



# WHH Board of Directors Meeting Part 1

**Wednesday 7<sup>th</sup> June 2023  
100am-12.30pm**

**Halton Education Centre, Lecture Theatre /  
MS Teams**

**TRUST BOARD MEETING – PART 1 (Held in Public)**  
**Wednesday 7<sup>th</sup> June 2023, 10.00am – 12.30pm**  
**Halton Education Centre/Via MS Teams**

| AGENDA ITEM | TIME  | AGENDA ITEM  | OBJECTIVE/DESIRED OUTCOME | PROCESS                    | PRESENTER  |
|-------------|-------|--|---------------------------|----------------------------|--|
| BM/23/06/49 | 10:00 | Engagement Story – Zack’s Story (film)   | <i>To Note</i>            | <b>Presentation</b>        | Jen McCartney - Head of Patient Experience and Inclusion |
| BM/23/06/50 | 10:15 | Welcome, Apologies and Declarations of Interest  | <i>To note</i>            |                            | Mike O’Connor, Senior Independent Director               |
| BM/23/06/51 | 10:17 | Minutes and Action Log of the previous meeting held on <b>29<sup>th</sup> March 2023</b> | <i>For decision</i>       | <b>Minutes</b>             | Mike O’Connor, Senior Independent Director               |
| BM/23/06/52 | 10:20 | Matters Arising  | <i>For assurance</i>      | <b>Verbal</b>              | Mike O’Connor, Senior Independent Director               |
| BM/23/06/53 | 10:25 | Chief Executive’s Report   | <i>For assurance</i>      | <b>Report</b>              | Simon Constable, Chief Executive                         |
| BM/23/06/54 | 10:35 | Chair’s Report   | <i>For info/update</i>    | <b>Report &amp; Verbal</b> | Mike O’Connor, Senior Independent Director               |
| BM/23/06/55 | 10:45 | Board Assurance Framework  | <i>For approval</i>       | <b>Report</b>              | John Culshaw, Company Secretary                          |



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| BM/23/06/56 | 10:50 | Integrated Performance Reports (IPR) and Assurance Committee Reports<br>i) IPR Dashboard   | <i>For assurance</i> | <b>Report</b>                    | All Executive Directors  |
|             |       | <b>Quality Dashboard</b><br><br><b>Including</b><br>Assurance Reports – Quality and Assurance Committee (QAC) – 11.04.23 & 09.05.23          | <i>For assurance</i> | <b>Report &amp; Presentation</b> | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO; Dan Moore, Chief Operating Officer; Paul Fitzsimmons, Exec Medical Director |
|             |       | <b>People Dashboard</b><br><br><b>Including</b><br>Assurance Report - Strategic People Committee (SPC) – 19.04.23/17.05.23                   | <i>For assurance</i> | <b>Report &amp; Presentation</b> | Michelle Cloney, Chief People Officer<br><br>Julie Jarman, Committee Chair   |
|             |       | <b>Sustainability Dashboard</b><br><br><b>Including</b><br>Assurance Report – Finance and Sustainability Committee (FSC) – 26.04.23/24.05.23 | <i>For assurance</i> | <b>Report &amp; Presentation</b> | Andrea McGee, Chief Finance Officer & Deputy CEO<br><br>John Somers, Committee Chair   |

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| (d) |  | Assurance Report – Audit Committee (AC) – 27.04.23 | <b>To note for assurance</b> | <b>Report</b> | Mike O'Connor, Committee Chair |
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 Quality

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| BM/23/06/57 | 11:45 | Maternity Update including.<br>I. Ockenden Review Updates<br>II. Perinatal Mortality Review Tool (PMRT) | <b>To note for assurance</b> | <b>Report</b> | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
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 People

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| BM/23/06/58 | 11:55 | National Staff Opinion Survey | <b>To note for assurance</b> | <b>Paper</b> | Michelle Cloney, Chief People Officer |
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 Sustainability

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| BM/23/06/59 | 12:05 | Trust Strategy<br>• Bi-Annual Update | <b>To note for assurance</b> | <b>Presentation</b> | Lucy Gardner, Director of Strategy & Partnerships |
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| GOVERNANCE  |       |  |                              |               |                                 |
|-------------|-------|--|------------------------------|---------------|---------------------------------|
| BM/23/06/60 | 12:15 | Compliance with Licence Annual Return – completion of General Condition 6 (G6(3)) and Continuity of Service Condition (Cos7) | <b>To note for assurance</b> | <b>Report</b> | John Culshaw, Company Secretary |
| BM/23/06/61 |       | Revised Provider Licence   | <b>To note for assurance</b> | <b>Report</b> | John Culshaw, Company Secretary |
| BM/23/06/62 |       | Committee Annual Reports<br>• Finance & Sustainability<br>• Strategic People Committee                                       | <b>For approval</b>          | <b>Report</b> | John Culshaw, Company Secretary |
| BM/23/06/63 |       | Finance & Sustainability Committee<br>• Terms of Reference<br>• Cycle of Business  | <b>For approval</b>          | <b>Report</b> | John Culshaw, Company Secretary |

| FOR APPROVAL |  |   |                     |               |   |
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| BM/23/06/64  |  | Trust Strategy: measures of success and governance arrangements | <b>For approval</b> | <b>Report</b> | Lucy Gardner, Director of Strategy & Partnerships |

**SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)**

| TO NOTE FOR ASSURANCE |                                    |                              |  |              |   |
|-----------------------|------------------------------------|------------------------------|--|--------------|---|
| BM/23/06/65           | Digital Strategy Group Report      | <b>To note for assurance</b> | Committee: Finance & Sustainability Committee<br>Date of Meeting: 24.05.23<br>Agenda Ref: FSC/23/05/40<br>Outcome: Noted           | <b>Paper</b> | Paul Fitzsimmons<br>Executive Medical Director      |
| BM/23/06/66           | Learning from Experience Q4 Report | <b>To Note</b>               | Committee: Quality Assurance Committee<br>Date of Meeting: 09.05.23<br>Agenda Ref: QAC/23/05/103<br>Outcome: The report was noted. | <b>Paper</b> | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
| BM/23/06/67           | DIPC Q4 Report                     | <b>To Note</b>               | Committee: Quality Assurance Committee<br>Date of Meeting: 09.05.23<br>Agenda Ref: QAC/23/05/104                                   | <b>Paper</b> | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |

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|   |   |                | Outcome: The report was noted  |                      |  |
| BM/23/06/68   | Violence Reduction Strategy Bi-Annual Report  | <b>To note</b> | Committee: Quality Assurance Committee<br>Agenda Ref: QAC/23/05/105<br>Date of Meeting: 09.05.23                                       | <b>Paper</b>         | Dan Moore, Chief Operating Officer   |
| BM/23/06/69   | Move to Outstanding Update Report   | <b>To Note</b> | Committee: Quality Assurance Committee<br>Date of Meeting: 09.05.23<br>Agenda Ref: QAC/23/05/03<br>Outcome: The presentation was noted | <b>Presentation</b>  | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO                          |
| BM/23/06/70   | Senior Information Risk Owner Annual Report   | <b>To note</b> | Committee: Finance & Sustainability Committee<br>Date of Meeting: 24.05.23<br>Agenda Ref: FSC/23/05/39                                 | <b>Report</b>        | Paul Fitzsimmons, Executive Medical Director                                 |
| BM/23/06/71   | Engagement Dashboard <ul style="list-style-type: none"> <li>Q4 Update</li> <li>Year End Report</li> </ul> | <b>To note</b> | Committee: Council of Governors<br>Date of Meeting: 11.05.23<br>Agenda Ref: COG/23/34<br>Outcome: The reports were noted.              | <b>Report Report</b> | Kate Henry, Director of Communications & Engagement                          |
| BM/23/06/72   | Guardian of Safe Working Q4 Report  | <b>To note</b> | Committee: Strategic People Committee<br>Date of Meeting: 17.05.23<br>Agenda Ref: SPC/23/05/68<br>Outcome: The report was noted.       | <b>Paper</b>         | Paul Fitzsimmons, Executive Medical Director                                 |
| BM/23/06/73   | Arbury Court  | <b>To note</b> | Committee: Quality Assurance Committee<br>Date of Meeting: 09.05.23<br>Agenda Ref: QAC/23/05/96<br>Outcome: The presentation was noted | <b>Presentation</b>  | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO                          |
| BM/23/06/74   | Hospital Volunteer Annual Report  | <b>To note</b> | Committee: Strategic People Committee<br>Date of Meeting: 22.03.23<br>Agenda Ref: SPC/23/04/51<br>Outcome: The report was noted        | <b>Report</b>        | Michelle Cloney, Chief People Officer  |
| BM/23/06/75   | Wellbeing Guardian Annual Report  | <b>To Note</b> | Committee: Strategic People Committee<br>Date of Meeting: 17.05.23<br>Agenda Ref: SPC/23/05/66<br>Outcome: The report was noted        | <b>Report</b>        | Michelle Cloney, Chief People Officer/Cliff Richards, Non-Executive Director |
| <b>CLOSING</b>  |   |                |  |                      |  |
| BM/23/06/76   | Review of meeting   |                |  |                      | Mike O'Connor, Senior Independent Director                                   |
| BM/23/06/77   | Any other Business  | <b>To note</b> |  | <b>Verbal</b>        | Mike O'Connor, Senior Independent Director                                   |
| <b>Date and Time of next meeting – 2<sup>ND</sup> August 2023</b> |   |                |  |                      |  |

**Warrington and Halton Teaching Hospitals NHS Foundation Trust**  
**Minutes of the Trust Board Meeting – Meeting held in Public**  
**Wednesday 29 March 2023**  
**Halton Education Centre/Via MS Teams**

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|-------------------------------|---|
| <b>Present</b>                |   |
| Steve McGuirk (SMcG)          | Chair   |
| Simon Constable (SC)          | Chief Executive   |
| Cliff Richards (CR)           | Non-Executive Director & Deputy Chair   |
| Michael O'Connor (MOC)        | Non-Executive Director & Senior Independent Director  |
| Julie Jarman (JJ)             | Non-Executive Director  |
| Jayne Downey (JD)             | Non-Executive Director  |
| John Somers (JS)              | Non-Executive Director  |
| Andrea McGee                  | Chief Finance Officer & Deputy Chief Executive  |
| Kimberley Salmon-Jamieson     | Chief Nurse & Deputy Chief Executive  |
| Michelle Cloney (MC)          | Chief People Officer  |
| Dan Moore (DM)                | Chief Operating Officer   |
| Paul Fitzsimmons (PF)         | Executive Medical Director  |
| <b>Apologies</b>              |   |
| Adrian Carridice-Davids (ACD) | Associate Non-Executive Director  |
| <b>In Attendance</b>          |   |
| Lucy Gardner (LG)             | Director of Strategy & Partnerships   |
| Kate Henry (KH)               | Director of Communications & Engagement   |
| John Culshaw (JC)             | Company Secretary & Associate Director of Corporate Governance                                |
| Dave Thompson (DT)            | Associate Non-Executive Director  |
| Jen McCartney (JMCC)          | Head of Patient Experience and Inclusion ( <i>in attendance for Agenda Item BM/23/03/22</i> ) |
| Deborah Carter (DC)           | Patient Safety Project Director   |
| Emily Kelso (EK)              | Corporate Services & Membership Manager ( <b>minute taking</b> )                              |
| <b>Observing Governors</b>    |   |
| Norman Holding                | Lead Governor   |
| Paul Bradshaw                 | Public Governor   |
| Sue Fitzpatrick               | Public Governor   |
| Nicola Newton                 | Appointed Governor  |
| John Fagan                    | Governor  |

| Agenda Ref         | Agenda Item   |
|--------------------|---|
| <b>BM/23/03/22</b> | <p><b>Engagement story – military veteran</b></p> <p>JM presented the engagement story, of Sgt Jo Pickstock, who had served for 18 years in the British Army. Jo had left the Army in 2015 and had since been working in the NHS currently as a Business Partner at the Trust since March 2022.</p> |

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

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|                           | <p>It was explained that Jo had an accident in August 2021, suffering significant injuries. Jo’s surgery was delayed because of capacity issues at the Trust. She subsequently received a briefing about the veteran’s support service offered at the Trust, her situation was reviewed, and her surgery expedited, Jo was now recovering well.</p> <p>JM explained the Trust’s next steps to engage further in the veteran’s support programme. It was confirmed that the Trust’s Armed Forces Advocate (AFA) had been working with operational teams across WHH to ensure that the Trust was able to fulfil its statutory duty with regards to the Armed Forces Act.</p> <p>It was confirmed that the Military of Defence would continue to fund the AFA post for a further 12 months as per the initial successful bid. Following this, options would be considered around funding of the post.</p> <p>MC also informed the Trust Board of the Veterans and Armed forces staff group, and the new legislation to help ensure armed forces personnel, veterans and their families are not disadvantaged by their service (Armed Forces Bill - 26 January 2021). DC confirmed that the bill required the Trust to implement its duty to prevent service personnel and veterans being disadvantaged when accessing healthcare. It was noted that this was complex national piece of work, and that WHH were fully committed.</p> <p><b>The Trust Board discussed and noted the Patient Story</b></p> |
| <p><b>BM/23/03/23</b></p> | <p><b>Welcome, apologies and declarations of interest.</b></p> <p>The Chair welcomed the Board guests and observers to the meeting, and noted the apologies received (as detailed above).</p> <p><b>The Trust Board noted the welcome, apologies and declarations.</b></p>   |
| <p><b>BM/23/03/24</b></p> | <p><b>Minutes and action log from the previous meeting held on 25 January 2022.</b></p> <p>The minutes of the meeting held on 25<sup>th</sup> January were agreed as an accurate record with no amendments.</p> <p>The Action Log was reviewed, and the completed actions were noted, there were no outstanding/ongoing actions.</p> <p><b>The Trust Board approved the minutes of the meeting held on 25 January 2023 and noted the Action Log.</b></p>   |
| <p><b>BM/23/03/25</b></p> | <p><b>Matters Arising</b></p> <p>There were no matters arising.</p>  |
| <p><b>BM/23/03/26</b></p> | <p><b>Chief Executives Report</b></p> <p>SC introduced the paper, highlighting the following key points:</p> <ul style="list-style-type: none"> <li>• Notification had been received that the BMA would take further industrial Action, junior doctors would strike for 4 days from 11<sup>th</sup> April which coincided</li> </ul>   |

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|                           | <p>with end of the Band Holiday weekend, the Trust were planning accordingly.</p> <ul style="list-style-type: none"> <li>• The NHS staff survey response completion rate was down from 40 to 35%, MC confirmed this was average when benchmarked. Actions were being considered to improve future uptake. The Board discussed the issues often raised by staff, governors, and patients; car parking and catering and agreed that catering was a focus for board committees to ensure progress was being made.</li> <li>• CMAST Briefing – it was agreed that a higher-level briefing paper would be produced for future meetings to focus Board discussions on any areas of risk. DT queried if it would be possible to see a similar style of reporting for Place-Based Partnerships. LG confirmed this would be possible from a Warrington perspective and would be picked up in future bi-monthly strategy reports.</li> </ul> <p><b>The Trust Board noted the Chief Executive’s Report.</b></p>  |
| <p><b>BM/23/03/27</b></p> | <p><b>Chair’s Report</b></p> <p>The report was taken as read. The following highlights were taken from the Board discussions:</p> <p>The Staff Thank You Awards - 17<sup>th</sup> March 2023 - had been a successful evening to celebrate the efforts of staff across the organisation. KH confirmed that a feedback survey had been circulated to attendees, with 100% positive responses received.</p> <p>JS queried whether any further clarity had been received on accountability and autonomy around Place-Based Partnerships accountability. SMcG confirmed that Place level accountability remained a challenge. SC added that very little delegated authority to Place and that it was subsumed by the ICS, it was likely this would be the case for at least the next 12 months. The Board would be kept informed of updates.</p> <p>LG confirmed that following Health and Care Partnership Interim Strategy (referenced within the report) was the ICB Five-Year Joint Forward Plan and that Places as part of that were developing content around delivery of the strategy. Warrington’s had been received and was to be reviewed by the Executive Team Execs before the end of the week.</p> <p>SMcG further highlighted the lifting of the enhanced monitoring status by General Medical Council, which was the result of a successful and extended programme of work by the Trust to support its junior doctors.</p> <p><b>The Trust Board noted the Chair’s update</b></p> |
| <p><b>BM/23/03/28</b></p> | <p><b>Board Assurance Framework (BAF)</b></p> <p>JC presented the BAF update and highlighted the following proposed updates since the last Board meeting:</p> <ul style="list-style-type: none"> <li>• The addition of one new risk #1846, as a result of the Paediatric audiology review, with at rating of 16.</li> <li>• Reduction in the rating 1275 around nosocomial Covid-19 infection from 20 to 16, the reduced rating was a result of the introduction of additional controls</li> </ul>  |

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|                           | <p>and assurance in place and the reduction in outbreaks.</p> <ul style="list-style-type: none"> <li>• The description of risk #1215 had been amended, to reflect the impending change from Block contract to Payment by Results (PbR)</li> <li>• No risks had been closed or de-escalated.</li> </ul> <p>JD sought assurance around the moderate rating of risk #145, currently sitting at 12 given the uncertainty around a new hospital build. SC confirmed that there was still no clarity about when decisions were going to be made and agreed that escalating of the risk should be considered. It was suggested, separating the risk around the new hospital, taking it from #145 which was an overall risk to the strategic vision encompassing ICS and partnership working.</p> <p>JD further queried risk #224 around capacity constraints, specifically the impact the potential closure of the 60 bedded Lilycross facility supporting transitional care capacity would have on patient discharge. DM explained that the System Sustainability Group were working through the details, and conversations with Place-Based partners were taking place. DM confirmed that the Board would be updated once more clarity was available.</p> <p>The Board discussed rating of risk #224, currenting rated at 25. SMCg commented that 25 should be saved only for those existential risks. DM responded that the rating could be debated as the Trust was managing, however functioning at high capacity with no respite was making conditions highly pressured for extended periods beyond winter which was unsustainable.</p> <p>KSJ commented that the risk was complex and patient safety was being impacted, as was staff morale given the current pressures. It was confirmed that that Place-Based Partners Winter planning was working towards a deadline of May which was crucial to ensure preparedness.</p> <p>SMcG summarised that the Board took assurance that planning was taking place with Place-Based Partners, however this was time crucial, updates would come through the Trust committee governance structure and if the May deadline was not achieved a Plan B would need to be considered by the Board.</p> <p>JC confirmed that some further work was to be undertaken around presentation of the BAF and assigning risk appetite to each strategic risk in line with the Trusts Risk Appetite Statement.</p> <p><b>The Trust Board discussed and noted the report and supported the proposed changes to the risks highlighted.</b></p> |
| <p><b>BM/23/03/29</b></p> | <p><b>Integrated Performance Report</b></p> <p>SC introduced the agenda item which provided a summary of the Trust performance, it was highlighted that the revised format would be used in presenting the IPR, Executive Leads would present each of their individual areas and highlight specific concerns or issues.</p> <p><b><i>Access &amp; Performance (DM)</i></b></p>   |

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SM confirmed that within Access and Performance there were a number of targets not being met, which historically the Trust would have delivered and were impacting performance in other domains for example workforce and finance. The following topics were discussed:

- 78 week waits – it was noted that several neighbouring Trusts were also in breach. DM confirmed the Elective Recovery Group had identified no key lessons to be learned and that CMAST Alliance were working together expediting mutual aid where available/required.
- Activity plans for 23/24 had been submitted at 103% of 2012/20. It was noted a forecast for 65 weeks would be challenging.
- SMCg queried sleep studies performance in relation to the CDC Business Case. DM confirmed that the numbers previously presented to Board had been revised and there was now less reliance on sleep studies to achieve the financial plan.

#### **Quality of Care (KSJ)**

KSJ highlighted the following key points from the presentation:

- CDI – cases were sitting at 52 YTD, exceeding the annual threshold by 15 – it was noted that a CDI prevention action plan was in place, with a focus on staff training to improve the position.
- Sepsis was still underperforming but improving. It was noted that several workstreams were in place to further improve the position, but that the 100% target in the current environment was a challenge.
- Staffing – pressures were ongoing, recent recruitment events had been successful including international nurse recruitment.

