake the selection process for Non-Executive Directors, elements of which may include: -

- Making arrangements for advertising and raising local awareness of the post(s);
- Making arrangements for the short listing of candidates;
- Making arrangements to conduct formal interviews;

so as to identify, through a process of open competition, suitable candidates and so as to make recommendations to the Council of Governors as to suitable candidates for approval by the Council of Governors. No more than five candidates shall be identified for each vacancy. The Council of Governors shall either appoint the recommended individual(s) or invite the Committee to make an alternative recommendation.

5.3 Save for in the case of the appointment of the initial Chair and initial other Non-Executive Directors of the Foundation Trust, where such appointments take place in accordance with paragraph 24 of this Constitution, in making such recommendations the Committee shall take account of the information prepared in accordance with Section 5.1 and the policy on the composition of the Non-Executive Directors.

5.4 On expiry of the initial Non-Executive Directors' current terms of appointment (or the period of 12 months, whichever is the greater) and on any subsequent vacancy, to consider whether to recommend to the Council of Governors the reappointment of the retiring Non-Executive Director. The Committee may not make any such recommendation other than for a first renewal of the appointment of a Non-Executive Director without first taking the steps outlined in Sections 5.1, 5.2 and 5.3 above. If the Council of Governors does not so appoint, or if the individual does not wish to continue, or if the Committee does not consider the reappointment appropriate, then suitable

new candidates will be identified by the Committee in accordance with the procedure outlined above.

5.5 To make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of Non-Executive Directors.

6. Quorum

The quorum necessary for the transaction of business will be three members of the Committee, comprising the Chair of the Committee and two Governors.

7. Frequency of Meetings

The Committee will meet at least annually and then as required to fulfil its responsibilities, as determined by the Chair.

8. Notice of Meetings

8.1 Meetings of the Committee will be called at the request of the Chair.

8.2 Details of each meeting, including the agenda and supporting papers will be forwarded to each member of the Committee at least seven working days before the date of the meeting.

9. Minutes of Meetings

Minutes of the meetings will be circulated promptly to all members of the Committee and to all other members of the Council of Governors as soon as reasonably practical.

10. Reporting Arrangements

10.1 The Chair will report on the proceedings of each meeting to the next meeting of the Council of Governors. This discussion will take place in a private session i.e. not open to members of the public, when the names and details of individuals are being discussed.

10.2 The Chair will attend the Annual Members' Meeting to report on the activities of the Committee in the previous 12 months.

11. Authority

The Committee is authorised to seek information and advice either within the Trust or externally on any matters within its terms of reference.

12. Review

The Committee will review its own performance, relevant sections of the Constitution and terms of reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes will be submitted by the Committee to the Council of Governors and to the Board of Directors for consideration.

ANNEX 5B – GOVERNORS' CODE OF CONDUCT

Introduction

This Code has been drawn up in accordance with the Constitution and it is intended to support and complement the Constitution and its Annexes.

Its purpose is to make clear the appropriate conduct for Governors and address the requirements of the office of Governor on the Governor's Council. As an elected or appointed Governor, it is important that Governors are in no doubt about the standards of conduct and personal behaviour expected of anyone who holds public office or works within the Trust.

Governors' attention is also drawn to a number of Trust polices and documents regarding the Trust's values, confidentiality and the use of information and social media:

- Information Governance Policy
- Freedom to Speak up Policy
- Media & Social Media Policy
- Equality, Diversity & Inclusion Policy
- Trust Values

Whilst these policies have been drawn up principally for staff, the principles of these policies should be adhered to by Governors (see section 3 paragraph 2 below). Any query regarding the content or interpretation of any Trust policy should be directed to either the Chair of the Trust or the Trust Secretary.

Guiding Principles

The principles underpinning this Code of Conduct are drawn from the 'seven principles of public life', as defined by The Nolan Committee Report (1996). These principles are as follows:

- **Selflessness.** Governors must take decisions solely in terms of the public interest. Decisions must not be made to gain financial or material benefit for themselves, their family or friends. Governors must not attempt to use their status to gain advantage within the Trust or any other organisation.

- **Integrity.** Governors must not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

- **Objectivity.** In carrying out public business, including making appointments, awarding contracts or recommending individuals for rewards and benefits, Governors must make their choice based on merit.

- **Accountability.** Governors are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their office.

- **Openness.** Governors must be as open as possible about all the decisions and actions they take, and must give reasons for decisions, restricting information only when the wider public interest clearly demands.

- **Honesty.** Governors have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership.** Governors should promote and support these principles by leadership and example.

The NHS Core Principles (as published by the Department of Health) also inform the Code of Conduct and should guide the activities of the Board of Governors. These principles dictate that the NHS will:

- Provide a universal service for all based on clinical need not the ability to pay.

- Provide a comprehensive range of services, shaped around the needs and preferences of individual patients, their families and their carers.

- Respond to the different needs of different populations.

- Work continuously to improve quality services and to minimise errors.

- Support and value its staff.

- Ensure public funds for healthcare are devoted solely to NHS patients.

- Work together with others to ensure a seamless service for patients.

- Help keep people healthy and work to reduce health inequalities.

- Respect the confidentiality of individual patients and provide open access to information relating to services, treatment and performance.

Code of Conduct

A Governor must observe the Governors' Code of Conduct whenever he/she conducts the business of the Trust and/or the Board of Governors or acts as a representative of the Trust and/or the Board of Governors.

As a Governor of WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST I will:

1. Act as an ambassador for the Trust and represent both members and the general public.

2. At all times comply with the Constitution and its Standing Orders, the Standing Financial Instructions and all other policies and procedures of the Trust.

3. Uphold the Seven Principles of Public Life as set out by the Nolan Committee.

4. Abide by the NHS Core Principles.

5. Actively support the Trust's vision, aims and priorities ensuring the needs and best interests of the public, service users, relatives, carers and staff are foremost when making decisions.

6. Adopt a team approach, working with the Board of Directors, Trust staff and partner organisation to achieve the success of the Trust.

7. Support and assist the Trust's Chief Executive in their responsibility to answer the regulatory body, commissioners and the public in fully and faithfully declaring and explaining the use of resources, and the performance of the Trust in enacting national policy and delivering national targets.

8. Seek to ensure that no-one person or group is unlawfully discriminated against because of for example religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.

9. Treat with dignity and respect the public, service users, relatives, carers, people who work within the Trust, and partners in other organisations.

10. Seek to ensure that my Governor colleagues are valued, and that judgements about them are consistent, fair, unbiased and properly founded.

11. Note that WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST is an apolitical organisation.

12. Recognise that if I am a member of any trade's union, political party or other organisation, (other than where a Governor has been appointed to the Governor's Council by an appointing organisation), I will not be representing that organisation or the views of that organisation.

13. Ensure that no political, religious or sectarian views influence any decisions I am party to.

14. Properly disclose and declare any actual or perceived personal, pecuniary or conflict of interest in any matter under discussion or consideration and refrain from any decision or vote on the matter, unless I am invited to participate by the Chair.

15. Not expect or seek any privileges, preferential or special treatment arising from being a Governor for either myself or my family or friends.

16. Ensure that when acting in my official capacity, or any other circumstances, I conduct myself in a way that will not bring the office of Governor, the Council of Governors or the Trust into disrepute. This includes the use of social media as described in paragraph 9 of 'Eligibility to be a Governor' laid out in Annex 5.

17. Not make, permit or knowingly allow to be made any untrue misleading statement relating to my own duties or the functions of the Trust.

18. Maintain a high level of confidentiality and not disclose any information given to me in confidence by anyone, or disclose information acquired which is or which I believe to be of a confidential nature without the consent of a person authorised to give it, unless I am required to do so by law. I will also not prevent another person from gaining access to information to which that person is entitled by law.

19. Raise any concerns regarding any matter relating to the activities of the Council of Governors, the Board of Directors or services within the Trust through the proper internal channels and within the terms of clause 42 of the Constitution.

20. At no time or for any reason speak to the press or media in relation to any Trust business or its employees or Board of Directors <u>any</u> official capacity unless authorised to do so by the Board of Directors or the Trust's Communications Department; and if approached by the press or media direct all enquiries to the Trust's Communications Department.

21. Ensure that the membership of the whole Constituency I am elected to represent, or the organisation I am appointed to represent is properly informed and their views are properly represented.

22. Exercise my responsibility in a corporate manner and ensure decisions are taken collectively with the Council of Governors acting as a unitary body, and support decisions taken by the Governor's Council even where I may not personally agree with the decision taken.

23. Not act individually or in informal groupings to take decisions on Council of Governors business outside the constitutional framework of Council of Governors meetings and Committees.

24. Undertake any training identified as required and receive guidance in respect of my responsibilities.

25. Attend all meetings of the Council of Governors and its Committees wherever possible in order to carry out my role as Governor.

26. Not, when acting as a Governor, visit any non-public area or setting in which treatment is provided, except where such a visit has been arranged by the Board of Directors or its representative.

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Personal Declaration

I (full name) …… have read, understood and agree to comply with the WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST's Code of Conduct for Governors, and I also agree to inform the Trust Secretary if at any time I become unable to comply with the Code or any part of the Code.

If during the course of my duties as a Governor I become involved with, or aware of any confidential information, including that relating to any person for example service users, carers, visitors, members of staff; or information relating to any Trust business, I will not at any time during or after my term of office as a Governor use or disclose such information inappropriately.

I understand that a breach of this code and the general obligation of confidentiality will be considered as a serious offence/misconduct issue and that I may be removed from the Council of Governors.

I understand that it is a requirement of the Constitution to sign the Code of Conduct and that failure to do so will preclude me from continuing in office as a Governor.

Signature ……

Date ……

ANNEX 6 – COUNCIL OF GOVERNORS STANDING ORDERS

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11 Changes to Standing Orders

Interpretation

1.1 Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they shall be advised by the Chief Executive and Director of Finance).

1.2 Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

"Accounting Officer" shall be the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Board" shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors and the Executive Directors appointed by the Appointments Committee of the Board.

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chair" is the person appointed by the Council of Governors in accordance with paragraphs 24 and 25 of this Constitution. The expression "the Chair of the Trust" shall be deemed to include the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent or is otherwise unavailable (the Deputy Chair).

"Chief Executive" shall mean the Chief Officer of the Trust.

"Committee" shall mean a committee appointed by the Council of Governors.

"Committee Members" shall be persons formally appointed by the Council of Governors to sit on or to chair specific committees.

"Director" shall mean a person appointed to the Board of Directors in accordance with the Trust's Constitution and includes the Chair.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated Officer" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

"Officer" means an employee of the Trust.

"SOs" means Standing Orders.

2 General Information

2.1 The purpose of the Council of Governors Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations. The Council shall at all times seek to comply with the Trust's Code of Conduct for Governors.

2.2 All business shall be conducted in the name of the Trust.

2.3 The Board of Directors shall appoint trustees to administer separately charitable funds received by the Trust and for which they are accountable to the Charity Commission.

2.4 A Governor who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Governor save where the Governor has acted recklessly. On behalf of the Council of Governors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

3 Composition of the Council of Governors

3.1 The composition of the Council of Governors shall be in accordance with paragraph 10 and Annex 3 of the Trust's Constitution.

4. Meetings of the Council of Governors

4.1 Meetings held in Public

4.1.1 Meetings of the Council of Governors must be open to the public, subject to paragraphs 4.1.2 and 4.1.3 below.

4.1.2 The Council of Governors may resolve to exclude members of the public from any meeting or part of a meeting on the grounds that it considers that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

4.1.3 The Chair may exclude any member of the public from the meeting of the Council if they consider that they are interfering with or preventing any conduct of the meeting.

4.1.4 Meetings of the Council of Governors shall be held at least three times each year at times and places that the Council of Governors may determine.

4.1.5 The Council may invite the Chief Executive, and other appropriate Directors, to attend any meeting of the Council to enable Governors to raise questions about the Trust's affairs.

4.2 Calling Meetings

Notwithstanding paragraph 4.1.4 above, the Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by a majority of the Governors, or if without so refusing the Chair does not call a meeting within fourteen days after requisition to do so, then the Governors may forthwith call a meeting provided they have been requisitioned to do so by more than 50% of their members.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer of the Trust authorised by the Chair to sign on his/her behalf shall be delivered to every Governor, or sent by post to the usual place of residence of such Governor, or sent by electronic email to any email address notified to the Trust by such a Governor, so as to be available to him/her at least twenty-one clear days before the meeting subject to paragraphs 4.3.2 and 4.3.3 below. Lack of service of the notice on any Governor shall not affect the validity of a meeting, subject to paragraph 4.3.4 below.

4.3.2 Notwithstanding the above requirement for notice, the Chair may waive notice in the case of emergencies or in the case of the need to conduct urgent business.

4.3.3 In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors calling the meeting and no business shall be transacted at the meeting other than that specified in the notice.

4.3.4 Failure to serve notice on more than three quarters of Governors will invalidate any meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent subject to paragraphs 4.3.2.

4.4 Setting the Agenda

4.4.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

4.4.2 In the case of a meeting called by the Chair, a Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.4.3 The Chair shall make arrangements to ensure that the final agenda and any supporting papers for the meeting, following the receipt of any requests in accordance with 4.4.2 above, are delivered to every Governor, or sent by post

to the usual place of residence of such Governor, so as to be available to him/her at least five clear days before the meeting.

4.5 Chair of Meeting

At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting or the Council of Governors is meeting to appoint or remove the Chair or decide their remuneration and allowances and other terms and conditions of office, the Deputy Chair shall preside. Otherwise, another Non-Executive Director shall preside.

4.6 Notices of Motions

4.6.1 A Governor of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert this in the agenda for the meeting. All notices so received are subject to the notice given being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to section 4.3.3 of these Standing Orders.

4.6.2 A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governors who gave it and also the signature of four other Governors. When any such motion has been disposed of by the Council it shall not be competent for any Governor, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

4.6.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

(a) An amendment to the motion.

(b) The adjournment of the discussion or the meeting.

(c) The appointment of an ad hoc committee to deal with a specific item of business.

(d) That the meeting proceed to the next business.

(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

4.7 Chair's Ruling

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.8 Voting

4.8.1 Decisions at meetings shall be determined by a majority of the votes of the Governors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

4.8.2 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

4.8.3 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.8.4 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.8.5 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.8.6 A Governor who is a member of the Public Constituency may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Trust Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a member of the Trust. A Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Governor's Council and every agenda for meetings of the Council of Governors shall draw this to the attention of the Governors.

4.9 Suspension of Standing Orders (SOs)

4.9.1 Except where this would contravene any statutory provision or a direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of members of the Council are present and that a majority of those present vote in favour of suspension.

4.9.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.9.3 A separate record of matters discussed during the suspension of SOs shall be

made and shall be available to the Directors.

4.9.4 No formal business may be transacted while SOs are suspended.

4.9.5 The Trust's Audit Committee shall review every decision to suspend SOs.

4.10 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- The amendment is approved by a simple majority of both the Board of Directors and the Council of Governors.

4.11 Record of Attendance

The names of the Governors present at the meeting shall be recorded in the minutes.

4.12 Minutes

4.12.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.12.3 Minutes shall be circulated in accordance with the Governors' wishes. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of section 4.1 of these Standing Orders.

4.13 Quorum

4.13.1 No business shall be transacted at a meeting of the Council of Governors unless at least one-third of all the members, at least five of which are elected Governors, of the Council of Governors are present.

4.13.2 If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5 Arrangements for the Exercise of Functions by Delegation

5.1 **Emergency Powers** - The powers which the Council of Governors has retained to itself within these Standing Orders may in an emergency be exercised by the Chair after having consulted at least five elected Governors. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Council for ratification.

5.2 **Delegation to a Governor** – The Council of Governors may delegate duties to an individual Governor but only under a clear remit approved by the Council.

5.3 The Nominations and Remuneration Committee of the Council of Governors shall exercise the functions set out in its Terms of Reference on behalf of the Council.

6 Confidentiality

6.1 A member of the Council of Governors shall not disclose a matter dealt with by, or brought before, the Council of Governors under Clause 4.1.2 above without the permission of the Chair and the Council of Governors.

6.2 Members of the Nominations and Remuneration Committee shall not disclose any matter dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or Committee resolves that it is confidential.

7 Declaration of Interests and Register of Interests

7.1 Declaration of Interests

7.1.1 Governors are required to comply with the Trust's Standards of Business Conduct and to declare interests that are relevant and material to the Council. All Governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.2 Interests regarded as "relevant and material" include any of the following, held by a Governor, or the spouse, partner, parent or child of a Governor:

a) Directorships, including non-executive directorships, held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of or employment with private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Significant share holdings (more than 5%) in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

7.1.3 If a Governor has any doubt about the relevance of an interest, they should discuss it with the Chair who shall advise him/her whether or not to disclose the interest.

7.1.4 At the time Governors' interests are declared, they should be recorded in the Council of Governors minutes and entered on a Register of Interests of Governors to be maintained by the Trust Secretary. Any changes in interests should be declared at the next Council meeting following the change occurring.

7.1.5 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report.

7.1.6 During the course of a Council meeting, if a conflict of interest is established, the Governor concerned shall, unless two thirds of those Governors present agree, otherwise withdraw from the meeting and play no part in the relevant discussion or decision.

7.1.7 There is no requirement for the interests of Governors' spouses or partners to be declared except where the Governor is cohabiting with their spouse or partner, whereby any interest of a spouse or partner in a contract shall be declared.

7.2 **Register of Interests**

7.2.1 The Trust Secretary, will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

7.2.3 Details of the Register will be kept up to date and reviewed annually.

7.2.4 The Register will be available to the public.

8 Compliance - Other Matters

8.1 All Governors shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the Trust.

8.2 All Governors of the Trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the Trust.

8.3 All Governors must behave in accordance with the seven Nolan principles of behaviour in Public Life (and the Trust's Code of Conduct for Governors as amended from time to time): -

- Selflessness;
- Integrity;
- Objectivity;

- Accountability;
- Openness;
- Honesty, and
- Leadership.

9. Resolution of Disputes with Board of Directors

9.1 Should a dispute arise between the Council and the Board of Directors, then the disputes resolution procedure set out below shall be followed.

9.2 The Chair, or Deputy Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

9.3 Failing resolution under 9.2 above, then the Board or the Council, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

9.4 The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board or Council as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

9.5 The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved, then the procedure outlined in 9.2 above shall be repeated.

9.6 If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair) and following the further discussions prescribed in 9.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council and Board accordingly.

9.7 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

9.8 On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

9.9 Nothing in this procedure shall prevent the Council, if it so desires, from informing Monitor that, in the Council's opinion, the Board has not responded constructively to concerns of the Council that the Trust is not meeting the terms of its authorisation.

10. Council Performance

The Chair shall, at least annually, lead a performance assessment process for the Council to enable the Council to review its roles, structure and composition, and procedures, taking into account emerging best practice.

11. Changes to Standing Orders

For the sake of clarity, future amendments to these Standing Orders are to be regarded as a change to the Trust's Constitution.

ANNEX 7 – BOARD OF DIRECTORS STANDING ORDERS
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12 Board Performance

13 Changes to Board Standing Orders

1. Interpretation

1.1 Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they shall be advised by the Chief Executive and Director of Finance).

1.2 Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

"Accounting Officer" shall be the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Board" shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors and the Executive Directors appointed by the Appointments Committee of the Board.

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chair" is the person appointed by the Council of Governors in accordance with paragraphs 24 and 25 of this Constitution. The expression "the Chair of the Trust" shall be deemed to include the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent or is otherwise unavailable (the Deputy Chair).

"Chief Executive" shall mean the Chief Officer of the Trust.

"Committee" shall mean a committee appointed by the Board of Directors.

"Committee Members" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Director" shall mean a person appointed to the Board of Directors in accordance with the Trust's Constitution and includes the Chair.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated Officer" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

"Officer" means an employee of the Trust.

"SOs" means Standing Orders

2. General Information

2.1 The purpose of the Board Standing Orders is to ensure that the highest standards of Corporate Governance are achieved in the Board and throughout the organisation. The Board shall at all times seek to comply with the Trust's Code of Conduct for Directors.

2.2 All business shall be conducted in the name of the Trust.

2.3 The Directors shall appoint trustees to administer separately charitable funds received by the Trust and for which they are accountable to the Charity Commission.

2.4 A Director, or Officer of the Trust, who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Director or Officer, save where the Director or Officer has acted recklessly. On behalf of the Directors and Officers, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

3. Composition of the Board

3.1 The composition of the Board shall be as set out in paragraph 21of the Trust's Constitution.

The number of Directors may be increased by the Board, provided always that at least half the Board, excluding the Chair, comprises Non-Executive Directors.

3.2 **Appointment and Removal of the Chair and Non-Executive Directors** - The Chair and Non-Executive Directors are appointed/removed by the Council of Governors in accordance with the Trust's Constitution.

3.3 **Appointment and Removal of the Executive Directors** – The Appointments Committee of the Board of Directors (excluding the Chief Executive) shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors). The Appointments Committee of the Board of Directors (inclusive of the Chief Executive) shall appoint or remove the other Executive Directors.

3.4 **Appointment and Removal of Deputy Chair** – For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors of the Trust will appoint one of the Non-Executive Directors to be the Deputy Chair.

3.5 **Powers of Deputy Chair** - Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to

perform their duties, be taken to include references to the Deputy Chair or otherwise to the Non-Executive Director appointed by the Board to preside for the time being over its meetings.

3.6 **Joint Directors** - Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count as one person.

3.7 Non-Executive Directors may seek external advice or appoint an external advisor on any material matter of concern provided the decision to do so is a collective one by the majority of Non-Executive Directors.

4. Meetings of the Board

4.1 Meetings

4.1.1 Meetings of the Board shall be held in public unless the Board decides otherwise in relation to all or part of such meetings for reasons of commercial confidentiality or for other special reasons the Board of Directors may determine.

4.1.2 The Board may resolve to exclude members of the public from any public meeting or part of a meeting on the grounds that it considers that:

a) publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

b) there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

4.1.3 The Chair may exclude any member of the public from the meeting of the Board if they consider that they are interfering with or preventing proper conduct of the meeting.

4.1.4 Meetings of the Board shall be held at least six times each year at times and places that the Board may determine.

4.1.5 The Board shall arrange, with the Council of Governors an annual members meeting to be held within 9 months of the end of each financial year.

4.2 Calling Meetings

The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him/her, at the Trust's Head Office, such one third or more Directors may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Notice of a meeting of the Board of Directors, shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least five clear days before the meeting. Lack of service of the notice on any Director shall not affect the validity of a meeting, subject to paragraph 4.3.4 below.

4.3.2 Notwithstanding the above requirement for notice, the Chair may waive notice in the case of emergencies or in the case of the need to conduct urgent business.

4.3.3 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.3.4 Subject to paragraph 4.3.2, failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.4 Setting the Agenda

4.4.1 The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

4.7.3 In the case of a meeting called by the Chair, a Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.8 Chair of Meeting

At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair appointed by the Council of Governors to take on the Chair's duties shall preside. Otherwise, such Non-Executive Director as the Directors present shall choose shall preside.

4.9 **Notices of Motions**

4.6.1 A Director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to paragraph 4.3.3 above.

4.9.1 A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.9.2 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Directors who gave it and also the signature of four other Directors. When any such motion has been disposed of by the Board it shall not be competent for any Director, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

4.9.3 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.9.4 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

a) An amendment to the motion.

b) The adjournment of the discussion or the meeting.

c) The appointment of an ad hoc committee to deal with a specific item of business.

d) That the meeting proceed to the next business.

e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under d) and e), to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate.

4.10 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.11 Voting

4.8.1 Decisions at meetings shall be determined by a majority of the votes of the Directors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

4.11.1 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.11.2 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.11.3 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.11.4 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.11.5 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

4.12 **Joint Directors**

Where an Executive Director post is shared by more than one person:

a) Each person shall be entitled to attend meetings of the Board;

b) In the case of agreement between them, they shall be eligible to have one vote between them;

c) In the case of disagreement between them, no vote should be cast;

d) The presence of those persons shall count as one person.

4.13 **Suspension of Standing Orders (SOs)**

4.10.1 Except where this would contravene any statutory provision or direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

4.13.1 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.13.2 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.13.3 No formal business may be transacted while SOs are suspended.

4.13.4 The Audit Committee shall review every decision to suspend SOs.

4.14 **Variation and Amendment of Standing Orders**

These Standing Orders shall be amended only if:

- The amendment is approved by a simple majority of both the Board of Directors and the Council of Governors; and
- The amendment is approved by Regulator.

4.15 Record of Attendance

The names of the Directors present at the meeting shall be recorded in the minutes.

4.16 Minutes

4.13.1 The minutes of the proceedings of a meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.16.1 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.16.2 Minutes shall be circulated in accordance with the Directors' wishes. The minutes of any public meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of section 4.1 of these Standing Orders.

4.16.3 Before holding a meeting, the Board of Directors shall send a copy of the agenda of the meeting to the Council of Governors and shall, as soon as practicable after holding the meeting, send a copy of the minutes of the meeting to the Council of Governors.

4.17 **Quorum**

4.14.1 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.

4.14.1a A director may join a meeting by electronic means. They may count towards the quorum and is entitled to vote if the requirement for their voice to be heard by the other directors present (and vice versa) is met.

4.17.1 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

4.17.2 If a Director has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5 Arrangements for the Exercise of Functions by Delegation

5.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee of Directors, or by a Director or an Officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

5.3 **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees of Directors, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

5.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to one of its Committees shall be exercised on behalf of the Board by the Chief Executive. They shall determine which functions they will perform personally and shall nominate Officers to undertake remaining functions but still retain an accountability for these to the Board.

5.5 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals that shall be considered and approved by the Board, subject to any

amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board as indicated above.

5.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Directors to provide information and advise the Board in accordance with any statutory requirements.

6 Committees

6.1 Appointment of Committees

6.1.1 The Board may appoint other committees of the Board subject to 5.1 and 5.3, consisting wholly or partly of Directors of the Trust. This may include the appointment of Committees in Common and Joint Committees with other NHS organisations

6.1.2 A committee so appointed may appoint sub-committees consisting wholly or partly of members of the committee but consisting of at least one Director of the Board

6.1.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board.

6.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide from time to time following reviews of the terms of reference, powers and conditions. Such terms of reference shall have effect as if incorporated into these Standing Orders.

6.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

6.1.6 The Board shall approve the appointments to each of the committees that it has formally constituted. Where the Board determines that persons, who are neither Directors nor Officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

6.1.7 Where the Trust is required to appoint persons to a committee, which is to operate independently of the Trust, such appointment shall be approved by the Board.

6.2 Confidentiality

6.2.1 A member of the Board shall not disclose a matter dealt with by, or brought before, the Board without its permission.

6.2.2 A member of a committee of the Board shall not disclose any matter dealt with by, or brought before, the committee, notwithstanding that the matter has been

reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

7 Declaration of Interests and Register of Interests

7.1 Declaration of Interests

7.1.1 Directors are required to comply with the Trust's Standards of Business Conduct and to declare interests that are relevant and material to the Board. All Directors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.2 Interests regarded as "relevant and material" include any of the following, held by a Director, or the spouse, partner, parent or child of a Director:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of or employment with private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

7.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

7.1.4 At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

7.1.5 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 During the course of a Board meeting, if a conflict of interest is established in accordance with this Standing Order, the Director concerned should, unless two thirds of the Directors present agree (including two Executive and two Non-Executive Directors), withdraw from the meeting and play no part in the relevant discussion or decision. If the Director remains present at the meeting on the agreement of two thirds of those Directors present, they shall not be entitled to vote on the issue in respect of which the conflict of interest has been established.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other relevant and material interests that have been declared by both Executive and Non-Executive Directors.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

8 Disability of Directors in Proceedings on Account of Pecuniary Interest

8.1 Subject to the following provisions of this Standing Order, if the Chair or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2 The Board shall exclude the Chair or a Director from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

8.3 The Board, as it may think fit, may remove any disability imposed by this Standing Order in any case in which it appears to the Board that, in the interests of the National Health Service, the disability shall be removed. Such action shall have the support of at least two-thirds of the Directors present at the meeting (including two Executive and two Non-Executive Directors).

8.4 Any remuneration, compensation or allowances payable to a Director of the Trust by virtue of paragraph 11 of Schedule 4 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.5 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to paragraphs 8.3 and 8.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) They, or their nominee is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; **or**

b) They are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and

c) In the case of persons living together the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.6 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) Of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

b) Of an interest in any company, body or person with which they are connected as mentioned above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.7 Where the Chair or a Director:

a) Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) The total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) If the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class.

This Standing order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

8.8 This Standing Order applies to a committee or sub-committee of the Board as it applies to the Board and applies to any member of any such committee or sub-committee (whether or they are also a Director of the Trust) as it applies to a Director of the Trust.

9 Compliance - Other Matters

9.1 All Directors of the Trust shall comply with the Standards of Business Conduct set by the Board for the guidance of all staff employed by the Trust.

9.2 All Directors of the Trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board.

9.3 All Directors must behave in accordance with the seven Nolan principles of behaviour in Public Life (and the Trust's Code of Conduct for Directors as amended from time to time): -

- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty; and
- Leadership.

10 Resolution of Disputes with Council of Governors

10.1 Should a dispute arise between the Board of Directors and the Council of Governors, then the disputes resolution procedure set out below shall be followed.

10.2 The Chair, or Deputy Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

10.3 Failing resolution under 10.2 above, then the Board or the Council, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4 The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board or Council as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5 The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved, then the procedure outlined in 10.2 above shall be repeated.

10.6 If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair) and following the further discussions prescribed in 10.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council and Board accordingly.

10.7 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8 On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

10.9 Nothing in this procedure shall prevent the Council, if it so desires, from informing the Monitor that, in the Council's opinion, the Board has not responded constructively to concerns of the Council that the Trust is not meeting the terms of its authorisation.

11 Notification to Monitor and Council of Governors

The Board shall notify Monitor and the Council of Governors of any major changes in the circumstances of the Trust, which have made or could lead to a substantial change to its financial well-being, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its authorisation.

12. Board Performance

The Chair shall, at least annually, lead a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programs for Directors.

13. Changes to Board Standing Orders

For the sake of clarity, future amendments to these Standing Orders by the Board are to be regarded as a change to the Trust's Constitution.

ANNEX 8 – MEMBERS - FURTHER PROVISIONS

Disqualification from membership

1. A person may not become a member of the Trust if within the last five years;

   a) They have received a Red Card under the Trust's Procedure for Care of Patients who are Violent or Abusive; or

   b) They have been involved as a perpetrator in a serious incident of violence at any of the Trust's Teaching Hospitals or facilities or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against volunteers.

2. A person may not become or continue as a member of the Trust if they are or has been the subject of a Sexual Offences Prevention Order, a Foreign Travel Order or a Risk of Sexual Harm Order made under the provisions of the Sexual Offences Act 2003.

3. A person may not become a member of the Trust if they are under 12 years of age.

4. A person may not become or continue as a member of the Trust if they do not agree to comply with the Trust's aims and values.

5. Where the Trust is placed on notice that a member may be disqualified from membership, or may no longer be eligible to be a member, the Trust Secretary shall give the member 14 days written notice to show cause why their name should not be removed from the register of members. If such information is not supplied by the member within 14 days, the Trust Secretary may, if they consider it appropriate, remove the member from the register of members. In the event of any dispute the Trust Secretary shall refer the matter to the Council of Governors to determine.

6. All members of the Trust shall notify the Trust Secretary of any change in their particulars, which may affect their entitlement to be a member.

Termination of membership

A member shall cease to be a member if:

1. They die;

2. They resign by notice to the Trust Secretary;

3. They cease to be entitled under this Constitution to be a member of any of the Trust's Constituencies;

4. They are expelled under this Constitution;

5. It appears to the Trust Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the

Council of Governors, they fail to establish that they wish to continue to be a member of the Trust.

Expulsion

A member may be expelled by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council. The following procedure is to be adopted:

1. Any member may complain in writing to the Trust Secretary that another member has acted in a way detrimental to the interests of the Trust.

2. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

   a) Dismiss the complaint and take no further action; or

   b) Arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors.

3. If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

4. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

5. If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council.

Voting at Public Governor Elections

A person may not vote at a Public Governor election for an elected Governor unless within the specified period they have made a declaration in the specified form setting out the particulars of their qualification to vote as a member of the Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

ANNEX 9 LEAD AND DEPUTY LEAD GOVERNOR ROLES

LEAD GOVERNOR ROLE DESCRIPTION

NHS E, in its Code of Governance asks that all Foundation Trusts have a 'lead governor'.

Primary Role

The primary purpose of the Lead Governor is to facilitate direct communication between the Regulator (NHS E) and the Council of Governors. The Regulator does not however envisage direct communication with Governors until such time as there may be a real risk of the Foundation Trust significantly breaching its licence or constitution and the Council's concerns cannot be satisfactorily resolved.

Once there is a risk that this may be the case, and the likely issue is one of board leadership, the Regulator will often wish to have direct contact with the Foundation Trust's Governors, but at speed and through one established point of contact – the Foundation Trust's nominated Lead Governor.

Such contact is likely to be a rare event and would be seen, for example, should NHS E wish to understand the view of the Governors about the capability of the chair, or be investigating some aspect of an appointment process of decision which may not have complied with the constitution.
It is important to remember that it is the Council of Governors *as a whole* (and no individual governor) that has the responsibilities and powers in statute.

Lead Governor Duties:

- Leading the Council of Governors in exceptional circumstances when it is not appropriate for the chair or another non-executive to do so)
- Collating the input of Governors for the senior independent director or chair regarding annual performance appraisals of the chair and non-executive directors.
- Leading Governors on the Governors nominations and remuneration committee (GNARC) in the process for appointing a chair and non-executive directors.
- To recommend to the Council of Governors on behalf of the Nominations and Remuneration Committee any appointments/reappointments of Chair and/or Non-executive Directors
- Acting as a point of contact and liaison for the chair and senior independent director,
- Acting as a co-ordinator of governor responses to consultations,
- Chairing informal governor-only meetings.
- Attend Pt1 and Pt 2 Board Meeting and report to the Council of Governors on performance of NED's
- Troubleshooting and problem solving by raising issues with the chair and chief executive,

- Leading Governors in holding the non-executive directors to account,
- Contribute to the induction of new Governors.
- Present the Annual Governor's Report to Members at the Annual Members Meeting
- Meet routinely with the Chair, Company Secretary and Deputy Lead Governor to plan and prepare the agenda for Council of Governors meetings
- Work with individual Governors who need advice or support to fulfil their role as a Governor,
- Acting as a point of contact for the CQC and NHS E/I
- Other duties as requested by the Council of Governors or the Chairman

Term

The 'term of office' two years or until the serving Governor's term ends, whichever is the sooner. The Lead Governor role is subject to two-yearly election or whenever a vacancy arises, whichever is sooner.

Eligibility

To be eligible to stand governors:

1. Must have served at least one year with the WHH Council of Governors
2. Must have achieved reasonable attendance at the CoG (min attendance is 75%)

DEPUTY LEAD GOVERNOR ROLE DESCRIPTION

The role of Deputy Lead Governor is not a statutory role under the NHS Foundation Trust Code of Governance.

Primary Role

The primary purpose of the Deputy Lead Governor is to provide the Foundation Trust with a point of contact for the Council of Governors should the Lead Governor be unavailable for a period or has a conflict of interest.

The Deputy Lead Governor will also:

- Meet routinely with the Chair, Trust Secretary and Lead Governor to plan and prepare the agenda for Council of Governors meetings,
- Attend Trust Board meetings in the absence of the Lead Governor.
- Other duties as requested by the Council of Governors or the Chairman

Term

The Deputy Lead Governor role is subject to two-yearly election or whenever a vacancy arises, whichever is sooner.

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Eligibility

To be eligible to stand governors:

1. Must have served at least one year with the WHH Council of Governors
2. Must have achieved reasonable attendance at the CoG (min attendance is 75%)

20. SUPPLEMENTARY PAPERS - BM/24/06/046- BM/24/06/054

Information Item

BM/24/06/045? Committee Chairs Annual Reports (Strategic People Committee 15.05.24)
BM/24/06/046- Patient Experience Strategy Annual Report (Quality Assurance Committee 09.04.24)
BM/24/06/047- Infection Prevention & Control Q4 Update (Quality Assurance Committee 07.05.24)
BM/24/06/048- Learning From Experience Summary Report Q4 (Quality Assurance Committee 07.05.24)
BM/24/06/049- Violence Reduction Strategy (Quality Assurance Committee 07.05.24)
BM/24/06/050- Guardian Of Safe Working Report Q3 (Strategic People Committee 17.04.24)
BM/24/06/051- Guardian Of Safe Working Report Q4 (Strategic People Committee 15.05.24)
BM/24/06/052 ? EPPR Compliance Update following Dec 2023 Report (Finance & Sustainability Committee 24.04.24)
BM/24/06/053 - Digital Strategy Group Update (Finance & Sustainability Committee 22.05.24)

REFERENCES

Only PDFs are attached

- 0. Supplementary Pack Cover Sheet 05.06.24 (1).pdf
- BM 24 06 045 Chairs Annual Report 202324 FINAL.pdf
- BM 24 06 046 Patient experience annual report QAC Final_.pdf
- BM 24 06 047 IPC HCAI Report 2023 2024 Q4.pdf
- BM 24 06 048 Learning from Experience Report Quarter 4 2023-24.pdf
- BM 24 06 049 Violence Prevention Reduction.pdf
- BM 24 06 050 GOSW Report Q3 2023-24.pdf
- BM 24 06 051 GOSW Report Q4 23-24.pdf
- BM 24 06 052 EPRR Core Assurance Update.pdf
- BM 24 06 053 Monthly Digital Report DSG.pdf

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting - Part 1

Wednesday 5 June 2024
10.00am-12.30pm
Trust Conference Room WHH

Supplementary Pack

BM/24/06/045– Committee Chairs Annual Reports (Strategic People Committee 15.05.24)
BM/24/06/046- Patient Experience Strategy Annual Report *(Quality Assurance Committee 09.04.24)*
BM/24/06/047- Infection Prevention & Control Q4 Update *(Quality Assurance Committee 07.05.24)*
BM/24/06/048- Learning From Experience Summary Report Q4 *(Quality Assurance Committee 07.05.24)*
BM/24/06/049- Violence Reduction Strategy *(Quality Assurance Committee 07.05.24)*
BM/24/06/050- Guardian Of Safe Working Report Q3 (Strategic People Committee 17.04.24)
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/24/05/31**			
SUBJECT:	**Committee Chairs Annual Report to the Trust Board**			
DATE OF MEETING:	15 May 2024			
ACTION REQUIRED:	**For Assurance**			
AUTHOR(S):	Michelle Cloney, Chief People Officer			
EXECUTIVE DIRECTOR SPONSOR:	Julie Jarman, Non-Executive Director			
LINK TO STRATEGIC OBJECTIVE	SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future.			
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: EIAs completed for all relevant projects.			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Trust Board that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance for the People IPR.			
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**	
RECOMMENDATION:	For Assurance			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
	None			

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Committee Chairs Annual Report to the Trust Board	AGENDA REF:	SPC/24/05/31

1. BACKGROUND/CONTEXT

The Committee is required to report annually to the Trust Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Strategic People Committee Annual Report which covers the reporting period 1st April 2023 – 31st March 2024.

The Strategic People Committee is accountable to the Board of Directors for providing oversight and assurance on all aspects of the Trust's human resources and organisational development arrangements. The Committee maintains a strategic overview 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. The Committee also maintains a strategic overview of the systems and processes in place to provide an inclusive working environment for our workforce through the delivery of the Workforce Equality, Diversity and Inclusion Strategy which provides assurance that the culture of the Trust is aligned to the NHS People Promise and has oversight of all regulatory submissions and reporting.

The Committee is accountable to the Board for ensuring that 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*** *is delivered and that* arrangements are in place to enable staff to have a voice, through the development of a just and restorative culture which values diversity, inclusion, compassionate leadership and equity for all.

The Committee provides oversight and assurance on organisational strategic workforce risks and ensures that these are managed appropriately.

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

2. KEY ELEMENTS

2.1 Terms of Reference and Cycle of Business

The Committee's Terms of Reference and Cycle of Business were reviewed during Quarter 4 of 2023-24. This included a review of the membership and duties and responsibilities of the Committee.

During the reporting period, the Committee has been composed of two Non-Executive Directors with a quorum of two (one of whom must be a Non-Executive Director). Any Non-Executive Director is able to attend the Committee to cover absence.

The Terms of Reference are attached in Appendix 1 and the Cycle of Business 2025-24 in Appendix 2. The Committee continues to focus on assurance monitoring, with its reporting Sub-Committees meeting to deliver the agenda.

Chair's Logs from Sub-Committees are provided to the Committee for assurance purposes.

2.2 Frequency of Meetings

Meetings continued to take place monthly in 2023-24. During the reporting period, there were 12 meetings.

The Committee attendance record is attached in Appendix 3.

2.3 Committee Effectiveness Review for 2023-24

The review of the effectiveness of the Strategic People Committee was undertaken during March 2024. Committee members and regular attendees were asked to complete an online questionnaire consisting of 17 multiple choice questions (first question was name only) and one free text question.

The responses to most of the of the multiple-choice questions were positive, with respondents either "agreeing" or "strongly agreeing" to each of the statements. Question 8 in relation to the clarity and conciseness of reports was the only exception to this with one "disagree" response.

The following two actions were identified from the survey:

1. Development of an in-house training guide on effective report writing for senior staff (report authors)
2. To review suggested focus areas identified and if appropriate build into the Committee Cycle of Business for 2024/25

2.4 Summary of Activity

2.4.1 Staff Stories

Staff Stories received by the Committee were:

- Theatre Staff Story
- Your Future Your Way
- Freedom to Speak up Champions
- Journey to Becoming a Consultant
- Occupational Health

2.4.2 Deep Dives

Deep Dives received by the Committee were:

- Job Planning
- Mandatory Training
- E-Rostering
- International Nursing
- Widening Participation
- Agile and Flexible Working
- Physician Associates
- Update on Action Against Bullying
- Strategic and Corporate Risks
- EDI Strategy

2.4.3 Hot Topic

Hot Topics received by the Committee were:

- CMAST Workforce Priorities 2023/4
- Industrial Action Update and Impact on WHH
- Band 2 to Band 3 Consultation Update
- ICS Assurance (Workforce)
- Changes to the Pension Scheme

- PSIRF
- Changes to the Role of HWB Guardian
- Band 2 - 3 HCA Skill Mix

2.4.4 Risk Management (Workforce)

The Committee oversees the Trust's Workforce Strategic Risks on behalf of the Board and liaises with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan on workforce issues and to provide the Audit Committee assurance regarding systems of internal control.

The Board Assurance (BAF) and Corporate Risks related to Workforce are presented to the Committee on a bi-monthly basis with actions, mitigations and scoring discussed and amended as appropriate. All changes are shared with the Trust Board.

Throughout the year 2023/24, the Committee monitored two risks on the Board Assurance Framework:

Risk #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.

Risk #1757: If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety.

In August 2023, the rating of risk #1757 was increased from 16 to 20 due to the impact of Industrial Action by Junior Doctors and Consultants and the announcement of further strike action in August.

In February 2024, the Committee undertook a deep dive of the risks for which the Committee was the monitoring Committee and reviewed the risk ratings, target scores, risk appetites and risk descriptions.

2.4.5 Strategy Updates

The Committee has received regular updates in relation to the strategic workforce priorities for the Trust. The People Strategy and Workforce Equality, Diversity and Inclusion (EDI) Strategy were approved for implementation in 2022 - 2025.

A dashboard has been developed to track the progress of programmes of work to achieve the People and Workforce EDI strategy covering 3 years, with bi-annual updates provided on progress, implementation, measures of impact and risks, to provide the Committee assurance.

2.4.6 Workforce Integrated Performance Report

The Trusts Integrated Performance Report (IPR) is reviewed at least annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date. The Workforce Indicators are reviewed by the Committee.

The Workforce Integrated Performance Indicators were reviewed in March 2023 and approved at Trust Board for inclusion in the Trust Integrated Performance Report (IPR) dashboard from April 2023 – March 2024.

The Committee review in March 2023 identified for the period April 2023 – March 2024, seven IPR indicators to be reported to the Trust Board and a new Strategic People Committee Workforce Indicator Report.

2.4.7 Regulatory and Statutory Reporting

The Committee continued to monitor the statutory and regulatory requirements relating to workforce, equality and diversity governance throughout the year which included:

- HEE Monitoring Visit
- GMC National Trainee Survey
- GMC Revalidation Annual Report / NHSE Statement of Compliance and Annual Organisation Audit
- Guardian of Safe Working Hours
- Facilities Time Off
- Equality Duty Assurance Report
- Workforce Equality Assurance Report
- Equality Delivery System 2022
- Gender Pay Gap Report
- Workforce Race Equality Standard
- Workforce Disability Equality Standard

The Committee receives a bi-annual Freedom to Speak Up (FTSU) Report presented to by the Freedom to Speak Up Guardian, providing an overview of policy changes; the range of issues raised by our workforce; the number of FTSU Champions; promotional activities promoting access to the FTSU service and training compliance. The Chair of the Committee is the FTSU Non-Executive Lead.

The Committee receives an annual Health and Wellbeing (HWB) Guardian Report. This report details benchmarking against national toolkits and HWB framework; the range of HWB activities and offers available to our staff – bespoke, individual and team based; details of access of these services and the benefits to our staff. The report is presented to the Committee by the HWB Guardian. In Q3 of 2023-24, amendments to the responsibilities of the HWB Guardian were reported to the Committee.

2.4.8 Workforce Policies and Procedures Overview Report

Following delegation for the approval of policies to Operational People Committee, the Committee received quarterly updates regarding policy development, review, and ratification workstreams managed through the People Policy and Procedure Group, JNCC and JLNC, and ratified at OPC. The Committee through this report also received oversight of the Trust people policy and procedure framework, receiving assurance that the framework is being maintained, policies remain valid and in date.

2.4.9 Improving People Practices Report

The Committee received bi-annual assurance regarding employee relations case management activity across the Trust. Employee relations in this context refers to the Disciplinary, Supporting Performance Improvement, Resolving Workplace Disputes and Supporting Attendance Policies.

The Committee received an overview of the level of activity, areas of risks, and wider actions to improve employee relations case management performance.

2.4.10 Monthly Safe Staffing Report

The Committee receive monthly updates regarding the staffing of wards to support the delivery of safe levels of care. The report provides assurance to the Committee that the Trust

is safely staffed, staffing is closely monitored and processes are in place to support appropriate escalation and to ensure risks are identified and mitigated accordingly.

2.5 Topics Carried Forward

There are a number of topics which the Committee will carry forward into 2023-24 to maintain oversight of including:

- Implementation of the People Strategy and Workforce Equality, Diversity and Inclusion Strategy programmes of work for the year.
- Oversight of the industrial relations climate and maintaining good relationships with the workforce and Staff Side colleagues, including implementation of the HCSW Framework and national review of job profiles and terms and conditions.
- Monitoring of the requirements of all regulatory and statutory reporting
- To ensure that the staff voice is heard, on a bi-monthly basis, with the Committee commencing with a staff story.
- National Transforming People Services and ICB Scaling People Services programmes of work.

2.6 Chair's Summary

I, as Chair of the Strategic People Committee, encourage honest and open discussion and challenge, so that areas of success can be celebrated, and areas of improvement identified, addressed and escalated as necessary.

The Committee has responded well to the change in frequency as well as responding to topics as they arise including overview of the Health Care Support Workers dispute, EDI Improvement Plan and the national Transforming People Services programme of work. Committee members have responded to these challenges and provided the assurance required as well as managing the operational demands of the Trust.

I would like to thank all members of the Committee and the workforce for their responses, support and contributions during the year.

Julie Jarman
Chair of the Strategic People Committee

3 ACTIONS REQUIRED/RESPONSIBLE OFFICER

Actions as per the Committees Action Log. Responsible Officer for the Committee is Julie Jarman, Non-Executive Director.

4 MEASUREMENTS/EVALUATIONS

Please refer to Section 2.3 Committee Effectiveness.

5 TRAJECTORIES/OBJECTIVES AGREED

Please refer to Section 2.3 Committee Effectiveness.

6 MONITORING/REPORTING ROUTES

Reported to Trust Board.

7 TIMELINES

Reporting period April 2023 – March 2024.

8 RECOMMENDATIONS

The Committee is asked to note the report for onward reporting to the Trust Board.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/04/15**			
SUBJECT:	**Patient Experience Annual Report – Patient Experience and Inclusion (PESC)**			
DATE OF MEETING:	April 2024			
ACTION REQUIRED:	**For Noting**			
AUTHOR(S):	Tracy Fennell, Deputy Chief Nurse			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper details an update of workstreams progressed by the Patient Experience Sub Committee in line with the objectives set out in the Patient Experience Strategy 2023–2025. An update is included in relation to: • Patient Feedback • National Adult Inpatient Survey Results 2022 • Volunteers • Patient Experience achievements: evidence of good practice to support the Trust in its mission to be outstanding.			
PURPOSE: (please select √ as appropriate)	**Approval**	**To note** √	**Decision**	
RECOMMENDATION:	The Quality Assurance Committee is asked to receive and note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Patient Experience and Inclusion		
	Agenda Ref.			
	Date of meeting	Monthly meetings October 2023 – March 2024		
	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)***	None			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Patient Experience Annual Report – Patient Experience and Inclusion (PESC)	AGENDA REF:	QAC/24/04/15

1. BACKGROUND/CONTEXT

This paper provides an update on the progress made during April 2023 to March 2024 in relation to the Patient Experience and Inclusion Strategy 2023-2025. Detailing updates on workstreams progressed and monitored by the Patient Experience Sub Committee.

The Patient Experience Strategy 2023-2025 focuses on four strategic objectives, which are:

- **Actively listen and learn from lived experience**; Communicating in a way that people understand and utilising a shared care approach to learning.
- **Work together to make an impact;** Working as an internal multi-disciplinary team for effective and inclusive change.
- **Value our partners to drive and sustain improvement;** Working with our volunteers and external partners to deliver a more holistic approach to healthcare and wellbeing.
- **Embed and celebrate good practice;** Celebrate good practice across our hospitals with our workforce and communities to embed lasting impressions.

To ensure a Trust wide approach in providing an outstanding experience for our patients this strategy will be delivered alongside the following strategies:

- Patient Service User and Carers Diversity, Inclusion and Belonging Strategy 2022 - 2025
- Food and Drink Strategy 2022 – 2025
- Working with People and Communities Strategy 2022 – 2025

2. KEY ELEMENTS

Progress against Patient Experience Strategy work plan

Goal 1 Actively Listen and Learn form lived experience.

There are 14 areas of focus within the workplan under this domain, all actions are progressing and remain on target, 10 actions are complete.

WHH has made significant progress in this area. Key achievements and events under this domain include-

Patient story library

A patient story library has been developed which allows staff to learn from patient's feedback, review and celebrate good practice and seek areas for improvement. Patient stories are sought from a variety of sources such as PALs, complaints, incidents, patient feedback and through learning from Experts by Experience. As the library develops further staff will have the option to search for stories to share with staff in relation to subject area/themes identified.

The Digital Patient Experience Portal (PEP)

WHH has secured funding from NHSE to implement a PEP. The PEP is a digital solution to enhance services for our patients and enable them to take an active role in their healthcare. Access to the portal will be via the NHS app, which plays a role in supporting patients and aid elective recovery. PEP is expected to improve patient experience by improving information for patients about their care, improving the patient letter process, and alleviating queries usually directed to the Trust and local GP practices. Communications are in development to support the launch and take-up of the PEP by WHH patients.

Patients can manage appointments, fill out forms, receive notifications or update their details for waiting lists. The PEP will support the reduction of DNAs with timely reminders, the ability to amend appointments from anywhere and receive information in different formats and languages. Data will be seamlessly shared with our clinical teams, and anyone involved in a patient's care, allowing them to access and update information in one place.

Almost 100 letter templates and accompanying documents have been recreated in the digital system. Work continues with our Digital Team working alongside our PEP provider DrDoctor to set up a test environment.

Still Me/Warrington Dementia Network Event

WHH joined Warrington Speakup (supporting advocacy, social inclusion, equity and social justice) along with other partners on 1 February 2024 at the quarterly Warrington Dementia Network event, Still Me. These events support the community by both bring people together for peer support and strengthen the voices of people and carers living with dementia through music and memory activities, and choir-led singalongs.

WHH Team Lunar 1st Birthday

Our Home Birth Team (Team Lunar) midwives held their first birthday celebration on 10 February, at Thelwall Parish Hall, Warrington. The event was an opportunity for the public to find out more about accessing home birth services and a chance to hear positive experiences from home birth families. The event included a raffle and tombola to raise funds for home birth equipment, as well as a soft play area and face painting for children and families.



Children and young people's pre-op journey

WHH's latest patient video provides a step-by-step guide for children and young people on what to expect during pre-operative appointments at the Trust. Requested by the children's ward and theatres, the video aims to ease the fears and anxieties of young patients before attending hospital, with a video link sent to patients and parents so they know what to expect during their care. Narrated by Jill Holland, Play Specialist, the video shows pre-op tasks including checks, anaesthetics, recovery, play and puzzles, so visiting patients experience as little stress as possible. The video can be accessed at https://youtu.be/Ao3le7ncjJ

Patient Information policy

A revised version of the Production of Patient Information Policy is being development and will go out for consultation imminently. This version references more clearly the processes for clinical sign off and requests for patient information video formatting.

Maternity explainer videos

Throughout 2023 our Communications and Engagement Team worked with maternity services, plus EbyEs and Maternity Voices Partnership to create six animated explainer videos, to support families during pregnancy, labour and beyond. WHH is currently working with suppliers to provide the animations in five alternative language and British Sign Language (BSL) formats, to support accessible communication for our patients and families. The completed animations aim to improve patient safety and awareness of the pregnancy journey and will support those within maternity who may face communication barriers.

Gamma Camera Unit

Patient journey WHH is making it easier for patients to find their way easily and quickly to the Gamma Camera Unit with an online virtual tour. The video navigates the corridors of Warrington hospital so patients can become familiar with the route before they arrive at their appointment. The brief virtual tour begins at the main entrance and guides patients past various shops and facilities to the new welcome desk located in the atrium. WHH Radiographers, Ruth and Nicole, narrate the video and talk through the tasks undertaken during an appointment so visiting patients know what to expect. The virtual tour is designed to help make things easier for patients to get to their appointments in good time and with as little stress as possible. Watch video here - https://youtu.be/cjTRhKSyqec

Accessible Information Standard and Communications

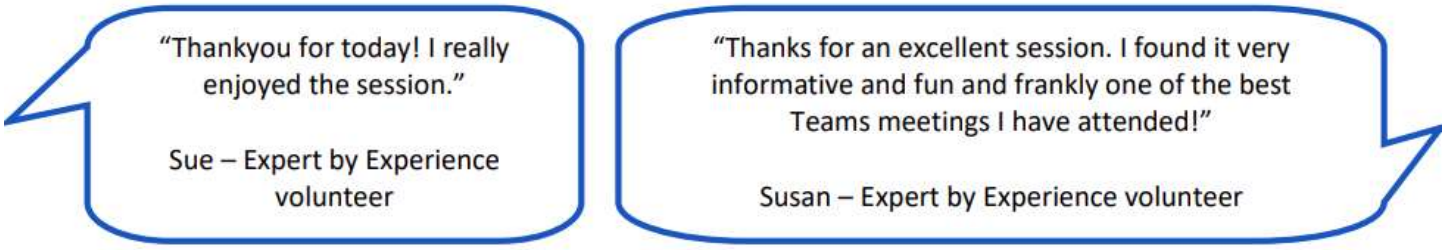
Launch and training Launch materials have been developed, including an animation for staff, in preparation for a campaign Go Live. Launch is dependent on a further workstream which is focusing on capturing data in the EPR and ensuring this can be exported and actioned for patient letters and communication adjustments. The Communication Passport (formerly Healthcare Passport) has been developed. Roll out of AIS materials is expected in 2024.

Call for Concern

Martha's Rule (Martha's Law) has been introduced into the NHS from April 2024 which allows patients the right to rapidly access a second clinical opinion in urgent or contested cases. Following this WHH has been piloting Call 4 Concern © which provides patients and carers/friends/family with a means to raise any concerns about a patient's deterioration directly with the Acute Care team, who can prioritise a call and act upon concerns in a timely manner. Calls can be made 24 hours a day, seven days a week, via a dedicated (staff) smart mobile phone. The phone has a text facility, voicemail, and WhatsApp to support patients with various accessibility needs. From 11 March 2024, the Call 4 Concern's pilot commenced on wards A2 and B18, alongside being trialled on ICU for patients stepping down to a ward. Outcomes from the initiative will be observed and evaluated as the project progresses to inform further rollout.

Experts by Experience Training

WHH in partnership with AQUA hosted a half day online Refresher Training Session to support EbyE volunteers in QI methods, co-production and evaluation of results/outcomes through lived experience. Held via Teams on 12 March, the session was attended by five EbyEs, with ten further EbyEs requesting to attend a future session. The training was well received by all attendees, as below:



EbyE Project Updates

Maternity Strategy Feedback

Feedback was sought from EbyEs on the Trust's Maternity Strategy 2023 – 2026, which outlined plans to achieve the national three-year delivery plan for maternity and neonatal services. WHH's maternity service provides aspects of maternity care for around 4,500 women per year, with approx. 2,700 women per year giving birth either in the Trust's maternity unit, or at home. 2 EbyEs shared their feedback on the draft strategy, including statistical queries, formatting suggestions, language feedback, and commentary which was shared with the Director of Midwifery to inform the content.

Innovation survey feedback

In partnership with the Research, Development and Innovation Team, public and EbyE participation was sought in a survey exploring the meaning and focus of innovation at WHH. 57 responses were collected in total, with key aims for innovation identified as:

1. Improving efficiency and workflow, allowing more time for patient care (21%)
2. Improving patient outcomes (20%)

3. Improving working conditions and wellbeing for staff (16%)
4. Improving care environment for patients and service users (16%)
5. Improving patient safety (13%).

The types of innovation would mean the most to respondents as a patient, carer, service user or member of the public were specified as:

1. Early disease detection (20%)
2. Personalised treatment plans (17%)
3. Diagnostic assistance (12%)
4. Patient engagement and empowerment through apps (9%)
5. Care co-ordination platforms (9%).

MH Strategy engagement

With approximately 1 in 4 people in the UK experiencing a mental health problem each year, WHH see increasing numbers of patients attending with (or because of) complex mental health issues. To support WHH's Mental Health Strategy and understanding, seven EbyEs with lived experience were recruited to embed patient voice throughout the Strategy's review and refresh. Info and details of the experiences of each EbyE was shared with the Associate Chief of Nursing (lead for the MH Strategy), to enable experiences of patients, family, carers and advocates to be a key part of informing the Trust's approach to mental health.

Redevelopment of WHH website

During December 2023 EbyEs have been consulted to support initial redevelopment of www.whh.nhs.uk, the website for Warrington and Halton Teaching Hospitals NHS FT. Sixteen Experts by Experience offered their thoughts and comments to help inform the website redevelopment to ensure information is accessible and site navigation is simpler. In summary, 94% or respondents felt we should focus on site navigation, with 56% of participants requesting a focus on search facilities, website accessibility and content. Though overall feedback was positive, there was a trend that information on the site could be more concise and easier to find. Nine respondents have requested to join further workshops/projects to develop the site. Further engagement is scheduled throughout the website redevelopment project.

Z beds to support Johns Campaign

Following a successful charitable funds bid we now have foldaway beds available for visitors/carers who are staying overnight with a patient. These are located in the facilities equipment store and can be requested from the team during the evening.
Contact | John's Campaign (johnscampaign.org.uk)

Goal 2 Work together to make an impact.

There are areas 3 of focus with 10 associated actions within the workplan under this domain, all actions are progressing and remain on target, 6 actions are complete.

Key achievements and events under this domain include:

Digital Enhancements

The Patient Experience Team have been working with the Digital Team to create alerts for deaf/ hard of hearing patients. The d/Deaf alert is now live on Lorenzo.

MaDE for Easter campaign

Updates have been shared via 'The Week', Team Brief and GMWHH ahead of and during MaDE (Multi-agency Discharge Event) for Easter. The initiative aimed to get as many patients as possible to return home to their loved ones before the Easter Bank Holiday weekend and this year is supported by the first NHS C&M Integrated Care System Super MaDE campaign.

Measles awareness campaign

The national NHS campaign on measles has been promoted throughout February and March, encouraging uptake of MMR vaccinations and advising anyone with symptoms to contact NHS 111/their GP before attending a healthcare setting. A variety of communications have been produced and the Communications and Engagement Team have updated and refreshed all the information on our 'Information about Measles' page and developed materials to support the IPC response which have been shared across NHS C&M and NHS England northwest region.

MS Society Information Event

On 9 November the Engagement and Involvement Officer joined partners from LiveWire Warrington, Healthwatch Warrington, Warrington Carers Hub, Warrington Voluntary Action and Warrington Disability Partnership to promote info and services with those individuals and families affected by Multiple Sclerosis. Opened by Cllr Maureen McLaughlin, the event highlighted the needs and feedback of those 400 people affected by MS living in the town, and sought to reignite interest and involvement in a Warrington MS Group.

Youth Wellness Marketplace

Organised by WHH's Youth Support Worker, the Youth Wellness Marketplace on 17 August focussed on supporting the wellbeing and mental health of young people and families affected by long term health conditions. There were 32 attendees (including patients, families, and hospital Governors)

visited the marketplace to speak with stallholders including Kooth, Talking Matters, Diabetes UK, and WHH's own Youth Service, Transition Team, Patient Engagement and Involvement Team, Paediatric Diabetes, Paediatric Respiratory, Paediatric Epilepsy, and Paediatric Dietetics teams. Analysis shows 100% of the event feedback was positive, and included comments such as:

Carers Cafes Relaunch

N-compass (WBC's commissioned carers support service for Warrington) worked with WHH to relaunch the Carers Café These commenced from 13 June 2023 and run on the 2nd Tuesday of every month, 1.15pm – 2.30pm at The Wingman Lounge.

Carers Week 2023

From 5 – 12 June WHH celebrated Carers Week at Warrington and Halton, an annual campaign raising awareness of caring, highlighting the challenges that unpaid carers face and recognising the contribution they make to families and communities. Events at both sites were an opportunity to promote WHH's Carer Passport, carer parking concessions, visiting time flexibility, n-Compass, Halton Carers Centre and WHH's Carers Cafes. For info visit https://whh.nhs.uk/patients-and-visitors/information-carers.

Armed Forces Day – The Tom Sephton Memorial Trophy Karen Wilkinson (Apprenticeships), Esstta Griffiths (Engagement & Involvement) and Anne Robinson (Governor) joined Warrington Armed Forces Day on 24 June at Crossfield's Rugby Club. The event was host to hundreds of visitors with Team WHH raising awareness of NHS careers, Reading Force, WHH Armed Forces Advocacy, Operation Courage and more.

Goal 3 Valuing our volunteers and partners to drive and sustain improvement.

There are 3 areas of focus with 3 actions within the workplan under this domain, all actions are progressing and remain on target, 2 actions are complete.

Key achievements and events under this domain include-

Hong Kong Nationals engagement event

WHH supported Hong Kong nationals living in the town on 9 February at an info sharing event organised by WBC, NW Regional Strategic Migration Partnership Hong Kong team and Cheshire, Halton & Warrington Race and Equality Centre Team. Staff teams from Communications and Engagement, Diabetes, and RDI hosted stands on the day and encouraged awareness of healthy living and participation in WHH clinical research and volunteering.



World Obesity Day

Held annually on 4 March, World Obesity Day is an international effort to improve understanding, prevention and treatment of obesity. On the day WHH's Community Diabetes Specialist Nurses, Natalie Collins and Liz Atkins, visited Runcorn Shopping City to talk to members of the public and raise awareness about Diabetes risk factors, health, physical activity and nutrition.

Building social value/Contribution to Anchor Institution

Living Well Hub opening event Officially opened by WHH, Warrington Borough Council, Bridgewater Community Healthcare and Mersey Care on Friday 1 March, the Living Well Hub welcomed over 100 guests with a morning of speeches, song, music and tours. The hub offers a welcoming and accessible 'one-stop shop' to empower residents to live as happily, healthily and independently as possible, with 25 organisations and more than 350 staff set to provide a wide range of NHS and non-clinical services under one roof. For more info visit https://www.warrington.gov.uk/living-well-hub

Goal 4 Embed and celebrate good practice.

There are 3 areas of focus within the workplan with 3 associated actions under this domain, all actions are progressing and remain on target, 2 actions are complete.

Key achievements and events under this domain include:

Shared Learning Forum

On 4 February WHH's Quality Academy hosted 2024/2025's first quarterly Shared Learning Forum, where staff were supported to learn from each other by sharing experiences, ideas, and feedback for current and future quality improvement initiatives. The Trust's Engagement and Involvement Officer presented the Experts by Experience programme and was joined by Expert by Experience (EbyE) volunteer, Lorraine Woolley, who shared her views and insight on the value of the EbyE role within Trust projects.

"Most EbyE projects I have been invited to participate with are services I use myself. I really feel it's given me the opportunity to really look at projects from every angle, to try and make them as inclusive and accessible as possible. It's great to have a voice and be able to say when things will work, or when they could be improved. If there is nobody to voice this sort of feedback, then nothing would change!"

Lorraine, WHH Expert by Experience volunteer

Collaboration work

Work in collaboration with the Integrated Care System, Community Partners and the Voluntary, Community, Faith and Social Enterprise (VCFSE) groups to learn and embed good practice enabling quality patient experience – continue and arrange events for 2024.

Equality Delivery System (EDS) public engagement feedback

Working together, WHH's Workforce EDI, Patient Experience, and Engagement and Involvement Teams held three events from 27 to 29 November to gain insight and input into the Trust's EDS

framework performance and self-assessment. Events were held at both Halton and Warrington Hospital, twenty-four community stakeholders joined the events. This feedback helped develop the Trust's response to the EDS standard in relation to Chaplaincy, Long Covid and Maternity services. Overall feedback was positive and partners view was alignment with our internal assessment Partners included Deafness Resource Centre, Healthwatch Halton, Warrington Carers Hub, Warrington Disability Partnership, Home-Start Warrington, Halton Carers Centre and Healthwatch Warrington.

"Chaplaincy's positive patient and carer stories speak volumes."