PF highlighted the following key points:

- Medicines Safety – remained a challenge reporting a worsening position, mitigation plans were in place. 3 new pharmacists had been recruited, and some work was being undertaken around digitalisation and automating some of the process.
- VTE performance was back on track following a successful improvement programme of work.

JC queried whether serious incidents trends had been identified/analysed, KSJ confirmed some trends had been identified in the Emergency Department and details could be brought back to the Quality Assurance Committee as a Hot Topic.

SMcG reflected on the improved sepsis position and noted the reassurance received from staff during Walkabout visits, where staff displayed high levels of commitment to reducing sepsis. CR acknowledged the positive aspect of this anecdotal feedback but nevertheless referred to the outputs of a recent MIAA Sepsis Audit where assurance was limited and reiterated the importance of the Trust demonstrating the clinical knowledge and improved practice to improve the external assurance position.

CR referred to the Quality Assurance Committee Reports, summarising each of the items being escalated up to Board, making reference to the impact of staffing issues on services.

### ***People (Workforce) (MC)***

MC provided an update, highlighting the following:

- Recruitment marketing company “Just R” had been contracted by the Trust to target areas of high vacancies.
- Work around annual leave had commenced to support pre-pandemic management of annual leave.
- Industrial Action (IA) was impacting performance across the IPR – noting the April bank holiday junior doctor strike dates would be complex to manage.

JD queried the delays in time to recruit, MC confirmed that digital programme NHS Jobs 3 had been causing multiple delays, the issues with the programme were explained. A new programme TRAC had been procured; implementation was expected by 1<sup>st</sup> June.

### ***Finance & Sustainability (AMcG)***

AMcG highlighted several areas for noting which included:

- Year to date deficit £5.6m which was on plan.
- Forecast £5.4m deficit, per revised plan, which had been confirmed to the ICS.

It was noted that the Trust had carried substantial risk throughout the year but had pulled together across the organisation to achieve plan.

AM explained the financial risks going into 2023/24 around the revised tariff activity funding mechanism, capacity issues which impact financial performance and level of vacancies leading to high-cost agency spend.

MOC queried the position on the 6.1m capital underspend if not spent within the year. AM explained that the Trust would lose the ability to spend capital. It was confirmed that mitigations were in place to deliver capital plans, however short fall was still a risk. AM further explained the process of vesting to spend capital before the close of 2022/23 and confirmed that the Trusts external auditors had provided direction around the financial governance aspects, they would assess.

DT queried the barriers to spending, AM explained barriers were complex including delays in external approval, scheme slippage. However, the Trust aimed to develop a more robust longer-term programme for capital spend, particularly those items that could be bought forward.

JJ confirmed that underspend on capital was an area of limited assurance at FSC where robust conversations had taken place and to improve governance particularly around estates, additional operational presence had been requested to attend committee meetings for assurance.

**The Trust Board noted the IPR updates from the Executive Leads and agreed to append to future Board minutes.**

### **Finance & Sustainability Committee (FSC) Assurance Reports**

JS highlighted the items of no assurance, which were:

- CIP & GIRFT

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|                    | <ul style="list-style-type: none"> <li>• Financial Risks to the CDC programme</li> <li>• Capital Position</li> </ul> <p>It was noted that each would be discuss further in part 2 of the Trust Board meeting.</p> <p><b>Clinical Recovery &amp; Oversight Committee Assurance Report</b><br/>Was taken as read, with no further questions.</p> <p><b>Audit Committee Assurance Report</b><br/>Was taken as read with no further questions.</p> <p><b>Charitable Funds Committee Assurance Report</b><br/>Was taken as read with no further questions.</p>  |
| <p>BM/23/03/30</p> | <p><b>MATERNITY UPDATE</b><br/><i>Ockenden</i></p> <p>KSJ introduced the report which provided an update in relation to Ockenden recommendations for the end of January, highlighting:</p> <p><b>Ockenden Part 1a:</b> WHH was 100% compliant.</p> <p><b>Ockenden 1b:</b> WHH was 92.5% compliant and on trajectory to be 100% compliant by 31<sup>st</sup> May 2023.</p> <p><b>Ockenden 2:</b> WHH was 51% compliant and was on trajectory to be 100% compliant by 30<sup>th</sup> June 2023.</p> <p>A draft report had been received by the Women’s and Children’s Clinical Business Unit following an MIAA audit of Ockenden, indicating ‘substantial assurance’. There were two recommendations, one with a risk rating of medium and one with a risk rating of low, and a management response has been returned to MIAA. A final report would be shared with QAC.</p> <p>JD sought clarity around the actions which were not owned by the Trust, KSJ confirmed she was attending W&amp;CCBU governance meeting monthly where progress on Ockenden actions were discussed in detail.</p> <p>JD commented that during monthly walkarounds, it was evident that maternity teams were working well and to the highest standard, new mums expressed their positivity about care received particularly on the neonatal ward.</p> <p>The Board agreed that the Ockenden review was a positive step forward in driving the highest quality of maternity care nationally.</p> <p><b>Avoiding Term Admissions into Neonatal Units (ATAIN) Programme</b><br/>KSJ introduced the report which provided information on the current position of the Trust against Safety Action 3 of the Maternity Incentive Scheme, which related to ATAIN. It was noted that items were moving forward significantly, and the Trust was performing well against the national targets.</p> <p><b>The Trust Board noted the updates in relation to Maternity.</b></p> |
| <p>BM/23/03/31</p> | <p><b>Freedom to Speak Up (FTSU) Guardian Bi-Annual Report</b></p>   |

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|                    | <p>KSJ introduced the report which provided the Board with an update on the activity of the Freedom to Speak Up Team between April 2022 to December 2022. The following key points were highlighted:</p> <ul style="list-style-type: none"> <li>• 35 disclosures were received an increase when compared to the same period in the previous year.</li> <li>• Most disclosures were related to culture, allegations of bullying and relationship issues within teams. The FTSU team continues work to support individuals and teams to resolve the issues highlighted.</li> </ul> <p>The Board discussed and agreed that it was positive to receive assurance that staff felt confident in speaking up and that clear processes were in place to manage disclosures and there was evidence that the Trust encouraged a “speak up” culture.</p> <p>The Board discussed the disconnect with staff survey responses as detailed within the paper, whereby it was noted that often surveys fail to capture the full spread of different staff groups. The Board agreed multiple avenues for communication around FTSU were important to communicate to those staff less likely to have access to and regularly check emails which was currently the main channel used.</p> <p>JJ queried whether FTSU disclosures were triangulated with complaints data, to identify themes/trends. KSJ confirmed that triangulation of both sets of data took place.</p> <p><b>The Trust Board noted the bi-annual report for assurance.</b></p> |
| <p>BM/23/03/32</p> | <p><b>Strategy Refresh Update – Bi-Monthly Update</b></p> <p>LG introduced the report which provided the Board with a bi-monthly update on the strategy refresh programmes of work, the following key points were highlighted:</p> <ul style="list-style-type: none"> <li>• <b>Living Well Hub in Warrington</b> – The Trust had completed on the lease and contractors had been appointed following a tender process.</li> <li>• <b>Community Diagnostics Centre</b> – Refurbishment work had commenced on the first phase of programme; designs were complete for the second phase of the programme and design work had commenced for the third and final new build phase.</li> <li>• <b>Breast Reconfiguration (Phase 2)</b> – The lease had been completed and services were expected to open by mid-May.</li> </ul> <p>JD queried the stalling on the transformation of pathology services in the Cheshire &amp; Merseyside pathology network. LG confirmed this was being termed a “proactive pause” due to concerns around the ability of the network. Conversations were taking place at Executive meetings around options. The Board agreed that open an honest update on delays should be communicated with pathology staff.</p> <p>MOC queried whether there were any successful pathology networks to draw from as an exemplar. JC responded that the system had been successful in a number of service transformations for example radiology which could be drawn on for</p>                                     |

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|                    | <p>learning, however it was clear that the pathology network required some additional focus from the ICS in order to move forward.</p> <p><b>The Trust Board noted the report.</b></p>  |
| <b>BM/23/03/33</b> | <p><b>Draft Trust Strategy 2023-25</b></p> <p>LG introduced the report which set out the final version of the Draft Trust Strategy for approval by the Board.</p> <p>LG explained that following approval at the meeting there would be a number of next steps, these included:</p> <ul style="list-style-type: none"> <li>• Professional design</li> <li>• Development of a communications plan</li> <li>• Deciding on KPIs to monitor delivery of the strategy– to ensure robust governance and reporting.</li> </ul> <p>DT sought assurance that accessibility and readability would be considered as part of design, prior to publication. LG confirmed this would form an important part of the design phase.</p> <p><b>The Trust Board approved the strategy and the associated next steps.</b></p> |
| <b>BM/23/03/34</b> | <p><b>Annual Review Scheme of Reservation &amp; Delegation (SORD) &amp; Standing Financial Instructions (SFIs)</b></p> <p>JC introduced the report which explained the purpose of the Trust’s Standing Financial Instructions (SFIs) to determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SoRD).</p> <p><b>The Trust Board approved:</b></p> <ul style="list-style-type: none"> <li>• the 5 proposed changes to the SoRD</li> <li>• the 1 proposed change to the SFIs.</li> </ul>   |
| <b>BM/23/03/35</b> | <p><b>Amendments to the Constitution</b></p> <p>JC introduced the report noting that the proposed amendments to the constitution had been approved by the Council of Governors at its meeting 16<sup>th</sup> February 2023 and were being recommended to the Board for ratification. The proposed amendments were summarised as:</p> <ul style="list-style-type: none"> <li>• The merger of Runcorn &amp; Widnes public constituencies to form a Halton constituency.</li> <li>• The increase of elected public governors from Rest of England constituency to 2.</li> <li>• The updates to sections; Eligibility to be a Governor &amp; Termination of office and removal of Governors.</li> </ul> <p><b>The Trust Board ratified the amendments to the Constitution</b></p>                            |
| <b>BM/23/03/36</b> | <p><b>Disestablishment of Clinical Recovery Oversight Committee (CROC)</b></p> <p>JC introduced the report explaining that the CROC was a temporary Committee</p>   |

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|                     | <p>established during the COVID-19 pandemic and was accountable to the Board. It was now proposed to disestablish the Committee and incorporate the duties within its ToR, within the remit of the Quality Assurance Committee and Finance &amp; Sustainability Committee as appropriate.</p> <p><b>The Trust Board approved the disestablishment of the Clinical Recovery Oversight Committee and thanked the members of the Committee for their commitment to this important governance arrangement.</b></p>   |
| <b>BM/23/03/37</b>  | <p><b>Cycle of Business – Trust Board 2023-24</b></p> <p>JC introduced the report and explained that in accordance with the Foundation Trust’s Constitution ‘Board of Directors – Standing Orders’ the Board were required to review their Cycle of Business on an annual basis.</p> <p>KH confirmed that the Working with People &amp; Communities Strategy would replace the Patient and Public Participation + Involvement Strategy, the amendment would be made following the meeting.</p> <p><b>The Trust Board approve the Cycle of Business 2023-24.</b></p>  |
| <b>BM/23/03/38</b>  | <p><b>Committee Cycles of Business 2023-24</b></p> <p>JC introduced the report explaining that, the Board were required to review and approve the Committees Cycles of Business on an annual basis. The Cycle of Business for the following committees were presented:</p> <ul style="list-style-type: none"> <li>• Charitable Funds Committee (CFC)</li> <li>• Audit Committee (AC)</li> </ul> <p>It was noted that each had been reviewed and approved by the respective committees.</p> <p><b>The Trust Board approved the 2023-2024 Cycles of Business, for</b></p> <ul style="list-style-type: none"> <li>• <b>Charitable Funds Committee (CFC)</b></li> <li>• <b>Audit Committee (AC)</b></li> </ul> |
| <b>FOR APPROVAL</b> |  |
| <b>BM/23/03/39</b>  | <p><b>Performance Assurance Framework</b></p> <p>AM introduced the paper which explained that The Performance Assurance Framework (PAF) outlined how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation.</p> <p>The proposed changes to the PAF for 2023/24 were detailed within the report which was taken as read by the Board.</p> <p><b>The Trust Board approved the amendments to the PAF as part of the annual refresh.</b></p>   |
| <b>BM/23/03/40</b>  | <p><b>Integrated Performance Report Refresh</b></p> <p>AM introduced the paper which explained that the Trust Integrated Performance</p>   |

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|  | <p>Report (IPR) Dashboard was 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 paper outlined the recommendations for new indicators and updates to existing indicators for Access and Performance, Quality, Workforce and Finance Sustainability and key performance indicators (KPIs).</p> <p><b>The Trust Board approved the proposed amendments to the IPR Dashboard for 2023/24.</b></p>  |
| <b>SUPPLEMENTARY PAPERS</b>  |  |
| <p>BM/23/03/41<br/>BM/23/03/42<br/>BM/23/03/43<br/>BM/23/03/44<br/>BM/23/03/45<br/>BM/23/03/46<br/>BM/23/03/47</p> | <ul style="list-style-type: none"> <li>• Digital Strategy Group Report</li> <li>• Guardian of Safe Working – Q3</li> <li>• Learning from Experience Summary Report – Q3</li> <li>• Directors of Infection Prevention and Control (DIPC) Quarterly Report – Q3</li> <li>• Safe Nurse Staffing Report; 6 Monthly Acuity Review</li> <li>• Mortality Review (Learning from Deaths Quarterly Report) – Q3</li> <li>• Changes to Enhanced Monitoring Status – General Medical Council</li> </ul> <p><b>The Trust Board noted the papers for assurance.</b></p>  |
| <p>BM/23/03/48</p>   | <p><b>Any Other Business</b></p> <p>DT queried the Trust's approach to accessible information standards, as a question had been raised by a staff member during the Leadership Observation Visits.</p> <p>KM confirmed the Trusts commitment to the standards informing the Board that a campaign had been developed and would soon be rolled out detailing the approach to ensure accessible Information Standards are met for both staff and patients. Part of this would include ensuring clinical systems had the accurate features to meet people needs.</p> <p><b>The meeting closed at 12.30 p.m.</b></p> |
| <b>The Date and Time of the next Trust Board Meeting is Wednesday 7<sup>th</sup> June 2023</b>                     |  |

Approved ..... Dated .....

**CHAIRMAN:** Steve McGuirk

|                         |             |                 |                        |                        |             |
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| <b>AGENDA REFERENCE</b> | BM/23/06/51 | <b>SUBJECT:</b> | TRUST BOARD ACTION LOG | <b>DATE OF MEETING</b> | 7 June 2023 |
|-------------------------|-------------|-----------------|------------------------|------------------------|-------------|

### 1. ACTIONS ON AGENDA

| Minute ref  | Meeting date | Item                      | Action  | Owner                                      | Due Date  | Completed date            | Progress                | RAG Status |
|-------------|--------------|---------------------------|---|--|-----------|---------------------------|-------------------------|------------|
| BM/23/03/26 | 29.03.23     | Chief Executives Report   | High Level CMAST briefings to be produced for future meetings.<br><br>Place-Based Partnership updates to be included in Bi-monthly strategy reports | Simon Constable<br><br>Lucy Gardener       | June 2023 |                           |                         |            |
| BM/23/03/28 | 29.03.23     | Board Assurance Framework | Review of Risk #145 to consider separating the risk around the new hospital.  | Lucy Gardener<br>John Culshaw<br>Dan Moore | June 2023 | 7 <sup>th</sup> June 2023 | Agenda Item BM/23/06/55 |            |
|             |              |                           |   |  |           |                           |                         |            |

### 2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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


### 3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

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

**REPORT TO BOARD OF DIRECTORS**

|  |  |          |                |          |
|--|--|----------|----------------|----------|
| <b>AGENDA REFERENCE:</b>   | BM/23/06/53  |          |                |          |
| <b>SUBJECT:</b>  | Chief Executive's Briefing   |          |                |          |
| <b>DATE OF MEETING:</b>  | 7 <sup>th</sup> June 2023  |          |                |          |
| <b>AUTHOR(S):</b>  | Simon Constable, Chief Executive   |          |                |          |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>   | Simon Constable, Chief Executive   |          |                |          |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><br><i>(Please select as appropriate)</i> | 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.   |          |                | ✓        |
| <b>LINK TO BAF RISK:</b>   | All  |          |                |          |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>   | 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. |          |                |          |
| <b>PURPOSE: (please select as appropriate)</b>                                   | Information<br>✓   | Approval | To note        | Decision |
| <b>RECOMMENDATION:</b>   | The Board is asked to note the content of this report.   |          |                |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>   | Committee  |          | Not Applicable |          |
|  | Agenda Ref.  |          |                |          |
|  | Date of meeting  |          |                |          |
|  | Summary of Outcome   |          |                |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>                                     | Release Document in Full   |          |                |          |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>                                    | None   |          |                |          |

|                |                                   |                    |                    |
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| <b>SUBJECT</b> | <b>Chief Executive's Briefing</b> | <b>AGENDA REF:</b> | <b>BM/23/06/53</b> |
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## 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 29<sup>th</sup> March 2023, some of which are not covered elsewhere on the agenda for this meeting.

## 2) KEY ISSUES

### 2.1 Current COVID-19 Situation Report

As at the time of writing (31<sup>st</sup> May 2023), we have a total of 22 COVID-19 positive inpatients (14 days or less since their first positive sample). In total, 57 of our inpatients have tested positive at any time during their admission. There has been a continuous steady burden of COVID-19 disease, either incidental or as a primary cause of admission since the beginning of this year.

We have discharged a total of 5675 patients with COVID-19 to continue their recovery at home. Sadly, a total of 906 patients testing positive for COVID-19 have died in our care.

On 19<sup>th</sup> May 2022, NHS England outlined the steps the NHS would need to take to transition from the COVID-19 response to recovery. As part of that response, the national NHS level 4 incident was at that point stepped down to a level 3 incident.

Since then, we have continued to see waves of COVID-19 infection. Like the rest of the NHS, we continue to treat COVID-positive patients in hospital, but we are now in a position to move to the next stage in our collective COVID-19 response. The World Health Organization has also recently announced that COVID-19 is no longer a Public Health Emergency of International Concern.

On 18<sup>th</sup> May 2023 we were therefore informed by NHS England that the NHS would be stepping down the COVID-19 incident. Stepping down the incident is undertaken in the knowledge that COVID-19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact on patient numbers, as well as staff absences, and we will also need to continue to provide services for those suffering the effects of 'long COVID'.

There are several implications of stepping down the NHS incident. As we move away from incident arrangements for COVID-19, the following will change:

- COVID-19 Patient Notification System (CPNS): As of 30<sup>th</sup> June 2023, NHS England will no longer be collecting data where an individual has died from COVID-19 via the CPNS system. Instead, data on individuals who have died with COVID-19 will be recorded using the death certification process which is the same as for other infectious diseases.
- The acute COVID-19 data collection process will be stood down with a subset of data incorporated into the existing UEC data collection from June. This will ease the burden on NHS trusts.
- Outbreak reporting: the outbreak reporting process is currently being reviewed and the future of this will be notified separately.

## 2.2 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 datasets. In this case, as we shift into a new reporting year and Trust Board cycle, this is month 1 - April 2023. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports. You will notice the different way this is expressed this month, with the aim of ensuring we have the greatest amount of clarity and focus our attention on areas for improvement.

As I have stated previously, our single most important operational performance challenge remains length of stay, although there have been some modest improvements in recent weeks, especially for Warrington residents. Our total number of super-stranded patients with a length of stay greater than 21 days remains extremely high at 118 (in my last Board report this figure was 145). The number of patients that do not meet the criteria to reside (NCTR) is also very high at 137 (in my last Board report this figure was 163). For Warrington Borough Council residents in hospital, this latter number is currently 70 (21.7%); for Halton Borough Council residents in hospital, it is 36 (25.9%). If the number of patients who do not meet the criteria to reside sat simply at the national average of 15% for both boroughs it would be 21 patients for Halton and 48 for Warrington. This is a total of 37 fewer patients in the hospital bed-base.