"Maternity have an innovative approach to ensuring positive patient experiences and meeting needs."

"The Long Covid service has gone from strength to strength and is constantly evolving to make the service the best it can be!"

Moving to Outstanding

EbyE newsletter on 19 December 2023 the Experts by Experience Programme was highlighted in the Trust's staff e-bulletin (The Week) in a Moving to Outstanding feature. The article showcased how our work with EbyEs is an example of excellent practice at WHH, which supports our mission: 'To be outstanding for our patients, our communities and each other'. Newsletter feedback has been positive from both EbyEs and staff. Comments included:

"Great to see all the achievements in 2023. Look forward to seeing the work develop more this year!"

Kate Henry, Director of Communications & Engagement

"I have just seen the Dec EbyE newsletter - great job!"

Rachel Moran, Head of Continuous Quality Improvement (Interim)

"EbyEs are invaluable. It's wonderful the Trust wants to engage us in this way"

Karen, EbyE volunteer

"Fantastic read!"

Adam Harrison-Moran, Head of Workforce Equality, Diversity and Inclusion

Improvements in stroke services

Warrington and Halton Teaching Hospitals (WHH) celebrated the first anniversary of its Singing Group, which is part of a transformative journey in stroke care. WHH introduced a weekly Singing Group in February 2023, to complement its existing Shared Reading Groups, both of which are aimed at encouraging recovery, preventing deconditioning, and improving the overall quality of life for patients who have had a stroke.

Catering Hot finger food

A hot option will be available for patients living with Dementia on the Forget me not ward from mid April 2024. This will include dishes such as mini quiche, sausages, chicken goujons and omelettes. Unfortunately, we're not able to roll this out to other wards until Digital meal ordering is in use. This will include a selection such as Sausage rolls, chicken goujons, mini quiche, beef burgers and potato waffle. Other areas are able to request this menu by contacting the catering department.

Multi-Sensory Room

A charitable funds bid was approved for the development of a multi-sensory room on B11, this will have sensory lighting, toys and soft furnishing and play items providing educational, sensory and stimulating experiences for our children, which will not only boost recovery times but provide an area where young children can build friendships and memories. Sensory equipment has been researched and put into practice in many other health settings. It has been a valuable resource for providing psychological and social support to children and young people not only with medical condition but also mental health challenges (Which we are seeing a significant increase in attendances). The paediatric team are now working together to submit a bid for the soft furnishing and equipment required.

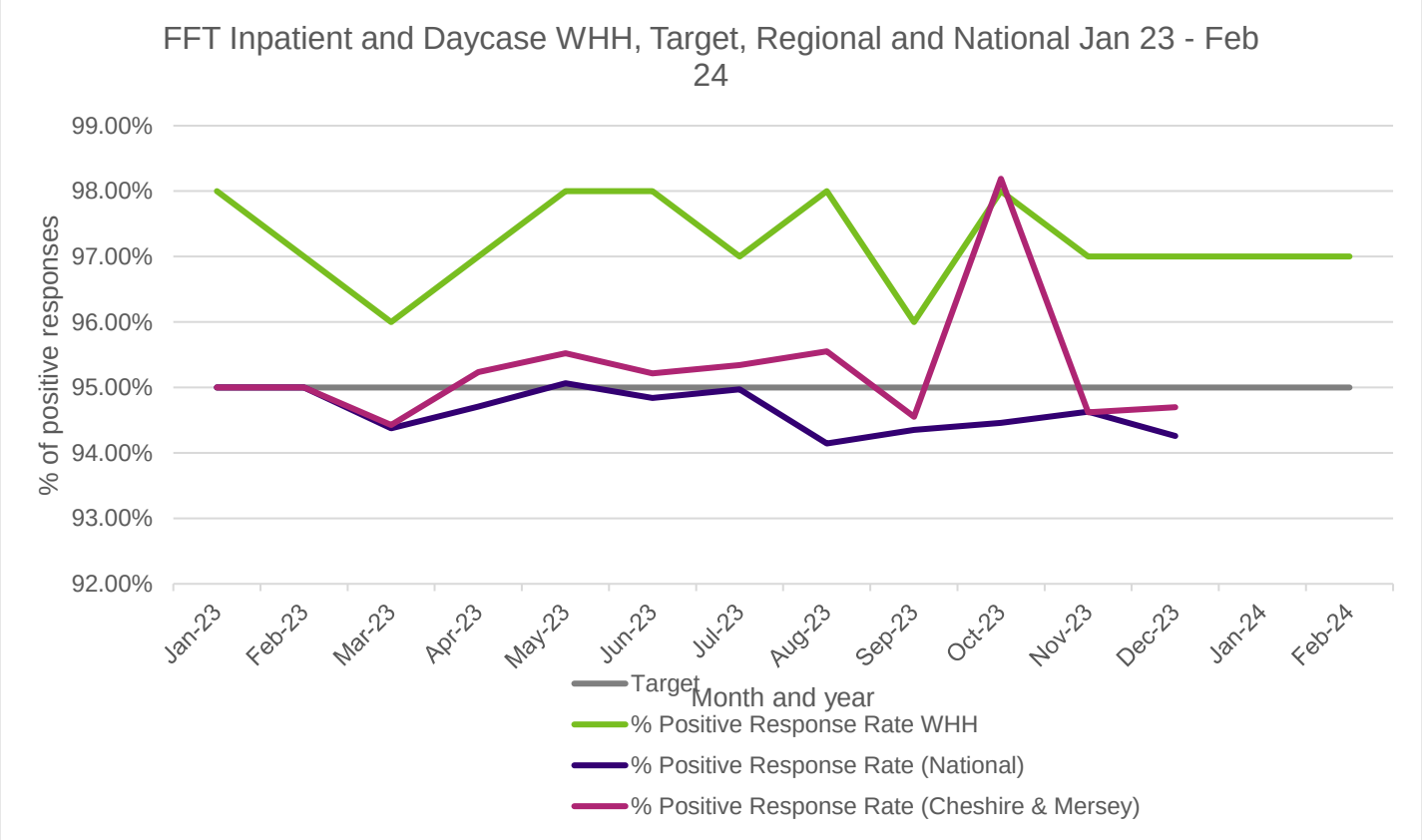
Patient Feedback - Friends and Family Test (FFT)

The Friends and Family Test (FFT) is a feedback tool used by patients and service users, which provides them with the opportunity to provide feedback on their experience of treatment and the care received. By listening and reviewing the feedback of patients it supports the Trust to identify what is working well and areas that can be improved. By introducing and promoting a digital method for providing feedback it has ensured the opportunity to feedback is accessible for all patients. Feedback can be provided in multiple formats such as:

- accessible in multiple languages
- easy read
- large print

Over the last 12 months the Trust achieved an average recommendation rate of 97% within inpatient and day case areas against an internal target of 95%. The National average and the Cheshire and Merseyside average rate recorded at 95%. (Figure 1)

Figure 1: Inpatient and Day Case FFT Performance



The Emergency Department (ED) has received an average 76% positive feedback rating in the last 12 months against an internal target of 87%. During Q3/early Q4 ED FFT scores both locally and regionally have declined. These scores are reflective of the challenges Emergency Departments are seeing with the number of patients presenting who experience extended waiting times. WWH noted the highest positive recommendation rate of 84% achieved in January 2023. (Figure 2)

Figure 2: FFT Emergency Department positive recommendation rate comparison to regional Cheshire and Merseyside average

Month	Emergency Department	Cheshire & Merseyside Average
September 2022	71%	75%
October 2022	74%	73%
November 2022	71%	74%
December 2022	66%	73%
January 2023	84%	84%
February 2023	78%	79%
March 2023	75%	77%

April 2023	81%	82%
May 2023	80%	80%
June 2023	72%	79%
July 2023	75%	81%
August 2023	79%	82%
September 2023	78%	80%
October 2023	77%	78%
November 2023	76%	78%
December 2023	73%	78%
January 2024	76%	Data not published
February 2024	71%	Data not published

Nationally Emergency Department improvements continue to be challenging due to the volume of patients attending ED, continually exceeding the capacity of departments.

At WHH ED feedback themes are in line with the national picture for Emergency Departments with the highest themes being noted as:

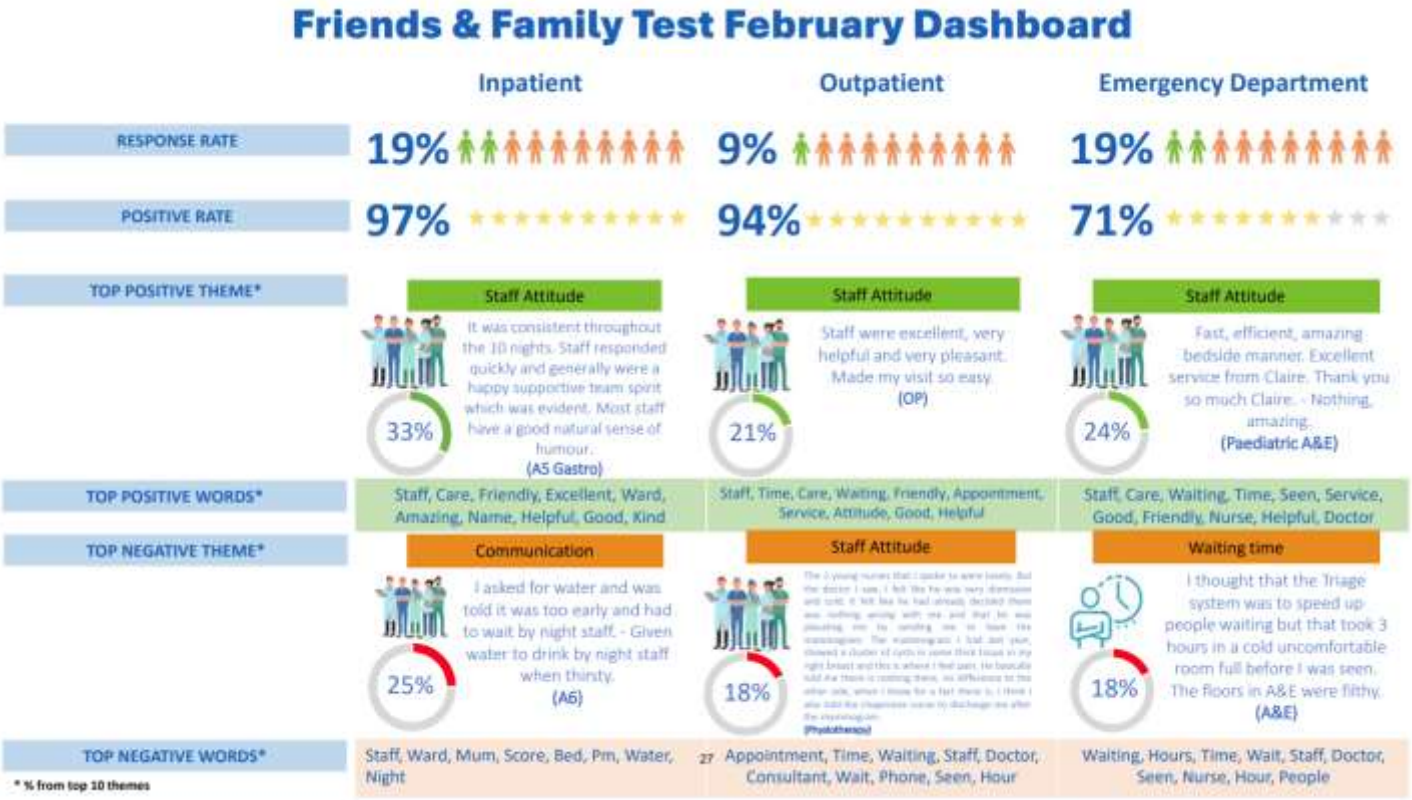
- wait times.
- communication
- environment

Despite the challenges WHH continues to drive ED patient experience improvements by:

- Refurbishing waiting areas; new seating and removal of visual clutter.
- Creating a volunteer rota for additional support.
- Ensuring drinks rounds are available at least every two hours.
- Trailing nurse/HCAs to support in waiting area.
- Provision of a Mental Health assessment room.
- Provision of a Bereavement room introduced.

Trust wide improvements are being developed to support increased response rates, data capture, reporting and sharing of information. A new FFT infographic dashboard was created and presented at Patient Experience Sub Committee for approval. The dashboard highlights the main areas for FFT focus, areas of improvement as well as areas of celebration. Example can be seen below (Figure 3)

Figure 3: FFT new dashboard February 2023



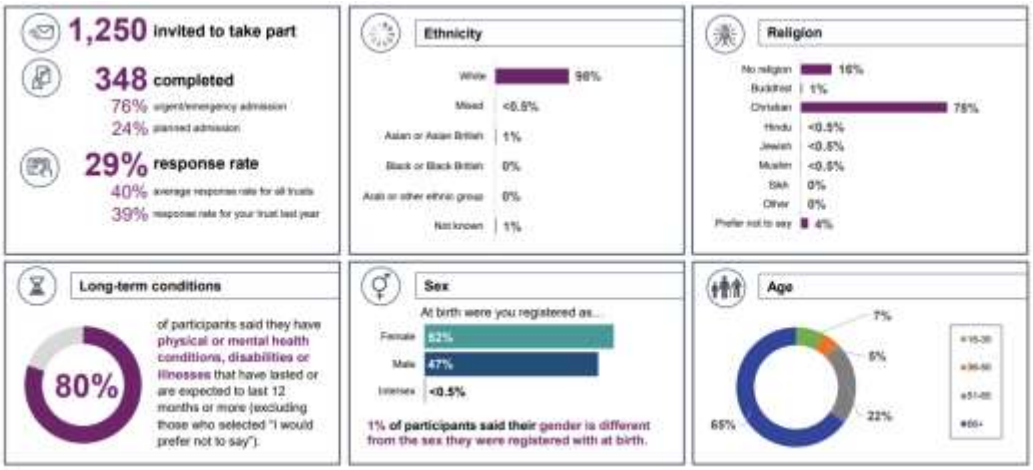
The dashboard was approved and is now being developed further for local areas so that departments can use the infographic to display local area/CBU feedback.

National Adult Inpatient Survey results 2022

The National Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission (CQC). The survey gathers experiences of adults who stayed a minimum of one night (16 years or older, excluding Maternity) at Warrington and Halton Teaching Hospital (WHH) in November 2022. The National Inpatient Survey results were published by CQC in September 2023.

The National Adult Inpatient Survey uses both online and paper methodology, the results are compared against the 2021 results and benchmarked against other Trusts both regionally and nationally. In total 133 NHS Acute and Specialist trusts were survey in England, with responses from 63,224 patients.

WHH overall response rate was 29% compared to a national average response rate of 40%. At WHH patient participant demographics consisted of:



WHH did not benchmark lower than other Trusts in any areas and ranked somewhat better than other Trusts on 2 questions:

- Were you prevented from sleeping at night due to hospital lightning?
- To what extend did you understand the information you were given about what you should or should not do after leaving hospital?

The survey compares WHH 2022 internal results to 2021 performance, this comparison can be seen below:

Section	WHH 2021	WHH 2022
1. Admission to hospital	6.8	6.6
2. The Hospital and ward	7.8	7.7
3. Doctors	8.8	8.8
4. Nurses	8.5	8.4
5. Care and treatment	8.1	8.2
6. Operation and procedures	8.4	8.6
7. Leaving hospital	7.2	7.2
8. Feedback on the quality of your care	1.7	1.9
9. Respect and dignity	9.2	8.8
10. Overall Experience	8.1	8.0
11. Long term condition – not comparable as new question in 2022	NA	6.7

WHH did see decline in 2 individual questions compared to the WHH 2021 survey, however these were not seen as statistically lower than other Trusts.

- Did you get enough help to eat your meals?
- Do you think the hospital staff did everything they could do to help your pain?

Actions to improve these areas feature in the 2022 Inpatient survey action plan and remain on target these will be monitored via PEDISC quarterly.

Areas identified where patient experience is best at WHH:

- Patients are not concerned with disturbance from hospital lighting and staff, patients at night (both sites).
- Cleanliness of hospital and wards across both sites.
- Taking own medications when needed, including being given pain relief. Higher scores noted on Halton site.
- Questions regarding discussing operations and procedures, pre and post operation provided better than expected results for the Trust as a whole.
- Many positive responses for questions regarding leaving hospital. This included patients, families and carers being involved in decisions when leaving hospital, being given information on advice after discharge, take home medications, contact points for patients who were worried post discharge and knowing what would happen next with care.
- Positive results seen for questions that patients felt they were treated with respect and dignity whilst in the hospital.
- Long term conditions were felt to be taken in account during patients care and treatment in hospital, across both sites.
- Overall experience whilst in hospital was rated much better than expected for both Halton and Warrington sites comparable to other Trusts.
- Waiting list times also noted positive scores in survey results.

Where patient experience could improve (to note: WHH is at national average when benchmarking, areas below are highlighted where scores could show further improvement to achieve higher than the national average)

- Hospital food quality: further improvements possible for patients to have greater access to food outside of set mealtimes.
- Communication: understanding information given by medical/nursing staff, being involved in your care at Warrington site.
- Nursing staffing question and ability to get staff attention when required on Warrington site.
- Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital.
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital.
- Pain control: where patients were in pain, did hospital staff do everything they could to help control their pain.
- Long term conditions: patients feeling that their long-term condition is taken into consideration whilst they were in hospital.

All actions have been completed and closed for the 2021 National Inpatient Survey Action Plan. Key areas identified for improvement for the 2022 action plan are, but not limited to:

- waiting times
- ward moves
- communication

The 2022 action plan has been produced, containing 42 actions across the 11 question categories. All actions remain on track. The action plan has been shared with existing workstreams and the overall action plan is tracked and reported quarterly though Patient Experience Sub-Committee, any escalations will be reported to Quality Assurance Committee (QAC).

2023 National Inpatient Survey results are now being collected. Following widespread Trust promotions, survey responses have already seen a noted increase in a response rate of 36% (compared to 29% in 2022). Further responses are being collated, this exercise concludes on 19 April 2024.

It is noted WHH has performed well in the 2022 National Inpatient Survey and has mechanisms to further improve and monitor further achievements throughout 2023. For further details please see presentation.

Volunteers

WHH have a thriving community of volunteers with 68 individuals in active volunteering roles. Onboarding and retention initiatives have been reviewed to ensure they are effective in removing delays in onboarding and retain an active cohort of volunteers.

Some of the work undertaken to improve and enhance the volunteer service includes:

- A Volunteer Policy has been developed outlining systems and processes to manage a safe and effective Volunteer Service this was approved at PESC in November 2023 and ratified by the HR Policy Development Group in February 2024 and JNCC in March 2024.
- 122 new volunteers registered with the Trust since April 2023.
- Since April 2023 volunteers have carried out 4520 hours overall in support of the Trust in a variety of roles.
- The WHH Volunteer Team has provided support to the Patient Experience and Inclusion Team with 26 Volunteers providing 1767 encounters of wayfinding assistance to our patients and visitors utilising the Welcome Service at the front of Warrington Hospital.
- Volunteers have also provided support during operational pressures, including 9 regular volunteers providing 140 hours of valued support to the patients in the Accident & Emergency Department from February 2024.
- The Trust recognised the work of one volunteer who supports Radio General at Warrington who celebrated 50 years of volunteering at the Trust in January 2024. This was acknowledged and the volunteer was personally thanked by the Chief Executive at a celebration afternoon tea event for the Trusts volunteers in December 2023.

WHH currently have volunteer roles supporting the following areas:

- Warrington wayfinder and welcome desk
- Halton tea bar
- Halton shop
- Halton welcome desk and wayfinder
- Radio General at Warrington
- Radio Halton
- Warrington Discharge Lounge
- Warrington Emergency Department
- Forget Me Not Ward activity roles
- Radiology support
- Chaplaincy support
- Bereavement administration
- WHH Charity receptionist

- CAN treat centre support
- Patient Advice and Liaison Service (PALs) support
- Administration support for IBD Nurses
- Living Well Hub Support
- Gardening

Patient Led assessments of Care Environment (PLACE) National and Regional results

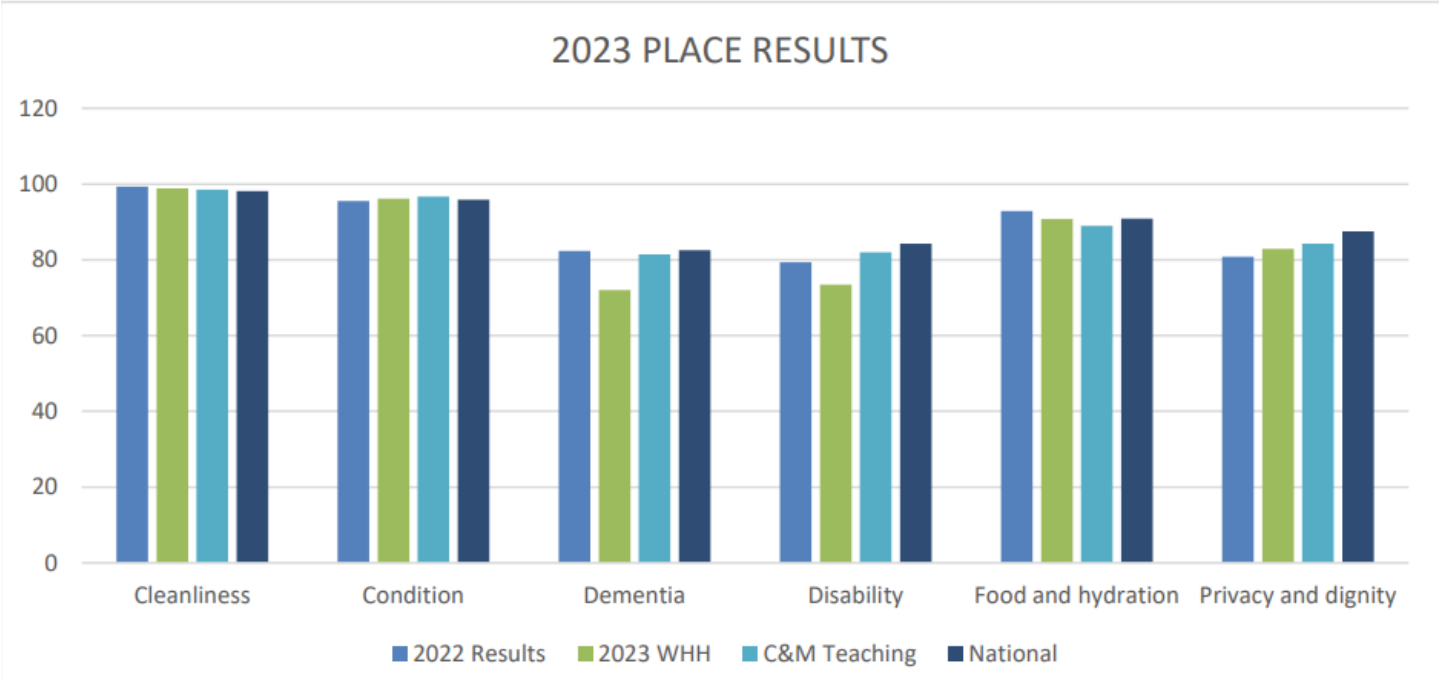
Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability. PLACE assessments are completed by 15 December 2023 and published in March 2024

Table 1 -WHH latest results from 2023 PLACE assessments are noted below:

Results comparison

	2022 Results	WHH	C&M teaching	National average
Cleanliness	99.32	98.84 ↓	98.50	98.10
Condition, maintenance appearance	95.49	96.13 ↑	96.72	95.91
Dementia	82.36	72.03 ↓	81.48	82.54
Disability	79.38	73.48 ↓	82.00	84.25
Food and hydration	92.91	90.78 ↓	88.98	90.85
Privacy, dignity and wellbeing	80.78	82.90 ↑	84.23	87.49



Key feedback related dementia and disability:

- Ensuring when a capital scheme is completed toilet doors are all a single distinctive colour.
- Ensuring all areas have large 18" clocks which display the date and time.
- Reviewing signage across the Trust.
- Improve seating in patient areas to cater for a range of patient needs.
- There is a requirement for all lighting levels to be dimmable – this would need a significant capital investment.
- Handrails in all patient areas- some of these have been added in public areas but again significant capital investment would be required to implement in all patient areas

There have been several achievements with teams working together to enhance and improve patient experience across the Trust in line with the Patient Experience Strategy. The Quality Improvement Team have recorded 85% of Quality Improvement Projects provide improvements to patient experience.

Next Steps - Patient Strategy 2025

Plans for revising the Patient Experience Strategy are underway with wide public engagement planned for Summer 2024.It is anticipated that the new strategy will be launched in April 2025.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Note the Trust has mechanisms to further improve and monitor further achievements throughout 2024.

4. MONITORING/REPORTING ROUTES

Oversight of progress against the Patient Experience Strategy and Action Plan will be reported to the Patient Experience Subcommittee quarterly, any escalations will be reported to Quality Assurance Committee.

5. TIMELINES

All actions to be complete by as per timeline on associated strategy action plan.

6. ASSURANCE COMMITTEE

Quality Assurance Committee.

7. RECOMMENDATIONS

Members of the Quality Assurance Committee are asked to note the report and receive assurance of the progress WHH made to improve patient experience as outlined in the Patient Experience and Inclusion Strategy 2023-2025.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/24/05/38**			
SUBJECT:	**Infection Prevention and Control Report Quarter 4**			
DATE OF MEETING:	7 May 2024			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah Chief Nurse/Director for Infection Prevention & Control			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		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:			
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 4 (Q4) 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 Q4 are: - • E. coli bacteraemia 81 cases against an annual threshold of 54 • Klebsiella Spp. bacteraemia 28 cases against an annual threshold of 18 cases • P. aeruginosa bacteraemia 11 cases against an annual threshold of 2 cases • C. difficile 55 cases against an annual threshold of 36 cases • MRSA bacteraemia 0 cases against the zero threshold and a rolling 18 months free			

<table>
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- MSSA bacteraemia 36 cases (no threshold)

Inpatient Covid-19 cases at end of Q4 are: -

- 506 (0-2 days)
- 104 (3-7 days)
- 166 (8-14 days – probable healthcare associated)
- 198 (15+ days – definite healthcare associated)

There were 13 inpatient Covid-19 outbreaks in the FY:

- 7 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.

There was a measles exposure incident in ED in February. Rapid actions were implemented to warn and inform ED attenders and exposed staff, advising vigilance for signs and symptoms. One patient contact was admitted for supportive care and was later confirmed as an epidemiologically linked measles case.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note ✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">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="3">Infection Control Sub-Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">ICSC/24/04/09</td></tr>
<tr><td>Date of meeting</td><td colspan="3">25 April 2024</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">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="4">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 4	AGENDA REF:	QAC/24/05/38

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control (IPC) activity for 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

Clusters of Covid-19 cases have been assessed and where outbreaks are determined, reported via the NHSE portal. Reporting via this portal will cease from 01 April 2024 as directed by NHSE.

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

RAG rating of Trust performance for HCAI by month is shown in Table 3, with more detailed information in appendix 1.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	J	A	S	O	N	D	J	F	M	Total	Yearend status
C. difficile	≤ 36	1	1	2	5	4	6	4	3	6	8	9	6	55	Over threshold
MRSA BSI	Zero	0	0	0	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	5	4	1	36	No threshold
E. coli BSI	≤ 54	8	8	6	5	8	7	6	8	9	7	3	6	81	Over threshold
Klebsiella spp. BSI	≤ 18	0	3	0	1	1	1	3	5	3	4	4	3	28	Over threshold
P. aeruginosa BSI	≤ 2	0	2	0	0	0	1	1	3	3	0	0	1	11	Over threshold

C. difficile: 23 cases reported in Q4 and over the annual threshold by 19 cases. Ribotyping of Trust apportioned cases continues, and no transmission has been identified between toxin positive cases. The existing C. difficile prevention action plan is being revised and refreshed, with a plan to share an awareness raising

message via the CEO briefing in April 2024. A plan is in place to schedule additional improvement activity into an assurance framework to drive further improvements in IPC standards.

MRSA Bacteraemia: Nil cases in Q4 and for the FY. The Trust has been MRSA bacteraemia free for a rolling 18 months.

MSSA Bacteraemia: 10 cases in Q4 and 36 cases for the FY. There are a mixture of primary sources including skin and soft tissue infection; central line associated; endocarditis, 1 possible surgical site infection, septic arthritis, osteomyelitis, discitis, and psoas abscess, an infected haematoma and 12 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 16 cases, Klebsiella spp. 11 cases and P. aeruginosa 4 cases reported in Q4. All GNBSI are over the annual thresholds. An in-depth review has been conducted and presented to the Quality Assurance Committee in April.

Actions in progress and next steps include: -

- P. aeruginosa audit – in progress
- UTI audit – in progress
- Hepatobiliary audit - review and interpretation of findings once received
- Revisit cases with unknown source
- Add Mortality data monitoring and align to PSIRF for learning
- Review Terms of Reference for GNBSI Prevention Group
- Revise GNBSI Prevention Plan and Driver Diagram
- Request and engage a Clinician to be part of the GNBSI prevention group
- Engage Practice Based Educators
- Relaunch prevention plan and activity
  - Nutrition and Hydration continued focus
  - Timely Microbiological sampling – blood cultures and urine (align to sepsis workstream)
- Continue to provide Mandatory Training on GNBSI prevention

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): -

- Face filtering piece FFP3 fit testing policy
- SOP for staff Covid-19 testing v14
- Influenza (pandemic and seasonal) policy
- Working with dogs in healthcare policy
- Measles Risk Assessment

- ED Measles Triage and Patient Placement SOP
- ICSC revised Terms of Reference

Audit

During Q4, 14 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, low/high level dust including extract vents, dusty IT equipment, dating of disposable curtains
Ward Kitchens	General tidiness, recording of fridge temperatures
Safe Handling/Disposal of Sharps	Temporary closure system not-activated, bins not labelled on assembly
Patient Equipment (General)	Missing I am clean labels, some items dusty and required cleaning
Short Term Catheter Management	Use of catheter securing straps to prevent urethral trauma, documentation of on-going requirement
Care of Peripheral Intravenous Lines	Completion of ongoing monitoring charts (Visual inspection Phlebitis) scores
Hand Hygiene	Access to sinks blocked - addressed at audit

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. Progress against action plans is monitored at the Infection Control Sub-Committee.

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 assessment results for Q1- Q3 and Q4 (not finalised at time of report writing) are shown in table 5.

Table 5 IVOS CQUIN results

Q1	Q2	Q3	Q4
28%	22%	14%	11%

The IVOS decision aid tool was launched on medical wards with good feedback of usability. 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, which will be used to inform future Trust strategy on antimicrobial stewardship.

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 91% at the end of March 2024 (table 6). Mandatory training is available via eLearning, face to face training and at corporate induction.

Table 6 Mandatory training Compliance

IPC Mandatory Training	A	M	J	J	A	S	O	N	D	J	F	M
Level 1 – Non-Clinical	94%	96%	94%	95%	95%	96%	95%	95%	96%	96%	96%	**96%**
Level 2 – Clinical	83%	84%	85%	86%	86%	86%	87%	87%	87%	87%	87%	**86%**
Overall compliance	**84%**	**90%**	**90%**	**91%**	**91%**	**91%**	**91%**	**91%**	**92%**	**92%**	**92%**	**91%**

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. These were undertaken by the Facilities and IPC Team during Q4. Further planning work is required to include attendance from the Estates Team and area managers, to meet the specification of NHS Cleaning Standards guidance.

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
Jan	66	22	38	32	159
Feb	37	5	9	10	60
Mar	15	4	8	9	36
Total	**506**	**104**	**166**	**198**	**974**

Covid-19 Outbreaks

One Covid-19 outbreak affecting patients and staff was reported in Q4. An Outbreak Control Groups was established to manage the outbreak with the Unplanned Care Group with additional oversight of infection prevention and control precautions.

Norovirus

The IPC Team worked closely with the operational teams to safely maximise bed capacity and prevent spread from the eleven Wards affected by norovirus in Q4.

Measles

UK Health Security Agency have reported an increase in measles cases since October 2023 with increased prevalence in areas of the country with lower Measles, Mumps and Rubella (MMR) vaccination uptake.

In February a patient attended ED who was later confirmed to be infectious for measles at the time of visit. Contact tracing of staff and patient was initiated and an epidemiologically linked case in a patient was identified 2 weeks later. 2 members of staff were also considered likely epidemiologically linked. Both members of staff were fully MMR vaccinated and these cases were considered breakthrough measles. Additional contact tracing was carried out and no further linked cases identified.

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. The latest repeat testing results show low numbers in one outlet and additional activity has been carried out as per the water safety plan with further repeat sampling results awaited.

Awareness Raising Activity

Facilities Team – Waste Management

Awareness raising sessions were hosted by the Facilities Team on the importance of correct waste segregation and the plan to move to tiger-stripe bags.