The Trust continues to undertake an elective recovery programme with minimal interruption despite urgent and emergency care pressure and the impact of industrial action; the priority is now on the elimination of waiting lists longer than 65 weeks by the end of this financial year on 31<sup>st</sup> March 2024. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees.

## 2.3 HM Government announcement on New Hospitals Programme funding

On 25<sup>th</sup> May 2023, following an announcement by the Secretary of State for Health and Social Care made in the House of Commons, we were disappointed to learn that we have 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 have been prioritised in this funding round. NHS Cheshire and Merseyside had previously identified Warrington and Halton Teaching Hospitals NHS Foundation Trust as its priority site for improvement.

This vital investment would have presented WHH with a unique opportunity to address significant challenges within the current hospital estate, including a lack of appropriate physical space to serve the fastest growing population in Cheshire and Merseyside, especially in the urgent and emergency care pathway through Warrington Hospital. The investment would have allowed us to build a new acute hospital in Warrington and a redeveloped hospital and wellbeing campus in Halton, both built to modern specifications and fully equipped with the latest technology and treatments.

Whilst we recognise that it is essential that hospitals with urgent health and safety challenges are addressed first (as we do in our own internal capital programme every year), the pressing need to create modern, sustainable and compliant estate which is fit for purpose and can deliver the best healthcare for our local population remains.



We are clearly disappointed to not have secured funding for a new hospital estate for the people of Warrington and Halton. The outcome of this latest funding round does not change the fact that our aging estate needs significant modernisation.

The Government has announced that going forward, new schemes, including those who have previously submitted an expression of interest like us, will be considered through a rolling programme of capital investment in hospital infrastructure.

We remain committed to continuing to work alongside key stakeholders and partners to identify further opportunities to develop our aspirations so that we can meet the evolving needs of residents, tackle health inequalities, and support the regeneration of our towns and communities. However, it should be considered that the progress we have made with partners in getting to this stage leaves us in a good position for the future, enabling the development of an alternative route to delivery with the same level of ambition.

We continue to maximise opportunities to progress our plans by changing and adapting how and where we deliver care. This includes investing to make the most appropriate and effective use of scarce clinical space for urgent and emergency care at Warrington Hospital and the introduction of new community facilities, such as the new Living Well Hub in Warrington town centre which is scheduled to open later this year (see below), and the creation of a Health and Education Hub in Runcorn town centre.

Whilst this has clearly been disappointing news, the imperative has not gone away, and we will work with partners on next steps.

## **2.4 Living Well Hub in Warrington**

Work is now under way on our new Living Well Hub in Warrington town centre. The Hub, based in the former Contact Warrington centre on Horsemarket Street, is set to open its doors later this year and will be a 'one-stop shop' of accessible healthcare services from multiple providers under one roof in a central location.

This is an exciting development for the Trust, and we are working hard with our place partners including Warrington Borough Council, Bridgewater Community Healthcare NHS Foundation Trust, and Mersey Care NHS Foundation Trust, along with voluntary and charitable sector organisations, to deliver our vision.

We received £3.1m funding for the Hub from Warrington's Town Deal, via the Government's Towns Fund. The Hub is part of the wider Living Well programme which aims to connect people, communities, and services to enable residents to live healthy, fulfilling lives and take greater control over their own health, wellbeing, and resilience.

In time, the Hub will help to ease pressure on other health and care services across the town, including GP and hospital appointments, and have a positive impact on future demands for nursing and social care. We want the Living Well Hub to be an open, welcoming space where members of our communities can drop in to get advice and guidance.

This is not a traditional walk-in centre for treating injuries and illnesses, it is a place you can go for information to assist with identifying potential problems earlier before any traditional intervention by a GP or hospital may be required. The Hub will be accessible to the whole community throughout the week with a range of services available including:

- support for children and families about how to lead healthier and more active lives
- assistance for older residents with early signs of frailty who want to continue to live independently at home
- health visitor advice and guidance
- antenatal/postnatal clinics
- dementia assessments and support
- support for people providing care to others.

There will be several clinical and non-clinical rooms for drop in and pre-booked appointments, and the plans also include the construction of a rooftop extension and refreshment area. Once built, the Hub will give people a new and different reason to come back into the town centre, which in turn will support the local economy. We know that the Hub will be a real asset to WHH and to the people of Warrington.

## **2.5 BMA Industrial Action**

Since our last Trust Board meeting, the British Medical Association has held junior doctor industrial action across the NHS for a further period of 96 hours. Our junior doctor colleagues at Warrington and Halton Teaching Hospitals took strike action from 0659 on Tuesday 11th April, finishing at 0700 Saturday 15th April. There were no derogations in place (negotiated exemptions for certain activities).

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

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

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

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

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

Further industrial action by the BMA is scheduled for the middle of June 2023.

## 2.6 Delivery safe maternity services in Warrington and Halton

As a service, nationally, maternity teams have come under intense scrutiny in the press over the last few years. Ensuring the safety of a maternity unit in the UK involves a combination of strategies and processes. One crucial aspect is the implementation of national guidelines and safety programs.

The Care Quality Commission (CQC) is responsible for monitoring and inspecting healthcare services in the UK, including maternity services. They assess the quality and safety of care provided by maternity units against national standards and guidelines. We expect a visit soon.

Another essential element of ensuring the safety of a maternity unit is a robust system of clinical governance. We have a team and processes to ensure the quality and safety of care, including incident reporting, clinical audit, and regular clinical outcome reviews.

The implementation of effective communication systems is also crucial to ensure the safety of maternity services. We have enabled this channel between families and healthcare teams to improve with the launch of BadgerNet, a bespoke maternity app-based electronic patient record (EPR). In addition, the involvement of patients and families in the planning and delivery of care is essential.

Ensuring the safety of a maternity unit requires a commitment to training and education for healthcare providers, including hands on simulation training, communications skills and human factor training, which midwives, maternity care support workers, obstetricians and anaesthetists attend together.

Some of the quality improvements we have brought to our daily management of care over the last seven years includes the following:

- The Birmingham System of Triage has been shown to improve the safety of maternity services by ensuring that women receive appropriate levels of care in a timely manner. The level of care required for each woman, allowing healthcare professionals to prioritise care and ensure that women receive appropriate interventions and treatment promptly.
- The Saving Babies' Lives Care Bundle is an initiative in the UK to reduce the number of stillbirths and neonatal deaths. It includes improving fetal growth and wellbeing, reducing smoking in pregnancy, improving fetal movement awareness, promoting safe delivery, and improving the management of pregnancies at risk of preterm birth.
- The Perinatal Mortality Review Tool is used as a standardised tool for reviewing each case of perinatal mortality, with the aim of identifying where care could have been improved or lessons can be learned. Parent voices are heard as their questions are answered and they have the opportunity to give feedback. This tool plays an essential role in ensuring that maternity services in the UK are safe and of high quality.
- ATAIN is a national quality improvement program that aims to reduce the number of babies born after 37 weeks requiring neonatal unit care. The program includes a range of interventions and tools that aim to improve the quality of care for babies. This includes the development of standardised care pathways, regular review of records, and the use of risk assessment tools to identify women who may be at risk of complications during pregnancy and birth.

WHH has demonstrated our commitment to delivering safe and high-quality maternity care to women and babies. It is vital that all maternity services continue to prioritise safety to ensure that every pregnancy and baby receive the best possible care during pregnancy, birth, and beyond.

## 2.7 Getting It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) has been a national programme in place for some time across the NHS in England. This year, implementing its recommendations for many specialities, is an important part of our improvement work, tackling key things such as length of stay.

GIRFT is designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. It aims to reduce or remove unwarranted variation to ensure our patients are getting the best care and outcomes across the board.

The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. GIRFT is part of an aligned set of programmes within NHS England and has the backing of the Royal Colleges and professional associations.

We work with the Cheshire and Merseyside GIRFT team (part of the national team), they support us and our local peers to look at and share best practice to improve our services and help us use our resources to get the best use from them for our patients. Here at WHH we are committed to supporting this programme of improvement and have a dedicated GIRFT team in place to do just this. We look at our own data, compare our performance and outcomes and use the recommendations to understand how we can improve. We use the Model Hospital and GIRFT websites. There is a wealth of information here to both see how well we are doing in many areas, things we could do even better and guidance on how to make these improvements.

The priorities for the year, by Care Group, are as follows:

### ***Planned Care***

- All Consultants to deliver against planned 42-week Clinical Theatre Activity – this is to ensure Theatre capacity is available for job plans to be fulfilled.
- Improve Day case activity rates in accordance with British Association for Day case Surgery (BADs) – this will support theatre utilisation.
- All Theatres will start before 9am – This is to support utilisation and will need to be in conjunction with list planning.
- List Planning - Improve standardisation and theatre utilisation by introducing a points system for listing.
- Fractured Neck of Femur – to improve this pathway in line with best practice KPIs to ensure quality a service for our patients.

### ***Unplanned Care***

- Achieve 76% ED 4 hour wait target through improving overnight waits and zero tolerance approach to non-admitted pathway breaches.
- Reducing Length of Stay for both No Criteria to Reside and Criteria to Reside patients – Ward based improvements using the SAFER bundle.
- Increase the use and number of Virtual Wards to support reducing length of stay – Respiratory and Frailty.

### ***Clinical Support Services (Outpatients)***

- Reduction in DNAs – including review of invitation and reminders.
- Advice & Guidance – Increase usage and standardise where appropriate.
- Virtual offerings – standardise and ensure capturing all work.



- OPD Pathways – in line with new GIRFT guidelines April 2023.
- New to Follow Up Ratios – Use of PIFU and pathway reviews to reduce these and increase capacity to address waiting list.

## 2.8 NHS 75<sup>th</sup> Birthday

July 5<sup>th</sup> 2023 will mark 75 years since the creation of the National Health Service. NHS organisations up and down the country are being asked to use the birthday to celebrate the amazing skills and dedication of staff and volunteers during what has been described as the toughest period yet for the NHS.

We are developing our own plans here at WHH and more information will follow on these in the coming weeks. We have the opportunity to be part of one of the key national events being held to celebrate the NHS 75th birthday.

On Wednesday 5<sup>th</sup> July from 11am to 12.30pm a multi-faith service will be held for NHS staff, volunteers and partners at Westminster Abbey, London.

I am delighted that the following members of staff have been nominated to attend and represent Warrington and Halton Teaching Hospitals on my behalf:

- Mr Ramandeep Chalokia, Locum Consultant Urologist
- Maria Keeley, Chief Pharmacy Technician
- Viki Caldwell, Senior Patient Flow Nurse
- Gareth Davies, Supply Chain Manager
- Emma Chadwick, Housekeeper - ITU

## 2.9 Belonging in WHH

Every fortnight I have the pleasure of welcoming our new starters at Halton Hospital as part of our induction course. I aim to emphasise three things, apart from all the usual facts and figures: i) our trust structure (not because on its own it is particularly helpful or interesting on your first day but it does give a sense of perspective of the bigger picture and where an individual sits within the wider WHH Team, ii) the importance of Freedom to Speak Up, and finally iii) how important our four staff networks are in shaping us as a Trust.

We marked National Staff Network Day 2023 on 10th May; this year's theme was 'Power'. Networks are all about people - they are about progressive change, supporting our workforce's experience and inspiring a feeling of belonging.

In April 2022, we published our new Workforce Equality, Diversity and Inclusion Strategy 2022-2025 which outlined our commitment to be the best place to work that we can possibly be. Given national and international events which have occurred over the past few years, never has it been more important or urgent to create an organisational culture where everyone feels they belong. This is something that we have seen reflected in our recent Staff Survey results for 2022. We can do more. In addition to this, the NHS Long Term Plan was published in 2019 with the NHS People Plan 2020/21 outlining the workforce strategy to ensure that as the NHS continually moves forward, we have a service that is fit for the future.

The NHS People Plan is organised around four pillars, one of which is "Belonging in the NHS". The NHS was established on the principles of social justice and equity and as such creating a culture of

belonging and trust for all is a fundamental part of our staff networks. At WHH we recognise that discrimination, violence and bullying has no place and we therefore are committed to supporting our staff networks to thrive, recognising that they help us to create separate safe spaces which allow us to share, learn and grow our understanding of the rich and diverse backgrounds and lived experiences of our people.

This year, Staff Network Day was all about celebration, inspiration, and transformation. It was the chance to celebrate the contributions that the networks have individually made and share a bit more about what they do to impact the culture of our Trust. Here are just a few examples over the last few years include:

- Supporting the Trust to achieve the Navajo Charter Mark – showcasing our commitment to both LGBTQIA+ colleagues and patients that we celebrate diversity and are a safe and zero tolerant place to receive healthcare.
- Introduction of the ‘Not all Disabilities are Visible’ blue badge parking signs, recognising, and raising awareness of hidden disabilities.
- Celebration of South Asian Heritage Month - as many of our staff are from South Asian Countries, South Asian Heritage Month is celebrated within WHH every year in truly WHH way by breaking the barriers beyond South Asian Countries by educating and celebrating the diversity at WHH.
- Increasing diversity at all levels - driving forward our Reciprocal Mentoring programme which was launched to break barriers and increase awareness of lived experience for both our workforce and Executive Team. The programme provided the foundations for achieving the diversity at all levels. Diversity is not just about ethnicity, sexual orientation, age, disability etc. It’s about our culture, and respecting and valuing difference, in all its forms. Including different opinions and approaches to problems.
- Development of our LGBTQIA+ Wellbeing and Support Guide for all staff with dedicated support for LGBTQIA+ colleagues across the Trust to access.
- Marking our inaugural remembrance and dedication service for Armistice Day with construction of our poppy fields at both sites organised by our Armed Forces and Military Veterans Community Network.

In addition to this, we are currently in the process of establishing a Women’s Staff Network as well as a network for our younger workforce. We want to continually improve our offer to make sure everyone feels they can be and bring their true authentic self to work every day.

## **2.10 Your Future, Your Way**

In April I attended the Celebratory Event of the programme we launched last November - *Your Future, Your Way* (YFYW).

YFYW was designed to develop aspiring nursing, midwifery and AHP leaders from multi-ethnic backgrounds (the global majority) reach equity, further recognising their talent and skills as well as helping to remove any barriers to professional career development. This first pilot programme ran in two parts: Part A aimed to ensure that our existing senior nursing, midwifery and AHP team develop a deeper understanding of the barriers that colleagues from a multi-ethnic background can face during their career. Part B was aimed at nurses, midwives and AHPs from multi-ethnic backgrounds in professional bands 5-6, providing delegates with the leadership skills, peer support and senior professional sponsorship to enable career development. Senior staff from Part A were then appointed as a ‘sponsor’ to a staff member on part B of the course.

22 staff members on YFYW (cohort 1 of the new programme) celebrated completion of the programme following submission of individual assignments which were showcased as poster presentations. We anticipate that all staff passed the qualification from the Chartered Management Institute (CMI). The individual improvement projects exceeded our expectations with a breadth of innovation covering the Trust and ranging from safety projects, staff education, upskilling projects and new innovative ways of supporting patient care including managing risk. Many of the projects will have the advantage of being able to be shared across other wards and departments. Meaningful sponsor relationships developed with positive outcomes of trust, understanding and support.

The speakers across both parts of the course were invaluable, many who we purposely sought out from a BAME background who could also share their personal and professional career stories. It was interesting to hear from our external 'expert' support that there had appeared to be a noticeable huge shift in mindset from those on the course from the beginning to the end. There was also a palpable level of improved confidence, enthusiasm, and desire to take the next steps in terms of personal and professional development. Seven staff members have now already been successful in promotion. We are reviewing next steps and cohort two starts next month.

The programme has created an environment in which both groups of staff can develop equally; both groups got something out of this course, in addition to the outcomes we wanted to see.

### **2.11 NHS England People Directorate recognition**

Adam Harrison-Moran, Head of Workforce Equality, Diversity and Inclusion, has been recognised as NHS England's People Professional "Star of the Future."

Adam initially joined the HR profession as a HR Trainee back in 2019 (as a band 4) working on his Level 5 CIPD professional qualifications. He showed great flexibility throughout the pandemic moving into managing the Redeployment Hub - for the safe deployment of staff into clinical and non-clinical areas as required. He is compassionate and inclusive, taking on the role as Chair of the LGBTQA+ Staff Network - hosting events throughout the two-year peak of the pandemic and ensuring that staff maintained contact with each other throughout. He demonstrates our trust values of kindness, inclusive, working together, excellence and embracing change. He embraces diversity within the people profession and has joined the NW Healthcare People Management Association (HPMA) Branch Committee to share and shape best practice.

Adam is now a Head of Service utilising his experience, credibility and knowledge to shape and inform our People Directorate approach to inclusivity. He seeks the views of others to direct his priorities and to manage expectations across the organisation. As a Freedom to Speak Up Champion he creates an energy and safety that enables others to be their authentic self in the workplace and to have their views and concerns addressed. He is an asset to the people profession and this has now been recognised nationally.

### **2.12 WHH Start the Year Conference**

On 18<sup>th</sup> May 2023 I was very pleased to host our very first *Start the Year Conference* since 2019 and the subsequent pandemic (and indeed my first as chief executive). Nearly 200 members of the WHH leadership community from across the Trust (including ward and department managers) attended the Halliwell Jones Stadium in Warrington to reflect upon the last few years, 'regroup' and hear about our priorities for the coming year. We had keynote speeches from Dr Phil Hammond (NHS doctor, author, comedian, journalist and broadcaster) as well as Chris Barez-Brown, who we have been working with over the last couple of years on the mental health wellbeing app, *Talk-It Out*. Aside from looking

forward to the coming year, the *Start the Year Conference* was an opportunity to collectively review the results of our last staff survey (2022), what staff are telling us and what we should do as a result.

### 2.13 Special Days/Weeks for professional groups

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

Stress Awareness Month: April 2023  
Autism Acceptance Month: April 2023  
International Day of the Midwife: 5<sup>th</sup> May 2023  
International Hand Hygiene Day: 5<sup>th</sup> May 2023  
Dying Matters Awareness Week: 8<sup>th</sup> - 14<sup>th</sup> May 2023  
National Staff Network Day: 10<sup>th</sup> May 2023  
International Nurses' Day: 12<sup>th</sup> May 2023  
National Operating Department Practitioner Day: 14<sup>th</sup> May 2023

### 2.14 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.

### 2.15 Employee Recognition

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

#### ***You Made a Difference Award (March 2023): Gary Siddall***

This award was made in recognition of the hard work and dedication shown, month-on-month, in single-handedly advocating for the Trust to donate surplus volumetric pumps to be made to the hospitals of the Ukraine. The volumetric pumps were provided to the Trust during the pandemic. Unfortunately, we were unable to use this type of pump and we were also unable to return them for use elsewhere within the NHS.

Despite many hurdles, Gary went above and beyond his duties to lead on this, working together with departments both within the Trust and the wider NHS, including charities and the people of the Ukraine to ensure the necessary paperwork and approvals for such a donation were completed.

I am immensely proud of his achievements and the kindness Gary has shown “doing the right thing.”

#### ***You Made a Difference Award (April 2023): Nikki Webb – Ward Manager, C23***

This award was made in recognition of the hard work and dedication shown in organising ‘Team Reward Weeks’ on Ward C23, bringing the team together to improve staff relationships and morale

on the ward. Nikki has gone above and beyond in her duties to lead on this, acting on staff feedback to provide opportunities for the team to get to know each other, in what can otherwise be a very fast-paced working environment. By further organising the same opportunities for night staff, Nikki has shown compassion and inclusivity at the heart of this, catering for those individuals participating in Ramadan by providing refreshments to enable them to join in with their colleagues.

The 'Thank You' notes which were sent to all areas of the Trust which support Ward C23 both directly and indirectly, as a token of the ward's appreciation, demonstrates the Trust's values of kindness and working together, and has enabled the team to recognise the areas which support them.