Dietetic Team GNBSI Prevention – Hydration

During Nutrition and Hydration week, the Dietetic Team carried out awareness raising activity to create energy and focus on the value of food and drink for the wellbeing of both patients and staff. Activity included afternoon teas, mocktails on thirsty Thursday as well as a stand with additional information on healthy diets and hydration stations.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies review 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: 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

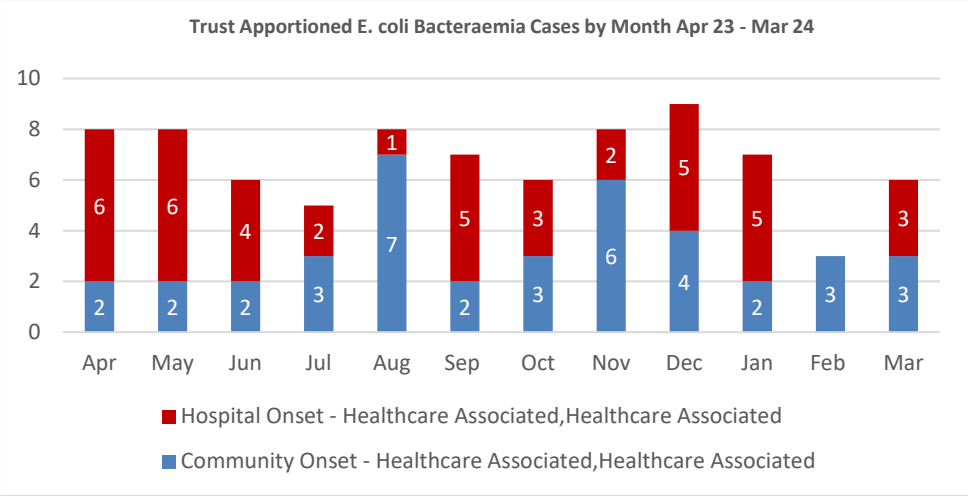
10. RECOMMENDATIONS

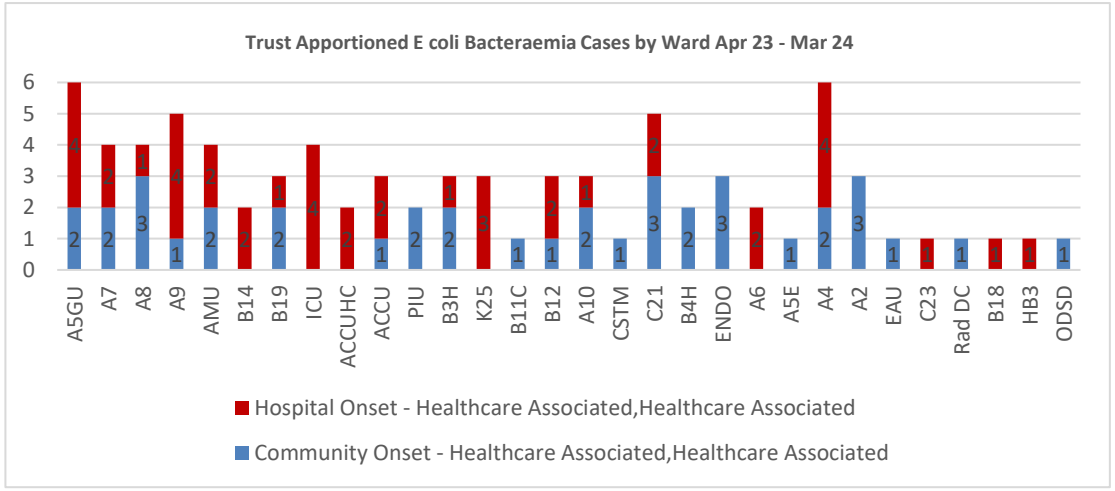
The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported, and progress made.

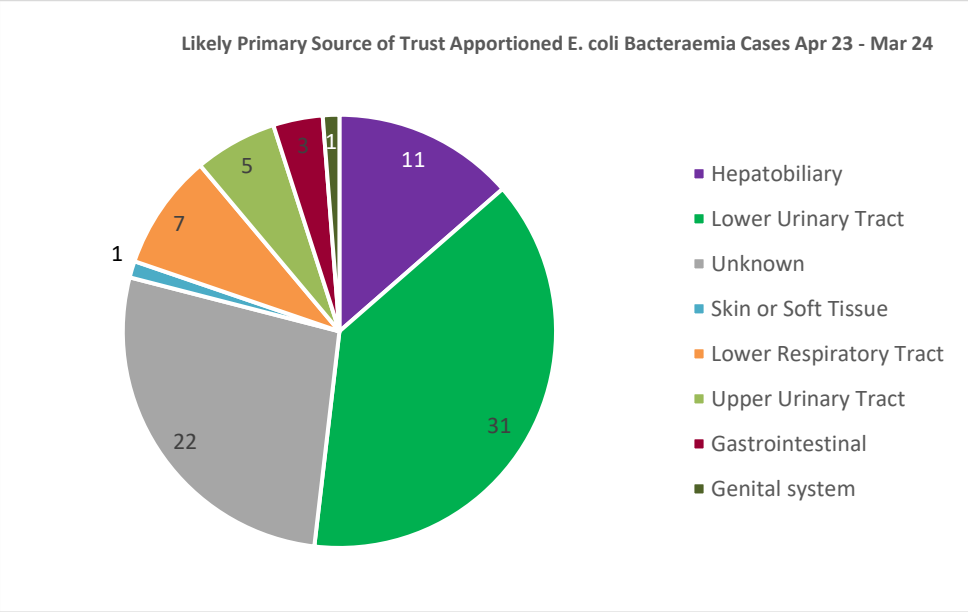
Appendix 1

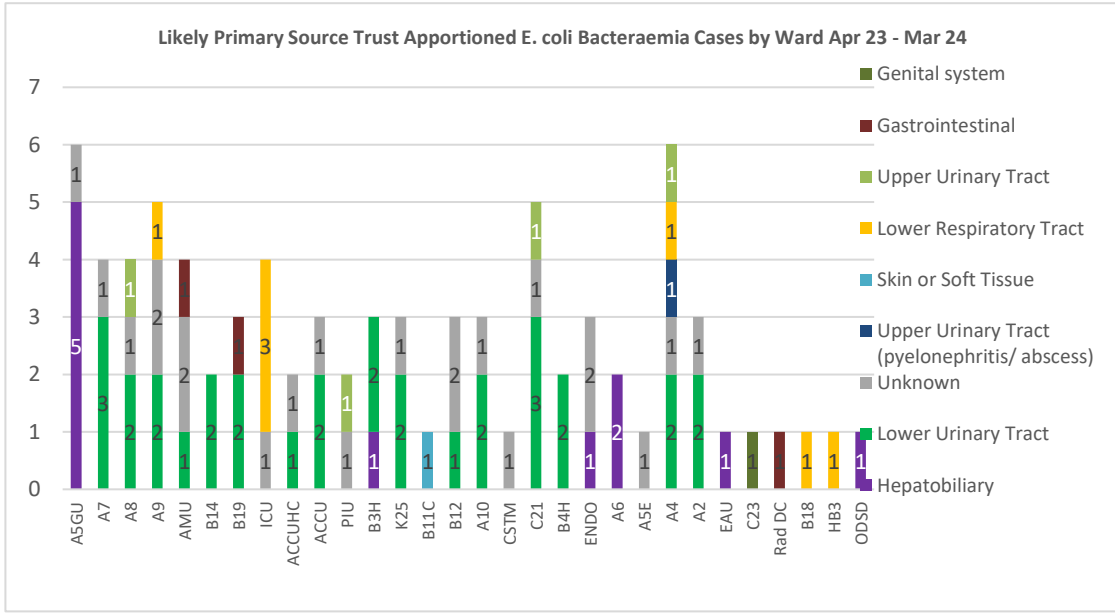
Gram Negative Bloodstream Infection: E. coli Apr 23 – Mar 24

Threshold	54
YTD Total	81



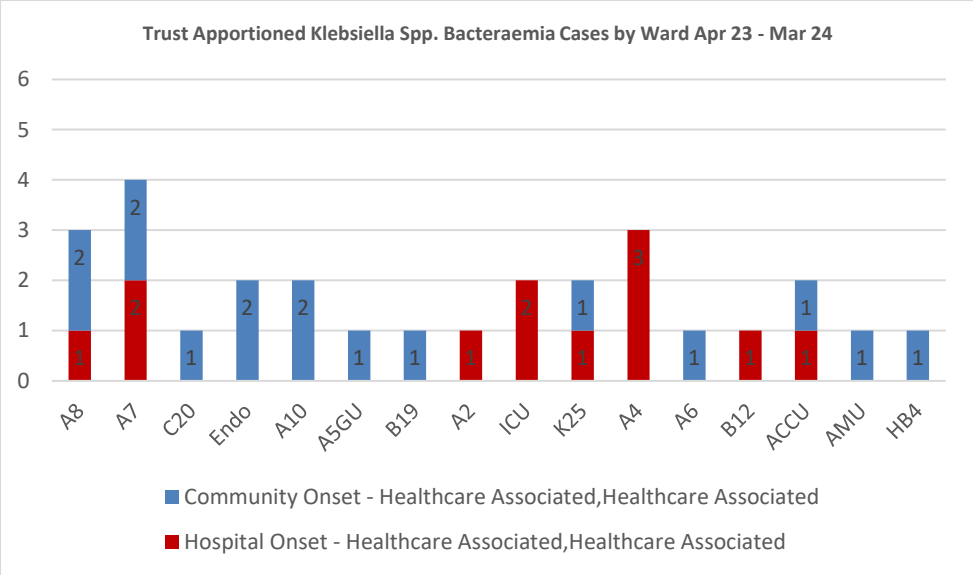


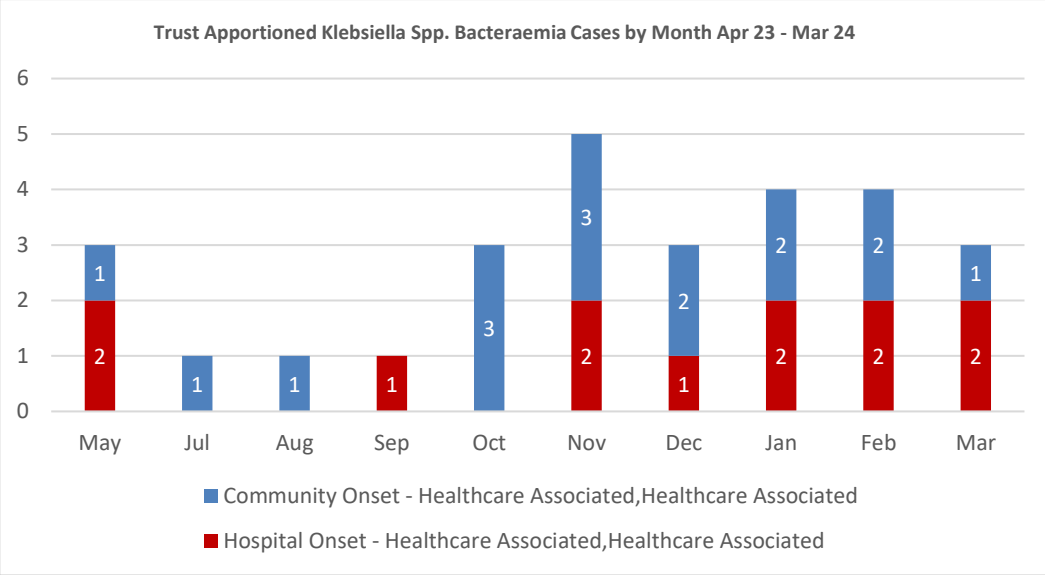


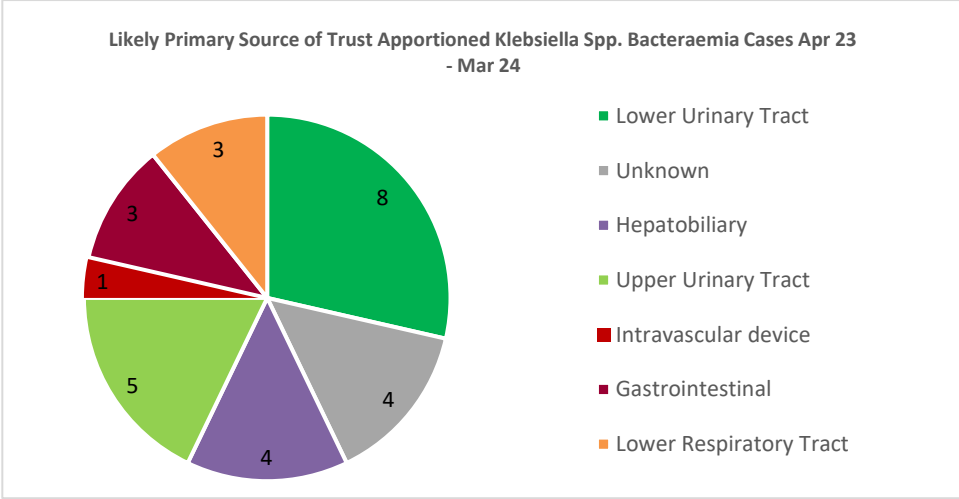


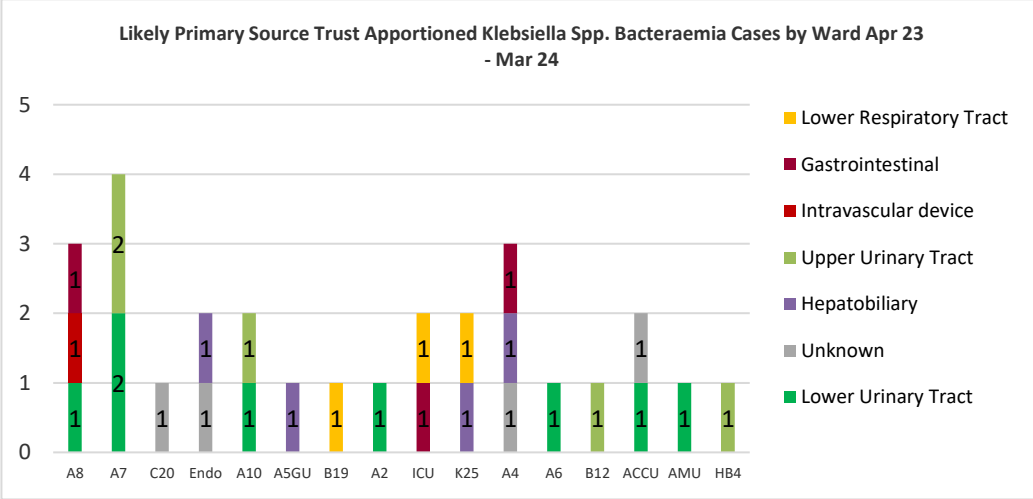
Gram Negative Bloodstream Infection: Klebsiella spp. Apr 23 – Mar 24

Threshold	18
YTD Total	28



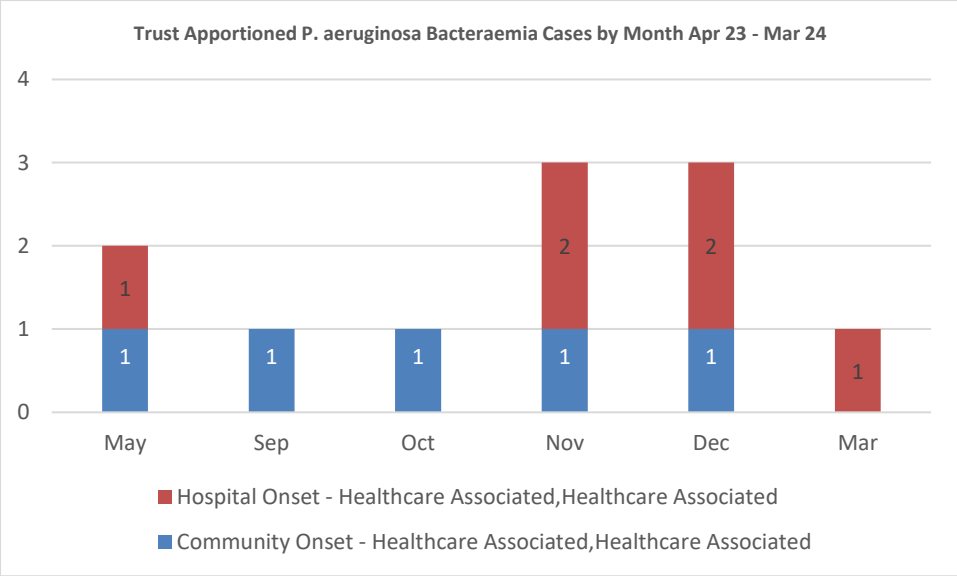


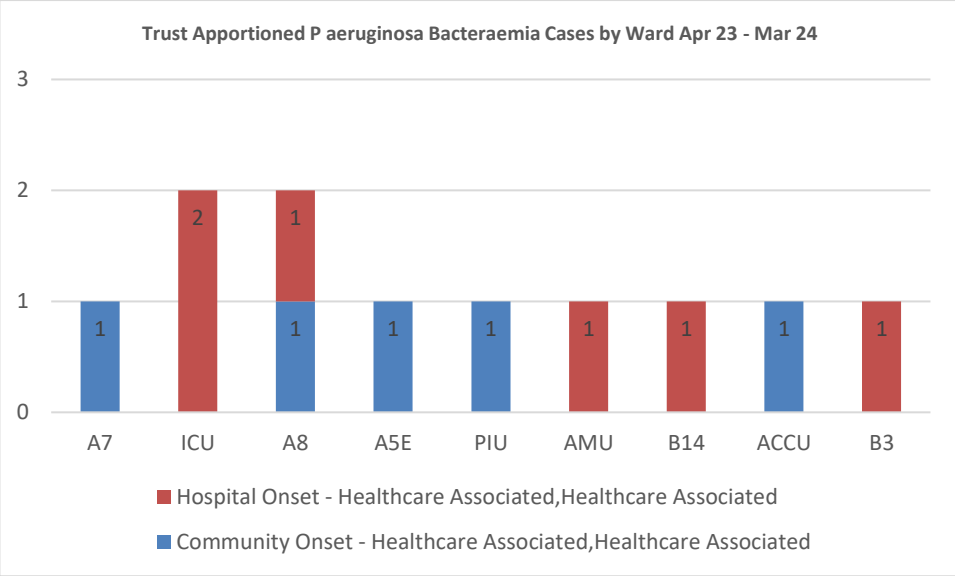


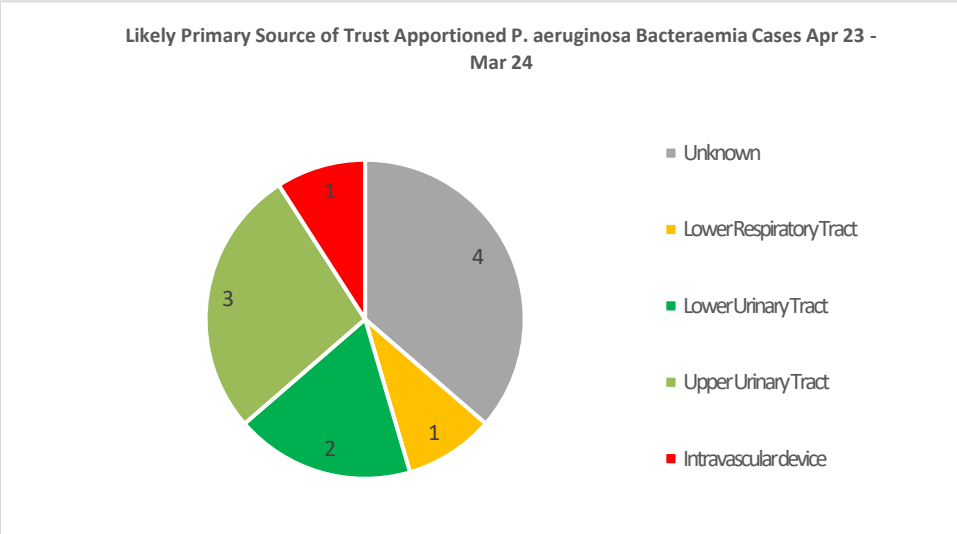


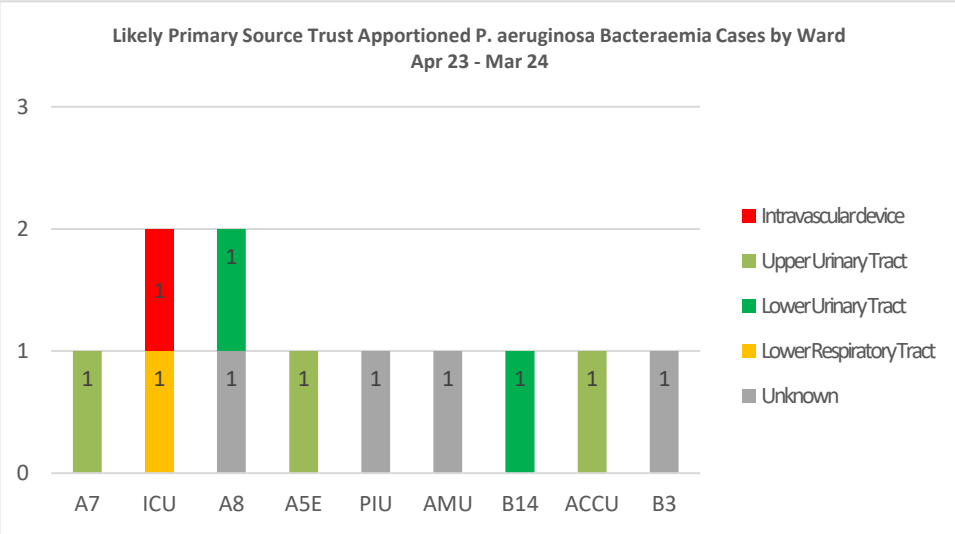
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr 23 – Mar 24

Threshold	2
YTD Total	11









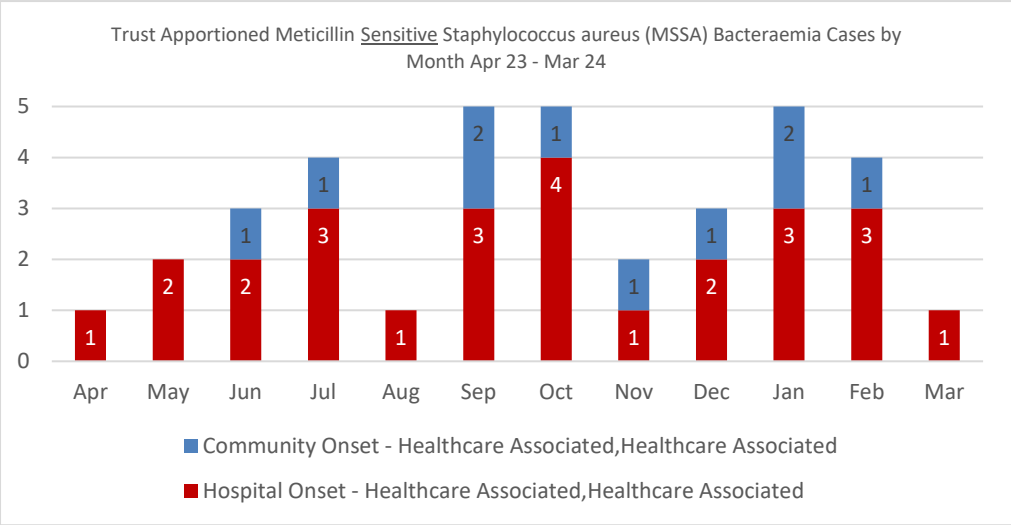
Threshold	**0**
YTD Total	**0**

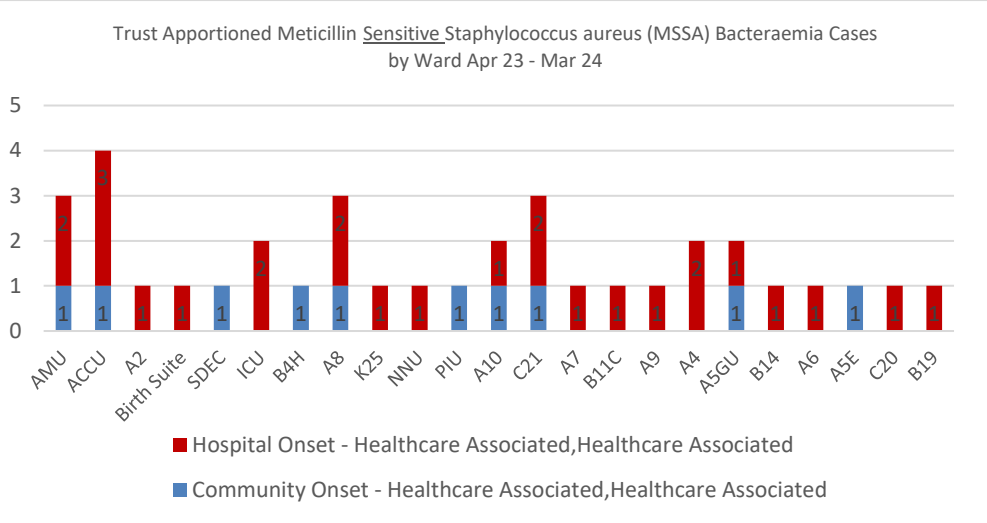
Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr 23 – Mar 24

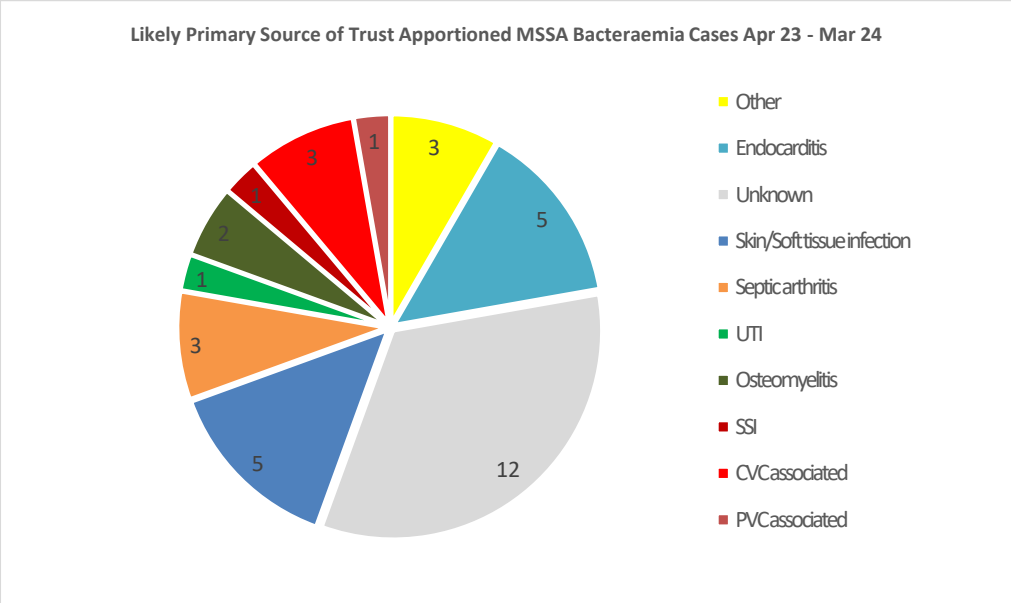
Rolling 18 Months MRSA bacteraemia free

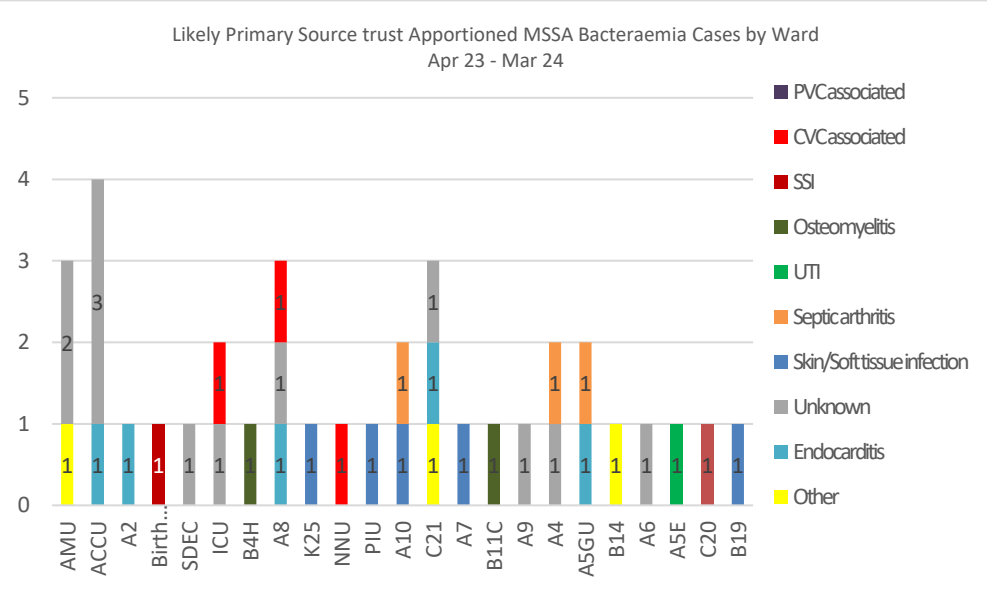
Gram Positive Bloodstream Infection: Staphylococcus aureus Apr 23 – Mar 24