***You Made a Difference Award (May 2023): WHH Choir***

This award is in recognition of the kindness the Choir showed towards a person who became lost and stumbled upon their rehearsal on the evening of Friday 31st March in the Wingman Wellbeing Lounge.

They all welcomed this person into their rehearsal, ensuring they were comfortable, offering them a warm drink and working together to include them in their singing - whilst other choir members contacted the appropriate people, demonstrates the trust values of working together and kindness at their very core. They all went above and beyond to support this individual, staying far later than they usually would have to ensure they were not left alone, felt included and safe.

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

***Chief Executive Award (March 2023): Dr Janice Fazackerley***

I have been able to recognise and honour Dr Janice Fazackerley, who has now formally retired from her role as Associate Medical Director for Appraisal and Revalidation.

After retiring from a very long and successful career as a consultant anaesthetist at WHH, Janice was appointed as AMD for Appraisal and Revalidation in the autumn of 2019. It was unfortunate that not long after starting the post we hit the COVID-19 pandemic and all usual appraisal processes were formally paused. Janice, however, kept the appraisal process going for those doctors who wanted to continue. She refined the Trust information that was provided in the appraisal folders (to everyone's delight, including my own) and introduced a quality assurance scoring system (known as PROGRESS) which looks at appraisal summaries and measures how strong they are. She then fed this back to individual appraisers for their reflection. She also re-designed the revalidation panel process, making it totally electronic.

Appraisers have gone from strength to strength during her tenure. In the past year there has also been the procurement of a new appraisal system; SARD was introduced into the Trust very successfully and seamlessly in January.

Janice will be much missed. This particular baton for a really important regulatory function is now handed over into the very capable hands of Dr Hilary Furniss, consultant obstetrician and gynaecologist.

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

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

- Jane Browne, Ward Sister - Ward B4 (Digestive Diseases)
- Wendy Powner, Staff Nurse - Ward B14 (Integrated Medicine & Community)
- Karen Murray, Healthcare Assistant – Outpatients (Clinical Support Services)
- Kate Henry, Director of Communications & Engagement

Dr Paul Fitzsimmons, Executive Medical Director  
Laura James, CBU Manager - Women's & Children's Health  
Sandra Smith, Higher Level Health Care Assistant (Digestive Diseases)  
Jeanette Carter, Midwife - Women's & Children's Health  
Lisa Whittle, Midwife - Women's & Children's Health  
Marie Garnett, Head of Contracts & Performance (Finance & Procurement)  
Vera Basnett, Catering Assistant (Estates and Facilities)  
Jane Alker, Ward Sister - Ward A6 (Surgical Specialities)

### 2.16 Signed under Seal

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

- Modular Bed Store
- Licence to alter Unit 42, Runcorn Shopping City

## 3) MEETINGS ATTENDED/ATTENDING

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

- NHS England Leadership Event for ICB & Trust Chief Executives – 19<sup>th</sup> April 2023
- NHS England Provider Collaborative Innovators Scheme In-Person Launch Event – 24<sup>th</sup> May 2023
- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)
- CMAST Clinical Pathways Programme (Various)
- Steven Broomhead, Chief Executive, Warrington Borough Council
- Stephen Young, Chief Executive, Halton Borough Council
- Carl Marsh, ICB Place Director (Warrington)
- Anthony Leo, ICB Place Director (Halton)
- Warrington Wider System Sustainability Group (Monthly)
- Clinical Research Network Northwest Coast Partnership Group Meeting (Quarterly)

## 4) RECOMMENDATIONS

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

## 5) APPENDICES

Appendix 1: CEO Dashboard – Month 1 (April 2023)

# Appendix 1 - CEO Dashboard Month 1 – April 2023

## Quality

| Operational Performance                  |            |        |     |
|--|------------|--------|-----|
| Indicator                                | Target     | Actual | SPC |
| Diagnostic 6 Weeks                       | 95.00%     | 7.40%  |     |
| RTT 18 Weeks                             | 92.00%     | 54.25% |     |
| A&E % patients seen within 4 hours       | 75.00%     | 67.85% |     |
| A&E % waiting longer than 12 hours       | < 2.00%    | 19.09% |     |
| Cancer 14 Days                           | 93.00%     | 69.48% |     |
| Breast Symptomatic 14 days               | 93.00%     | 13.73% |     |
| Cancer 28 Day Faster Diagnostic Standard | 75.00%     | 73.16% |     |
| Cancer 62 Days Urgent                    | 85.00%     | 50.52% |     |
| Ambulance Handovers within 60 mins       | 100%       | 80.48% |     |
| Discharge Summaries 24 hours             | 95.00%     | 89.98% |     |
| Cancelled Operations – 28 days           | 0          | 0.05%  |     |
| Fracture Clinic – 72 Hours               | 95.00%     | 75.40% |     |
| Super Stranded Patients                  | Trajectory | 132    |     |
| Theatre Utilisation                      | 85.00%     | 73.16% |     |
| Day cases                                | 85.00%     | 86.30  |     |

| Quality of Care   |                        |        |     |
|---|------------------------|--------|-----|
| Indicator   | Target                 | Actual | SPC |
| Incidents open over 40 days   | 0                      | 0      |     |
| Sepsis Screening Emergency  | 90.00%                 | 72.00% |     |
| Sepsis Screening Inpatients   | 90.00%                 | 80.00% |     |
| Sepsis Antibiotics Emergency  | 90.00%                 | 84.00% |     |
| Sepsis Antibiotics Impatient  | 90.00%                 | 84.00% |     |
| Inpatient Falls (cumulative)  | 20.00% reduction       | 34     |     |
| VTE   | 95.00%                 | 95.39% |     |
| Pressure Ulcers (cumulative)  | 10.00% reduction       | 15     |     |
| Medication Reconciliation (24 hrs)  | 80.00%                 | 38.00% |     |
| Complaints over 6 months  | 0                      | 0      |     |
| Healthcare Infections - MRSA  | N/A                    | 0      |     |
| Healthcare Infections – CDI (cumulative)  | Less than 36 (2023/24) | 1      |     |
| Healthcare Infections - E. coli (cumulative)  | Less than 54 (2023/24) | 8      |     |
| Healthcare Infections – Klebsiella (cumulative)   | Less than 18 (2023/24) | 1      |     |
| Healthcare Infections - P. aeruginosa (cumulative)                                      | Less than 2 (2023/24)  | 0      |     |
| Maternity Postpartum Haemorrhage >1500ml  | Less than 3.7%         | 2.43%  |     |
| Maternity 3rd and 4th Degree tears  | Less than 1.85%        | 0.48%  |     |
| Maternity Pregnancy Bookings before 10 weeks  | 75%                    | 56%    |     |
| Maternity Pregnancy Bookings before 13 weeks  | 90%                    | 81%    |     |
| Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) | N/A                    | 7%     |     |
| MUST nutritional assessment completion  | 85%                    | 58%    |     |

## Sustainability

| Finance                             |                |         |     |
|-------------------------------------|----------------|---------|-----|
| Indicator                           | Plan           | Actual  | SPC |
| Income & Expenditure (culm)         | -£2.02m        | -£2.51m |     |
| Capital Spend                       | £1.56m         | £0.52m  |     |
| Cash Balance                        | £30.30m        | £32.35m |     |
| Better Practice Payment Code (culm) | 95.00%         | 96.00%  |     |
| CIP In Year Delivered (culm)        | £0.6m          | £0.6m   |     |
| CIP Forecast (Recurrent)            | £0.6m          | £0.14m  |     |
| Agency Ceiling                      | Less than 3.7% | 5.3%    |     |

## People

| Indicator               | Target          | Actual | SPC |
|-------------------------|-----------------|--------|-----|
| Supporting Attendance   | Less than 4.20% | 6.11%  |     |
| Retention               | 85.00%          | 84.74% |     |
| Core/Mandatory Training | 85.00%          | 88.59% |     |
| PDR Compliance          | 79.00%          | 70.64% |     |

## Strategy

Strategy

- Runcorn Town Deal Health and Education Hub** – The Trust continues to work in partnership with providers across Halton to refine the design for the hub. A number of stakeholder sessions have been held with the design team Cassidy + Ashton to develop floorplans ahead of a planning application submission later this summer. The hub is expected to be operational in Spring 2025. There will be a public engagement session held at The Brindley Theatre, Runcorn on 9<sup>th</sup> June 2023 between 2pm and 6pm to view the progress and interact with the other projects making up Halton's Town Deal Programme.
- Community Diagnostic Centre (CDC)** – Work is nearing completion in the Nightingale building to create the first phase of our new CDC at Halton. The service is due to be operational in June 23. The design for Phase 3 (New Build CDC) is progressing with the clinical teams.
- Breast relocation** - Building works to enable the remaining Breast services from Kendrick Wing to transfer to Bath Street concluded this month. The new service is now fully operational from Bath Street with clinical breast screening services no longer operating out of Kendrick wing.
- Warrington Living Well Hub**- Build works have commenced on the new facility to be created in Warrington Town Centre with an expected completion date of late Autumn 2023. The Hub will provide services from partners organisations across the Borough aimed at early intervention and prevention of mental and physical ill health.
- Acute Collaboration with STHK**– Joint recruitment is live to fill vacant ENT Consultant posts across the Trust and STHK. Once these posts are filled, a shared on-call rota with STHK will be developed.

## REPORT TO TRUST BOARD

|   |   |          |              |          |
|---|---|----------|--------------|----------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/54</b>  |          |              |          |
| <b>SUBJECT:</b>   | <b>Chair's Briefing</b>   |          |              |          |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |          |              |          |
| <b>AUTHOR(S):</b>   | Steve McGuirk, Trust Chair  |          |              |          |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | 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.  |          |              | ✓        |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | All   |          |              |          |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>This report seeks to draw attention to matters that the Chair believes are of particular significance to the Board of Directors and not covered elsewhere on the Board agenda.</p> <p>This update draws attention to:</p> <ul style="list-style-type: none"> <li>• New hospital submission outcome</li> <li>• NED Appraisals/ Chairs Appraisal</li> <li>• New Partner NED (Chester University)</li> <li>• Industrial Action</li> <li>• CMAST Update</li> <li>• ICS Update</li> <li>• COG matters inc. Governor Focus Conference - NHS Providers</li> </ul> |          |              |          |
| <b>PURPOSE: (please select as appropriate)</b>  | Information<br>X  | Approval | To note<br>X | Decision |
| <b>RECOMMENDATION:</b>  | <p>The Trust Board is asked:</p> <p>i) To note the meetings/engagement of the Chair over the reporting period (since the last Board meeting)</p> <p>ii) To make any comments or ask any questions arising from the report.</p>  |          |              |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full  |          |              |          |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>   | None  |          |              |          |

|                |                         |                    |                    |
|----------------|-------------------------|--------------------|--------------------|
| <b>SUBJECT</b> | <b>Chair's Briefing</b> | <b>AGENDA REF:</b> | <b>BM/23/06/54</b> |
|----------------|-------------------------|--------------------|--------------------|

## 1. BACKGROUND/CONTEXT

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

## 2. KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

### 2.1 General Update

The period April to June has been relatively quiet in respect of matters on which to provide an additional or specific update (in addition to the matters already covered on the agenda) and there are just three matters to raise. There are several reasons for this, not least the coincidence of the Easter period with the King's Coronation.

It should also be noted that, because of changing the dates of Trust Boards from the last Wednesday of the month to the first, I will be on leave for this Board. This is only the second Board meeting missed in eight years, so the attendance record is very good. Notwithstanding, the meeting will be chaired by the Senior Independent Director.

### 2.2 New hospital submission

We were extremely disappointed in late May to receive news that we had not been successful with our bid for funding for a new hospital for Warrington (and the redevelopment for the Halton campus). It is very disappointing; not least given the length of time it has taken to decide. More will be covered elsewhere on the agenda, but I did want to take this opportunity to thank everyone involved in assembling the case and making the submission both of which were extremely strong. A huge amount of effort went in to developing the proposition and it would also be fair to say that local MPs very much put party politics to one side. So much so, that we cannot just let matters rest. All the reasons why our case was so strong, namely that our current facilities are not fit for purpose for a modern, growing community, remain valid. As a result, we have already started work on *Plan B* to ensure we have a plan and a strategic approach to making our facilities the best they can be, even if that is not a new hospital.

### 2.3 NED Appraisals

Another general point worth drawing attention to is the fact that this last period has involved undertaking appraisals for all NEDs by the Chair. Alongside this, the Senior Independent Director is in the process of facilitation of my appraisal as Chair for 2023. In terms of NED Appraisals, there have been deliberately broad objectives set for NEDs. All Board Directors, governors and a wider group of stakeholders will be invited to provide 360<sup>0</sup> feedback as part of this process, and the final outcome, as in previous years, will be presented to the COG and, thus, in the public domain for transparency purposes.

## **2.4 Partnership with Chester University – Opening of new Warrington Campus**

A final general point to highlight relates to our ambition to move from being a teaching hospital trust to a university hospital trust over the next few years, and speaks to our strategic partnership with Chester University, for which we created an additional (University) Non-Executive Board Director role. For a variety of reasons, the previous incumbent stepped down and it has taken time to get the right successor in place. It is pleasing to report a successor is now in place, though, as they are still undertaking the necessary governance checks it is not possible, at this stage, to provide a name in the public domain. The individual concerned will attend the next meeting as a director.

Linked to this partnership, myself and the Medical Director also recently attended the opening of the new [Chester University Warrington Campus](#) which has a particular focus, as well as excellent facilities, for people on a variety of health or public services education programmes.

## **2.5 Industrial action**

This period has continued to see episodes of industrial action and there is more to come. There has now been a pay deal done with some members of staff, and, as a result, we have been directed to implement the pay award for all relevant staff. With that being said, it should also be pointed out that the deal has not been accepted by the Royal College of Nursing (RCN) who are currently considering what action they may take.

## **2.6 CMAST Update**

The only issue to which I would wish to draw attention is to note that work on the CMAST workstreams is continuing at pace and to note the continuing and extensive involvement of Exec Board Directors and the Chair, but increasingly also other Non-Executive Directors.

## **2.7 ICS Update**

It is fair to say that the last few months have been intense for the NHS with demand continuing to be unprecedented and with the continued drive for elective recovery. But, as will be observed from the daily media coverage, it is extremely tough and it is clear that Cheshire and Merseyside is amongst the hardest hit systems. As a result, the system is coming under intense scrutiny - as are its component parts (including WHH) - and being directed to utilise national, improvement support.

In this respect, NHS England have recently confirmed that local NHS systems and ambulance trusts would be placed into one of three tiers, each receiving a different level of improvement support, with Cheshire and Merseyside named as one of seven Integrated Care Boards in Tier 1. This means the system will be in receipt of the highest level of national support and scrutiny to diagnose problems and develop an improvement plan, as well as provide hands-on implementation support and direct access to national Urgent and Emergency Care and Improvement teams.

There are four metrics being used to determine this tiering and they include:

- 76% delivery against the A&E four-hour standard
- execution of the 30-minute category two ambulance response time

- the 12-hour time in Emergency Dept measures, and
- the proportion of general and acute beds occupied by patients over a 14-day length of stay.

It can be expected that while the tiering is being applied to the ICS, it will subsequently be cascaded down through individual trust levels and places.

Other developments of note include the fact that on 9 May 2023, NHSE published their '**Delivery plan for recovering access to primary care**'. The plan outlines the national ambitions for 2023-24 across General Practice and Community Pharmacy Primary Care services. It has two central ambitions: to tackle the 8am rush and reduce the number of people struggling to contact their practice and for patients to know on the day they contact their practice how their request will be managed.

## **2.8 Council of Governors**

There was a full COG on 12 May 2023 and the minutes of that meeting will shortly be available.

### ***Governor Focus Conference - NHS Providers***

On Tuesday 23<sup>rd</sup> May, two WHH Governors (and two corporate colleagues) attended a Governor Focus Conference hosted by NHS Providers at the Kia Oval in London. The conference was attended by 250 Governors from across the country and provided a valuable networking opportunity. Governors heard from several speakers, who covered a range of topics including national policy update, the role of Governors in diversity inclusion and health inequalities and the governors' role in a sustained crisis.

Governors were also asked to submit applications for a *Governor Showcase* to provide examples of creative ideas to promote, inspire, and acknowledge governors' role. The Trust's submission of the WHH Governor Handbook was selected for the Showcase. Governors received praise for the handbook as well as the Trust's forward-thinking approach to openness and transparency with Governors particularly the inclusivity of Governors in observing Committee meetings (and encouraged to provide reflective reports for the COG), observational visits and Walkabouts.

It is fair to say that the feedback from governors to their colleagues was that there was nothing talked about or referred to as good practice at this conference that we weren't doing at WHH. Indeed, further than that there was a lot of good practice at WHH that was a long way from being replicated at other trusts. While we cannot and will not be complacent and will continue to develop, we should also pause to acknowledge the huge amount of work that has established a demonstrably good situation.

### ***Governor Observation Visits***

There have been two observation visits in this period, the first on 23 April to the Warrington Discharge Suite, and the second on 16 May to Ward B4 on the Halton Campus. In both cases comprehensive reports were completed and have been taken forward for action by relevant Exec colleagues.

### ***Governors Q and A Sessions and Working Group***

Governors have held two, Q and A sessions with the Chair since the last meeting.

## **3. RECOMMENDATIONS**

The Trust Board is asked:

- i) To note and make any comments or ask any questions arising from the report.

## REPORT TO BOARD OF DIRECTORS

|   |   |  |                     |
|---|---|--|---------------------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/55</b>  |  |                     |
| <b>SUBJECT:</b>   | <b>Board Assurance Framework</b>  |  |                     |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |  |                     |
| <b>AUTHOR(S):</b>   | John Culshaw, Trust Secretary   |  |                     |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Simon Constable, Chief Executive  |  |                     |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.  |  | ✓                   |
|   | SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.   |  | ✓                   |
|   | SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.   |  | ✓                   |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | All   |  |                     |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.</p> <p>Since the last meeting:</p> <ul style="list-style-type: none"> <li>• It is proposed to add one new risk</li> <li>• The rating of one risk has been reduced and it is proposed to reduce the rating of three further risks</li> <li>• There have been no changes to the descriptions of any of the risks</li> <li>• No risks have been closed or de-escalated; however, it is proposed to de-escalate one risk to the Corporate Risk Register for continued monitoring.</li> </ul> <p>Notable updates to existing risks are also included in the paper.</p> |  |                     |
| <b>PURPOSE: (please select as appropriate)</b>  | Information   | Approval<br>✓  | To note<br>Decision |
| <b>RECOMMENDATION:</b>  | The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.   |  |                     |
| <b>PREVIOUSLY CONSIDERED BY:</b>  | <b>Committee</b>  | Quality Assurance Committee, Audit Committee, Finance & Sustainability Committee, Strategic People Committee |                     |
|   | <b>Agenda Ref.</b>  | Multiple   |                     |
|   | <b>Date of meeting</b>  | Multiple   |                     |
|   | <b>Summary of Outcome</b>   | Approved   |                     |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full  |  |                     |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>   | None  |  |                     |

## REPORT TO BOARD OF DIRECTORS

|                |   |                    |                    |
|----------------|---|--------------------|--------------------|
| <b>SUBJECT</b> | <b>Board Assurance Framework and Strategic Risk Register report</b> | <b>AGENDA REF:</b> | <b>BM/23/06/55</b> |
|----------------|---|--------------------|--------------------|

### 1. BACKGROUND/CONTEXT

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

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

### 2. KEY ELEMENTS

#### 2.1 New Risks

Following discussion at the Audit Committee and Risk Review Group it is proposed to add a new risk (detailed below) in relation to securing sufficient funding for a new hospital. It is proposed to add the risk at a rating of 12.

| ID  | Risk description   | Rating        | Executive Lead |
|-----|--|---------------|----------------|
| TBC | 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. | 12<br>(3 x 4) | Lucy Gardner   |

#### 2.2 Amendment to Risk Ratings

Since the last meeting the rating of one risk has been reduced and it is proposed to reduce the rating of three further risks.