No Threshold	
YTD Total	36



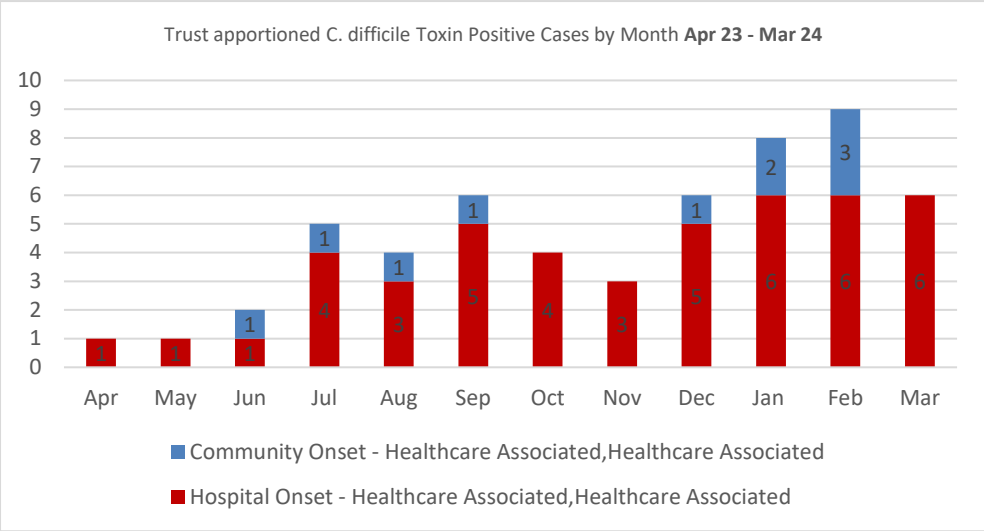


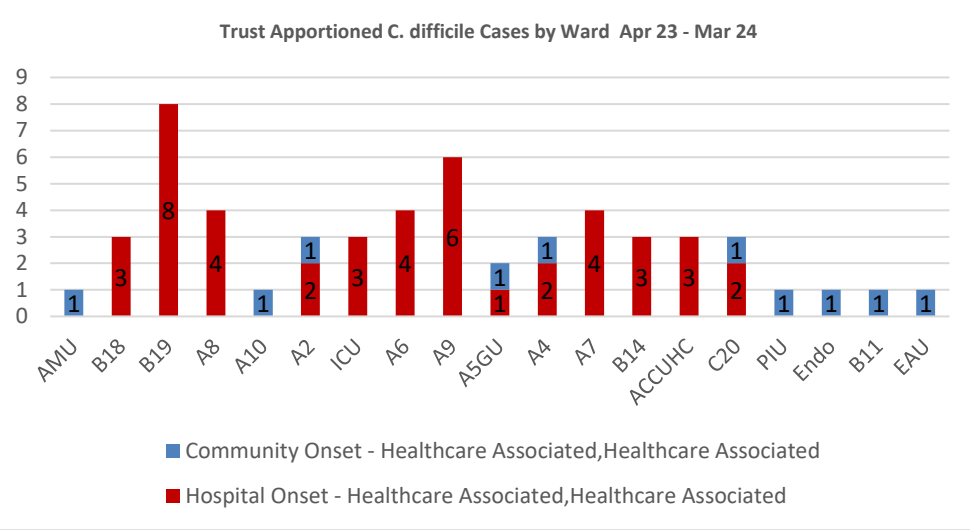


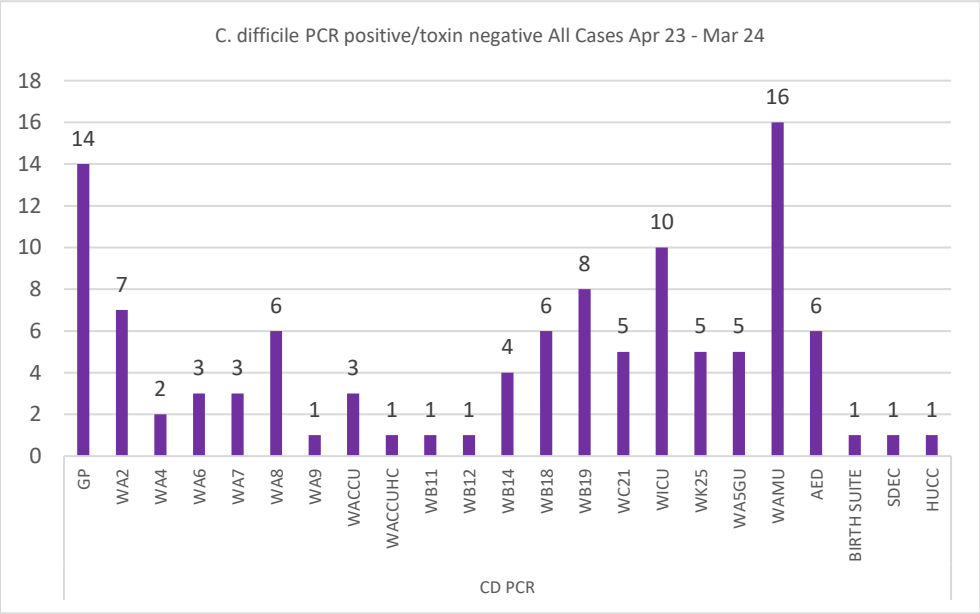


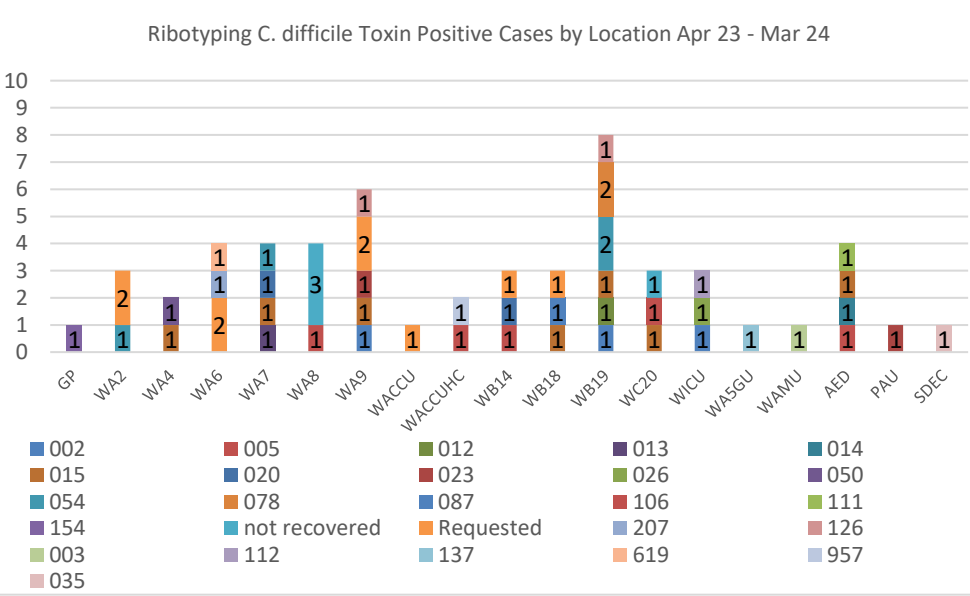
Threshold	36
YTD Total	55

Clostridioides difficile (C. difficile) Toxin Apr 23 – Mar 24

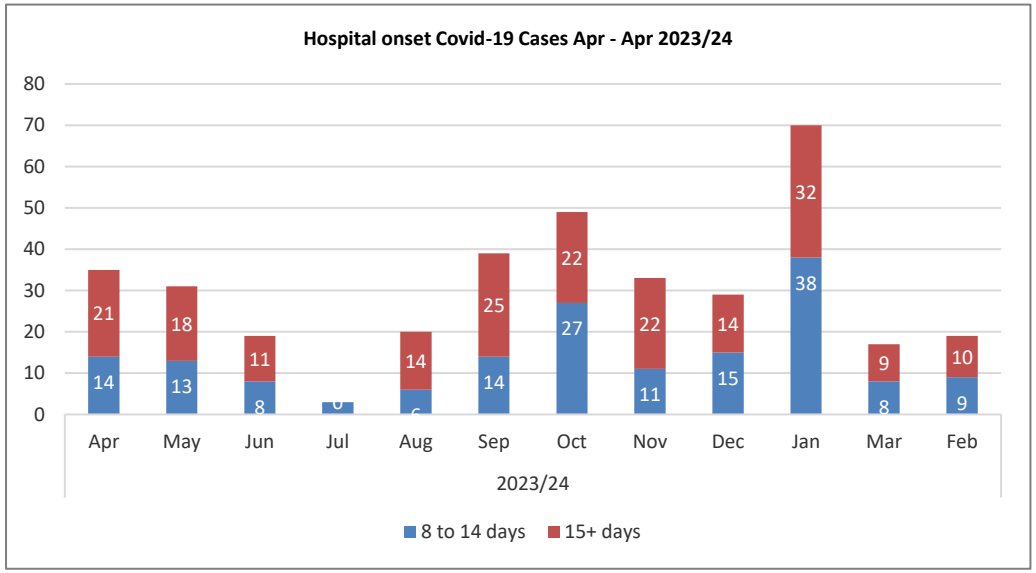


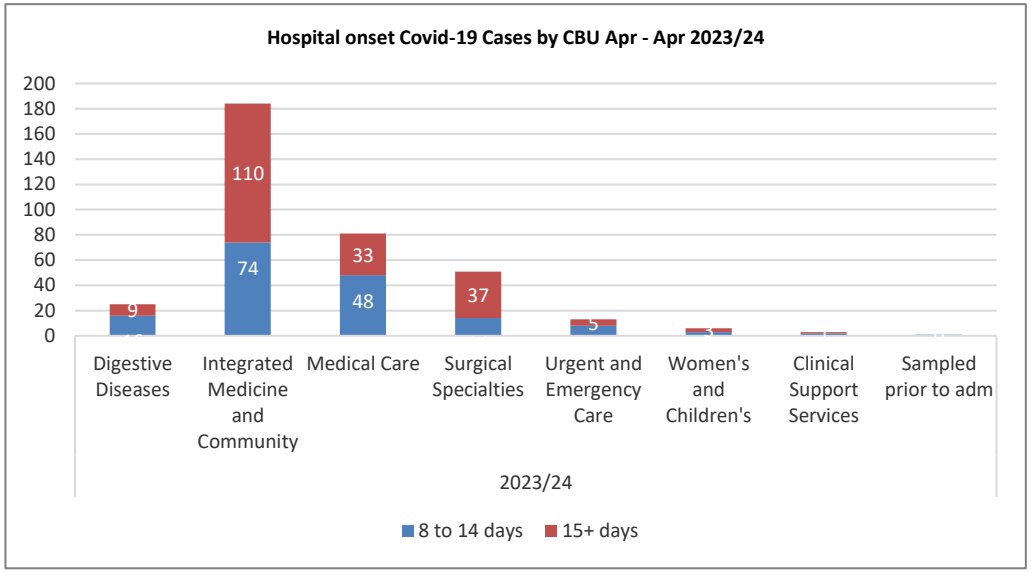


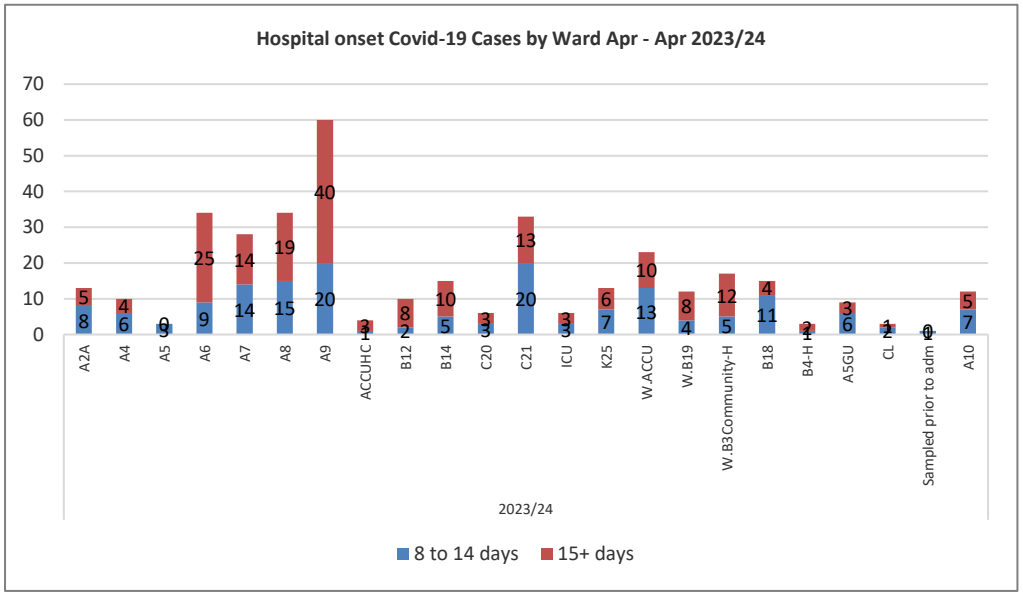


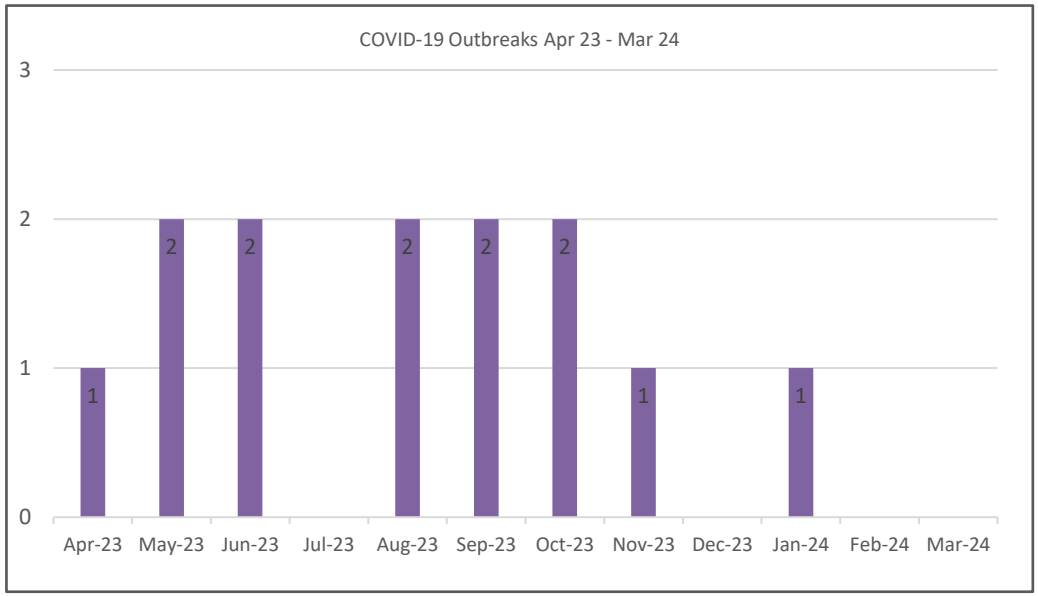


Covid-19 Surveillance Data Apr 23 – Mar 24









Appendix 2 IPC Audits by CBU

UEC CBU

Ward	EAU	RESP LOW CARE	MINORS	AMU	TRIAGE	MAJORS	Resus High care
Environment	91%	95%	75%	97%	95%	95%	82%
Ward Kitchens	90%	N/A	N/A	92%	N/A	N/A	N/A
Handling/Disposal of Linen	100%	100%	N/A	91%	N/A	100%	100%
Departmental Waste	100%	100%	100%	100%	100%	100%	100%
Safe Handling Disposal of Sharps	88%	71%	695	94%	94%	94%	87%
Patient Equipment (General)	94%	100%	85%	95%	91%	90%	86%
Personal Protective Equipment	92%	100%	N/A	100%	100%	100%	100%
Short Term Catheter Management	100%	100%	N/A	87%	N/A	100%	86%
Care of peripheral intravenous lines	83%	83%	N/A	83%	N/A	100%	83%
Isolation Precautions	N/A	100%	N/A	100%	N/A	N/A	N/A
Hand Hygiene	100%	100%	93%	100%	100%	95%	100%
Overall Compliance	94%	95%	84%	94%	97%	97%	91%

IMC CBU

Ward	A10	B19
Environment	80%	93%
Ward Kitchens	91%	96%
Handling/Disposal of Linen	91%	100%
Departmental Waste	100%	1005
Safe Handling Disposal of Sharps	100%	100%
Patient Equipment (General)	89%	100%
Personal Protective Equipment	93%	93%
Short Term Catheter Management	87%	94%
Care of peripheral intravenous lines	83	100%
Isolation Precautions	N/A	100%
Hand Hygiene	86%	96%
Overall Compliance	90%	97%

DD CBU

Ward	A4
Environment	89%
Ward Kitchens	83%
Handling/Disposal of Linen	91%
Departmental Waste	92%
Safe Handling Disposal of Sharps	94
Patient Equipment (General)	86%
Personal Protective Equipment	83%
Short Term Catheter Management	88%
Care of peripheral intravenous lines	60%
Isolation Precautions	100%
Hand Hygiene	86%
Overall Compliance	87%

SS CBU

Ward	UIU
Environment	94%
Ward Kitchens	100%
Handling/Disposal of Linen	100%
Departmental Waste	100%
Safe Handling Disposal of Sharps	100%
Patient Equipment (General)	100%
Personal Protective Equipment	100%
Short Term Catheter Management	100%
Care of peripheral intravenous lines	N/A
Isolation Precautions	N/A
Hand Hygiene	93%
Overall Compliance	99%

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/05/37**			
SUBJECT:	**Learning from Experience, Quarter 4 2023/24**			
DATE OF MEETING:	7 May 2024			
ACTION REQUIRED:	The Quality Assurance Committee is asked to note the contents of this paper.			
AUTHOR(S):	Nicola Edmundson – Associate Director of Governance			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Learning from Experience Report, Quarter 4 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, Compliance, Quality Improvement and Research and Development related to Quarter 4 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**	Quality Assurance Committee		
	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			

SUBJECT	Learning from Experience, Quarter 4 2023/24	AGENDA REF:	QAC/24/05/27

1. Background / Context

The Learning from Experience Report, Quarter 4 2023/24 relates to data reviewed during the period 1 January 2024 to 31 March 2024. 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 Learning Events, Complaints, Claims, Health and Safety, Clinical Audit, Compliance, Quality Improvement and Research and Development.

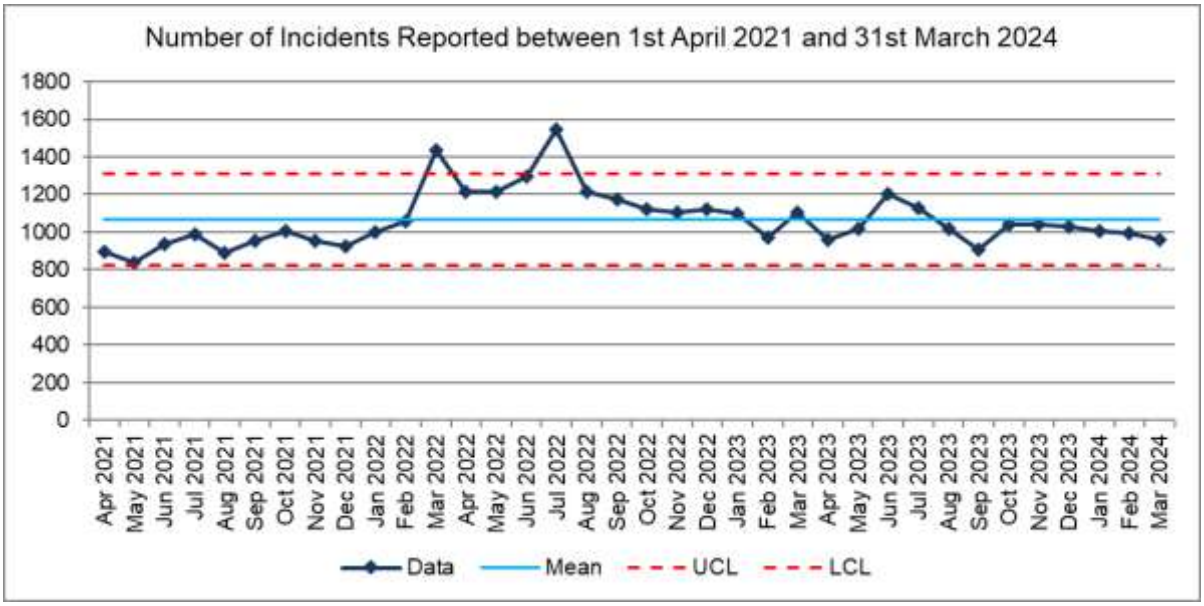
The report includes a summary of themes, trends and key findings that have influenced learning and action to support and sustain improvement.

2. Learning from Incidents

2.1 Incident Reporting Position

In Quarter 4 2023/24, a total of 2964 incidents were reported compared to Quarter 3 2023/24 where 3111 incidents were reported. This represents a decrease of 147 incidents (4.73%). The area with the largest decrease in the number of incidents reported is Surgical Specialties with a variance of 85 (25.84%).

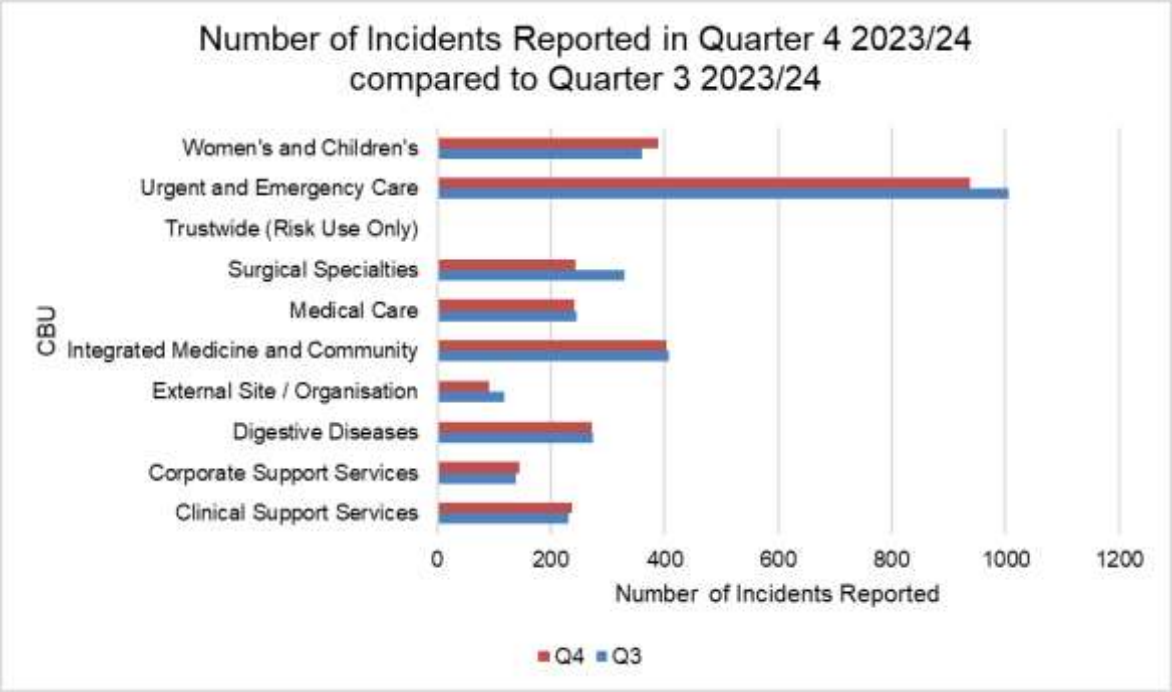
Graph 1



2.2 Incident Reporting Position per Clinical Business Unit (CBU)

In Quarter 4 2023/24, a total of 2727 patient safety events were reported across the CBU's and Clinical Support Services as shown in Graph 2. The remaining 237 incidents were reported as external incidents (92) and Corporate Support Services (145). The top 3 Corporate Support Services reported areas were Estates and Facilities, Digital Services and Human Resources.

Graph 2



The CBU with the highest increase in reported patient safety events was Women's and Children's (29) (8.03%). The CBU with the highest decreases in reported patient safety events was Surgical Specialties (85) (25.84%). There had been a decrease of 23 safety events reported on ward A6 in Quarter 4 linked to nurse staffing compared to Quarter 3, this is a positive reflection of an increase in staffing levels on both days and nights.

2.3 Themes and Learning from Planned Care Group

Women's and Children's

Themes include term admissions to the Neonatal Unit (NNU) and postpartum haemorrhage (PPH) ≥1500mls. An increase in medication incidents were also noted both in the Gynaecological and Paediatrics service.

There were 15 medication incidents across the paediatric service (12 for B11 and 3 for the Neonatal Unit). As a result, several actions were implemented:

- Topic of the month for April 2024 is medication led by the Clinical Educator.
- Joint nursing and medical medication audit has commenced to undertake a deep dive into the incidents.
- Regular meetings with the Medicine Safety Optimisation Nurse and Paediatric Senior Nursing Team for support. Discussions to be held with clinical supervisors from the medical team in relation to prescribing issues.
- There is a new Medication Link Nurse in post who will attend Trust Medicine Safety Meetings.
- Nursing staff, undertaking audit and updating medicine competencies where this has been identified as a need.

For Gynaecology the theme linked to medicines brought in by patients and work is underway to ensure all medications are stored securely upon admission.

In Maternity 40 cases of term admissions of neonate were noted to the NNU were reported in Quarter 4 2023/24. All cases of term admissions are reviewed through the Avoiding Term Admissions into Neonatal Services (ATAIN) Working Group, and this process identifies both good practice and learning. This is shared via the 'Learning from ATAIN' newsletter and a formal ATAIN action plan is in place to ensure continuous improvement. As part of this action plan, an audit is also underway to explore elective caesarean sections taking place before 39 weeks gestation with no medical indication or for maternal request. There is also work ongoing to ensure earlier detection of deterioration of babies on the Birth Suite and the Postnatal Ward to ensure earlier intervention can be instigated, potentially avoiding admission to NNU. Alongside the ATAIN action plan, a quality improvement project is also underway to enhance the Transitional Care offering, which it is anticipated will further reduce term admissions and separation of mothers and babies.

There were 26 PPH ≥1500ml in quarter 4 of 2023/2024. All cases of PPH ≥1500mls are reviewed via the Multi-Disciplinary Team (MDT) Intrapartum Review Group to ensure any urgent learning is enacted as well as feeding into the PPH Quality Improvement (QI) project. Rates of PPH ≥1500mls are also reported via the Maternity dashboard to CBU Governance Meetings.

A formal QI project is underway within the Maternity Service to reduce the occurrence of PPH at WHH. A detailed action plan has been developed led by the PPH QI group which meets fortnightly. To date the PPH guideline has been reviewed, updated, and recirculated. Several multidisciplinary simulations and walkthroughs of the patient journey have also been completed alongside detailed process mapping within the QI framework.

Surgical Specialities

The top 3 themes in Quarter 4 were, Access, Transfer and Discharge (34), Infection Prevention and Control (28) and Antisocial/Abusive/Violent Behaviour (20).

An After-Action Review learning response was undertaken, which linked to Virtual Fracture Clinic (VFC) and ambulatory trauma patients, which identified learning related improvements in communication and documentation. It has been agreed that Pathpoint (the electronic orthopaedic data base) will now be utilised to include ambulatory trauma patients, where updates can now be recorded. A policy regarding the VFC pathway is now in place along with an updated patient information leaflet.

Digestive Diseases

The top 3 themes in Quarter 4 were Access, Transfer and Discharge (39), Medication (30) and Infection Prevention and Control (26)

An example of learning from an incident identified in CSTM theatres, linked to an equipment failure. This was immediately taken out of use and isolated. The problem transpired to be a software error and the equipment required an update. An equipment test was carried out prior to use which did not indicate an error. The newly installed software would now indicate if there was an error. All similar equipment has been updated and the patient safety event was reported to the MRHA.

2.3.1 Themes and learning from Unplanned Care Group

Medical Care

The top 3 themes in Quarter 4 were Infection Prevention and Control (41), Access, Transfer and Discharge (26) and Slips, Trips and Falls (23).

The largest proportion of incidents categorised under Infection Prevention and Control are in relation to cases of Covid-19. These patients continue to be managed in line with Trust policy and are isolated in a timely manner to reduce the risk of the transfer of the virus.

Incidents relating to access, transfer and discharge in Medical Care are largely related to those patients who step down from level 2 or 3 care on the Intensive Care Unit (ICU), but where a ward bed (level 1 care) is not available. This results in patients being cared for on the ICU for longer than their clinical condition requires. Single sex accommodation guidelines apply to those patients being nursed on level 1 care, and because of a prolonged Intensive Care stay there are some instances where mixed sex breach occurs on the ICU. The ICU team will cohort level 1 patients to meet single sex accommodation guidelines wherever possible, with early escalation to the Patient Flow Team to specify the need for a ward bed. However, there are times where this is not possible, and as such a mixed sex breach is reported.

Of the 23 slips, trips and falls reported in Medical Care in Quarter 4, all were no harm (17) or low harm (6). All slips, trips and falls were dealt with appropriately, and any learning identified from the incidents are shared with the teams.

During Quarter 4 an incident was reported in relation to Dermatology provision. The Trust does not have a Dermatology service, or a Service Level Agreement (SLA) from an external provider. As such, when patients attend or are admitted to the Trust, they are dealt with on a case-by-case basis according to their clinical need. However, this can cause a delay in the patients accessing specialist assessment and treatment. Whilst this only affects a small number of patients, there was a reported incident in Quarter 4 where a patient attended the Emergency Department. The presentation of this patient's condition indicated an urgent Dermatology review. Community services were contacted however they declined to see them due to being an out of area patient and nearby hospitals would not review. The medical registrar recognised that the need for urgent review and contacted the Burns Unit at Whiston Hospital. The patient was accepted by Burns Unit, enabling the patient to access the care they required. This incident highlighted good practice from the medical registrar However, it highlighted the need for a clear referral and escalation process for patients requiring an urgent Dermatology review. As a result, guidance for referral process and escalation of Dermatology patients has been produced and shared with clinical teams.

Integrated Medicine and Community (IMC)

The top 3 themes in Quarter 4 were Infection Prevention and Control (78), Antisocial /Abusive/Violent Behaviour (70) and Slips, Trips and Falls (57).

In IMC, infection prevention and control incidents were largely in relation to Covid-19 cases, which is consistent with Medical Care. During Quarter 4, the Trust saw a decline in the total numbers of inpatients with a positive Covid-19 test. As a result, the need for a dedicated Covid-19 ward was no longer required and therefore A9 returned to function as a general medical ward for the first time since 2020. The IPC team and the Patient Flow Team will continue to work together to monitor the number of inpatients with Covid-19, and A9 will be utilised as the Covid-19 cohort ward should it be required.

Antisocial/abusive/violent behavior incidents were reported on 70 occasions during Quarter 4. Of these incidents, the top three reporting areas were A8 (18), B12 (18) and B19 (23). The reported incidents are a combination of antisocial behavior by a patient and physical assault by patient on staff. The majority of these cases involve a patient who lacks capacity, and therefore use of the Trust's Unacceptable Behavior Policy is limited as these sanctions would not be appropriate. All staff are required to complete conflict resolution training, and

compliance for IMC is 94.22%. Staff are being encouraged to complete their de-escalation training to support the management of these situations. Staff who are affected by these incidents are supported by their line manager and CBU team, with input from Occupational Health and/or the Wellbeing Hub, as required.

Of the 57 slips, trips and falls reported in Quarter 4 in IMC all were no harm (48) or low harm (9). All ward areas have falls action plans in place to reduce the occurrence of falls. These action plans and any learning identified from incidents are overseen by the Lead Nurse of the CBU and the Unplanned Care Group Associate Chief of Nursing.

An incident involving a discharge of a patient via the Discharge Lounge, highlighted an issue with the transfer of patient medications from the staff in the discharge lounge to the ambulance crew collecting the patient. This occurred as the ambulance crew do not sign for the collection of To Take Out (TTO) Medication. The CBU Team and providers of the ambulance services that the Trust use are meeting to agree a process for the transfer of medications, which will reduce the risk of this incident recurring.

Urgent Emergency Care (UEC)

The top 3 themes in Quarter 4 were Pressure Ulcer-Present on Admission (183), Access, Transfer and Discharge (94) and Medication (86). These three areas are consistently the top three reported categories in UEC. However, there has been a reduction observed in the number of incidents in relation to access, transfer and discharge. This was expected, due to the reporting of patients waiting above 12-hours on Datix being ceased on 04.01.24. This information is reported through performance meetings and national reporting and is consistent with the Trust's focus on >12 hour time in department.

An emerging theme of an increased number of incidents being reported within the ED waiting room, triage area or corridor was observed during Quarter 4. This increase in incidents correlates with high department occupancy and overcrowding, with high numbers of patients being cared for on the corridor, and an increase in ambulance attendances. As a result, a review of the nurse staffing model took place, and a nurse is now assigned to the waiting room on each shift. This support ensuring that patients can commence their treatment in a timely manner, despite the high department occupancy.

Cheshire Police went live with Phase 1 of Right Care Right Person (RCRP) during January 2024, and Phase 2 is being planned for May 2024. To support learning and shared understanding across the system Cheshire Police have established a working group for the implementation of this project for Urgent Care. Representatives from Warrington ED and WHH Safeguarding Team attend this meeting to ensure that learning is brought back to the team, and any issues are escalated in a timely manner.

2.3.2 Themes and learning from Clinical Support Services

The top 3 themes in Quarter 4 were Medication (42), Diagnostic Imaging (39) and Treatment and Procedures (38) In Quarter 4 there were 3 moderate harm patient safety events reported: 2 within the Radiology Department and 1 from the Histopathology Laboratory.

Radiology:

One case linked to a patient who underwent a CT scan. An After-Action Review was completed as it was identified as being a radiation safety incident.

Some incidents involving unintended radiation, as in this case, are reportable to the Care Quality Commission (CQC), this has been reported.

The following were learning outcomes:

- It has been agreed that all CT and MRI scans requested as a result of community ultrasound imaging are to be assessed by a Consultant Radiologist and a safety alert to this affect has been issued.
- The CBU are currently collating information about community ultrasound scans (US) performed over the last year that have generated further imaging to look for any themes and trends and this will determine the next course of action in managing these types of referrals.

A SWARM learning response was completed for a case whereby a patient had a delay in the completing of an ultrasound scan to confirm a rotor cuff injury. Actions from this were:

- Incident to be reviewed at the consultants meeting to agree the process to streamline, standardise the communication with appointments team upon receipt of a request for an urgent US. Changes in practice will be taken through the Radiology Governance Meeting to support.
- To explore the possibility of upgrading urgent US referrals to a priority 7 on the CRIS system within the department, so that the appointments team know to prioritise these referrals. This action remains ongoing and has a target date for completion of June 9th, 2024.

The process has been agreed for communication with the appointments team upon receipt of a request for an urgent US. This has been shared as an item on the Trust wide safety brief.

2.4 Learning from Incidents and Assurance

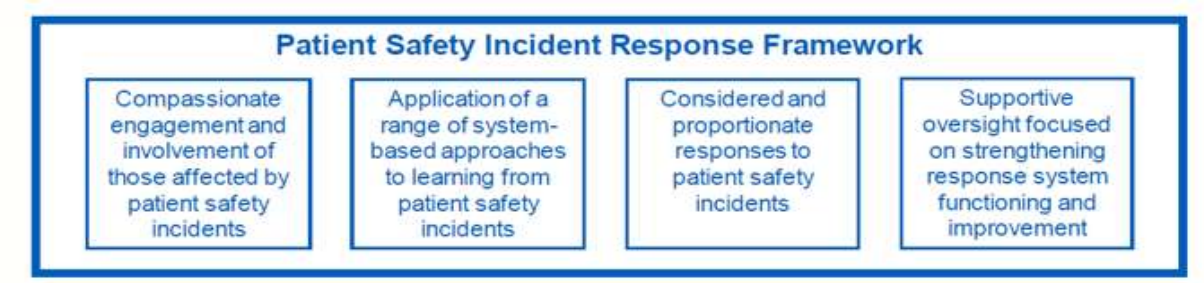
The Patient Safety Manager has continued to attend the PLACE (previous CCG) Cheshire and Mersey Serious Incident Panel meetings alongside the Investigating Officer. There remain Serious Incident Reports and action plans which require sign off under the former SI process. Once these reports are approved this group will no longer meet and incidents investigated under the new Patient Safety Incident Framework process will be signed off by the Trust. 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 1 September 2023 and is mandated for any organisation who provide funded NHS care. Currently approximately 70% of organisations across the NHS have gone live. All NHS providers in Cheshire and Merseyside are now live with PSIRF. 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 is not an investigation framework.
- PSIRF aims to support organisations to change culture 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 focuses 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:

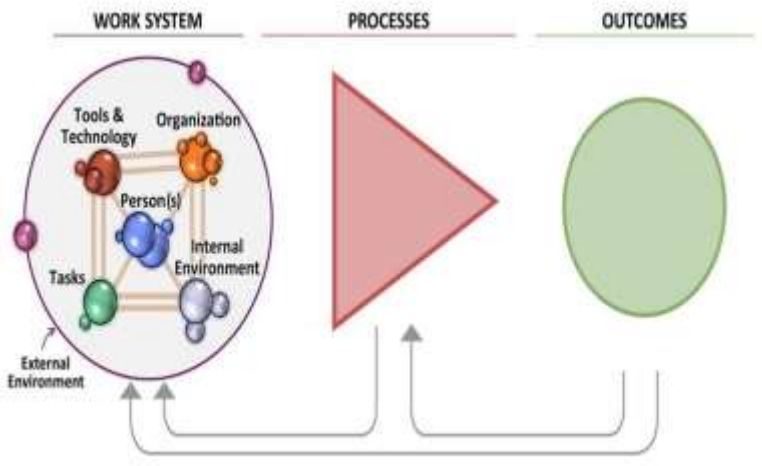


The various tools, and types of investigations and reviews that can be used for learning and improving patient safety include:

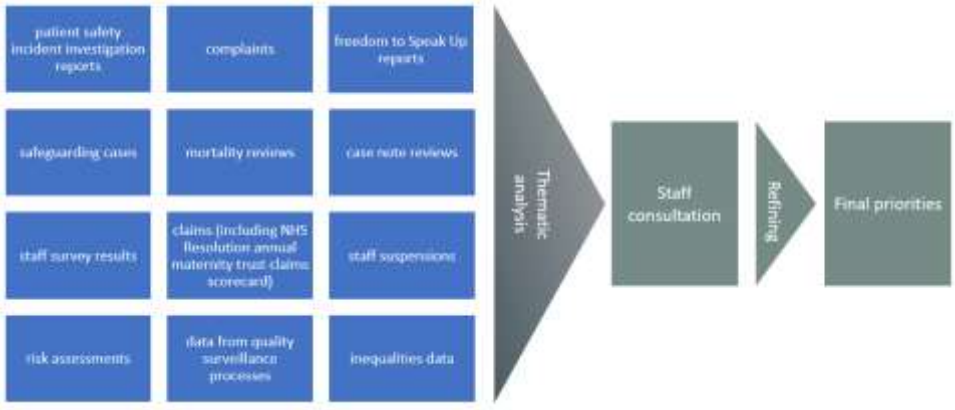
- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how.
- Multidisciplinary Team Review – aims through open discussion to agree the key contributory factors and system gaps that impact on safe patient care.
- Swarm Huddle – initiated as soon as possible after an event and involves an 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 learning response methodologies require the use of a systems approach to investigation, which encourages the review to consider the work environment in which the event occurred. The following model shows how a work system (or socio-technical system, left) can influence processes (work done, middle), which in turn shapes outcomes (right).