##### Approved

Following a reduction in the number of cancelled elective procedures, a reduction in the number of patients treated in the corridor and currently no requirement to escalate to the Cath Lab, it was agreed at the Quality Assurance Committee on 11<sup>th</sup> April to reduce the rating of **risk #224** (detailed below) from 25 to 20 (L5xC4)

| ID  | Risk description   | Rating (previous) | Rating (current) | Executive Lead |
|-----|--|-------------------|------------------|----------------|
| 224 | If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and | 25                | 20               | Daniel Moore   |

|  |  |  |  |  |
|--|--|--|--|--|
|  | 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. |  |  |  |
|--|--|--|--|--|

### Proposed

#### 1. Risk #1215

In light of plans to address the capacity deficit, for example TIF, CDC, mutual aid, GIRFT, validation; it is proposed to reduce the risk rating from **25 to 20**.

| ID   | Risk description  | Rating (current) | Rating (proposed) | Executive Lead |
|------|---|------------------|-------------------|----------------|
| 1215 | If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. | 25               | 20                | Daniel Moore   |

#### 2. Risk #1275

The number of cases of COVID-19 has reduced and there are currently no outbreaks. As a consequence, the operational impact has reduced, and contact bays are not being closed. It is therefore proposed to reduce the rating from **16 to 9**

| ID   | Risk description  | Rating (current) | Rating (proposed) | Executive Lead            |
|------|---|------------------|-------------------|---------------------------|
| 1275 | If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. | 16               | 9                 | Kimberley Salmon-Jamieson |

#### 3. Risk #1846

Further to the additional controls that are now in place, it is proposed to reduce the rating of the risk from **16 to 12**.

| ID   | Risk description  | Rating (current) | Rating (proposed) | Executive Lead            |
|------|---|------------------|-------------------|---------------------------|
| 1846 | 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. | 16               | 9                 | Kimberley Salmon-Jamieson |

## 2.3 Amendments to descriptions

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

## 2.4 De-escalation of Risks

Since the last meeting, no risks have been closed or de-escalated; however, it is proposed to de-escalate one risk.

Further to the proposal to reduce the rating of **Risk #1275** in relation to the prevention of nosocomial infection as described in section 2.2, it is also proposed de-escalate the risk to the Corporate Risk Register for continued monitoring.

## 2.5 Existing Risks - Updates

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

| Risk ID | Strategic Risk   | Update since last Risk review   | Current Risk Rating | Impact of update on risk rating |
|---------|--|---|---------------------|---------------------------------|
| 1215    | If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm, failure to achieve constitutional standards and financial plans. | <p><u>Controls</u></p> <ul style="list-style-type: none"> <li>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.</li> <li>Recruitment to Dom Care ICAHT &amp; Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24</li> <li>Digital Validation commencing in May 2023 to improve data quality of the Trust waiting lists</li> </ul> <p><u>Assurances</u></p> <ul style="list-style-type: none"> <li>Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists.</li> <li>Planning round for 2023/24 activity plan in progress to achieve targets set in the guidance issued this year. Final submission due end of March 2023. This is triangulated with finance and workforce plans.</li> <li>GIRFT/Efficiency programme to increase theatre productivity and utilisation</li> </ul> <p><u>Gaps</u></p> <ul style="list-style-type: none"> <li>Operational planning guidance 2023/24 has indicated a movement away from Block to PBR, clarification of detail is awaiting</li> </ul> | 25                  | Proposed to reduce rating to 20 |

| 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. | <p><u>Controls</u></p> <ul style="list-style-type: none"> <li>Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&amp;E</li> <li>Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside.</li> <li>Work plan to reduce super stranded and o criteria to reside in 2023/24 is being finalised by the System Sustainability Group</li> </ul> <p><u>Assurances</u></p> <ul style="list-style-type: none"> <li>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</li> </ul> <p><u>Gaps in Controls</u></p> <ul style="list-style-type: none"> <li>Ongoing industrial action across a number of staffing groups including junior medical staff and nursing.</li> <li>Notified March 2023 of the potential closure of the 60 bedded Lilycross facility supporting transitional care capacity. If the closure takes place this will impact from the end of quarter 1 2023</li> </ul> <p><u>Gaps in Assurances</u></p> <ul style="list-style-type: none"> <li>Increase growth of higher acuity in types 1 &amp; 3 as a result of population need and lack of access to Primary Care</li> </ul> | 20                  | Rating reduced from 25 to 20    |
| 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.  | <p><u>Assurances</u></p> <ul style="list-style-type: none"> <li>21 new starter band 5 nurses to join the Emergency Department in July/August 2023</li> <li>Reduction in experienced midwife vacancies to 4.35 WTE in April 2023</li> <li>Reduction in turnover in Maternity (10% reduced over last 12 months to 19.07% April 2023)</li> <li>Reduction in agency spend April 2023 (£25K)</li> </ul> <p><u>Gaps</u></p> <ul style="list-style-type: none"> <li>15.48% turnover April 2023</li> </ul>   |                     |                                 |

| Risk ID | Strategic Risk  | Update since last Risk review   | Current Risk Rating | Impact of update on risk rating |
|---------|---|---|---------------------|---------------------------------|
| 134     | If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton | <p><u>Controls</u></p> <ul style="list-style-type: none"> <li>Capital &amp; Revenue Plans for 2023/24 approved by the Trust Board in March 2023</li> <li>Review of all aspects of 2023/24 operational plan to seek to improve financial forecast</li> <li>Weekly review at Finance Executive Team Meeting of CIP/GIRFT, activity, cost pressure and agency spend</li> <li>Capital &amp; Revenue Plans for 2023/24 approved by the Trust Board in March 2023 &amp; updated and approved by the Trust Board in May 2023</li> <li>Reviewed of all aspects of 2023/24 operational plan resulting in an improved finance forecast</li> <li>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 safety and CIP has been fully identified.</li> <li>Introducing process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance &amp; sustainability Committee</li> </ul> <p><u>Assurances</u></p> <ul style="list-style-type: none"> <li>Capital Plan 2022/23 delivered with £0.1m underspend subject to external audit</li> <li>2022/23 forecast achieved subject to external audit</li> <li>Not all cost pressures have been funded in plan for 2023/24</li> <li>Achieve ICS control total in 2022/23 (subject to external audit)</li> <li>Delivered 2022/23 Capital Plan (subject to external audit)</li> <li>C&amp;M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Overall, no change in WTE plan, however there is a plan to reduce agency and bank and increase substantive staffing.</li> </ul> | 20                  | No impact on risk rating        |
| 1114    | If we see increasing demands upon   | <p><u>Controls</u></p>  | 16                  | No impact                       |

| Risk ID | Strategic Risk  | Update since last Risk review   | Current Risk Rating | Impact of update on risk rating |
|---------|---|---|---------------------|---------------------------------|
|         | 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. | <ul style="list-style-type: none"> <li>Resolution of issues regarding security patches on 5 servers 2008 R2: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system &amp; Winscribe dictation system.</li> <li>Full migration off the end of life Office 2010 platform completed through the N365 deployment plan</li> </ul> <p><u>Gaps in Assurance</u></p> <ul style="list-style-type: none"> <li>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)</li> </ul> |                     | on risk rating                  |
| 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.   | <p><u>Controls</u></p> <ul style="list-style-type: none"> <li>Testing symptomatic patients on admission by using Lateral Flow device testing</li> <li>Planned procedure testing SOP just for higher risk patients</li> </ul> <p><u>Assurance</u></p> <ul style="list-style-type: none"> <li>Case numbers have reduced and there are no current outbreaks</li> </ul> <p><u>Gaps</u></p> <ul style="list-style-type: none"> <li>Low compliance with FFP3 fit testing requirement (48.01%)</li> </ul>  | 16                  | Proposed to reduce rating to 9  |
| 1846    | If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage   | <p><u>Controls</u></p> <ul style="list-style-type: none"> <li>The Trust is ensuring that for any babies who require testing, that this is carried out safely and in line with national best practice. This includes on site supervision provided by audiologists from an IQIPS accredited audiology service, for each ABR undertaken.</li> <li>Audiology services to participate in Cheshire and Mersey Peer Review process to ensure oversight and consistency of ABR results</li> <li>Auditory brain stem testing is carried out with commissioner support, with a contract variation in place.</li> </ul>  | 16                  | Proposed to reduce rating to 12 |

| 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  | <u>Gaps</u> <ul style="list-style-type: none"> <li>Threat to the delivery of capital schemes due to the lengthy process to obtain full design costs in an uncertain market.</li> <li>Updated Estates strategy in development</li> </ul>  | 15                  | No impact on risk rating        |
| 145     | If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. | <u>Assurances</u> <ul style="list-style-type: none"> <li>Full refresh of the Trust 5-year strategy complete</li> <li>Pace of pathology collaboration no longer poses such a significant risk to service delivery for WHH as challenges within histopathology are being addressed via mutual aid and recruitment.</li> </ul> <u>Controls</u> <ul style="list-style-type: none"> <li>Revised plans for CDC approved by Trust Board and national diagnostics team.</li> <li>Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation.</li> <li>Contractors appointed to commence the capital works for Health &amp; Wellbeing Hub.</li> <li>Full Business Case for Health &amp; Education Hub approved by Government.</li> <li>Strategy refresh completed and updated strategy for 2023/24 – 2024/25 presented to Trust Board for approval.</li> <li>Director of Strategy &amp; Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan.</li> <li>Adaptive Reserve Fund created with Warrington PLACE partners.</li> </ul> <u>Assurances Gaps</u> <ul style="list-style-type: none"> <li>Pace of Pathology collaboration enhances the risk to the Trust's delivery of Pathology services.</li> <li>Trust's capacity to deliver significant number of capital projects</li> </ul> | 12                  | No impact on risk rating        |

### 3 RECOMMENDATIONS

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

# Board Assurance Framework

| <b>Board Assurance Framework</b>   |                           |   |                             |                |               |               |                                    |
|--|---------------------------|---|-----------------------------|----------------|---------------|---------------|------------------------------------|
| 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               |
| 1215   | Daniel Moore              | If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.   | 1                           | 25 (5x5)       | 6 (3x2)       | TBC           | Quality Assurance Committee        |
| 224  | Daniel Moore              | If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. | 1                           | 20 (5x4)       | 8 (2x4)       | TBC           | Quality Assurance Committee        |
| 115  | Kimberley Salmon-Jamieson | If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.  | 1                           | 20 (5x4)       | 12 (4x3)      | TBC           | Quality Assurance Committee        |
| 134  | Andrea McGee              | If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton   | 3                           | 20 (5x4)       | 10 (5x2)      | TBC           | Finance & Sustainability Committee |
| 1134   | Michelle Cloney           | If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff   | 2                           | 20 (4x5)       | 8 (4x2)       | TBC           | Strategic People Committee         |
| 1114   | Paul Fitzsimmons          | If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.   | 1                           | 16 (4x4)       | 8 (2x4)       | TBC           | Finance & Sustainability Committee |

# Board Assurance Framework

|      |                           |   |   |          |            |     |                                    |
|------|---------------------------|---|---|----------|------------|-----|------------------------------------|
| 1275 | Kimberley Salmon-Jamieson | If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.   | 1 | 16 (4x4) | 5 (5x1)    | TBC | Quality Assurance Committee        |
| 1372 | Paul Fitzsimmons          | If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety   | 3 | 16 (4x4) | 8 (2x4)    | TBC | Finance & Sustainability Committee |
| 1757 | Michelle Cloney           | If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety  | 2 | 16 (4x4) | 8 (4x2)    | TBC | Strategic People Committee         |
| 1846 | Kimberley Salmon-Jamieson | If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage   | 1 | 16 (4x4) | 4 (1x4)    | TBC | Quality Assurance Committee        |
| 125  | Daniel Moore              | If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns  | 1 | 15 (3x5) | 10 (2 x 5) | TBC | Executive Management Team          |
| 145  | Simon Constable           | If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. | 3 | 12 (3x4) | 8 (4x2)    | TBC | Executive Management Team          |

Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.

Strategic Objective 2: We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future

Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

# Board Assurance Framework

## Risk Appetite Statement

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

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

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

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

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

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

### Quality

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

# Board Assurance Framework

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

## People

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

## Financial and Operational Sustainability

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

## Regulation

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

## Reputation

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

# Board Assurance Framework

| <b>Risk ID:</b>             | 1215   | <b>Executive Lead:</b> | Dan Moore | <b>Rating</b>   |          |  |  |   |  |       |        |         |    |
|-----------------------------|--|------------------------|-----------|-----------------|----------|--|--|---|--|-------|--------|---------|----|
| <b>Strategic Objective:</b> | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.  |                        |           |                 |          |  |  |   |  |       |        |         |    |
| <b>Risk Description:</b>    | 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.  |                        |           | <b>Initial:</b> | 25 (5x5) |  |  |   |  |       |        |         |    |
| <b>Assurance Details:</b>   | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>Clinical Services Oversight Group (CSOG) established</li> <li>Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery</li> <li>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.</li> <li>Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23.</li> <li>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.</li> <li>Waiting lists are reviewed through the Performance Review Group Weekly</li> <li>Workforce is continually reviewed to ensure that all wards and teams are staffed safely.</li> <li>Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery</li> <li>The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures.</li> <li>Capacity identified and being utilised with appropriate independent sector providers</li> <li>To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reserve programme of work.</li> <li>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 &amp; 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</li> <li>Clean/green pathways have been developed for those priority 2 patients (cancer &amp; urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward A5 on the Warrington site.</li> <li>Weekly theatre scheduling to ensure listing of patients in line with national guidance.</li> <li>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.</li> <li>Continue to specifically focus on and monitor patients waiting greater than 52 weeks &amp; 104 weeks</li> <li>Continue to ensure urgent cancers are prioritised in line with national guidance</li> <li>Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends.</li> <li>Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients</li> <li>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.</li> <li>Recruitment to Dom Care ICAHT &amp; Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24</li> <li>Digital Validation commencing in May 2023 to improve data quality of the Trust waiting lists</li> </ul> |                        |           | <b>Current:</b> | 25 (5x5) |  |  |   |  |       |        |         |    |
|                             |  |                        |           | <b>Target:</b>  | 6 (3x2)  |  |  |   |  |       |        |         |    |
|                             |  |                        |           |                 |          |  |  | <table border="1"> <thead> <tr> <th>Stage</th> <th>Rating</th> </tr> </thead> <tbody> <tr> <td>INITIAL</td> <td>25</td> </tr> <tr> <td>CURRENT</td> <td>25</td> </tr> <tr> <td>TARGET</td> <td>6</td> </tr> </tbody> </table> |  | Stage | Rating | INITIAL | 25 |
| Stage                       | Rating   |                        |           |                 |          |  |  |   |  |       |        |         |    |
| INITIAL                     | 25   |                        |           |                 |          |  |  |   |  |       |        |         |    |
| CURRENT                     | 25   |                        |           |                 |          |  |  |   |  |       |        |         |    |
| TARGET                      | 6  |                        |           |                 |          |  |  |   |  |       |        |         |    |

# Board Assurance Framework

|  |   |                                |                                   |                             |                               |
|--|---|--------------------------------|-----------------------------------|-----------------------------|-------------------------------|
|  | <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>All elective patients have been clinically reviewed and categorised in line with national guidance.</li> <li>New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.</li> <li>Post Anaesthetic Care Unit (PACU) operational from January 2021</li> <li>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.</li> <li>Same Day Emergency Care Centre (SDEC) opened in August 2022</li> <li>Bioquell Pods in ED live and operational</li> <li>Harm and waiting lists reported to Quality Assurance Committee, Finance &amp; Sustainability Committee and Patient Safety &amp; Clinical Effectiveness Sub-Committee.</li> <li>Additional ultrasound contract awarded and commenced in January 2022</li> <li>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</li> <li>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 &amp; recent review of the rate card payments</li> <li>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.</li> <li>Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists</li> <li>Planning round for 2023/24 activity plan in progress to achieve targets set in the guidance issued this year. Final submission due end of March 2023. This is triangulated with finance and workforce plans.</li> <li>GIRFT/Efficiency programme to increase theatre productivity and utilisation</li> </ul> |                                |                                   |                             |                               |
| <p><b>Controls &amp; Assurance Gaps:</b></p>             | <ul style="list-style-type: none"> <li>Capacity challenge with social workers to keep on top of demand and necessary patient assessments.</li> <li>Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility.</li> <li>Limited bed base within A5 elective footprint</li> <li>Operational planning guidance 2023/24 has indicated a movement away from Block to PBR, clarification of detail is awaiting.</li> </ul>   |                                |                                   |                             |                               |
| <p><b>Recommendation</b></p>                             | <p><b>Action Description</b></p>  | <p><b>Actions Required</b></p> | <p><b>Responsible Officer</b></p> | <p><b>Deadline Date</b></p> | <p><b>Completion Date</b></p> |
| <p>Working with wider system on wider sustainability</p> | <p>Recruit to Dom Care ICAHT &amp; Discharge Team posts</p>   | <p>Complete Recruitment</p>    | <p>Dan Moore</p>                  | <p>31/08/2023</p>           |                               |

# Board Assurance Framework

| <b>Risk ID:</b>             | 224  | <b>Executive Lead:</b> | Moore, Daniel | <b>Rating</b>  |           |          |       |         |    |          |    |          |    |         |    |        |   |
|-----------------------------|--|------------------------|---------------|--|-----------|----------|-------|---------|----|----------|----|----------|----|---------|----|--------|---|
| <b>Strategic Objective:</b> | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.  |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |
| <b>Risk Description:</b>    | 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   |                        |               | <b>Initial:</b>  | 16(4x4)   |          |       |         |    |          |    |          |    |         |    |        |   |
|                             |  |                        |               | <b>Current:</b>  | 20(5x4)   |          |       |         |    |          |    |          |    |         |    |        |   |
|                             |  |                        |               | <b>Target:</b>   | 8 (2 x 4) |          |       |         |    |          |    |          |    |         |    |        |   |
| <b>Assurance Details:</b>   | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day</li> <li>Discharge Lounge/Patient Flow Team/Silver Command</li> <li>ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing</li> <li>Private Ambulance Transport to complement patient providers in and out of hours</li> <li>FAU/Hub operational operating 5 days per week.</li> <li>Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint &amp; more cubicle space. This supports compliance with RCEM guidance.</li> <li>Increase IMC provided by the system such as the opening of the additional bedded capacity</li> <li>Increase IMC at home</li> <li>Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.</li> <li>Same Day Emergency Care Centre (SDEC) completed July 2022.</li> <li>Upgrade to Minor’s resulting in Oxygen points in all cubicles</li> <li>Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients</li> <li>ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised.</li> <li>Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly.</li> <li>Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED &amp; KPI Meetings</li> <li>Additional Senior Manager on call support a weekends</li> <li>Senior Dr at Triage Function</li> <li>Ward A10 opened as winter escalation capacity funded by the ICB.</li> <li>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.</li> <li>Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.</li> <li>Plans to co-locate ED Minors in the SDEC building to enhance patient pathways. The capital project is now agreed and set to be operational in April 23.</li> <li>Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter</li> <li>Virtual frailty ward, live from 1<sup>st</sup> February 2023, in line with national planning. This will help reduce admissions from care home to A&amp;E</li> <li>Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside</li> <li>Work plan to reduce super stranded and o criteria to reside in 2023/24 is being finalised by the System Sustainability Group</li> </ul> <p><b>Assurances</b></p> |                        |               | <table border="1"> <caption>Performance Metrics</caption> <thead> <tr> <th>Category</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>INITIAL</td> <td>16</td> </tr> <tr> <td>PREVIOUS</td> <td>16</td> </tr> <tr> <td>PREVIOUS</td> <td>25</td> </tr> <tr> <td>CURRENT</td> <td>20</td> </tr> <tr> <td>TARGET</td> <td>8</td> </tr> </tbody> </table> |           | Category | Value | INITIAL | 16 | PREVIOUS | 16 | PREVIOUS | 25 | CURRENT | 20 | TARGET | 8 |
| Category                    | Value  |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |
| INITIAL                     | 16   |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |
| PREVIOUS                    | 16   |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |
| PREVIOUS                    | 25   |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |
| CURRENT                     | 20   |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |
| TARGET                      | 8  |                        |               |  |           |          |       |         |    |          |    |          |    |         |    |        |   |

# Board Assurance Framework

|   |  |   |                            |                      |                        |
|---|--|---|----------------------------|----------------------|------------------------|
|   | <ul style="list-style-type: none"> <li>Systemwide relationships including social care, community, mental health and CCGs</li> <li>System actions agreed supporting the Winter Plan</li> <li>Redeveloped ED 'at a glance' dashboard</li> <li>Trust implemented NHS 111 allowing for directly bookable ED appointments</li> <li>Integrated discharge Team in place</li> <li>Respiratory Ambulatory Care Facility agreed by CCG</li> <li>Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved</li> <li>Reinstated CAU 24/7</li> <li>Non-Elective flow activity now above 2019/20 activity levels for type 1 &amp; 3</li> <li>Same Day Emergency Care Centre (SDEC) opened July 2022</li> <li>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</li> </ul> |   |                            |                      |                        |
| <b>Assurance Gaps:</b>  | <p><b>Gaps in Controls</b></p> <ul style="list-style-type: none"> <li>Staffing pressure created in part as a result of COVID-19 Global pandemic.</li> <li>Ongoing industrial action across a number of staffing groups including junior medical staff and nursing.</li> <li>Notified March 2023 of the potential closure of the 60 bedded Lilycross facility supporting transitional care capacity. If the closure takes place this will impact from the end of quarter 1 2023</li> </ul> <p><b>Gaps in Assurances</b></p> <ul style="list-style-type: none"> <li>Increase growth of higher acuity in types 1 &amp; 3 as a result of population need and lack of access to Primary Care</li> </ul>   |   |                            |                      |                        |
| <b>Recommendation</b>   | <b>Action Description</b>  | <b>Actions Required</b>   | <b>Responsible Officer</b> | <b>Deadline Date</b> | <b>Completion Date</b> |
| Continued Escalation of Breaches and Patients Requiring Admission | Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.  | Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.                | Field-Delaney, Sheila      | 30/06/2023           |                        |
| Ongoing Monitoring of the Emergency Access Standard               | ED Insight report<br>daily SITREP report<br>National report and benchmarking outcome<br>UEC north dashboard<br>Robust ongoing monitoring   | Ongoing monitoring of risk via daily report SITREP,<br>Daily Capacity and Demand report from 4* daily bed meetings.<br>Weekly PRG | Field-Delaney, Sheila      | 30/06/2023           |                        |

# Board Assurance Framework

| <b>Risk ID:</b>             | 115  | <b>Executive Lead:</b>  | Salmon-Jamieson, Kimberley | <b>Rating</b>  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
|-----------------------------|--|-------------------------|----------------------------|--|------------------------|--|----------|-------|---------|----|----------|----|----------|----|----------|----|---------|----|--------|----|
| <b>Strategic Objective:</b> | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.  |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| <b>Risk Description:</b>    | 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.   |                         |                            | <b>Initial:</b>  | 20 (5x4)               |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
|                             |  |                         |                            | <b>Current:</b>  | 20 (5x4)               |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
|                             |  |                         |                            | <b>Target:</b>   | 12 (4x3)               |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| <b>Assurance Details:</b>   | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG)</li> <li>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</li> <li>Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity</li> <li>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</li> <li>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</li> <li>Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making</li> <li>Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust</li> <li>Workforce plan in place, includes agency reduction plan</li> <li>Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team</li> </ul> <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>21 new starter band 5 nurses to join the Emergency Department in July/August 2023</li> <li>Reduction in experienced midwife vacancies to 4.35 WTE in April 2023</li> <li>Reduction in turnover in Maternity (10% reduced over last 12 months to 19.07% April 2023)</li> <li>Reduction in agency spend April 2023 (£25K)</li> <li>International Nurse recruitment in place</li> <li>Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead</li> <li>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</li> <li>Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift</li> <li>Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews, over recruitment plans approved</li> <li>Retention – Internal Transfer process in place for staff</li> </ul> |                         |                            | <table border="1"> <caption>Line Chart Data</caption> <thead> <tr> <th>Category</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>INITIAL</td> <td>20</td> </tr> <tr> <td>PREVIOUS</td> <td>25</td> </tr> <tr> <td>PREVIOUS</td> <td>20</td> </tr> <tr> <td>PREVIOUS</td> <td>16</td> </tr> <tr> <td>CURRENT</td> <td>20</td> </tr> <tr> <td>TARGET</td> <td>12</td> </tr> </tbody> </table> |                        |  | Category | Score | INITIAL | 20 | PREVIOUS | 25 | PREVIOUS | 20 | PREVIOUS | 16 | CURRENT | 20 | TARGET | 12 |
| Category                    | Score  |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| INITIAL                     | 20   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| PREVIOUS                    | 25   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| PREVIOUS                    | 20   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| PREVIOUS                    | 16   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| CURRENT                     | 20   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| TARGET                      | 12   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| <b>Assurance Gaps:</b>      | <ul style="list-style-type: none"> <li>Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need (E.g. B3, B4, A10, Catheter Laboratory)</li> <li>Increased staffing pressures experienced for prolonged periods</li> <li>Time to post when recruiting new staff</li> <li>15.48% turnover April 2023</li> <li>Predicted 60%-80% Band 6/7 Pharmacy vacancies</li> <li>National increase in nursing vacancies</li> <li>National increase in Allied Health Professional vacancies, particularly Occupational Therapists</li> </ul>   |                         |                            |  |                        |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |
| <b>Recommendation</b>       | <b>Action Description</b>  | <b>Actions Required</b> | <b>Responsible Officer</b> | <b>Deadline Date</b>   | <b>Completion Date</b> |  |          |       |         |    |          |    |          |    |          |    |         |    |        |    |

# Board Assurance Framework

|  |  |   |                    |                   |  |
|--|--|---|--------------------|-------------------|--|
| <p>Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.</p> | <p>Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.</p> | <p>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:</p> <ul style="list-style-type: none"> <li>• Domestic and international nursing recruitment</li> <li>• Position and plans for staff retention.</li> <li>• Planning for the future – succession planning and staff development.</li> <li>• 6/12 establishment reviews.</li> <li>• Triangulation of staffing position alongside patient safety measures.</li> </ul> | <p>Kennah, Ali</p> | <p>31/08/2023</p> |  |
|--|--|---|--------------------|-------------------|--|

# Board Assurance Framework

| <b>Risk ID:</b>             | 134   | <b>Executive Lead:</b> | McGee, Andrea | <b>Rating</b>   |          |          |        |         |    |         |    |        |    |
|-----------------------------|---|------------------------|---------------|---|----------|----------|--------|---------|----|---------|----|--------|----|
| <b>Strategic Objective:</b> | Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.   |                        |               |   |          |          |        |         |    |         |    |        |    |
| <b>Risk Description:</b>    | 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   |                        |               | <b>Initial:</b>   | 20 (5x4) |          |        |         |    |         |    |        |    |
|                             |   |                        |               | <b>Current:</b>   | 20 (5x4) |          |        |         |    |         |    |        |    |
|                             |   |                        |               | <b>Target:</b>  | 10 (5x2) |          |        |         |    |         |    |        |    |
| <b>Assurance Details:</b>   | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>• Core financial policies controls in place across the Trust</li> <li>• Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning</li> <li>• Weekly review at Finance Executive Team Meeting of CIP/GIRFT, activity, cost pressure and agency spend</li> <li>• Workshop undertaken with - Exec, CBU, Corporate to review 2022/23 cost pressures</li> <li>• Workshops undertaken 2022/2023 budget setting</li> <li>• Procurement/tender waiver training in place</li> <li>• Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed &amp; submitted by Cheshire &amp; Merseyside Health &amp; Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&amp;M</li> <li>• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years)</li> <li>• Latest guidance from MIAA Counter Fraud Team circulated</li> <li>• Counter Fraud campaign took place for national anti-fraud week in November 2022</li> <li>• Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&amp;SC introduced.</li> <li>• Appointed GIRFT Finance Lead and 3 Clinical Leads</li> <li>• Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022</li> <li>• CDC phase 2 application approved for £4.5m capital over three years</li> <li>• Capital &amp; Revenue Plans for 2023/24 approved by the Trust Board in March 2023 &amp; updated and approved by the Trust Board in May 2023</li> <li>• Introduced system of escalation where there are risks to CIP delivery</li> <li>• Reviewed of all aspects of 2023/24 operational plan resulting in an improved finance forecast</li> <li>• 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 safety and CIP has been fully identified.</li> <li>• Introducing process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance &amp; sustainability Committee</li> </ul> <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>• Achieve ICS control total in 2022/23 (subject to external audit)</li> <li>• Achieved Break Even in 2021/22</li> <li>• Delivered 2022/23 Capital Plan (subject to external audit)</li> <li>• Unqualified audit opinion (2021/22)</li> <li>• Completed MIAA Governance Checklist received by Audit Committee</li> <li>• 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.</li> </ul> |                        |               | <table border="1"> <thead> <tr> <th>Category</th> <th>Rating</th> </tr> </thead> <tbody> <tr> <td>INITIAL</td> <td>20</td> </tr> <tr> <td>CURRENT</td> <td>20</td> </tr> <tr> <td>TARGET</td> <td>10</td> </tr> </tbody> </table> |          | Category | Rating | INITIAL | 20 | CURRENT | 20 | TARGET | 10 |
| Category                    | Rating  |                        |               |   |          |          |        |         |    |         |    |        |    |
| INITIAL                     | 20  |                        |               |   |          |          |        |         |    |         |    |        |    |
| CURRENT                     | 20  |                        |               |   |          |          |        |         |    |         |    |        |    |
| TARGET                      | 10  |                        |               |   |          |          |        |         |    |         |    |        |    |

# Board Assurance Framework

|   | <ul style="list-style-type: none"> <li>Capital is reported monthly to F&amp;SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations.</li> <li>C&amp;M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Overall, no change in WTE plan, however there is a plan to reduce agency and bank and increase substantive staffing.</li> <li>HFMA self-assessment completed and audited.</li> <li>All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed.</li> <li>We have allocated CIP targets under an approved new methodology for 2023/24</li> </ul>  |  |                                   |               |                 |
|---|---|--|-----------------------------------|---------------|-----------------|
| <b>Control &amp; Assurance Gaps:</b>  | <ul style="list-style-type: none"> <li>Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position.</li> <li>No external funding support for Halton Healthy New Town or Warrington Hospital new build.</li> <li>Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine)</li> <li>Risk of unforeseen costs due to further COVID-19 / Flu surge / Industrial action</li> <li>Availability of social care to support the current super stranded position (currently c25% of bed base). Estimated annual cost of at least £11m</li> <li>Introduction of protocol for changing forecast outturn with the potential impact of restricting financial freedoms and access to capital.</li> <li>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</li> <li>Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan</li> <li>Currently developing operational plan for 2023/24 noting the significant overspend will impact on cash</li> <li>Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR</li> <li>Not all cost pressures have been funded in plan for 2023/24</li> <li>Risk to financial freedoms as the Trust has a deficit plan</li> <li>Sufficient cash available based on operational plan however, deterioration from plan represents a risk to cash.</li> </ul> |  |                                   |               |                 |
| Recommendation  | Action Description  | Actions Required   | Responsible Officer               | Deadline Date | Completion Date |
| Identify CIP to support delivery of the overall financial plan  | Identify CIP  | Establish Leadership and oversight with the Executive Medical Director and meeting with Care Groups. Joint reporting to F&SC | McGee, Andrea & Fitzsimmons, Paul | 30.06.2023    |                 |
| Monitor operational activity delivered under PbR as per plan  |   |  | Moore, Dan                        | 30.03.2024    |                 |
| Ensure additional capacity is closed in line with operational plan  |   |  | Moore, Dan                        | 30.03.2024    |                 |
| Risk Assessments and mitigation plans in place for funding requests and cost pressures not supported. Oversight process to be implemented | Identify unsupported funding requests and develop risk assessments and mitigation plans   | <ul style="list-style-type: none"> <li>Complete risk assessments and plans</li> <li>Implement process</li> </ul>             | Lead Executive                    | 31.05.2024    |                 |

# Board Assurance Framework

| <b>Risk ID:</b>                         | 1134  | <b>Executive Lead:</b> | Cloney, Michelle | <b>Rating</b>   |          |  |  |   |  |       |        |         |    |
|---|---|------------------------|------------------|-----------------|----------|--|--|---|--|-------|--------|---------|----|
| <b>Strategic Objective:</b>             | Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.   |                        |                  |                 |          |  |  |   |  |       |        |         |    |
| <b>Risk Description:</b>                | 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   |                        |                  | <b>Initial:</b> | 20 (4x5) |  |  |   |  |       |        |         |    |
| <b>Control &amp; Assurance Details:</b> | <p><b>Sickness Absence</b><br/>Sickness absence has decreased from 7.6% in December 2022 to 5.6% in February 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. The rolling 12-month sickness absence rate it 6.44% as at February 2023.</p> <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, update policy to be implemented April 2023.</li> <li>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.</li> <li>Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. These actions have all supported an increase in compliance with target being met September 2022 - December 2022.</li> <li>Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management,</li> <li>People Health and Wellbeing Group. The group have focused on understanding the Trust's absence reasons and reducing the volume of absences recorded as 'unknown'.</li> <li>Supporting Attendance Month - roadshows, drop-in sessions, comms and events to showcase the Trust's commitment to Supporting Attendance</li> <li>Focused welcome back conversation recording and internal audit</li> <li>Review of policy implementation in September 2022 internally with Trade Unions, staff and managers. Awaiting feedback from NHSE</li> </ul> <p><b>Assurance</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.82% in February 2023.</li> <li>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</li> <li>Actions to improve WBC compliance have all supported an increase in compliance with target being met September 2022 - December 2022.</li> </ul> <p><b>Turnover and Attraction</b></p> <ul style="list-style-type: none"> <li>Turnover in February 2023 was 15.98% compared to 15.87% in December 2022. Turnover of permanent staff in February 2023 was 14.73% compared to 14.84% in December 2022.</li> <li>Work-life balance continues to be the number one known reason people leave WHH, followed by retirement. A significant number of people delayed their retirement plans in 2020 and 2021, and we have now seen a significant</li> </ul> |                        |                  | <b>Current:</b> | 20 (4x5) |  |  |   |  |       |        |         |    |
|   |   |                        |                  | <b>Target:</b>  | 8 (4x2)  |  |  |   |  |       |        |         |    |
|   |   |                        |                  |                 |          |  |  | <table border="1"> <thead> <tr> <th>Stage</th> <th>Rating</th> </tr> </thead> <tbody> <tr> <td>INITIAL</td> <td>20</td> </tr> <tr> <td>CURRENT</td> <td>20</td> </tr> <tr> <td>TARGET</td> <td>8</td> </tr> </tbody> </table> |  | Stage | Rating | INITIAL | 20 |
| Stage                                   | Rating  |                        |                  |                 |          |  |  |   |  |       |        |         |    |
| INITIAL                                 | 20  |                        |                  |                 |          |  |  |   |  |       |        |         |    |
| CURRENT                                 | 20  |                        |                  |                 |          |  |  |   |  |       |        |         |    |
| TARGET                                  | 8   |                        |                  |                 |          |  |  |   |  |       |        |         |    |

# Board Assurance Framework

|  |   |  |
|--|---|--|
|  | <p>increase in the number of individuals choosing to retire, with some choosing to return to the workplace (retire and return) (these still count as a leaver)</p> <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>• Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted action. This information is available on the Trust Workforce Information Dashboard.</li> <li>• Rugby League Cares have been supporting WHH since July 2021</li> <li>• Grief and Menopause cafes</li> <li>• Social media accounts have been created to support recruitment attraction across a number of social media platforms</li> <li>• Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream</li> <li>• To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice. A dedicated area to supporting Agile/Flexible working is available on the extranet, and in April 2023, a summary of the survey will be provided to the Executive team, before further promotion of the various tools available for managers/employees.</li> </ul> <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>• The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.</li> <li>• 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.</li> </ul> <p><b>Temporary Staffing &amp; Agency spend</b></p> <p>Bank and Agency reliance in February 2023 was 17% compared to 15.84% in December 2022. Reasons for the variation can be attributed to sickness absence, high turnover and additional capacity.</p> <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>• The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: <ul style="list-style-type: none"> <li>○ ECF process for non-clinical vacancies approval</li> <li>○ ECF process for bank and agency temporary staffing pay spend approval</li> <li>○ Medical Rate Escalations approved by Medical Director</li> </ul> </li> <li>• A Resourcing Task and Finish group has been established to review any gaps identified through the Agency Controls best practice toolkit. This will support plans to work with agencies to ensure they are operating within controls and improve the use of the Trusts bank rather than agency staff.</li> </ul> <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>• Compliance against our processes and rate cards monitored through the Finance and Sustainability Committee</li> <li>• To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace the ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group. This report will be updated accordingly.</li> </ul> |  |
|--|---|--|

# Board Assurance Framework

| <b>Assurance Gaps:</b>   | <ul style="list-style-type: none"> <li>Sickness absence continues to be above target. This is reflective of sickness absence regionally</li> <li>Turnover continuing to be above target, review of actions to reduce and make impact</li> <li>Agency spend above previous years, definitive actions to be identified to reduce agency spend</li> <li>Compliance with NHSE Agency Rate card very low, need identified actions to support increase in compliance</li> <li>Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend</li> </ul> |   |                     |               |                 |
|--|--|---|---------------------|---------------|-----------------|
| Recommendation   | Action Description   | Actions Required  | Responsible Officer | Deadline Date | Completion Date |
| Develop Trust approach to agile working                                      | Establish a best practice toolkit, processes and policies to support agile working at WHH  | <ul style="list-style-type: none"> <li>Establishment of T&amp;F group</li> <li>Survey of organisation to identify best practice</li> <li>Review of national best practice recommendations</li> <li>Development of toolkit</li> </ul>  | Carl Roberts        | 31.03.2023    |                 |
| Establishment of Resourcing Task and Finish Group                            | Establishment of Resourcing Task and Finish group to review: agency cap, agency spend reduction, agency controls, retention and recruitment marketing  | <ul style="list-style-type: none"> <li>Establish group and ToR</li> <li>Establish governance structure for group to support reporting</li> <li>Establish action plan</li> </ul>   | Carl Roberts        | 31.03.2023    |                 |
| Develop a recruitment marketing approach to support retention and attraction | Develop a recruitment marketing approach to support retention and attraction to WHH. Initial specific focus on ED, Pharmacy and Maternity  | <ul style="list-style-type: none"> <li>Identify organisation that can provide recruitment marketing</li> <li>Develop recruitment marketing campaign and agreed timescales for implementation</li> </ul>   | Carl Roberts        | 31.05.2023    |                 |
| Establish action plan to reduce agency spend                                 | Through the resourcing Task and finish group, establish an action plan to reduce agency spend  | <ul style="list-style-type: none"> <li>Establish group and ToR</li> <li>Establish governance structure for group to support reporting</li> <li>Establish action plan to include:</li> <li>Assessment by Deputy Medical Director and Deputy Chief Nurse against a combined NHSE and East Lancs Best Practice Toolkit for controlling agency spend</li> <li>Development of recommendations and approaches to bring down agency costs including:</li> <li>Reduction in commission for long line bookings</li> <li>Walk down Medical and Dental agencies over a period of time; firstly, to within the 50% cap and then to close to the rate cap</li> <li>Implementation of tiering of agencies, offering priorities to agencies who are within rate cap</li> </ul> | Carl Roberts        | 31.03.2023    |                 |

# Board Assurance Framework

|  |  |   |  |  |  |
|--|--|---|--|--|--|
|  |  | <ul style="list-style-type: none"><li>• Implementation of check and challenge around agency use</li><li>• Review of Frameworks to ensure best service and value for money</li><li>• Development of a refined ECF process for Medical and Dental temporary staffing bookings is in development</li></ul> |  |  |  |
|--|--|---|--|--|--|