The development of Local Priorities has taken place following extensive review of WHH data to identify issues which have been enduring and impact across a range of data sources 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 10 PSII's in progress (3 have been commissioned in the current month), 3 of these are linked to the local priorities (one mapped to each of the 3 above), 3 relate to patients who have passed away and 4 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. Further Human Factors training is being provided in Women's and Children's Services and the Theatres Team are scoping requirements for their teams.

WHH Patient Safety and Quality Teams recently worked with AQUA to develop and deliver a PSIRF training programme at WHH which they are now going to use as part of their training offer. The training was well evaluated by colleagues who attended the first course in March 2024.

Training compliance is currently:

Patient Safety Essentials for boards and senior leadership – 84%
Patient Safety Essentials – Level 1: 93%
Patient Safety (Higher Level Practice) – Level 2: 78%

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. This links closely with the launch of the Culture programme, we are WHH.

Alongside the implementation of PSIRF, the Trust have adopted the new national learning and reporting system Learn from Patient Safety Events (LFPSE) which in October 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 WHH patient safety events feed directly into the LFPSE system.

Approximately 70% 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, as well as system wide improvements. We are working with Datix to upgrade from issue 5 of LFPSE to issue 6, which when completed will provide greater flexibility and more manageability of data.

WHH continues to participate with PLACE and ICB partners across Cheshire and Mersey to share learning to further support embedding of PSIRF and LFPSE.

There were two PSIIs closed in Quarter 4.

These were the cases of two patients who had surgery on the same elective colorectal list who developed deterioration in liver function post operatively and both sadly passed away. From extensive investigation, the conclusion was that this incidence is extremely rare. A literature search failed to find a report of two patients affected on the same operating list, this therefore appears to be a global unique event. It is therefore unlikely that any clinicians would see this again. It is difficult to provide robust recommendations as the Trust would be looking to prevent the future occurrence of an extremely rare event that it is most unlikely anyone would ever see again. Recommendations have been written from the findings of the investigation to include:

- A “theatre etiquette” document which must include consideration of PPE wearing and when it is and is not necessary. To consider a viral cause of fulminant hepatic dysfunction, especially in the face of disproportionately high Transaminase levels.

- To consider publication in the medical literature of these two cases, such that early consideration of a viral cause of unexplained post operative hepatitis is at least considered, if extremely unlikely.

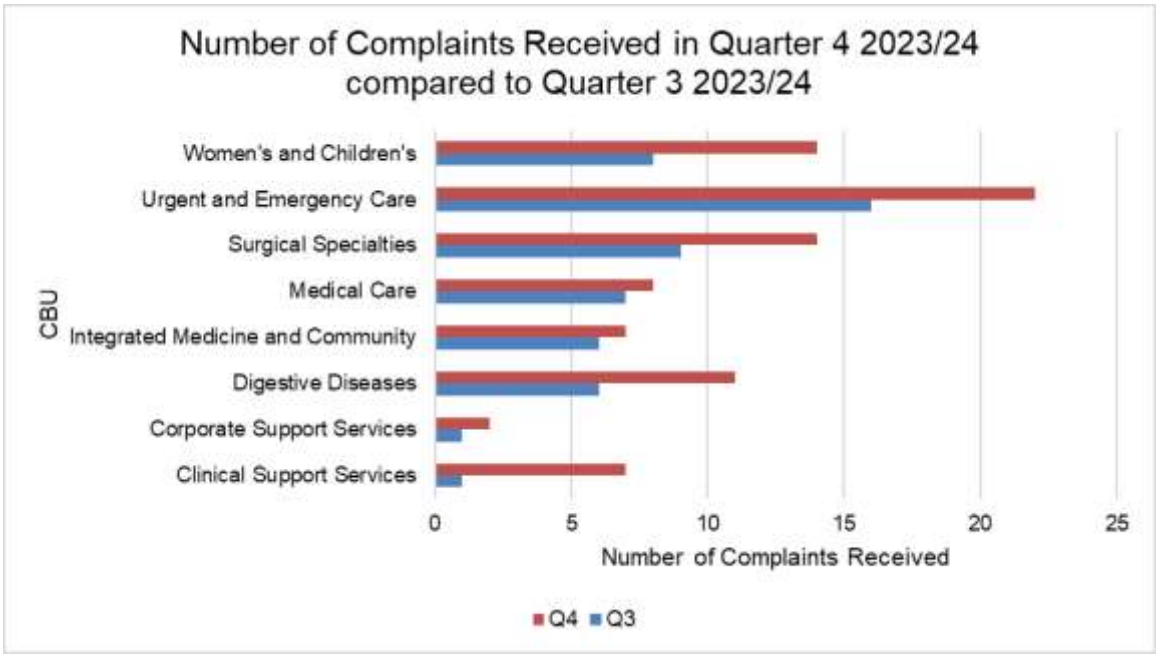
3. Learning from Complaints and PALS

3.1 Complaints

3.1.1 Complaints Received

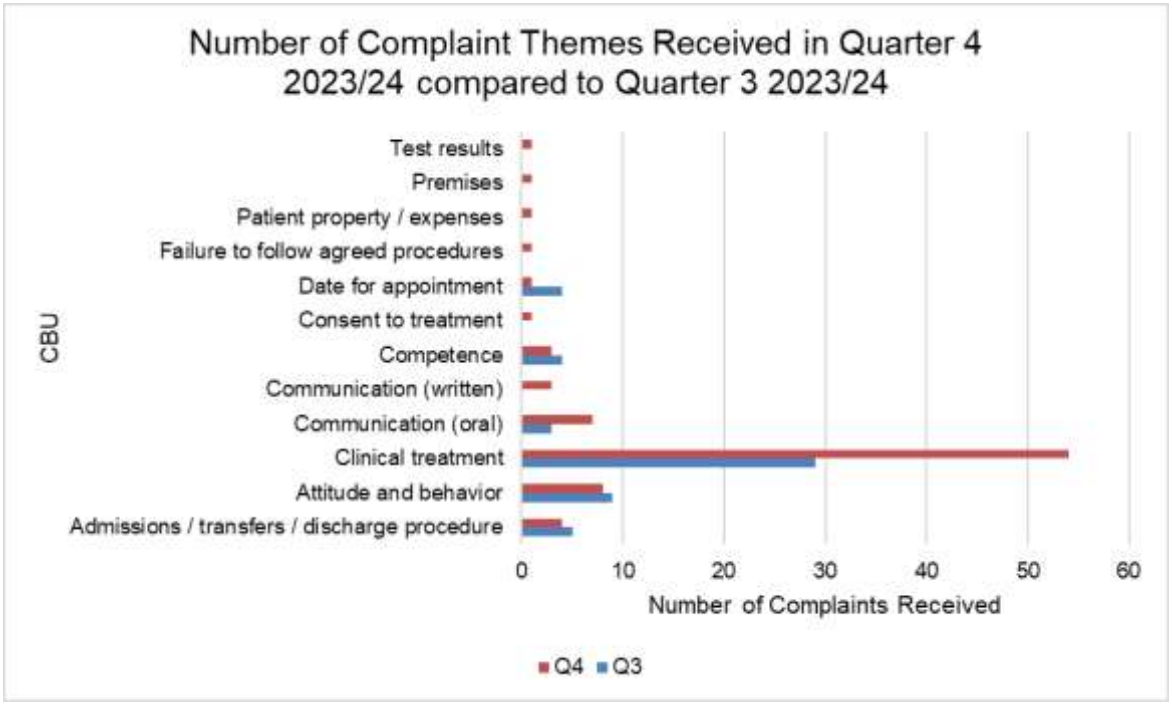
In Quarter 4 2023/24, there were 85 complaints received which is an increase of 31 (57.41%) compared to Quarter 3 2023/24.

Graph 3



The themes of complaints received in Quarter 4 2023/24 compared to Quarter 3 2023/24 are outlined within **Graph 4**. Clinical Treatment remains the most common theme of complaints received. The top 3 sub-themes of this are coordination of medical treatment, wrong diagnosis and issues with nursing care. The number of complaints relating to this theme has increased by 25 complaints (86.21%) compared to Quarter 3 2023/24. The complaints received with the theme Clinical Treatment are spread across CBU's and a variety of specialties.

Graph 4



3.1.2 Complaints Closed

The following table demonstrates the outcomes for the complaints closed in Quarter 4 2023/24 compared to Quarter 3 2023/24. In Quarter 4, a smaller percentage of complaints were not upheld (51% in Quarter 4 compared to 53% in Quarter 3). There was a greater percentage of complaints that were partially upheld in Quarter 4 (42% in Quarter 4 compared to 31% in Quarter 3). The percentage of upheld complaints in Quarter 4 has decreased compared to Quarter 3 (7% in Quarter 4 compared to 16% in Quarter 3).

***Partially upheld complaints are those where aspects of the complaint are upheld, but the main issues are not.

Outcome of Complaint	Quarter 4	Quarter 3	Grand Total
Not Upheld	29	30	59
Partially Upheld	23	18	41
Upheld	4	9	13
Grand Total	56	57	113

3.1.3 Actions Resulting from Complaint Investigations

The following table provides examples of complaints raised in Quarter 4, 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.

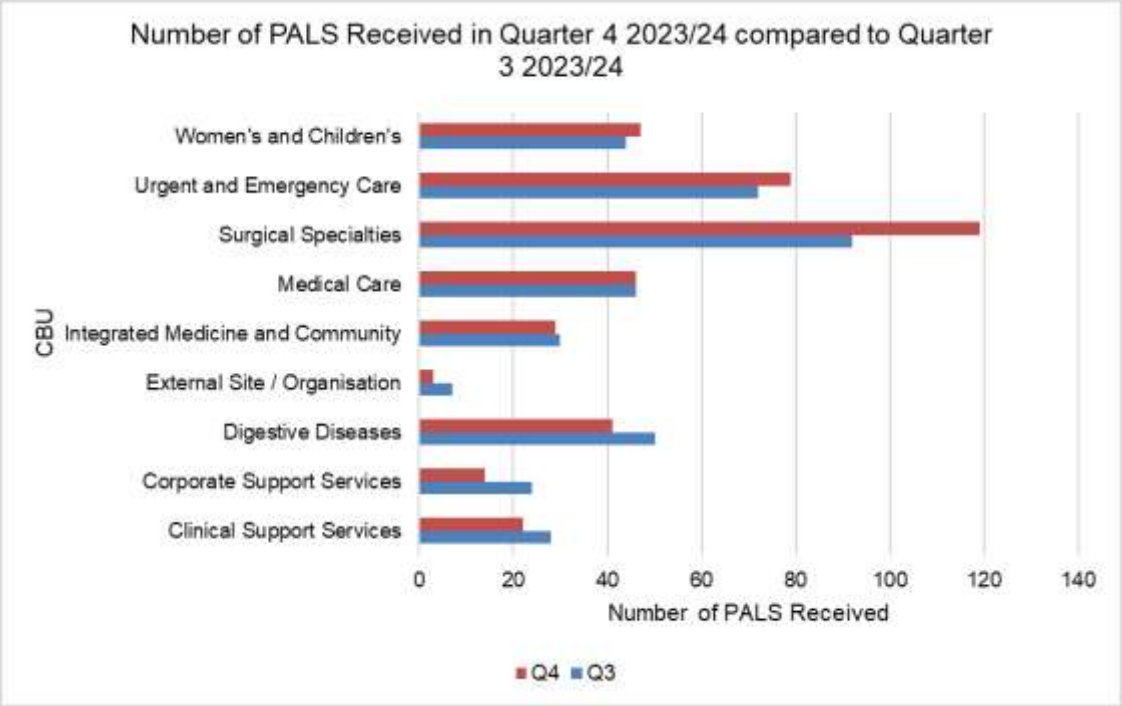
You Said….	We Did….
Emergency Care: Patient has raised concerns including wait times in the Emergency Department, lack of pain relief and poor communication	Apologies expressed for experience. Additional seating has been provided in the department and a nurse to support patients in the waiting room has now been recruited.
Medical Care: Family member raised concerns relating to nursing care, lack of pain relief offered, coordination of treatment and miscommunication their family members palliative status.	Key performance indicators have been developed to measure whether the individualised plan of care and associated symptom observation charts are being used effectively. This is a quality improvement project.
Estates and Facilities: Concerns raised regarding car park costs, lack of car parking spaces and payment machines being inconveniently placed.	Car parking charges have been significantly reduced for a four-week period for all members of the public utilising the car park as a gesture of goodwill. The payment machines have now been relocated inside the hospital premises to improve the public experience when paying.

3.2 Patient Advice and Liaison Service (PALS)

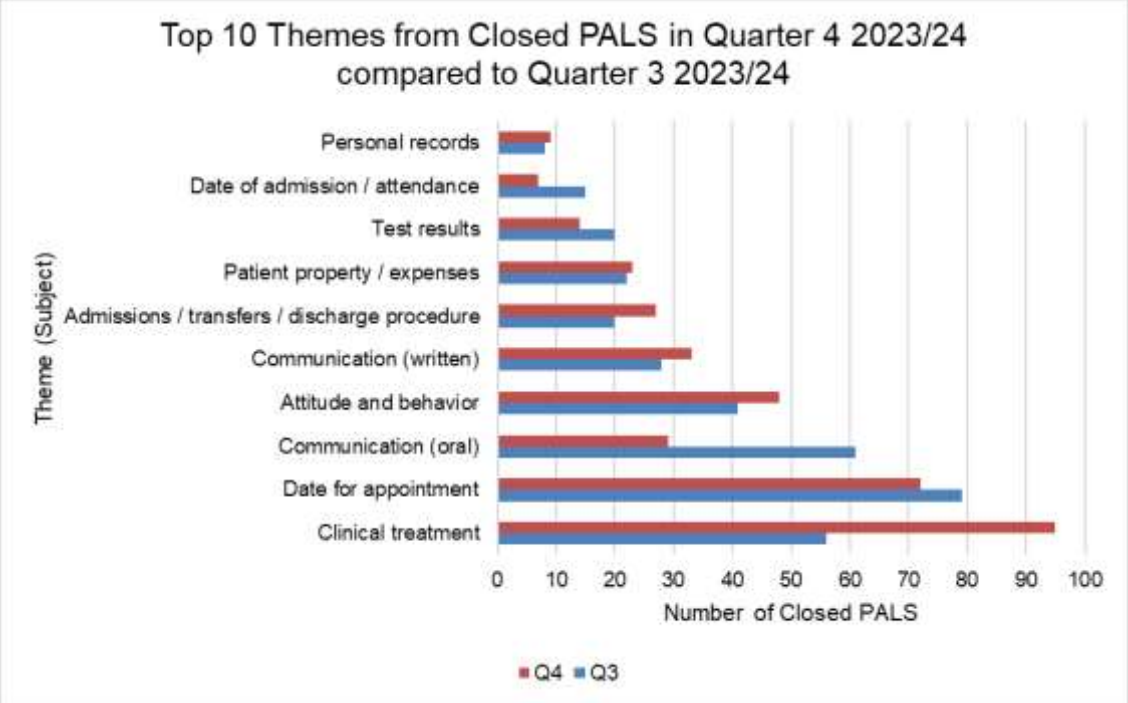
3.2.1 PALS Received

There were 400 PALS referrals received in Quarter 4 2023/24 which was an increase of 7 (1.78%) compared to Quarter 3 2023/24. **Graph 5** demonstrates the breakdown of PALS received for each CBU.

Graph 5



Graph 6



4. Learning from Quality Improvement (QI) and Knowledge and Evidence

4.1 Learning from QI Training Evaluation

This year, in line with the newly launched NHS Impact (Improving Patient Care Together) recommendations, we have defined as an organisation to build a foundation of six levels of Continuous Quality Improvement (CQI) capability which is targeted to the role that each staff member must play in supporting our culture for improvement. The training ranges from level one (an introduction to QI) to level 6, which is represented by our Expert Faculty and an implementation plan for this is in progress.

As part of our internal training process, 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.

- The quality of QI Foundation (Level 2) and QI practitioner (Level 3) training sessions were rated an average of 9 out of 10 during quarter 4.

- We asked how confident participants felt in starting and delivering their own QI project at the start and end of training and found the overall participant confidence score had increased by 57%.

Further Opportunities for Learning from QI Experience

QIPC (Quality Improvement Practitioner Community)

Ongoing support for QI practitioners' post-training completion was highlighted as an area for further development. Additional one to one coaching sessions and support are offered, and we have now launched the QIPC. This is a community of practice approach with a formal bi-monthly touchpoint and quarterly learning event to support QI practitioners to build coaching skills and the capability of the practitioners to further support quality improvement work within their departments or across the trust on a wider scale.

Shared Learning Forum

A Shared Learning Forum was launched in February 2024 with an aim to provide an opportunity for WHH colleagues, partners, and people with lived experience of our services to share, learn and engage in interactive activities. The vision is to bring together improvement and innovation projects, from a wide range of quality and safety related initiatives, share patient and staff feedback, and celebrate and learn from excellent practice- both clinical and non-clinical services.

Improvement Excellence Celebration Events

Following an evaluation of how we highlight and share learning from and success of QI projects it was recognised that we needed to share success of QI work more widely. As a result, we have updated the QI practitioner celebration event from the next financial year to include an invitation of all staff involved in the completion of QIPs that have achieved our certification criteria and the criteria for meeting a standard of excellence in QI.

4.2 Learning from Registered QIPs Completed Within January – March 2024

Project Aim	Project Lead	Start Date	Completion Date	Lessons learnt/next steps
To reduce Pressure Ulcers occurring on the heels of patients on ward C21 by 50% by 31st March 2023.	Kelly Bullows	25/01/2021	27/02/2024	1. At the end of the 8 weeks staff nurse and care support workers reported that they felt more confident in checking and monitoring heels for pressure damage. Staff explained that they felt staff nurses and care support workers were working and communicating better and that checking heels had become an important part of the routine. 2. Reduction in C21 hospital acquired pressure ulcers achieved following the implementation of the Heels hero project in January 2023.
Bring Geriatric medical review, falls assessment, bone health assessment, post-op delirium assessment for all fractured NoF patients to within National Standards within 25% of current KPI targets by 30th September 2023 for WHH patients over the age of 60.	Ian James Turner	01/09/2023	18/03/2024	1. The importance that improving KPI standards has an overall effect on patient care. 2. The introduction of the new proforma meant that we became compliant with national standards. 3. We did not experience any barriers in launching this proforma however this service is an in-reach service and so remains vulnerable if removed from this patient group.
To improve the management of alcohol withdrawal in the Emergency Department by ensuring 90% of alcohol withdrawal patients are commenced on the Alcohol Pathway by the end of December 2022.	Adam Roscoe	31/12/2022	18/03/2024	1. Large amount of data – reviewing all the 200-300 patients' notes per month was exhausting and long-winded. This was identified as an issue early in the quality improvement process. It was rectified quickly by increasing the size of the team to assist with data collection. 2. Multiple staff collecting data - the downside of increasing the number of staff collecting data was the accuracy. There was

				no way, without checking all the data collected independently, to comment on the accuracy of the data collected. There may have been multiple points of error within the dataset. 3. Problems with electronic notes – collection of data required a review of the clinician notes, nursing notes, prescription charts and scanned-in paper notes. A number of these files were missing or corrupted. As a result, some patients were excluded whilst others were assigned a negative value. This may have impacted on the results to a small degree. 4. The changing clinical course of a patient – not all patients included started their Emergency Department journey as alcohol withdrawal. Some patients in the dataset attended with alcohol intoxication. Due to the long waiting times in the Emergency Department, a proportion of these patients would progress to alcohol withdrawal. Time differences between Triage and CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol assessment) or chlordiazepoxide dosing may have been prolonged in this group of patients.

4.3 Learning from the Application of Knowledge and Evidence

4.3.1 Views of International Nurses, Midwives and AHPs Contribute to Dialogue Around Actions 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 outlined the key actions which would encourage them to remain working at WHH and/or in the NHS which included:

- Greater flexibility around rostering
- Longer periods of leave to enable international travel.
- Improved mentoring and supervision
- Addressing racism and discrimination.

The findings from the consultation correlated closely with responses collected by Legacy Nurse Wendy Johnson in the 'What Matters Survey'. Feedback has triggered conversations and contributed further weight to ongoing projects looking at:

- Team rostering being piloted on B19 and ACCU and later A&E to improve flexibility and work/life balance and enabling international staff to take extended periods of leave in the winter.
- Preceptorship review with more frequent access to mentors and informal buddying schemes.
- Addressing racism, especially micro-aggressions across the trust through work led by the Chief Nurse, Ali Kennah and Head of Culture and Inclusion.

4.3.2 Information Provided on a Rare Condition Supported Staff to Access and Deliver Specialist Support to a Patient and her Family

Learning Outcomes

PolG (polymerase γ) related mitochondrial disease is a very rare genetic disease and as such was unknown to the Physiotherapy department when a patient attending received a diagnosis for this disease. Clinical Specialist Physiotherapist, Mary Rowland contacted the KES for further information and guidance on this disease. The team provided:

- Specialised guidance from the UK, Australia and the USA
- Contact details of physiotherapists working in highly specialised mitochondrial disease centres in the UK
- Identified other key agencies which offered specialised information and support.

Impact:

- **Increased expertise and confidence supported conversations with specialists**: "Having that background insight made us feel more confident in speaking to the mitochondrial specialists in Newcastle and that in itself has given us another level of expertise."

  "Having connections to other specialists has given us the confidence to be able to find the answers to things we're not sure about. When you're dealing with very rare conditions it's really useful to have those links into other places that have that extra level of experience …and background understanding of a relatively rare condition and to have an understanding of the right language and terminology."

- **Enabled informed and compassionate conversations with the patient and her family**:

  "The patient already had some information about her condition from when she received her diagnosis, so we wanted to be able to meet her at a level where we had a baseline understanding of what she had been told. We needed to have the right language to be able to discuss the condition with the patient on a one-to-one basis, and also with her Mum who often attended appointments and would become emotional due to heritable nature of the condition."

- **Improved patient experience and confidence:**

  "Prior to her diagnosis the patient would often become upset at our appointments because she felt like no one could tell her what was wrong and what would happen to her, but now we have the right language to be able to have those difficult conversations and it has helped us to build a rapport.

  Even though we can't always tell her what is going to happen, we can think about what might happen. We can't think too far ahead but we can try to future proof her life a bit and whilst we can't cure her, we can try to make life easier for her. Having that knowledge of her condition has allowed us to give a better quality of care and I hope the fact that we have an understanding of the patients' condition has improved her patient experience. I hope it's given her the reassurance that if we don't know the answer to any of her questions then we'll search it out and that we know where to go to find the answers." Clinical Specialist Physiotherapist, Mary Rowland.

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, noted as pop-ups on computer screens and shared at daily brief. There were 40 alerts issued throughout Quarter 4: 13 in January, 16 in February and 11 in March. When alerts are issued, some will be shared over several 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:

Security Assistance. When staff require security assistance, they will need to use the security codes. This is so that security can prioritise urgent and non-urgent requests.

Resus trollies. It has been highlighted recently after an incident that some staff are unaware of how to open a resus trolley leading to a delay in care in emergencies. This is a safety issue, particularly during an arrest.

6. Learning from Claims

6.1 Clinical Claims

6.1.1 Clinical Claims Received

There were 24 clinical claims received in Quarter 4, 24 were received in the previous quarter.

6.1.2 Clinical Claims Closed

There were 43 ongoing Clinical Claims closed in Quarter 4, 16 with damages (totalling £3,303,507.00 (excluding costs of instructing Trust solicitors), 1 Successfully repudiated and 26 withdrawn including closed due to lack of further correspondence from the claimant.

Specialty	Damages Paid	No of Claims
Anaesthetics and Pain	£3,000.00	1
General Surgery	£320,000.00	1
Upper GI and Colorectal Surgery	£166,900.00	2
Care of the Elderly	£2,000.00	1
General Medicine	£15,000.00	2
Cardiology	£3,000.00	1
ENT	£217,388.00	1
Ophthalmology	£2,150,000.00	1
Trauma and Orthopaedics	£70,500.00	2
Emergency Medicine	£355,719.00	4
Grand Total	**£3,303,507.00**	**16**

6.2 Non-Clinical Claims (Employee Liability / Public Liability)

6.2.1 Non-Clinical Claims Received

There were 3 employer liability claims and no public liability claims received in Quarter 4. This was 1 more employer liability claim than received in Quarter 3.

Quarter 4

Employer Liability	3
Abuse etc of Staff by patients	1
Moving and handling incident	1
Exposure to infection, hazardous substance, electricity	1
Public Liability	**0**
Grand Total	**3**

6.2.2 Non-Clinical Claims Closed

There were 4 Employer Liability Claims closed in Quarter 4, 3 with damages paid. There were 3 Public Liability Claims closed, all with damages paid. The total damages paid is £34,244.80 excluding costs.

6.2.3 Claims Learning and Actions

Following claims investigations for claims closed in Quarter 4, 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	
Incorrect diagnosis of Takotsubo cardiomyopathy following coronary angiogram	Consultants have been encouraged to consult existing literature/current guidelines, if in doubt of any pathology. They should also ask the opinion of their colleagues in such cases.

Claims Learning	
	If there is discrepancy between the recommendations of two or more Consultants, the cases should be re-discussed. If patients are seen in outpatients, after being discharged, the Consultant should communicate pending tests. Results should be sent back to the referring Consultant, who is obliged to communicate these to the patient.
End of procedure checklist failed to identify missing piece likely due to combination of multiple sets, new packaging and Scrub Nurse assisting Registrar in keeping wound dry. Guide was not identified on the images in theatres at the end of surgery.	Two identified staff members must identify and record number of sets including any deviation from normal. End of procedure x-ray to be completed to confirm position and a metalwork check undertaken. Communication of remaining steps to completion between Consultant and Registrar when Consultant leaves the operating room to be documented on the ORMIS system. Feedback provided to the Emergency Department regarding missed x-ray post back slab application. Personal reflections completed. Implementation of a halt moment in theatres before a consultant leaves the operating room to determine outstanding steps. Orthopaedic surgical kits adjusted to include that the drill guide and the screw are 2 separate items. Spot-check audits completed by the theatre manager to ensure that instruments are checked thoroughly and that halt moments are being performed and documented. Tabards implemented to highlight not to disturb the runner who does the double-checking process of the checklist. Stop And Focus Everyone (SAFE) initiative that is already in place in theatre was a focus of the month to remind staff of its benefits on patient safety. Standardisation of the counting process on all sites as the investigation found differences in this process.

Claims Learning	
	If any drill guide is used during a procedure, then this is to be added to the swab board for checking as a secondary safety check. Final x-ray at end of procedure should be made available to view on PACS or Lorenzo. If the x-ray is a printed copy, then administrators must be asked to scan this into the system. Reviewed the possibility of x-ray meeting within the Orthopaedic Speciality for education of the teams and patient safety. Feedback regarding the investigation shared to the CBU and extended teams for learning and awareness. Communications shared to inform that Consultants must be present at debriefs following surgical procedures.

7. Learning from Inquests

16 inquests were heard and concluded in Quarter 4. 7 were narrative conclusions, 5 were natural causes, 1 was industrial disease, 1 was misadventure, 1 was a suicide (at home) and 1 was an accidental death. The Cheshire Coroner was satisfied with the learning implemented. There were no Regulation 28 (Prevention of Future Deaths) reports issued. Of the 16 inquests, 8 had legal representation.

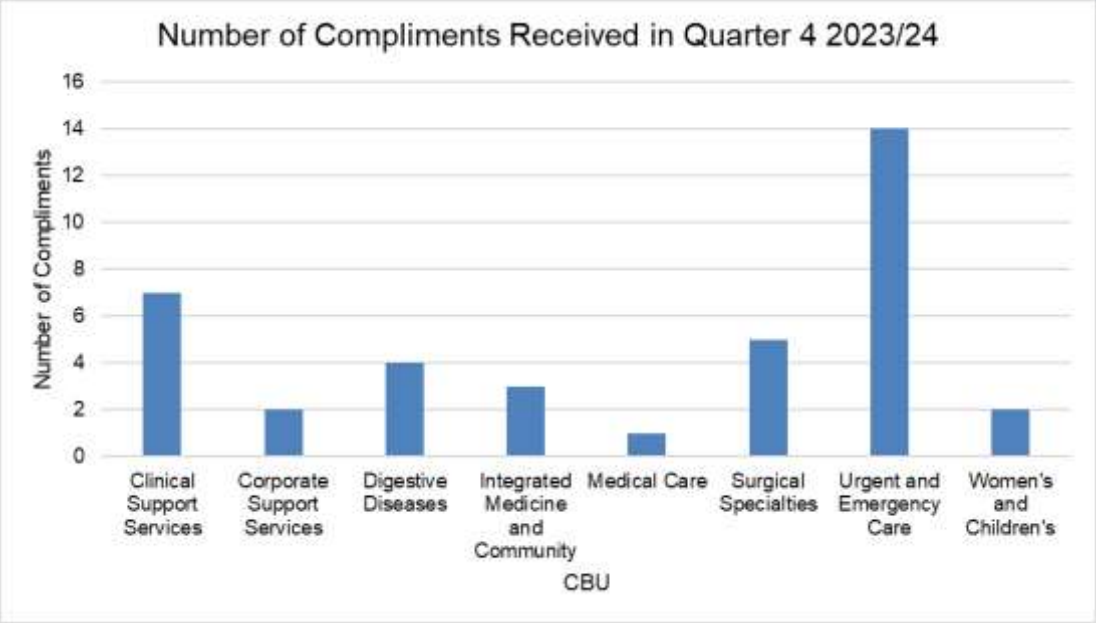
1 narrative verdict concluded with a rider of neglect despite the solicitor making submissions that a rider of neglect should not apply because although it was accepted that there was inadequate replacement of fluid and electrolytes, the patient was still provided with a significant amount of fluids during her admission and management of her ileus was attempted with the insertion of the NG and Ryles tube on a number of occasions. However, the Coroner noted there was not a single error but a number of factors to consider. She felt it was too narrow to say that there was not a gross failure on the basis that she was administered significant IV fluids. Therefore, the Coroner did not apply Regulation 28.

Support is also being provided by the Head of Legal, Complaints and PALS to prepare witnesses for court and attend inquests in a supportive capacity. Inquest Awareness sessions have been scheduled to take place with FY1 and FY2 doctors during May 2024.

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 Quarter 4 2023/24, the Trust received 38 compliments which has increased by 9 (31.03%) compared to Quarter 3 2023/24.

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. This is highlighted to the CBU's for dissemination within their teams.

9. Learning from Patient Experience and Inclusion

The Patient Experience and Inclusion Team continue to develop patient stories with CBU's. These patient stories are shared across multiple committees, not limited to: Patient Experience Sub Committee, Patient EDI Sub Committee, Quality Assurance Committee, Trust Board. 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 and feedback from patients, carers and their families. This allows the Trust to review areas of concern and celebration of good practice. Enabling areas to initiate improvements required that are identified via the feedback. Various methods used include:

- The National Friends and Family Test, via text, QR codes, telephone calls, paper copies.
- Local departmental surveys.
- National surveys.
- Patient Experience and Inclusion team face to face survey and feedback.
- Patient Experience and Inclusion team monthly observation rounds.
- Monthly First Impression observation rounds that are triangulated with PLACE inspections and the Leadership and Governors observations.
- Feedback from complaints / PALS.
- Feedback from Community Partners and Advocacy Groups.
- Knowledge and Evidence as a resource for best practice.
- Working with Experts by Experience.
- Area specific patient journey mapping.