# Board Assurance Framework

|                             |  |                        |                   |  |          |
|-----------------------------|--|------------------------|-------------------|--|----------|
| <b>Risk ID:</b>             | 1114   | <b>Executive Lead:</b> | Fitzsimmons, Paul | <b>Rating</b>  |          |
| <b>Strategic Objective:</b> | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.  |                        |                   |  |          |
| <b>Risk Description:</b>    | 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.  |                        |                   | <b>Initial:</b>  | 20 (5x4) |
| <b>Assurance Details:</b>   | <p><b>Assurance:</b></p> <ul style="list-style-type: none"> <li>Risks for Cyber on risk register in line of national requirements of the DSPT &amp; NHS Digital</li> <li><b>Digital Governance Structure</b> including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The <b>Quality Assurance Committee report provides</b> assurance against all key security measures (i.e. Risks/GDPR/Data Security &amp; Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures).</li> <li><b>Digital annual IT audit</b> plan inclusive of ever-present overarching Data Security &amp; Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.</li> <li><b>Trust benchmarking</b> activities including Use of Resources reviews (Model Hospital).</li> <li>ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.</li> <li>Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021)</li> <li>Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital</li> <li>WHHT return for assurance re cyber security to NHS England</li> </ul> <p><b>Controls:</b></p> <ul style="list-style-type: none"> <li><b>Digital Operations Governance</b> 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.</li> <li>Active membership of the <b>Sustainability Transformation Partnership Cyber Group</b>.</li> <li><b>Digital Change Management</b> regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.</li> <li><b>Trust Data Quality</b> Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting <b>EPR Training</b> regime for new starters including doctor's rotation and annual mandatory training.</li> <li><b>Cyber Training</b> for the Trust Exec Board</li> <li>The use of automatic patching software to rollout security updates to devices.</li> <li>Existing external network traffic is monitored by NHS Digital for both HSCN &amp; Internet links.</li> <li>Resolution of issues regarding security patches on 5 servers 2008 R2: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system &amp; Winscribe dictation system.</li> <li>Full migration off the end of life Office 2010 platform completed through the N365 deployment plan</li> <li>Secondary secure backup at Halton Data Centre</li> <li>Remote devices no longer bypassing the web proxy</li> <li>Active Directory password set to expire again (covid working from home-related).</li> </ul> |                        |                   | <b>Current:</b>  | 16 (4x4) |
|                             |  |                        |                   | <b>Target:</b>   | 8 (2x4)  |
|                             |  |                        |                   | <p>The chart displays a score trend over five stages: INITIAL (20), PREVIOUS (16), PREVIOUS (20), CURRENT (16), and TARGET (8). The scores are represented by purple circles connected by a line, showing a downward trend from the initial score to the target score.</p> |          |

# Board Assurance Framework

|   | <ul style="list-style-type: none"> <li>Fully recruit to the Digital Service restructure Phase 1 restructure</li> <li>Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness.</li> <li>Local device (PC &amp; laptop) based firewalls now enabled</li> </ul>  |   |                     |               |                 |
|---|--|---|---------------------|---------------|-----------------|
| <b>Assurance Gaps:</b>  | <p><b>Gaps In Assurance:</b></p> <ul style="list-style-type: none"> <li>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)</li> <li>ITHealth Assurance Dashboard license expires this financial year</li> </ul> <p><b>Gaps In Controls:</b></p> <ul style="list-style-type: none"> <li>No real-time early warning of zero-day attacks due to the lack of network pattern matching software.</li> <li>Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need).</li> <li>Using generic logins staff usernames and passwords are stored in browser when selecting “remember me”</li> <li>No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21)</li> <li>Using SharePoint 2010 for the Hub</li> <li>Lack of process to check antivirus alerts in console. MIAA to review processes and tools</li> <li>Administrator accounts still have access to the Internet &amp; email, although only used when required (SIRO approved process, best solution between operational vs security)..</li> <li>No controls in place for Bluetooth connectivity.</li> <li>The extension of the mainstream support for SQL Server 2012 ended on 12 July 2022</li> <li>Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS</li> <li>Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server</li> <li>MFA on limited number of systems</li> <li>Limited 24/7 dedicated cyber cover</li> <li>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</li> <li>CISCO network requires a hardware refresh</li> <li>Version 7 of Clinisys Ice is end of life</li> </ul> |   |                     |               |                 |
| Recommendation  | Action Description   | Actions Required  | Responsible Officer | Deadline Date | Completion Date |
| <p>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.</p> <p>We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).</p> <p>[Delivers: Best Practice]</p> | Migrate all 2003 and 2008 servers to 2016.   | <ul style="list-style-type: none"> <li>Engage with the CBU's/Departments regarding migration and potential costs and plan migration.</li> <li>Migrate the servers to Windows Server 2016</li> <li>Extend Support for Windows Server 2008 until Feb 2022</li> </ul> <p>NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22.</p> <p>[All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers</p> | Deacon, Stephen     | 30/06/2023    |                 |

# Board Assurance Framework

|  |   |  |                    |            |  |
|--|---|--|--------------------|------------|--|
|  |   | and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]   |                    |            |  |
| Cisco Phase 2 upgrade to replace aging network equipment   | Approve the business case<br>Complete mini tender<br>Place orders in advance<br>Delivery of equipment<br>Install and configure equipment                      | Approve the business case<br>Complete mini tender<br>Place orders in advance<br>Delivery of equipment<br>Install and configure equipment   | Waterfield, Tracie | 31/05/2023 |  |
| Mitigations to be put in for ORMIS security issue  | Mitigations to be put in for ORMIS security issue   | To set up security groups to stop unauthorised access to the SQL database.   | Deacon, Stephen    | 31/05/2023 |  |
| Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward.<br><br>We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system. | Migrate/decommsion Server 2012 servers  | <ul style="list-style-type: none"> <li>Engage with the CBU's/Departments regarding migration and potential costs and plan migration.</li> <li>Migrate the servers to the latest Windows Server operating system or decommission them.</li> </ul> | Waterfield, Tracie | 31/10/2023 |  |
| Upgrade and enable DLP to enable USB read-only. Disabled as its crashing desktops, needs the ePO agent on the server to be upgraded.   | Upgrade and enable DLP  | Upgrade and enable DLP   | Waterfield, Tracie | 31/05/2023 |  |
| Renew ITHealth Assurance Dashboard   | Renew ITHealth Assurance Dashboard as this provides NHSD, Trust and ICB assurance regarding out Cyber Stance including NHS Digital's Cyber Security Bulletins | Obtain capital and renew the license   | Deacon, Stephen    | 31/05/2023 |  |
| Upgrade Clinisys Ice to the new version  | Upgrade Clinisys Ice to the new version   | Meet with Clinisys Ice regarding funding, contractual questions and V7 End of life   | Deacon, Stephen    | 31/05/2023 |  |

# Board Assurance Framework

|                                     |   |                           |                            |  |                        |
|-------------------------------------|---|---------------------------|----------------------------|--|------------------------|
| <b>Risk ID:</b>                     | 1275  | <b>Executive Lead:</b>    | Salmon-Jamieson, Kimberley |  |                        |
| <b>Strategic Objective:</b>         | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.   |                           |                            |  | <b>Rating</b>          |
| <b>Risk Description:</b>            | 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.   |                           |                            |  |                        |
| <b>Assurance Details:</b>           | <p><b>Controls</b></p> <p>Testing symptomatic patients on admission by using Lateral Flow device testing<br/>           Planned procedure testing SOP just for higher risk patients<br/>           Guidance for staff returning to on-site working (with positive results)<br/>           COVID-19 results processed daily<br/>           Agile working policy is in PLACE Information technology infrastructure is in place to support remote working.<br/>           Providing and maintaining a clean environment that facilitates the prevention and control of infections.<br/>           Communications through TWSB to staff reinforcing updates to Covid-19 SOPs.<br/>           Bioquell Pods now in place in ICU, ED and B18.<br/>           Cohorting of COVID-19 positive patients in place.<br/>           IPC Team liaison with clinical teams on AGP precautions (using the latest definitions)<br/>           IPC Team liaison with Patient Flow Team on patient placement<br/>           FFP3 fit testing programme in place.<br/>           Updates to Trust Guidance/SOPs in line with publication of national guidance and upload to the Hub<br/>           Attention focussed on isolation of immunosuppressed patients from 01/09/2022<br/>           Winter Respiratory Virus Testing &amp; Escalation Plan in place<br/>           Cleanliness Standards for Functional risks 1 and 2; 4 or 5 star ratings with 2-4 hour timescale to rectify issues<br/>           IPC Team and patient flow collaboration on optimal use of side rooms</p> <p><b>Assurance</b></p> <p>Case numbers have reduced and there are no current outbreaks<br/>           Trust completed learning from Nosocomial outbreaks sessions.<br/>           Outbreak meetings held with lessons learned shared across the Trust.<br/>           Updated IPC measures in place including the relaxation of mask wearing in certain areas of the Trust, a return to pre pandemic visiting arrangements and 1 relative/carer to accompany patients in the Emergency Department.<br/>           COVID-19 quality metrics in place.<br/>           Staff training in safe donning and doffing of PPE is included in mandatory training<br/>           Updated National Guidance in place from 1st September 2022<br/>           Working with NHSE to revise hand hygiene audits using QR codes and visitor reporting</p> |                           |                            |  |                        |
| <b>Assurance Gaps:</b>              | <p>Increased risk from return to pre-pandemic standards with removal of social distancing requirements, removal of universal masking and opening up visiting<br/>           Non-compliance with PPE<br/>           Site-wide assessment of ventilation (mechanical and manual) – action plan required to ensure all areas with mechanical ventilation are compliant with standards<br/>           Assurance on hand hygiene audits<br/>           Low compliance with FFP3 fit testing requirement (48.01%)</p>   |                           |                            |  |                        |
|                                     |   |                           |                            | <p>INITIAL PREVIOUS CURRENT TARGET</p> |                        |
| <b>Recommendation</b>               | <b>Action Description</b>   | <b>Actions Required</b>   | <b>Responsible Officer</b> | <b>Deadline Date</b>                   | <b>Completion Date</b> |
| Site-wide assessment of ventilation | action plan required to ensure all areas with mechanical ventilation are compliant with standards   | Production of action plan | Wright, Ian                | 31/08/23                               |                        |

# Board Assurance Framework

| <b>Risk ID:</b>             | 1372  | <b>Executive Lead:</b>  | Fitzsimmons, Paul          | <b>Rating</b>   |                        |       |        |         |    |         |    |        |   |
|-----------------------------|---|-------------------------|----------------------------|---|------------------------|-------|--------|---------|----|---------|----|--------|---|
| <b>Strategic Objective:</b> | Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.   |                         |                            |   |                        |       |        |         |    |         |    |        |   |
| <b>Risk Description:</b>    | 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   |                         |                            | <b>Initial:</b>   | 12 (3 x 4)             |       |        |         |    |         |    |        |   |
|                             |   |                         |                            | <b>Current:</b>   | 16 (4 x 4)             |       |        |         |    |         |    |        |   |
|                             |   |                         |                            | <b>Target:</b>  | 8 (2 x 4)              |       |        |         |    |         |    |        |   |
| <b>Assurance Details:</b>   | <p><b>Assurance:</b></p> <ul style="list-style-type: none"> <li>A revised OBC has received Trust Board approval in Feb 2023 in line with emerging guidance on managed convergence.</li> <li>Working with our partners STHK &amp; S&amp;O to finalise procurement timetable and align OBS timelines to deliver a partnership procurement</li> <li>MOU and Partnership Procurement Group in Place reporting to EPR Project Group (and escalation/assurance through Digital, FSC and Trust Board)</li> <li>Regular, documented conference calls with the ICS NHSE and NHSD – external partners supportive of managed convergence relaunch.</li> </ul> <p><b>Controls:</b></p> <ul style="list-style-type: none"> <li>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</li> <li>Trust financial modelling includes 3-year Lorenzo costs</li> <li>ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance.</li> <li>Senior Programme Manager assigned.</li> <li>Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs</li> <li>Identification of further realistic cash releasing benefits</li> </ul> |                         |                            | <table border="1"> <thead> <tr> <th>Stage</th> <th>Rating</th> </tr> </thead> <tbody> <tr> <td>INITIAL</td> <td>12</td> </tr> <tr> <td>CURRENT</td> <td>16</td> </tr> <tr> <td>TARGET</td> <td>8</td> </tr> </tbody> </table> |                        | Stage | Rating | INITIAL | 12 | CURRENT | 16 | TARGET | 8 |
| Stage                       | Rating  |                         |                            |   |                        |       |        |         |    |         |    |        |   |
| INITIAL                     | 12  |                         |                            |   |                        |       |        |         |    |         |    |        |   |
| CURRENT                     | 16  |                         |                            |   |                        |       |        |         |    |         |    |        |   |
| TARGET                      | 8   |                         |                            |   |                        |       |        |         |    |         |    |        |   |
| <b>Assurance Gaps:</b>      | <p><b>Gaps In Assurance:</b></p> <ul style="list-style-type: none"> <li>Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC</li> <li>ICS strategic approach to managing financial consequences of delivering managed convergence through partnership procurement remain unclear</li> </ul> <p><b>Gaps In Controls:</b></p> <ul style="list-style-type: none"> <li>Lorenzo is at end of life and is unlikely to see significant future development or enhancements</li> <li>Delay due to a re-launch of procurement to ensure compliance with managed convergence guidance puts the procurement process out of schedule with current national Digital funding programs resulting in as yet unresolved capital expenditure scheduling issues</li> <li>Any further delay due to delays incurred through nonalignment of timelines across the partnership procurement timetable risk procurement exceeding the approved funding period for the Lorenzo extension and/or the Lorenzo product withdrawal date</li> </ul>   |                         |                            |   |                        |       |        |         |    |         |    |        |   |
| <b>Recommendation</b>       | <b>Action Description</b>   | <b>Actions Required</b> | <b>Responsible Officer</b> | <b>Deadline Date</b>  | <b>Completion Date</b> |       |        |         |    |         |    |        |   |
|                             |   |                         |                            |   |                        |       |        |         |    |         |    |        |   |

# Board Assurance Framework

| <b>Risk ID:</b>  | 1757   | <b>Executive Lead:</b>   | Cloney, Michelle    |               |  |        |  |                 |            |                 |            |                |           |
|--|--|--|---------------------|---------------|--|--------|--|-----------------|------------|-----------------|------------|----------------|-----------|
| <b>Strategic Objective:</b>  | 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  |  |                     |               | <table border="1"> <tr> <th colspan="2">Rating</th> </tr> <tr> <td><b>Initial:</b></td> <td>16 (4 x 4)</td> </tr> <tr> <td><b>Current:</b></td> <td>16 (4 x 4)</td> </tr> <tr> <td><b>Target:</b></td> <td>8 (4 x 2)</td> </tr> </table> | Rating |  | <b>Initial:</b> | 16 (4 x 4) | <b>Current:</b> | 16 (4 x 4) | <b>Target:</b> | 8 (4 x 2) |
| Rating   |  |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| <b>Initial:</b>  | 16 (4 x 4)   |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| <b>Current:</b>  | 16 (4 x 4)   |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| <b>Target:</b>   | 8 (4 x 2)  |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| <b>Risk Description:</b>   | 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  |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| <b>Control &amp; Assurance Details:</b>                                    | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>Weekly IA Task and Finish group established from 28th October 2022 requiring representatives from across all departments to attend to plan for IA.</li> <li>Derogation list for required services drafted for review as required with Staff Side once notification of strike received.</li> <li>Weekly meetings with Staff Side established to manage partner relationships.</li> <li>Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible.</li> <li>IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH.</li> </ul> <p><b>Assurance</b></p> <ul style="list-style-type: none"> <li>Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.</li> <li>Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.</li> <li>Results received so far are that only Chartered Society of Physios have met IA threshold for WHH.</li> <li>Results for Junior Doctors have met the IA threshold IA planned for the 13-17 March 2023 - special March IA rate card agreed to support the Trust's response.</li> <li>AfC IA paused whilst decision made to accept/reject government offer</li> </ul> |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| <b>Assurance Gaps:</b>   | <ul style="list-style-type: none"> <li>Uncertain whether IA will be national or regional approach and potential impact for different unions. RCN approach is based on individual Trusts.</li> <li>Lack of clarity from the ICB regarding mutual aid</li> <li>Lack of MOU from ICB</li> </ul>   |  |                     |               |  |        |  |                 |            |                 |            |                |           |
| Recommendation   | Action Description   | Actions Required   | Responsible Officer | Deadline Date | Completion Date  |        |  |                 |            |                 |            |                |           |
| Weekly meeting with staff side chair and deputy                            | Weekly meeting with staff side chair and deputy to be diarised to take place with People Directorate in order to plan and update regarding Industrial Action   | Weekly meeting to be diarised to include People Directorate representatives and Staff Side                 | Hilton, Laura       | 31/05/2023    |  |        |  |                 |            |                 |            |                |           |
| Weekly Industrial Action Update to Execs                                   | Executive Management Team to receive weekly updates on Industrial Action   | Executive Management Team to receive weekly updates on Industrial Action                                   | Hilton, Laura       | 31/05/2023    |  |        |  |                 |            |                 |            |                |           |
| Set up Industrial Action task and finish group                             | To set up a Trust wide Industrial Action Task and Finish group to prepare for industrial action  | Identify key stakeholders<br>Set terms of reference and frequency of meeting<br>Set work plan              | Hilton, Laura       | 31/05/2023    |  |        |  |                 |            |                 |            |                |           |
| Participate in regional ICB Workforce Industrial Action preparedness group | Participate in regional ICB Workforce Industrial Action preparedness group   | Attending and participating in regional ICB Workforce Industrial Action preparedness group                 | Hilton, Laura       | 31/05/2023    |  |        |  |                 |            |                 |            |                |           |
| Clarify mutual aid and MOU approach from ICB                               | Communicate with ICB to clarify regional mutual aid and MOU approach   | Through HR and Emergency preparedness meetings with ICB, work to establish ICB mutual aid and MOU approach | Hilton, Laura       | 31/05/2023    |  |        |  |                 |            |                 |            |                |           |

# Board Assurance Framework

|   |  |  |                            |                      |                        |  |
|---|--|--|----------------------------|----------------------|------------------------|--|
| <b>Risk ID:</b>                                   | 1846   | <b>Executive Lead:</b>   | Salmon-Jamieson, Kimberley | <b>Rating</b>        |                        |  |
| <b>Strategic Objective:</b>                       | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.  |  |                            |                      |                        |  |
| <b>Risk Description:</b>                          | If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage  |  |                            | <b>Initial:</b>      | 16 (4x4)               |  |
|   |  |  |                            | <b>Current:</b>      | 16 (4x4)               |  |
|   |  |  |                            | <b>Target:</b>       | 4 (1 x 4)              |  |
| <b>Assurance Details:</b>                         | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>Allocation of the Patient Safety Project Director to lead the incident response.</li> <li>Appointment of an audiology Patient Safety Project Review Manager to prepare a comprehensive service review document and a whole project timeline.</li> <li>The Trust is ensuring that for any babies who require testing, that this is carried out safely and in line with national best practice. This includes on site supervision provided by audiologists from an IQIPS accredited audiology service, for each ABR undertaken.</li> <li>Allocation of technical support to maintain and effective waiting list and ongoing patient management tracking functionally.</li> <li>Operational support to action service change requirements.</li> <li>Audiology services to participate in Cheshire and Mersey Peer Review process to ensure oversight and consistency of ABR results</li> <li>Auditory brain stem testing is carried out with commissioner support, with a contract variation in place.</li> </ul> <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>WHH is working with Rochdale (Northern Care Alliance NHS Group) on the continuation of the ABR pathway and WHH staff training.</li> </ul> |  |                            |                      |                        |  |
| <b>Assurance Gaps:</b>                            | <p><b>Gaps in Controls</b></p> <p>The Trust is currently not providing auditory brain stem testing for new born babies.</p>  |  |                            |                      |                        |  |
| <b>Recommendation</b>                             | <b>Action Description</b>  | <b>Actions Required</b>  | <b>Responsible Officer</b> | <b>Deadline Date</b> | <b>Completion Date</b> |  |
| Full investigation to be carried out.             | A programme of works to be set out to enable the Trust to carry out a complete and concise investigation of ABR testing since 2018.  | An incident cell has been formed to oversee the actions required identified as part of the review. This requires the management of multiple stakeholders across local, regional and national bodies. In addition, there is the requirement to undertake a due diligence exercise for each baby who has had an ABR review since the beginning of 2018 up until 2/02/23. | Deborah Carter             | 31/07/2023           |                        |  |
| Pause of the Audiology Brain Stem Testing Service | Pause of the Audiology Brain Stem Testing Service  | Pausing of the audiology brain stem testing service.   | Deborah Carter             | 31/07/2023           |                        |  |
| Incident group to be set up.                      | A full service review to be undertaken of the audiology service.   | A full service review to be undertaken of the audiology service.   | Deborah Carter             | 31/06/2023           |                        |  |