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:

- The Launch in August 2023 of monthly d/Deaf awareness training sessions, running until March 2024, open to all Trust colleagues.
  - Feedback from the training sessions, Deafness Resource Centre to develop and provide bitesize face to face BSL training.
- The introduction on Lorenzo of a d/Deaf alert for patients in July 2023.
  - Auditing commenced via alerts to Patient Experience Team
- Focused meetings and ward visits to ensure compliance with the interpretation policy.
- Continuous focus on keeping areas clutter free and tidy, with clear signage in place as part of the First Impressions programme.
- Following the end of the Armed Forces Advocate role, the Patient Experience and Inclusion Team have taken on the assignment and are working closely with workforce and the staff network.

10. Learning from Clinical Audit

10.1 Learning from National Audits

National Audit of Dementia (NAD) Round 5

Summary:

The National Audit of Dementia care in general hospitals (NAD) examines aspects of care received by people with dementia in general hospitals in England and Wales. Round 5 of NAD collected data between September 2022-January 2023.

Standards are derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals Charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges.

Key Findings:

- The Trust scored 100% for delirium screening, pain assessment and pain reassessment.
- Almost all of the other metrics scored higher than national figures.
- However, patients did receive a higher median length of stay (17days) compared to national data (10 days).

The audit has highlighted the importance of building the audit into 'everyday business' as opposed to the mindset that it's something we do once a year.

As the audit is now prospective as oppose the retrospective, it really supports implementing quality improvements based on the findings of NAD. However, this requires focused efforts beyond the time frame of the audit people living with dementia are admitted across the hospital, but predominantly for a medical reason.

People with dementia are at risk of delirium. The 4AT is a highly sensitive and specific delirium detection tool designed for easy and effective clinical use. Management of delirium relies on early recognition, elimination or correction of underlying causal factors and general symptomatic and supportive measures.

Improvement Action Plan:

- Project to increase 4AT screening in the organisation. (embedding the 4AT tool into practice provides an opportunity for developing a formal system of measures which

aim to prevent delirium and the negative outcome measures which are associated to it).

- Length of stay is to be explored a part of the planned improvements to 4AT screening.

- Increase the uptake of carers questionnaire completion in future rounds of NAD.

Assurance rating (using Trust assurance rating matrix): High Assurance

10.2 Learning from Local Audits

Summary:

Discharge Summaries have been the focus of an improvement plan at WHH since 2018-19. The quality of discharge summaries and timely distribution to the GP are key quality and performance indicators. The quality of discharge summaries is audited every 6-12 months covering both Planned Care and Unplanned Care Groups. Timely distribution of the discharge summary is a performance indicator that is reported on the Integrated Performance Report to CCG.

The objective of the audit was to assess the completion of all elements of the Discharge Summary form with relevant and complete information.

Key Findings:

- The audit findings provide significant assurance overall for the quality of completion of Inpatient Discharge Summaries to the GP.
- The improvement in the quality of completion of Discharge Summaries noted in the last audit in October 2022 for Planned and Unplanned Care has been sustained.
- The amended Discharge Summary template has allowed for a significant improvement overall in completion of the fields as it has been abridged to include relevant information only and excluded fields that were present in the previous Discharge Summary template that were poorly filled out and of minimal relevance to the GP.
- There is improved compliance with use of the newly introduced Ward Round CDC forms for Ward Round documentation and this has improved quality of completion due to auto-population of the Discharge Summary.

Learning:

The learning was that good compliance with quality of completion of Discharge Summary. Some improvement required though with completing information on Action for GP and Follow-up arrangements.

Improvement Action Plan:

Action for GP - Disseminate to junior doctors the requirement to complete this section with relevant actions.

Follow up arrangements - Disseminate to junior doctors the requirement to complete this section with information on relevant follow-up arrangements**.**

Assurance rating (using Trust assurance rating matrix): High Assurance

11. Compliance

11.1 Learning from the recent Maternity Care Quality Commission (CQC) Inspection

The CQC continues to rate the Trusts Maternity Services as 'Good', following an inspection in September 2023. The service was inspected as part of the National Maternity Inspection Programme which involved an announced inspection of Maternity Services.

The inspections focussed on whether services are safe and well-led, with the aim of providing an up-to-date view of hospital maternity care across the country. The inspectors carried out an on-site inspection, interviews with key staff and stakeholders and sought feedback from those who have used the service. They also submitted requests for evidence and detailed data analysis.

The inspectors report, published on Wednesday 17 January 2024, is a positive account across both the Trust's safe and well-led domains, both of which were remained 'Good'.

The Trust received no 'must do' actions, with inspectors reporting 5 'should do' actions to improve services. There are:

- The service should continue to improve training compliance rates for all staff in all relevant areas.
- The service should ensure that 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.

Action planning is taking place to ensure that these matters are implemented.

11.2 Learning from CQC Engagement and Risk Meetings

The CQC visited the Trust on Monday 29 January 2024 to discuss Urgent and Emergency Care provision, as well as service discussions on Surgery and Medical Service risks affecting provision and insight into mitigating actions with have been implemented by the Trust. Following this meeting, the CQC wrote to the Trust on Monday 11 March 2024 requesting further information regarding the service areas discussed. The information was sent to the CQC before the deadline of Thursday 28 March 2024.

As part of the CQC's new regulatory framework procedures, CQC officers have requested an Engagement Meeting for Tuesday 23 April 2024. No further information has been requested and the visit was deemed a positive experience by the Executive Team.

The CQC have also requested that arrangements are made for their officers to observe one of the Trust's private and public board meetings.

11.3 CQC Presentation and Workshop on the new Single Assessment Framework

The CQC provided a presentation and workshop on the new Single Assessment Framework on Tuesday 26 March 2024. The presentation focussed on what this will mean in terms of practicalities for the Trust and services delivered. The presentation advised of the new CQC strategy and how the CQC were changing their internal structure and approach to regulation. This included the new single assessment framework, ongoing quality and risk assessments

by services rather than the whole Trust assessments and how the scoring methodology was changing from key lines of enquiry (KLoE's) to 34 "I / We" statements.

The CQC advised they would provide a further workshop if the Trust requested this.

12. Learning from Research and Development Activity

12.1 Learning from Research and Development (R&D)

Team Affina Journey:

The RD&I team continue on their Affina Journey with a collaborative spirit, aligning with Pharmacy and Finance colleagues to solidify team objectives and enhance role clarity. A representative from Health Innovation Northwest Coas joined the session and shared insights on avenues for Research Development and Innovation (RD&I) and WHH to leverage innovation efforts. The Affina Journey not only fosters cohesion within the team, spanning across two sites, but also serves as a conduit for valuable cross-system learning experiences, enriching their understanding of working within the broader healthcare landscape.

"Grow Your Own Brilliance" Northwest Research Conference:
A Senior Research Nurse attended this conference hosted by R&D Northwest focussed on talking, sharing, showcasing, developing and considering how a career in health and care research can grow. The Physiotherapist Research lead was also in attendance presenting the work on developing NMAHP capacity and capability at WHH. A great opportunity to share best practice and learn from others, the day was informative and engaging, with high quality speakers and breakout sessions. The learning gained will help to shape how NMAHPs are involved in research across the Trust, from champion to research leader.

Principal Investigator Forum:

A new Research Principal Investigator (PI) Forum launched in February. The forum will serve as a platform for Research Principal Investigators and Associate Principal Investigators engaged in research projects, offering an opportunity to share best practices, formulate strategic approaches for portfolio diversification and growth, and contribute to the sustainability of our research endeavours. The primary aim of the PI Forum is to foster a collaborative environment, promoting knowledge exchange, facilitating networking, and collectively addressing the common challenges encountered by Principal Investigators. Chaired by Deputy Associate Medical Director for Research, it was attended by our research leaders from Gastroenterology, Anaesthetics, Microbiology, Speech and Language Therapy and Intensive Care. A previous ICU trainee also provided an insightful presentation about the Associate Principial Investigator Scheme, a six month in-work training opportunity, providing practical experience for healthcare professionals starting their research career.

Research Awareness and Education

The RD&I team are also focusing on the learning and education of others though a specific programme of engagement with Nurses, Midwives and Allied Health professionals, thus opening the dialogue for conversations about research and evidence-based practice.

RD&I is now embedded in the Preceptorship Programme with monthly hour-long sessions and a quarterly full day development session. Based on formal evaluation to date, the training has been well received by participants on all sessions and feedback has helped to shape the content of future training.

The RD&I team are learning, through surveys, discussions and evaluation forms, about the research training needs of WHH staff and how best to address those needs. The outcomes will be improved awareness and increased capacity and capability to undertake and develop research for the benefit of patients.

The Annual Research Awareness Survey was rolled out in January and will be repeated in May on International Clinical Trials Day to boost the response rate.

13. Recommendations

The Quality Assurance Committee is asked to note the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/05/39**			
SUBJECT:	Violence Prevention and Reduction Strategy – Bi-Annual Update			
DATE OF MEETING:	May 2024			
ACTION REQUIRED:	**To note the content of the paper and the progress made against the Violence Prevention and Reduction Strategy**			
AUTHOR(S):	Ian Wright, Associate Director of Estates & Facilities			
EXECUTIVE DIRECTOR SPONSOR:	Dan Moore, Chief Operating Officer & Deputy			
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 Violence Prevention and Reduction Standard provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence. All NHS commissioners and all providers of NHS-funded services operating under the NHS Standard Contract should have regard to the violence prevention and reduction standard and are required to review their status against it. A Violence Prevention and Reduction Strategy is a requirement of the standards and this paper reviews the status of the strategy.			
PURPOSE: (please select as appropriate)	Approval	To note √	Decision	
RECOMMENDATION:	The committee is asked to note the content of the paper and the progress made against the Violence Prevention and Reduction Strategy			
PREVIOUSLY CONSIDERED BY:	**Committee**	n/a		
	Agenda Ref.			
	Date of meeting			

	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Violence Prevention and Reduction Strategy – Bi-Annual Update	AGENDA REF	QAC/24/05/39

1. BACKGROUND/CONTEXT

The violence prevention and reduction standard provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence.

The violence prevention and reduction standard employs the Plan, Do Check, Act (PDCA) approach, an iterative four-step management method to validate, control and achieve continuous improvement of processes.

- **Plan**

The NHS organisation must review their status against the violence prevention and reduction standard and identify their future requirements, to understand what needs to be completed and how, who will be responsible for what, and what measures will be used to judge success. This phase of the process includes developing or updating strategies, policies and plans to deliver the aims.

- **Do**

The NHS organisation must:
- assess and manage risks
- organise and implement processes, and communicate plans to, and involve NHS staff and key stakeholders in their delivery
- provide adequate resources and training.

- **Check**

The NHS organisation must ensure that the plans are implemented successfully, assess how well the risks are controlled and determine if the aims have been achieved, ~~ie~~i.e. via audit measures. As part of the process, the NHS organisation should routinely assess any gaps and ensure swift corrective action.
Credible, accurate and unambiguous data will assist in checking incidents of violence have fallen.

- **Act**

The NHS organisations must review its performance to enable the senior management team to direct and inform changes to policies or plans, in response to any localised lessons learnt, and incident data collected in respect of violence prevention and reduction. The NHS organisation should share critical findings with internal and external stakeholders.

2. Violence Prevention Strategy

The Violence Prevention and Reduction Strategy is a guide for all colleagues to ensure that measures are put in place to better protect staff against deliberate violence and aggression from patients, their families, and the public, and to prosecute offenders more easily. Experiencing violence and aggression does not form any part of any role within the Trust, as such, it is the mission of WHH to prevent and reduce incidents of violence and aggression towards its staff by raising awareness and improving corporate arrangements to address areas of concern. The aim of this Violence Prevention and Reduction Strategy is to set out a plan for WHH to address this significant and ever-increasing risk to staff from violence and aggression.
This supports staff to work in a safer and more secure environment, to safeguard against abuse, aggression, and violence. Work is ongoing to achieve the objectives of the strategy.

Below demonstrates what has been achieved to date of the Violence Prevention & Reduction Strategy:

Improved staff safety:

- Undertaken a self-assessment on compliance with the Violence Prevention and Reduction Standard using the Plan, Do, Check, Act model.
- Ward/Department Risk Assessments undertaken.
- Reduction in the number of incidents in key areas and the level of harm regarding violence and aggression.
- Strengthened the monitoring of incidents reported regarding violence, identifying any trends, and escalating to the Corporate Risk Register if required.
- Provided appropriate training in Conflict Resolution Training and De-escalation Training commensurate to roles and risks posed following a training needs analysis (TNA)

Improved staff experience by:

- Continually ensuring all individuals who have been affected by or exposed to violence and aggression will be offered appropriate individualised support.
- Raised awareness and communicate the ‘Staff Support violence aggression support protocol’.
- Initiated a poster campaign and security newsletter to prevent violence and aggression and respect our staff.
- Annual Security Awareness month held in February 2023.

3. Risk Assessments

The standards relay the importance for all areas to have relevant and current risk assessments in place to mitigate against violence and aggression towards staff. The Trust Local Security Management Specialist (LSMS) provides template security risk assessments to all CBU managers and equips them with completion guides. Risk assessments are completed by 'area' of the Trust with mitigations and actions allocated.

4. Audit

To ensure all areas have current risk assessments, the Trust LSMS audits the completion of security risk assessments in relation to violence and aggression by asking CBUs to report on a template audit form. Those areas that are faced with challenges to the completion of risk assessments or audits are supported by the security department. Out of the 87 of the departments across the trust 58% have been audited since October 2023, (audits are annual), which equates to 67 areas. Of those 67 areas 10% of those areas didn't have a risk assessment in place, LSMS has assisted these areas which are now up to date. The remaining 42% will be audited before the next update.

Questions asked as part of the audit process:

- How are risk assessments when new or having been reviewed communicated to staff?
- Do you have a paper and/or an electronic copy of the risk assessment?
- Is the risk assessment fit for purpose e.g. is the title correct?
- Has the risk assessment been reviewed and what information did you use to review e.g. accident information or is it a new process?
- Are controls adequate to manage the risk?
- Is there an action plan in place?
- Do the staff know where they can locate the Risk Assessment?
- Do your staff know their roles and responsibilities in relation to Trust policy?
- Are the staff aware of conflict resolution training, and can you provide training figures for the ward or department?
- Are the staff aware of de-escalation training and, can provide the training figures?

LSMS continues to provide support in relation to the risk assessment process.

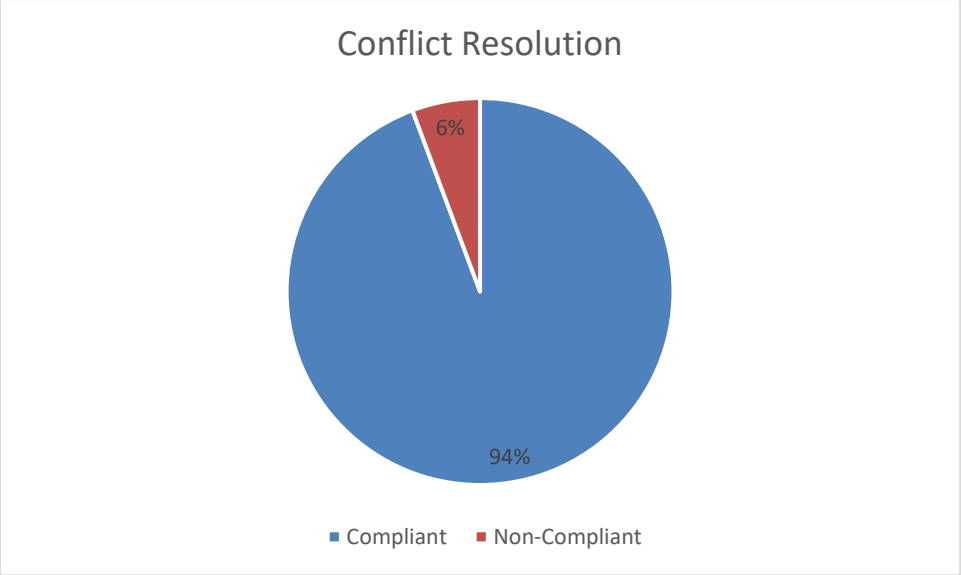
5. Training

As part of the Violence Prevention & Reduction Strategy the Trust has:

- Provided a robust training plan for all staff groups within the Trust.
- Ensured staff attend regular update training.
- Evaluated the effectiveness of current training provisions.

Conflict Resolution Training

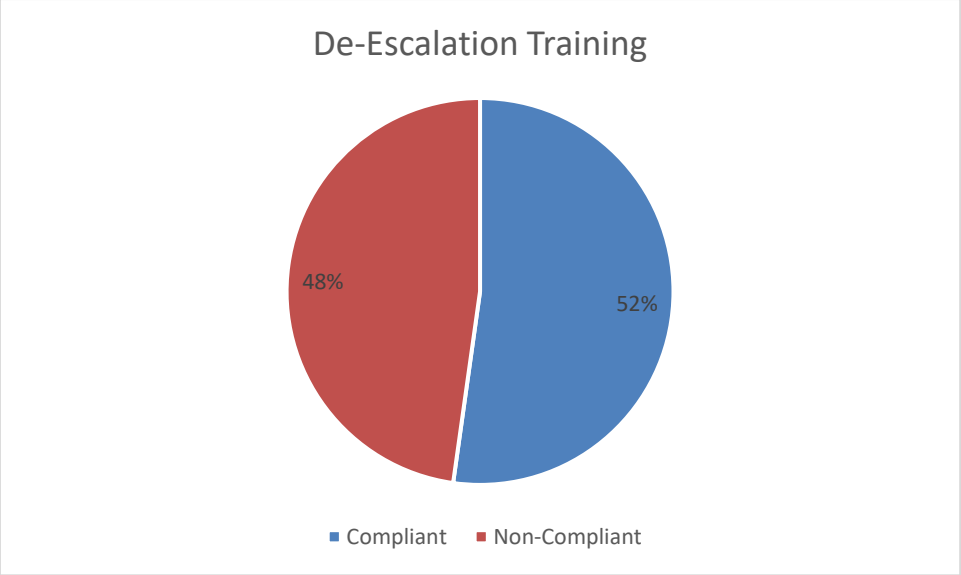
Chart 1 below shows a Trust wide 94% compliance rate in Conflict resolution training. This is monitored monthly.



De-Escalation Training

Clinical Education along with the LSMS developed a TNA to identify staff groups that require training. Once the TNA was finalised, funding was provided for a trainer to deliver De-escalation Training for the staff groups identified that require this training.

Chart 2 below shows a Trust wide **52%** compliance rate in De-escalation training. Since November 2022. At last reporting period this was **51%,** the slight increase is due to staff renewing their accreditation and the Trust unfortunately having only one trainer for a long period, due to other trainer having other training commitments elsewhere. However, there are plans to train two more staff and are currently waiting on CPD funding. Once additional trainers are qualified, addition sessions will be facilitated.



This is how we are achieving this.

- Training Needs Analysis (TNA) has been developed based on incident data from high-risk areas.
- Training requirements and incident data has now been added to ESR/ Business Intelligence (BI) Workforce and will be monitored monthly and presented at the Violence and Reduction Group.
- Evaluating the effectiveness of training delivered will be carried out by course evaluation questionnaires.
- The de-escalation Trainer will be invited to the Violence and Reduction Group Bi-monthly to highlight any issues.

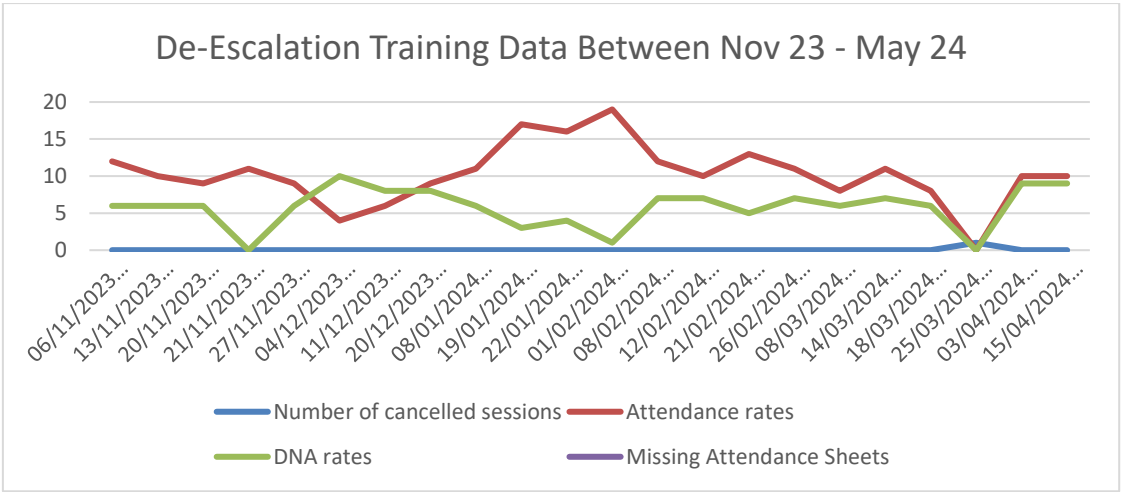


Chart 3 above, shows the compliance with relation to De-escalation training between November 2023 – May 2024. The chart above shows One course cancelled due to no trainer available. 226 staff attended the training between these dates and 127 staff did not attend. The DNA are mainly due increased operational pressures within the trust.

Breakdown of Chart 3 is shown below:

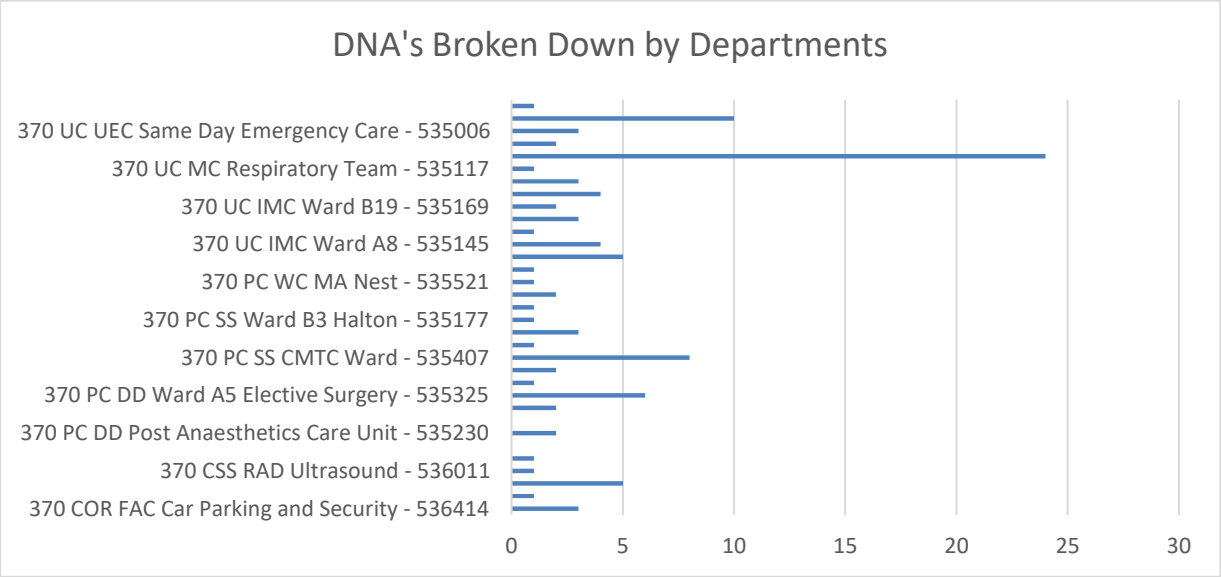
Date	Number of cancelled sessions	Attendance rates	DNA rates	Missing Attendance Sheets
06/11/2023 (HALT)	0	12	6	
13/11/2023 (HALT)	0	10	6	
20/11/2023 (HALT)	0	9	6	
21/11/2023 (Inter Nurses)	0	11	**0**	
27/11/2023 (HALT)	0	9	**6**	
04/12/2023 (HALT)	0	4	10	
11/12/2023 (HALT)	0	6	8	
20/12/2023 (HALT)	0	9	8	
08/01/2024 (HALT)	0	11	6	
19/01/2024 (HALT)	0	17	**3**	
22/01/2024 (HALT)	0	16	**4**	
01/02/2024 (HALT)	0	19	**1**	
08/02/2024 (HALT)	0	12	**7**	
12/02/2024 (HALT)	0	10	7	
21/02/2024 (HALT)	0	13	**5**	
26/02/2024 (HALT)	0	11	7	
08/03/2024 (HALT)	0	8	6	
14/03/2024 (HALT)	0	11	7	
18/03/2024 (HALT)	0	8	6	
25/03/2024 (HALT)	1	0	0	Trainer Unavailable
03/04/2024 (HALT)	0	10	9	
15/04/2024 (HALT)	0	10	9	

Chart 4 below demonstrates the position of training compliance withing the CBU's. Areas that are struggling are receiving extra support from the LSMS in relation to additional training.

Estates & Facilities	100%
Medical Care	78.18%
Emergency Care	55%
Women & Childrens	26.53%
Clinical Support Services	47%
Unplanned Care Management	25%
Digestive Diseases	56.90%
Integrated Medicine & Community	35.58%
Surgical Specialties	66%

Chart 5 below shows a break down in DNAs by departments. Top three areas for the highest amount of DNA's are:

Department	Number of DNA's
Emergency Department	24
Ward A1	10
CSTM	8



Dates have now been booked for De-escalation training through to December 2024

Date	Location	Date	Location
~~08/01/24~~	~~A4, Halton~~	01/07/24	A4, Halton
~~19/01/24~~	~~A4, Halton~~	08/07/24	A4, Halton
~~22/01/24~~	~~A4, Halton~~	17/07/24	A4, Halton
~~01/02/24~~	~~A4, Halton~~	22/07/24	A4, Halton
~~08/02/24~~	~~A4, Halton~~	29/07/24	A4, Halton
~~12/02/24~~	~~A4, Halton~~	05/08/24	A4, Halton
~~21/02/24~~	~~A4, Halton~~	12/08/24	A4, Halton
~~26/02/24~~	~~A4, Halton~~	19/08/24	A4, Halton
~~08/03/24~~	~~A4, Halton~~	27/08/24	A4, Halton
~~14/03/24~~	~~A4, Halton~~	02/09/24	A4, Halton
~~18/03/24~~	~~A4, Halton~~	09/09/24	A4, Halton
~~25/03/24~~	~~A4, Halton~~	16/09/24	A4, Halton
~~03/04/24~~	~~A4, Halton~~	23/09/24	A4, Halton
~~15/04/24~~	~~A4, Halton~~	30/09/24	A4, Halton
~~24/04/24~~	~~A4, Halton~~	07/10/24	A4, Halton
29/04/24	A4, Halton	14/10/24	A4, Halton
10/05/24	A4, Halton	21/10/24	A4, Halton
15/05/24	A4, Halton	28/10/24	A4, Halton
20/05/24	A4, Halton	04/11/24	A4, Halton
29/05/24	A4, Halton	11/11/24	A4, Halton
05/06/24	A4, Halton	18/11/24	A4, Halton
10/06/24	A4, Halton	25/11/24	A4, Halton
17/06/24	A4, Halton	02/12/24	A4, Halton
24/06/24	A4, Halton	09/12/24	A4, Halton
		16/12/24	A4, Halton

6. Incidents

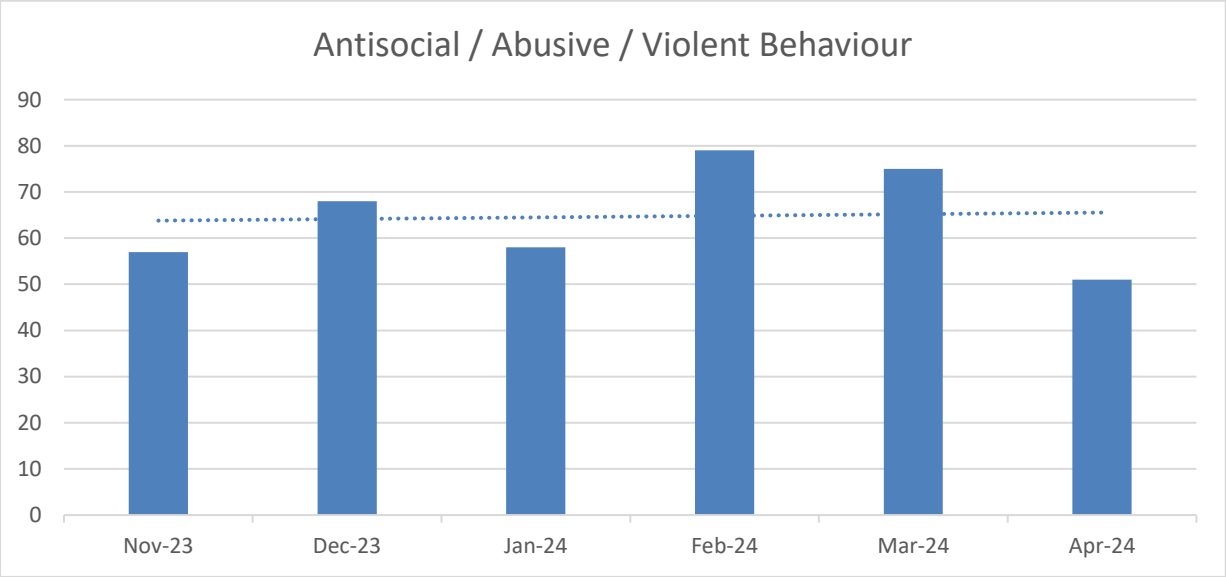
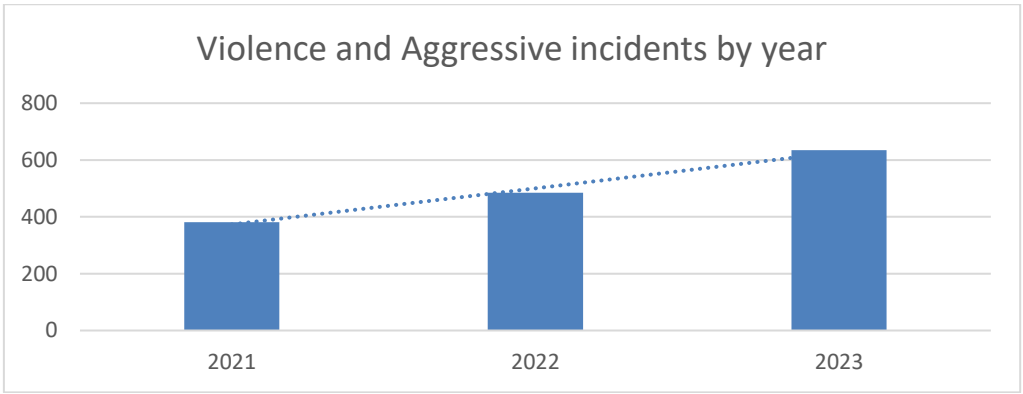


Chart 6 above shows a slight decrease in incidents by month since 1st November 2023.

Staff record incidents of violence and aggression in line with the Trust inccident reporting policy via DATIX. The tables below indicate incidents recorded on DATIX.

The following charts demonstrates the recorded incidents of violence and aggression at WHH.

Between 1st May 2023 to the 31st October there were **398** incidents of Violence & Aggression recorded this is compared to **388** incidents of Violence & Aggression recorded between 1st November 2023 to the 30th April 2024



7. Violence Prevention and reduction initiatives

Over the last reporting period, several initiatives have been explored and initiated collectively by the LSMS and key internal stakeholders.

Poster Campaign

- LSMS is continuing with reviewing the posters in relation to violence and aggression across the trust.

Support

- LSMS has continued to attend areas with increased violence and aggression, offering support to staff and advice with positive feedback.
- Self-defence sessions have been booked for the staff working in the Path lab due to an incident that occurred whist a staff member was on lunch break off site. 3 sessions booked.
- Debrief sessions held for staff who have been subjected to aggression.

Awareness

- Security awareness session have been booked for September 2024. LSMS will be holding security awareness sessions for staff, one for Warrington & One for Halton

CCTV

- Upgraded new PTZ (Pan, tilt & zoom) 4 in total, providing clear images of incidents that occur externally ensuring successful prosecutions when required.

Car Park Payment Machines

- Upgraded the car park payment system across both sites with an updated pay on exit system. The new system will help patients and visitors pay for parking with ease. We envisage a reduction in complaints and a reduction in visitors becoming frustrated which can be a cause of conflict

Access Control & CCTV

- New door access and CCTV have now been installed in Thelwall house due to reports of suspicious incidents occurring within the building. DATIX report have been completed and this has been the outcome of the investigation.

8. Equality, Diversity & Inclusion

The Violence Prevention Reduction Strategy ensures that it meets the individual needs of all, considering the protected characteristics outlined in the Equality Act 2010: age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity. As well as this, we also explore how wider socioeconomic factors impact on specific groups of people.

This strategy ensures equity in access to our hospitals and the experience of all our workforce is reviewed whilst we create a culture of belonging in which everyone feels supported, safe and secure.

The local security management specialist has been working with the ED&I lead along with the trust DATIX administration team data sets within the incident reporting system. This will allow for better monitoring of incidents against protected characteristics. Please see below 3-year plan:

- In **year one** within the strategy, WHH will undertake a review of what information we record, how we utilise data related to equality, diversity and inclusion and our internal systems and processes. **- COMPLETED**
- In **year two**, we will focus on ensuring that inequality and disparity in the experience of staff groups with protected characteristics is addressed and monitored through systems and processes. We will work with our subject matter experts to ensure that our objectives and work plans apply due regard and meet our regulations under the Public Sector Equality Duty. - **ONGOING**
- In **year three**, WHH will focus on working with our staff networks and patient groups to embed learnings, principles, and findings from years one and two to ensure they are fully embedded in business as-usual organisational procedures.

Data is currently retrieved from the NHS staff survey results.

Summary

In summary the paper provides an overview of the initiatives undertaken and the progress made in deterring violence and promoting a safer environment within WHH. The paper highlights key strategies, programs, and outcomes achieved during the specified reporting period.

The paper also highlights the collective efforts made in preventing and reducing violence. It showcases the implementation of comprehensive strategies, policy, staff engagement, education, new technology, and data-driven approaches to achieve positive outcome.

It also acknowledges the challenges faced in violence prevention and reduction. It identifies areas that require further attention, such as addressing training, risk assessments and strengthening partnerships across the Trust. The Trust LSMS will continue to work to meet the objectives of the Violence Reduction and Prevention Strategy.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/23/04/10**			
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q3, 2023/24**			
DATE OF MEETING:	17 April 2024			
ACTION REQUIRED:	**To note the contents of the report**			
AUTHOR(S):	Dr Rachel Wallis Guardian of Safe working			
EXECUTIVE DIRECTOR SPONSOR:	Dr Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			√	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of exception reports via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During this reporting period a new GSW was appointed and took up the vacant post on 1st December 2023. During Quarter 3 (1st October – 31st December) 2023-24, 75 exception reports were submitted of which 0 were highlighted as an immediate safety concern. The majority (67 individual reports, equating to 89.3%) of exception reports relate to hours of working. 2 exception reports relate to patterns of work, 2 relate to missed educational opportunities and 4 exception reports submitted relate to service support available to the doctor. However, the narrative where provided often indicates an overlap between categories.			

	The total number of exception reports for this quarter has decreased which is in line with trends from previous years.		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.		
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):	Choose an item.		
	Choose an item.		

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – Quarter 3 2023-24 (1ST October to 31st December)	AGENDA REF	SPC/24/04/10

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

Most junior doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

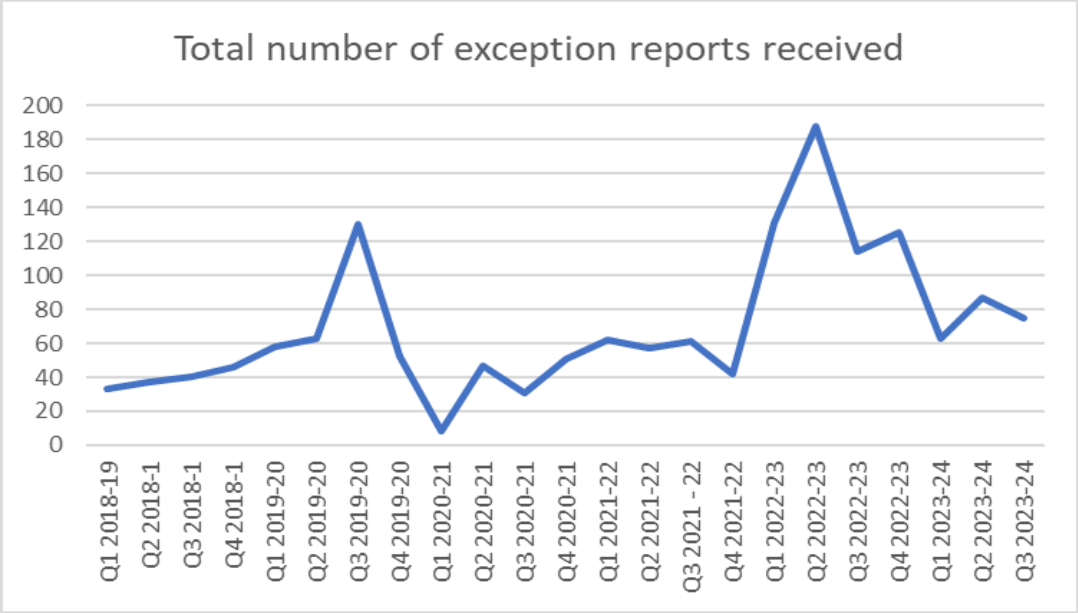
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

Exception Reporting (Oct 23 – Dec 23)

During Q3, 2023-2024, 75 exception reports (ERs) were submitted which is fewer than Q2 and from Q3 2022 there is a large decrease (Q3 2022 114). Following change over (as can be noted from previous years) there is a predictable increase in exception reports which generally reduce/resolve following a period of settling in. Please see Chart 1 for exception reporting trends over previous years.

Chart 1 below illustrates reporting trends:



Fines

The GSW has responsibly for protecting the safeguards contained in the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.

As per the TCS above any of the following breaches will incur a financial penalty.

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13-hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours rest in a 24-hour period has not been achieved (excluding on-call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

During Q3, no fines were levied by the GSW however the GSW post was vacant from June to December so it is likely there will be some retrospective fines to consider which will be reported in Q4.

Themes for Q3 (Oct 23 – Dec 23)
For this quarter there has been widespread exception reporting which may reflect the promotion of the GSW role and all Junior Doctor/trainee induction. Reports have been from many specialties and grades of doctor. There are numerous rota gaps in all specialities, and this is impacting junior doctors across the board.

General Medicine

It is noted that there are number of exception reports relating to General Medicine and in particular the Foundation Y1 (FY1) trainees (12 in total) and while this is a significant amount, we have seen a considerable reduction from last Qtr (Q2) which had 27 in this speciality. Following changeover, it is predicted that a large proportion of this relates to a general settling in period, and, in particular, for the FY1 group can be expected as this is their 1st placement within the secondary care setting. A gradual reduction should be anticipated. I will however continue to monitor this for the subsequent Qtrs to ensure that this is not an ongoing or repeating trend.

General Surgery

During Q3 we have seen a large increase in the exception reports relating to General Surgery (19 reports) with a particular trend from Foundation Doctors (both FY1 and FY2). On review of the narrative of the submitted reports, the main focus relates to management of workload, and operational pressures. This will continue to be monitored by the GSW and a meeting has been scheduled with the CD for Surgery to review.

T&O

Following the declining in trend in T&O over preceding Qtrs there has unfortunately again been a significant increase in Q3 with 24 exception reports submitted by Foundation Doctors (both F1 and F2). The main theme of the reports relates to hours of working, caused by challenges in patient management and variable support in particular surrounding orthogeriatric patients. The GSW met with trainees in T&O supported by Medical Education to explore the issues being faced and offer supportive measures. These issues were then fed back to the leads in T&O and an action plan was generated which will be monitored and a further meeting will be scheduled with all parties to review current position.

Summary

- Number of exception reports raised = 75
- Number of work schedule reviews that have taken place = 6
- ERs flagged as immediate safety concerns = 0. 1 ER was raised as immediate safety concerns but on examination did not meet the criteria but was related to workload and dealt with as a standard ER.
- Fines that were levied by the Guardian = 0

Exception Reports (ER) over past quarter	
Reference period of report	01/10/23 - 31/12/23
Total number of exception reports received	75
Number relating to immediate patient safety issues	1
Number relating to hours of working	67
Number relating to pattern of work	2
Number relating to educational opportunities	2
Number relating to service support available to the doctor	4

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

We continue to monitor any delays in signing off ERs and regular reminders are sent by the Medical Trainees Workforce Administrator. At the end of Q3 there were 68 unresolved ERs. Due to a changeover of GSW and Medical Trainees Workforce Administrator, with the new postholders taking up their roles in Dec 2023, monitoring of this area was temporarily paused. The new GSW will monitor outstanding ERs and encourage continued engagement from both trainees and educational supervisors.

The 2nd JDF meeting is scheduled 24th February for the new cohort and outcomes will be reported in Q4s report. The GSW will continue to provide pastoral support to juniors throughout the difficult period of strike action and the JDF remains a lively and productive meeting resulting in positive change.

Additionally, GSW has reported to the Lead Employer on the exception reports and activity for Q3 with regard to CT1 and above. In total 7 exception reports were submitted, none of which were identified as an immediate patient safety issue. All have been resolved and no fines were issued**.**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- To continue to monitor areas of high exception reporting.
- To continue to monitor action plan generated by T&O and review progress in line with target dates
- To encourage early resolution of exception reports and access to time off in lieu as the preferred outcome where appropriate in line with national recommendations to reduce junior doctor fatigue and promote wellbeing.

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	24
Total number of overtime payments	28
Total number of work schedule reviews	6
Total number of reports resulting in no action	2
Total number of organisation changes	0
Compensation	0
Unresolved	68
Total number of resolutions	**60**
Total resolved exceptions	**56**

***Note**:*

** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

6. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours’ Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust’s Annual Quality Account and signed off by the Chief Executive;

the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

7. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q3 – (end of December 2023) – Submit February 2024
- Q4 – (end of March 2024) – Submit April 2024
- Q1 – (end of June 2024) - Submitted August 2024
- Q2 – (end of September 2024) – Submit November 2024

8. RECOMMENDATIONS

The Strategic People Committee is asked to consider the contents and assurances made in the report.

The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/24/05/30**			
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q4, 2023/24**			
DATE OF MEETING:	15 May 2024			
ACTION REQUIRED:	**None**			
AUTHOR(S):	Dr Rachel Wallis Guardian of Safe working			
EXECUTIVE DIRECTOR SPONSOR:	Dr Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			√	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of exception reports via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 4 (1st January – 31st March) 2023-24, 65 exception reports were submitted of which 0 were highlighted as an immediate safety concern. The majority (61 individual reports, equating to 94%) of exception reports relate to hours of working. 1 exception reports relate to patterns of work, 3 relate to missed educational opportunities and 0 exception reports submitted relate to service support available to the doctor. However, the narrative, where provided, often indicates an overlap between categories.			

	The total number of exception reports for this quarter has decreased which is in line with trends from previous years.		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.		
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):	Choose an item.		
	Choose an item.		

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – Quarter 4 2023-24 (1 January to 31 March 2024)	AGENDA REF	SPC/24/05/30

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

Most junior doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

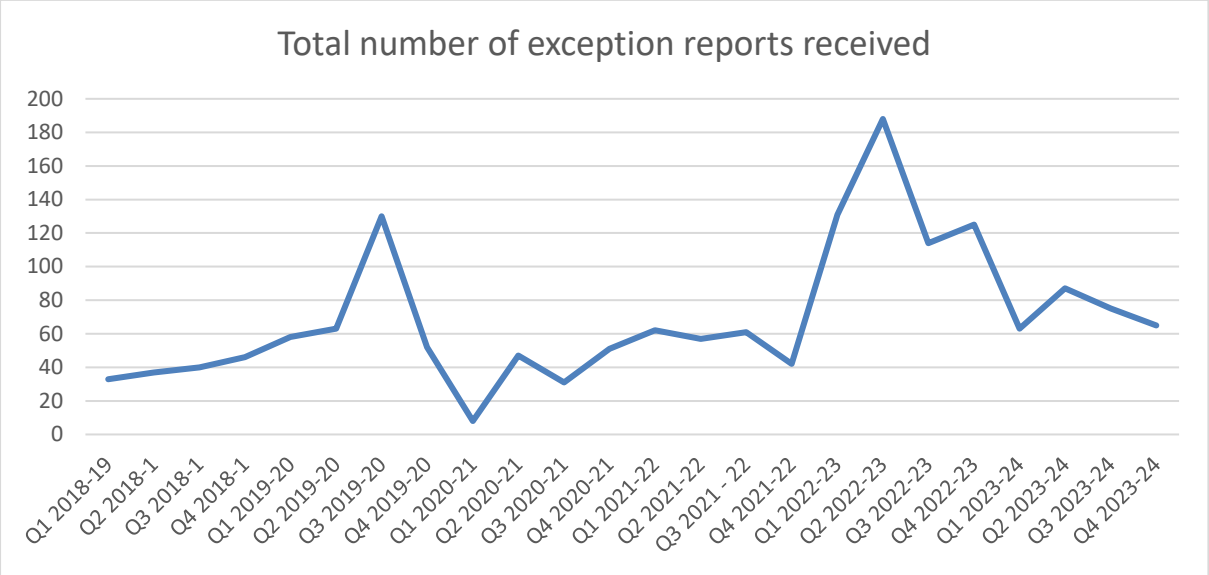
2. KEY ELEMENTS

Exception Reporting (Jan 24- March 24)

During Q4, 2023-2024, 65 exception reports (ERs) were submitted which is fewer than Q3 and from Q4 2023 there is a large decrease (Q4 2023 125). Following change over (as can be noted from previous years) there is a predictable increase in exception reports which generally reduce/resolve following a period of settling in. Please see Chart 1 for exception reporting trends over previous years.

Chart 1 illustrates reporting trends:

Chart 1



Fines

The GSW has responsibly for protecting the safeguards contained in the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.

As per the TCS above any of the following breaches will incur a financial penalty.

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13-hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours rest in a 24-hour period has not been achieved (excluding on-call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

During Q4 5 fines were accrued, all relating to a breach of the maximum 13 hr shift length. These ranged from 0.5 to 2.0 hrs and were all FY doctors. Fines are being calculated according to the formula provided by NHSE and will be reported in the next quarter's report along with those accrued for breaches which occurred during the period of time the GSW role was vacant.

Themes for Q4 (Jan 24 – March 24)
For this quarter there has been widespread exception reporting which may reflect the promotion of the GSW role and all Junior Doctor/trainee induction. Reports have been from many specialties and grades of doctor. There are numerous rota gaps in all specialities, and this is impacting junior doctors across the board.

General Medicine
It is noted that there are number of exception reports relating to General Medicine and in particular the Foundation Y1 (FY1) trainees (15 in total) which is an increase on last Quarter (12). These relate to hours worked but are felt to represent an increase in the intensity of workload on specific wards. The GSW has spoken with the clinical leads for the respective areas and will participate in a medical staffing review for the medical wards.

General Surgery
During Q4 we have seen a large increase in the exception reports relating to General Surgery (22 reports) with a particular trend from Foundation Doctors (both FY1 and FY2). On review of the narrative of the submitted reports, the main focus relates to management of workload, and operational pressures. Following discussions with the clinical leads for surgery and urology issues have been identified regarding timing of ward rounds and activity into the afternoon which has lead to difficulties in completing tasks prior to the end of the normal working day of 4pm for this group of doctors. The leads have been asked to review this to reduce the risk of work running over.

T&O
Although reporting is still significant in T&O we have seen a decline in Q4 with 14 exception reports submitted by Foundation Doctors (both F1 and F2) reduced from 24 in the previous QTR. The main theme of the reports relates to hours of working, caused by challenges in patient management and variable support in particular surrounding orthogeriatric patients. Following the previous meeting with trainees and speciality leads it us encouraging to see some improvement in the numbers however a further meeting is scheduled to review the current position and ensure the action plan is being monitored.

O&G
During Q4 there has been a significant number of exception reports in O&G with 13 being submitted across all grades all relating to hours of work. It is recognised that previously there have been very few exception reports submitted by doctors in O&G. The GSW met with the CL and manager to review the issue. Following this the clinical team met with the doctors to explore the issues and have identified several issues in the way of working which were negatively impacting on the ability of doctors to complete their work and handover within their normal hours of work. Measures have been put into place to address this and will be reviewed in the near future to determine their impact.

Summary
- Number of exception reports raised = 65
- Number of work schedule reviews that have taken place = 1
- ERs flagged as immediate safety concerns = 0
- Fines that were levied by the Guardian = 5

Exception Reports (ER) over past quarter	
Reference period of report	01/01/24 - 31/03/24
Total number of exception reports received	65
Number relating to immediate patient safety issues	0
Number relating to hours of working	61
Number relating to pattern of work	1
Number relating to educational opportunities	3
Number relating to service support available to the doctor	0

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

We continue to monitor any delays in signing off ERs and regular reminders are sent by the Medical Trainees Workforce Administrator. At the end of Q4 there were 50 unresolved ERs which is a significant improvement on Q3 (68 unresolved). The GSW will monitor outstanding ERs and encourage continued engagement from both trainees and educational supervisors.

The 2nd JDF meeting took place on the 24th February with good attendance from the majority of trainee groups and rota administrators. The GSW will continue to provide pastoral support to juniors throughout the difficult period of strike action and the JDF remains a lively and productive meeting resulting in positive change.

Additionally, GSW has reported to the Lead Employer on the exception reports and activity for Q4 with regard to CT1 and above. In total 8 exception reports were submitted, none of which were identified as an immediate patient safety issue. All have been resolved and 1 historic fine was issued relating to ST7 in T&O, length of shift exceeding 13hours due to clinical demand**.**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- To continue to monitor areas of high exception reporting.
- To continue to monitor action plan generated by T&O and review progress in line with target dates
- To encourage early resolution of exception reports and access to time off in lieu as the preferred outcome where appropriate in line with national recommendations to reduce junior doctor fatigue and promote wellbeing.

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	43
Total number of overtime payments	31
Total number of work schedule reviews	1
Total number of reports resulting in no action	1
Total number of organisation changes	1
Compensation	0
Unresolved	52
Total number of resolutions	**77**
Total resolved exceptions	**76**

Note *:*

** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

6. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours' Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

7. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q4 – (end of March 2024) – Submit May 2024
- Q1 – (end of June 2024) - Submit August 2024
- Q2 – (end of September 2024) – Submit November 2024
- Q3 – (end of December 2023) – Submit February 2024

8. ASSURANCE COMMITTEE (IF RELEVANT)

N/A

9. RECOMMENDATIONS

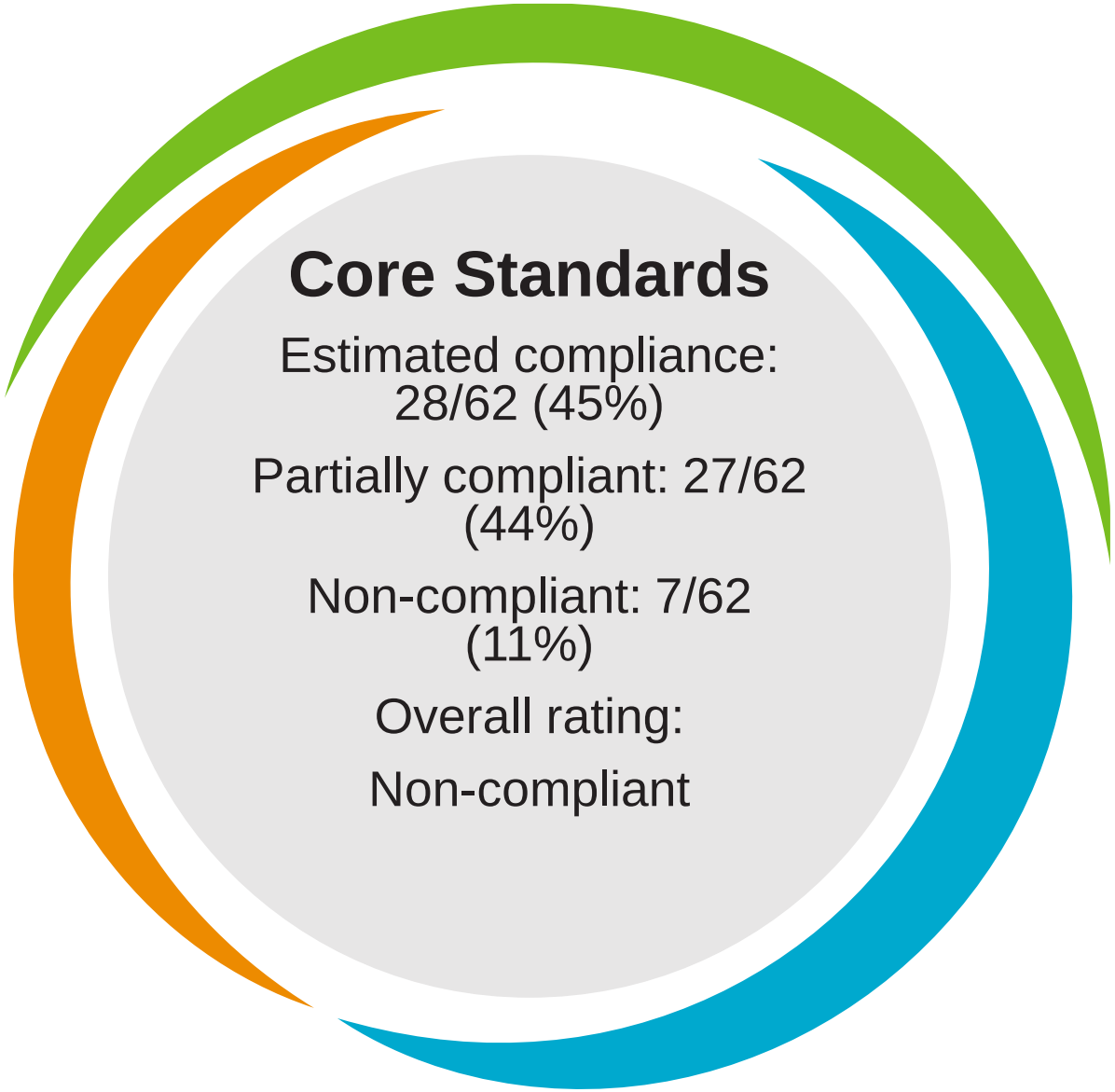
The Committee are asked to consider the contents of the report and consider the assurances made accordingly. The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Finance and Sustainability Committee
24 April 2024

EPRR Update

Rachel Clint, Head of Emergency Preparedness



To achieve compliance, 48 standards must be self-assessed (and agreed) as being fully compliant

April 2024 update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

February-March Focus on the following core standards themes

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and Information
- Cooperation

April focus on the following core standards themes

- Business Continuity
- Hazmat / CBRN
- Duty to maintain plans (further work on Major Incident, Evacuation and Shelter, Mass Casualties)

Estimated timescale

- June 2024 Core Assurance letters and process begins
- July – August gathering of information, self-assessment and beginning of internal governance processes
- September – collaboration across C&M to support check and challenge. Submission to ICB/ NHS England
- October – Check & challenge prior to final submission 31st October

Estimated status March 2024

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	3	6	2	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	5	2	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	2	1	1	3
Business continuity	10	1	5	4	1
Hazmat/CBRN	12	0	12	0	7
Total	**62**	**28**	**27**	**7**	**11**

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Percentage Compliance	45%
Overall Assessment	**Non-Compliant**

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

Notes

Actual outcomes of 22/23 process

Domain	Total Applicable Standards	Fully Compliant			Partially Compliant			Non Compliant		
		SA	1st	2nd	SA	1st	2nd	SA	1st	2nd
Governance	6	6	0	1	0	6	5	0	0	0
Duty to Risk Assess	2	2	0	0	0	2	2	0	0	0
Duty to Maintain plans	11	10	0	0	1	11	11	0	0	0
Command and control	2	2	0	0	0	2	2	0	0	0
Training and Exercising	4	3	0	0	1	4	4	0	0	0
Response	7	6	0	0	1	7	7	0	0	0
Warning and informing	4	4	0	0	0	4	4	0	0	0
Cooperation	4	4	1	2	0	3	2	0	0	0
Business Continuity	10	8	0	0	2	10	10	0	0	0
Hazmat / CBRN	12	12	0	0	0	12	12	0	0	0
Totals	**62**	**57**	**1**	**3**	**5**	**61**	**59**	**0**	**0**	**0**

Percentage compliance 2022/23:
5%
Non-compliant

Risks Identified

Theme	Narrative	Mitigation and RAG
Training and exercising	Limited availability of training through UKHSA and NHS England	Continue to explore opportunities and escalate to ICB
Portfolios	Significant ask of colleagues and requires administration	Revisit through training events and the monthly Event Planning Group
Business Continuity	Refresh and review of all departments Business Continuity Plans	Template and training slides prepared
Timescale to adhere to the advice from the 2022/23 cycle	A lot of work is still required to adapt to the new ways of governing EPRR	Head of EPRR continues to work on policies and gaps, with more collaboration across C&M network
Unknown criteria of assessment	Learning from the West Midlands, during the second review there was not notable improvement measured after the first cycle of the Core Assurance process	Head of EPRR continues to act on advice and guidance from ICB

Resourcing

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust	Total beds	Multi sited	No. employees	Band 8b	Band 8a	Band 7	Band 6	Band 5	Band 4	Band 3	Total WTE
Alder Hey	300	No	4000		1 WTE			1 WTE			2
East Cheshire	300	Yes	2500		1 WTE				1 WTE		2
Mid Cheshire	500	Yes	4000		1 WTE		1 WTE			1 WTE	3
LUHFT	1500	Yes	13000		1 WTE	2 WTE					3
MWL	1200	Yes	11000		1 WTE		1 WTE		1 WTE		3
Hull	1200	Yes	11000		1 WTE	1 WTE	1 WTE			2 WTE	5
Mid Yorkshire	1100	Yes	8500		1 WTE				1 WTE		2
Royal Free London	1200	Yes	11000	1 WTE	1 WTE	1 WTE					2
WHHFT	600	Yes	5000		1 WTE						1

Summary of April position

The Finance and Sustainability Committee are asked to note the content of the report and the following summary:

- An Incident Response Plan has been developed, this covers a lot of the areas around the following metrics; Governance, Duty to risk assess, Duty to maintain plans and Command and control
- Multiple new guidelines have been drafted, including Incident Coordination Centre SOP, Debrief guidelines and templates and key incident documentation including writing a strategy
- All updates to date will continue to be reported through the Event Planning Group
- Stakeholders engaged from IPC, Communications and UEC to pay attention to the domains beyond EPRR
- Engagement with ICB working groups to act on guidance, learn from C&M colleagues and share good practice
- Training and exercise opportunities have been sought, not many opportunities via the usual UKHSA route- this could impact on our compliance, but will be a common issue across C&M
- Moving into the new financial year, the focus is on CBRN and Business Continuity – covering 22 of the domains. These will require a significant input but there is the expectation for substantial progress to be made in April with measurable outcomes by 31st May, and with training opportunities in June- July 2024 it is anticipated compliance will significantly improve
- ICB are still advising to be prudent and manage expectations regarding likely outcomes of the forthcoming cycle based on the Midlands experience

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REF:	**FSC/24/05/42**			
SUBJECT:	**Digital Strategy Group (DSG) update**			
DATE OF MEETING:	22nd May 2024			
ACTION REQUIRED:	**To note**			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on the 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)** Limited Assurance **Items for escalation to Finance and Sustainability Committee** (for information only):			

<table>
<tr><td></td><td colspan="3">

EPR procurement – on track for preferred supplier announcement at the end of May 2024
eBCMS – business case updated, but confirmation of NHSE funding still not secured
PEP – planned go live date for the PEP is the 10th of June 2024
DMA – the 2nd national NHS Digital Maturity Assessment (DMA) process is underway and results will be published end of June 2024

</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 FSC is asked to note the contents of the report, including assurance levels.

Laboratory Information Management (LIMS) update – updated FBC scheduled for final Trust Board approval
eBCMS – business case updated following FSC review, but Trust Board approval delayed as formal confirmation of funding still not secure from NHSE
EPCMS – WHH to hold discussions with Dedalus about potential contract extension as timelines for delivery have slipped and the costs need to be included in the FBC
Patient Engagement Portal – The revised plan is now to go live on 10th June 2024. Radiology will remain on HCC and the Trust will go live with just Lorenzo functionality in the first instance, with Radiology appointments to follow asap (target end June)

</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td></td></tr>
<tr><td colspan="2">Date of meeting</td><td></td></tr>
<tr><td colspan="2">Summary of Outcome</td><td></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">Share with Finance & Sustainability Committee</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Section 43 – prejudice to commercial interests</td></tr>
</table>

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF:	FSC/24/05/42

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

Digital Transformation Delivery Highlight Report (Moderate Assurance)

*Please note the following was raised by exception.

- ***Diagnostic Update:*** Nothing raised by exception.
- ***Warrington Together:*** This month's meeting was stood down due to confirmed attendance being low. The group were advised that this meeting will be relaunched next month with an updated ToR to be circulated.
- ***Patient Engagement Portal (PEP):*** WHH, Synanetics and DrDoctor have completed initial integration for patient demographics between Lorenzo and DrDoctor – successfully tested registering a patient, updating demographic details e.g mobile number. This has all been updated successfully into DrDoctor.
  During April, 49,841 letters were sent via Synertec costing £8,165. When compared to what this would have cost the Trust to send these letters through Internal Post (franked) the Trust has accumulated a saving of £18,749.
-

- **Items for escalation:**
  - PEP Phase 1 go-live: Radiology will remain on HCC and the Trust will go live with just Lorenzo functionality in the first instance

Digital Service Delivery Highlight Report (Moderate Assurance)

*Please note the following was raised by exception.

- There has been a service delivery concern this month with Service Desk cover, calling wait times and abandonment. The immediate issues were resolved, but further work is required to alleviate pressure on the desk and to improve cover arrangements (e.g. SLAs, self-service, change in 1st time fix policy and internal processes in Digital)

- ***ePR Vendor Management:*** Confirmed that V7 series of ICE will be EOL from April 2025, met with Clinisys to discuss WHH position in this. If WHH are not in a position to upgrade before April 2025, a risk document needs to be completed and submitted to NHSE and Clinisys.

- ***Cyber Security:*** All risks have been updated in relation to the Digital Risk Framework. 1 high cyber alert reported by NHSE, WHH not affected due to the Trust not utilising the Palo Alto firewall software.
  Successful Cheshire and Merseyside wide Cyber Desktop Exercise completed in March, the outputs of this ensued a rewrite and review of the C&M Cyber Incident Response Plan. This is now complete with a view to retest in December 2024 to see if the changes are successful. IOs and IAs have been fully assigned to the Trust's Critical Systems.

Items for escalation from the Digital Service Delivery Group

- The SLA details for Digital service provision at WHH will be presented to DSG in June, with Care Groups & CSS to review and sign off for formal introduction from start of Q2.

Digital Analytics Highlight Report (Moderate Assurance)

- ***Fraxinus and Data Warehouse infrastructure project:*** The server was Migrated successfully, and the team are now planning for the separation of the Datawarehouse from Fraxinus.
  Resources required to continue with EPCMS activities and to maintain BAU are still not confirmed leading to risk of service degradation or slippage on EPCMS activity.
  Reporting and Integration/migration strategy requirements have been communicated to the Programme manager as there is dependant activity to be completed by other project stakeholders before these strategies can be fully developed.

Items for escalation

- None raised.

Digital Care Delivery Highlight Report (Limited Assurance)

*Please note the following was raised by exception due to the meeting being stood down.

- ***Maternity Update:*** Following escalation to service delivery manager, System C have completed config changes to enable blood group and rhesus factor blood test results to automatically import into the system avoiding manual transcription.
- ***Pharmacy Update:*** Critical Medication – Upcoming release of the Pharmacy's updated Critical Medication policy will allow for clinicians to add a 'critical' status to medication for patients within Lorenzo.
- Antibiotic Indication - In order to improve the Trust's Antimicrobial Stewardship, work is being undertaken to add in a mandatory indication field within Lorenzo, this will improve the quality of the data obtained as well as improving the prescribing choice.
- Logical Printing/Outpatient Prescribing - Logical printing is now successfully working within the Trust, SOPs are being produced to support this process along with process mapping to ensure the procedures in place are correct prior to rolling out to select clinics for outpatient prescribing as a trial, prior to rolling out to the entire Trust.

Items for escalation

- ***Maternity HL7 Messaging outage:*** Due to local DSS db replication, issue messages were not able to be processed. Root cause was local replication had broken due to the

LOB data being too large to replicate. Required customer IT to increase the setting. Once this was completed, messages were then processed.

EPCMS Electronic Patient Care Management System Report (Moderate Assurance)

- Ongoing development of the FBC in line with the overall programme delivery. The Trust are to schedule discussions with Dedalus about a potential contract extension as timelines for delivery have slipped and the costs need to be included in the FBC.
- A financial impact assessment on spend across years will need completing as part of the FBC, following the completion of procurement processes.
- Continuing the work for EPCMS readiness and updating of plans to get overall delivery back to green RAG status.

Items for escalation

- None raised.

EBCMS Electronic Bed Care Management System Report (Limited Assurance)

- The Revenue request was submitted for approval by April Trust Board meeting. Prior to full Trust Board approval, the Trust requires formal written confirmation from NHSE regarding the funding allocation.
- Further work is ongoing to update the financial model ensuring that the cash releasing benefits are being identified. Additional revenue costs are fully funded via a combination of reduced costs (staffing) and increased cash releasing benefits (RTLS).
- A draft plan is being further developed for March 2025 go live for the implementation of the appropriate solution.

Items for escalation

- Delays with confirmation of funding from NHSE are putting this programme at risk of not being able to deliver key objectives by the end of 2024/25

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. MEASUREMENTS/EVALUATIONS

5. TRAJECTORIES/OBJECTIVES AGREED

6. MONITORING/REPORTING ROUTES

Digital Strategy Group.

7. TIMELINES

Monthly report.

8. ASSURANCE COMMITTEE (IF RELEVANT)

Digital Strategy Group.

9. RECOMMENDATIONS

The FSC is asked to note the contents of the report, including assurance levels.