# Board Assurance Framework

|                                       |   |  |                            |  |                        |  |
|---------------------------------------|---|--|----------------------------|--|------------------------|--|
| <b>Risk ID:</b>                       | 125   | <b>Executive Lead:</b>                 | Moore, Dan                 | <b>Rating</b>  |                        |  |
| <b>Strategic Objective:</b>           | Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.   |  |                            |  |                        |  |
| <b>Risk Description:</b>              | 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  |  |                            | <b>Initial:</b>  | 20 (5x4)               |  |
|                                       |   |  |                            | <b>Current:</b>  | 15 (3x5)               |  |
|                                       |   |  |                            | <b>Target:</b>   | 10 (2 x 5)             |  |
| <b>Assurance Details:</b>             | <p><b>Controls:</b><br/> Annual capital funding is allocated to business critical, mandated and statutory estates projects<br/> Planned Maintenance Program<br/> Reactive maintenance process<br/> Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance<br/> 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<br/> Capital Planning Group and associated capital funding allocation process<br/> Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments</p> <p><b>Assurance:</b><br/> Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers<br/> Non funded capital schemes are risk rated and monitored through the above group<br/> Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management<br/> PLACE assessment with subsequent action plan<br/> Capital Planning Group – determine how the trust capital is spent<br/> Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks<br/> Cleanliness monitoring identifies estates issues that are addressed through the estates building officer<br/> Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations<br/> Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills<br/> In September 2022 it has been confirmed that phase 1 of the CDC &amp; the Targetted Investment Fund (TIF) for delivery of elective recovery at the Halton site have both been approved. The capital builds in these cases will substantially increase diagnostic &amp; elective capacity for the Trust in the form of an additional Endoscopy room, a 5<sup>th</sup> Theatre as CSTM, a daycase unit and increased CT and MR capacity<br/> Updated Estates Strategy in development</p> |  |                            | <p>A line chart with four data points connected by a purple line. The points are labeled '20', '16', '15', and '4' from left to right. Below the chart, the labels 'INITIAL', 'PREVIOUS', 'CURRENT', and 'TARGET' are aligned with their respective data points.</p> |                        |  |
| <b>Assurance Gaps:</b>                | <p>Limited capital funding to address backlog<br/> Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM)<br/> Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers<br/> Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome<br/> Cost pressures – unfunded elements of unforeseen and emergency maintenance in I&amp;E budget<br/> Threat to the delivery of capital schemes due to the lengthy process to obtain full design costs in an uncertain market.</p>  |  |                            |  |                        |  |
| <b>Recommendation</b>                 | <b>Action Description</b>   | <b>Actions Required</b>                | <b>Responsible Officer</b> | <b>Deadline Date</b>   | <b>Completion Date</b> |  |
| Upgrade Warrington kitchen facilities | Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress   | Complete upgrade of kitchen facilities | Ian Wright                 | 30/06/2023   |                        |  |

# Board Assurance Framework

|   |  |   |            |            |  |
|---|--|---|------------|------------|--|
| Develop estates maintenance compliance monitoring tools | Integrate performance and compliance into routing estates maintenance operations | Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance and in turn improve compliance against recommended guidelines and internal KPIs | Ian Wright | 30/06/2023 |  |
| Develop new estates strategy                            | Update Estates Strategy  | Complete strategy update for approval   | Ian Wright | 31/08/2023 |  |

# Board Assurance Framework

| <b>Risk ID:</b>             | 145   | <b>Executive Lead:</b> | Constable, Simon | <table border="1"> <thead> <tr> <th colspan="2">Rating</th> </tr> </thead> <tbody> <tr> <td><b>Initial</b></td> <td>20 (5x4)</td> </tr> <tr> <td><b>Current</b></td> <td>12 (3x4)</td> </tr> <tr> <td><b>Target</b></td> <td>8 (4x2)</td> </tr> </tbody> </table>        |  | Rating   |       | <b>Initial</b> | 20 (5x4) | <b>Current</b> | 12 (3x4) | <b>Target</b> | 8 (4x2) |        |   |
|-----------------------------|---|------------------------|------------------|--|--|----------|-------|----------------|----------|----------------|----------|---------------|---------|--------|---|
| Rating                      |   |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| <b>Initial</b>              | 20 (5x4)  |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| <b>Current</b>              | 12 (3x4)  |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| <b>Target</b>               | 8 (4x2)   |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| <b>Strategic Objective:</b> | Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.   |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| <b>Risk Description:</b>    | 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.   |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| <b>Assurance Details:</b>   | <p><b>Controls</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>The Trust has developed effective clinical networking and integrated partnership arrangements.</li> <li>The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients.</li> <li>Council and PLACE Teams in both Warrington &amp; Halton supportive of development of new hospitals.</li> <li>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 &amp; Halton Health &amp; Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy &amp; Performance Board.</li> <li>Clinical strategies at Specialty level have been refreshed</li> <li>Breast Centre of Excellence opened. Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved.</li> <li>Pathology – Draft outline business case for pathology reconfiguration across Cheshire &amp; 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.</li> <li>Revised plans for CDC approved by Trust Board and national diagnostics team.</li> <li>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.</li> <li>Town Deal plan for Warrington approved. Included the proposed provision of a Health &amp; Wellbeing hub in the town centre and a Health &amp; Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health &amp; Wellbeing Hub and £1m for the Health &amp; Social Care Academy. Health &amp; Social Care Academy opened. - Full Business Case for the Health &amp; Wellbeing Hub approved by the Government. Contractors appointed to commence the capital works for Health &amp; Wellbeing Hub.</li> <li>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 &amp; Education Hub approved by Government.</li> <li>Strategy refresh completed and updated strategy for 2023/24 – 2024/25 presented to Trust Board for approval.</li> <li>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 &amp; Merseyside.</li> </ul> |                        |                  | <table border="1"> <thead> <tr> <th>Category</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>Initial</td> <td>20</td> </tr> <tr> <td>Previous</td> <td>15</td> </tr> <tr> <td>Current</td> <td>12</td> </tr> <tr> <td>Target</td> <td>8</td> </tr> </tbody> </table> |  | Category | Value | Initial        | 20       | Previous       | 15       | Current       | 12      | Target | 8 |
| Category                    | Value   |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| Initial                     | 20  |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| Previous                    | 15  |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| Current                     | 12  |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |
| Target                      | 8   |                        |                  |  |  |          |       |                |          |                |          |               |         |        |   |

# Board Assurance Framework

|   | <ul style="list-style-type: none"> <li>• Consistent Trust representation within Cheshire &amp; Merseyside ICS. WHH CEO appointed as lead for Clinical Pathways within C&amp;M and the Trust is playing an active role within the Cheshire &amp; Merseyside Acute &amp; Specialist Trust (CMAST) provider collaborative.</li> <li>• Trust representation on newly established place-based Boards within both Warrington &amp; Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected.</li> <li>• £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Drafts of both reviews complete.</li> <li>• Formal partnerships developed with key educational partners to enable tailored education &amp; training and research opportunities.</li> <li>• Director of Strategy &amp; Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan.</li> <li>• Adaptive Reserve Fund created with Warrington PLACE partners</li> <li>• Discussions with neighbouring Trusts to accelerate collaboration taking place</li> </ul> <p><b>Assurances</b></p> <ul style="list-style-type: none"> <li>• Regular Strategy updates are provided to the Council of Governors &amp; Trust Board</li> <li>• 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 &amp; Dietetics services. Halton Health Hub in Shopping City opened in November 2022.</li> <li>• Full refresh of the Trust 5-year strategy complete</li> <li>• 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.</li> <li>• 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.</li> </ul> |   |                            |                      |                        |
|---|--|---|----------------------------|----------------------|------------------------|
| <b>Assurance Gaps:</b>  | <ul style="list-style-type: none"> <li>• Self assessments of both Warrington &amp; 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.</li> <li>• Trust's capacity to deliver significant number of capital projects</li> </ul>  |   |                            |                      |                        |
| <b>Recommendation</b>   | <b>Action Description</b>  | <b>Actions Required</b>   | <b>Responsible Officer</b> | <b>Deadline Date</b> | <b>Completion Date</b> |
| Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level. | Participate in meetings and influence new governance development.  | Participate in meetings and influence new governance development. | Simon Constable            | 31/10/2023           |                        |
| Ensure sufficient capacity to deliver increased number of capital projects  | Undertake Gap Analysis of requirements vs resource   | Address any gaps identified                                       | Lucy Gardner & Dan Moore   | 31/08/2023           |                        |

**REPORT TO BOARD OF DIRECTORS**

|   |  |   |
|---|--|---|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/56</b>   |   |
| <b>SUBJECT:</b>   | <b>Integrated Performance Report</b>   |   |
| <b>DATE OF MEETING:</b>   | June 2023  |   |
| <b>AUTHOR(S):</b>   | Marie Garnett – Head of Contracts, Performance and Commercial Development<br>Bethan Thompson – Senior Performance and Systems Development Lead   |   |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Paul Fitzsimmons, Executive Medical Director<br>Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive<br>Michelle Cloney – Chief People Officer<br>Andrea McGee - Chief Finance Officer and Deputy Chief Executive<br>Dan Moore - Chief Operating Officer  |   |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.  | x |
|   | SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future  | x |
|   | SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.   | x |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | <p><b>#224</b> Failure to meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.</p> <p><b>#1215</b> Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm</p> <p><b>#1275</b> 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.</p> <p><b>#115</b> 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.</p> <p><b>#1289</b> Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm</p> <p><b>#134</b> Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.</p> <p><b>#1125</b> Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer, and ED Performance.</p> |   |

|  |  |  |              |          |
|--|--|--|--------------|----------|
| <b>EXECUTIVE SUMMARY<br/>(KEY ISSUES):</b>     | <p>The Trust has 82 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance over the last 7 months. <b>Table 1</b> sets out the “Assurance” and “Variation” of all indicators, of these, there are <b><u>10 indicators that are both failing and are a variation concern</u></b>, these are:</p> <p><b>Quality</b></p> <ul style="list-style-type: none"> <li>• Pressure Ulcers</li> <li>• Medication Safety Reconciliation within 24 hours</li> <li>• Staffing - Care Hours Per Patient Day (CHPPD)</li> </ul> <p><b>Access and Performance</b></p> <ul style="list-style-type: none"> <li>• Referral to treatment Open Pathways</li> <li>• A&amp;E Waiting Times – over 4 hours wait</li> <li>• Cancer 14 Days</li> <li>• Breast Symptoms 14 Days</li> <li>• Cancer 62 Days Urgent</li> <li>• Theatre Utilisation (measured as productive operating time only)</li> </ul> <p><b>Workforce</b></p> <ul style="list-style-type: none"> <li>• Bank and Agency Reliance</li> </ul> <p>The 2022/23 position closed at £7.9m deficit £2.5m worse than the £5.4m deficit control total with agreement from C&amp;M ICS and the national team. The Trust has submitted a £15.7m deficit plan for 2023/24. At Month 1 the plan is a £2.0m deficit, however the actual deficit was £2.5m with the overspend being due in the main to industrial action costs and continued escalation in A&amp;E. The position assumes no clawback of PBR relating to an underperformance on activity. At month 1 this is a risk of circa £1.2m.</p> |  |              |          |
| <b>PURPOSE: (please select as appropriate)</b> | Information  | Approval<br>X  | To note<br>X | Decision |
| <b>RECOMMENDATION:</b>                         | <p>The Trust Board is asked to:</p> <ol style="list-style-type: none"> <li>1. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive.</li> <li>2. Note the contents of this report.</li> </ol>   |  |              |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>               | <b>Committee</b>   | Finance and Sustainability Committee   |              |          |
|  | <b>Agenda Ref.</b>   |  |              |          |
|  | <b>Date of meeting</b>   |  |              |          |
|  | <b>Summary of Outcome</b>  | <ul style="list-style-type: none"> <li>• Capital Requests Supported</li> </ul> |              |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>   | Release Document in Full   |  |              |          |
| <b>FOIA EXEMPTIONS APPLIED:</b>                | Choose an item.  |  |              |          |

## REPORT TO BOARD OF DIRECTORS

|                |                               |                    |             |
|----------------|-------------------------------|--------------------|-------------|
| <b>SUBJECT</b> | Integrated Performance Report | <b>AGENDA REF:</b> | BM/23/06/56 |
|----------------|-------------------------------|--------------------|-------------|

### 1. BACKGROUND/CONTEXT

#### 1.1 IPR Indicators

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

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

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







- Quality
- Access and Performance
- Workforce
- Finance Sustainability



### 2. KEY ELEMENTS

#### 2.1 Making Data Count Assurance and Variation Categories

**Table 1** contains the number of IPR indicators in each Making Data Count “Assurance” and “Variation” category. **Table 2** contains the number of IPR indicators in each Making Data Count “Variation” category.

**Table 1: KPIs by Assurance and Variation Categories**

|   | <br><b>Special Variation of a Concerning Nature</b>  | <br><b>Common Cause Variation</b>   | <br><b>Special Variation of an Improving Nature</b> | <br><b>No SPC/Not Enough Datapoints/NA</b>  |
|---|---|--|--|--|
|   | <b>*CONSISTENTLY FAILING TARGET &amp; DECLINING PERFORMANCE</b>   | <b>*CONSISTENTLY FAILING TARGET &amp; VARYING PERFORMANCE</b>  | <b>*CONSISTENTLY FAILING TARGET &amp; IMPROVING PERFORMANCE</b>  | <b>*CONSISTENTLY FAILING TARGET &amp; NO SPC</b>   |
| <br><b>Consistently Fails the Target (based on the last 7 months)</b> | <b>Quality</b><br>12. Pressure Ulcers <b>(15 – 9 target)</b><br>13. Medication Safety <b>(38% - 80% target)</b><br>Reconciliation within 24 hours<br>15. Staffing - Care Hours Per Patient Day (CHPPD) <b>(7.9 – 7.8 target)</b><br><b>A&amp;P</b><br>35. Referral to treatment Open Pathways <b>(54% - 92% target)</b><br>36. A&E Waiting Times – over 4 hours <b>(68% - 75% target)</b><br>37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge <b>(19.1% - 2% target)</b><br>39. Cancer 14 Days <b>(69% - 93% target)</b><br>40. Breast Symptoms 14 Days <b>(13.73%, 93% target)</b><br>45. Cancer 62 Days Urgent <b>(51% - 85% target)</b><br>65. Theatre Utilisation <b>(73% - 85% target)</b><br><b>Workforce</b><br>71. Bank and Agency Reliance <b>(17% - 9% target)</b> | <b>Quality</b><br>21. Friends and Family (ED and UCC)<br>23. Sepsis - % screening for all emergency patients.<br>24. Sepsis - % screening for all inpatients<br>25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis to patients with red flag<br>26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis<br>33. MUST nutritional assessment completion<br><b>A&amp;P</b><br>34. Diagnostic Waiting Times 6 Weeks<br>47. Ambulance Handovers within 15 minutes<br>48. Ambulance Handovers within 30 minutes<br>49. Ambulance Handovers within 60 minutes<br>50. Discharge Summaries - % sent within 24hrs | <b>Workforce</b><br>68. Supporting Attendance<br>69. Retention<br>70. Turnover<br>73. Safeguarding Training<br>74. PDR                 | <b>Quality</b><br>31a. Maternity Pregnancy Bookings before 10 weeks<br>31b. Maternity Pregnancy Bookings before 13 weeks<br><b>A&amp;P</b><br>58. Elective Outpatient Activity<br><b>Finance</b><br>80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m) |
| <br><b>Inconsistently Passes/Fails the Target</b>                   | <b>*INCONSISTENTLY PASSING TARGET &amp; DECLINING PERFORMANCE</b>   | <b>INCONSISTENTLY PASSING TARGET &amp; VARYING PERFORMANCE</b>   | <b>INCONSISTENTLY PASSING TARGET &amp; IMPROVING PERFORMANCE</b>   | <b>INCONSISTENTLY PASSING TARGET &amp; NO SPC</b>  |
|   |   | <b>Quality</b><br>5. Healthcare Acquired Infections (CDI)<br>6. Healthcare Acquired Infections (Ecoli)<br>7. Healthcare Acquired Infections (Klebsiella)<br>10. VTE Assessment<br>11. Inpatient Falls & harm levels<br>14. Staffing - Average Fill Rate<br>28. Acute Kidney Injury<br><b>A&amp;P</b><br>41. 28 Day Faster Cancer Diagnosis Standard<br>51. Discharge Summaries - Number NOT sent in 7 days<br>62. Reduction in Outpatient Follow Ups compared to 19/20 activity  | <b>A&amp;P</b><br>59. Patients seen in the Fracture Clinic within 72 hours<br><b>Finance</b><br>78. Better Payment Practice Code       | <b>A&amp;P</b><br>77. Capital Programme (£m)   |

|  | <b>*CONSISTENTLY PASSING TARGET &amp; DECLINING PERFORMANCE</b>                                      | <b>CONSISTENTLY PASSING TARGET &amp; VARYING PERFORMANCE</b>   | <b>CONSISTENTLY PASSING TARGET &amp; IMPROVING PERFORMANCE</b>  | <b>CONSISTENTLY PASSING TARGET &amp; NO SPC</b>  |
|--|--|--|---|--|
| <br><b>Consistently Passes the Target (based on the last 7 months)</b> | <b>Quality</b><br>42. Cancer 31 Days First Treatment   | <b>Quality</b><br>1. Incidents<br>2. Duty of Candour (serious incidents)<br>8. Healthcare Acquired Infections (PA)<br>19. Complaints<br>20. Friends and Family (Inpatients & Day cases)<br>22. Mixed Sex Accommodation Breaches (Non ITU Only)<br><b>A&amp;P</b><br>43. Cancer 31 Days Subsequent Surgery<br>44. Cancer 31 Days Subsequent Drug<br>52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.<br>54. Urgent Operations Cancelled for 2nd Time | <b>Quality</b><br>3. Healthcare Acquired Infections (MRSA)<br>18. NICE Compliance<br><b>A&amp;P</b><br>46. Cancer 62 Days Screening<br>53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation<br><b>Workforce</b><br>72. Core/Mandatory Training | <b>Finance</b><br>76. Cash Balance (£m)<br>79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)   |
| <br><b>No SPC/Not Enough Datapoints/Not Applicable</b>                 | <b>*NO ASSURANCE SPC &amp; DECLINING PERFORMANCE</b><br><b>Quality</b><br>16. Mortality ratio - HSMR | <b>NO ASSURANCE SPC &amp; VARYING PERFORMANCE</b><br><b>Quality</b><br>4. Healthcare Acquired Infections (MSSA)<br>9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks<br>17. Mortality ratio - SHMI<br>32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))<br><b>A&amp;P</b><br>55. Super Stranded Patients<br>64. % Patients discharged to their usual place of residence  | <b>NO ASSURANCE SPC &amp; IMPROVING PERFORMANCE</b><br><b>Quality</b><br>38. Average time in department ED<br><b>A&amp;P</b><br>61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions<br>67. RTT - Number of patients waiting 65+ weeks                                     | <b>NO ASSURANCE SPC &amp; NO SPC</b><br><b>Quality</b><br>27. Ward Moves between 10pm and 6am<br>29. Maternity Postpartum Haemorrhage<br>30. Maternity 3rd and 4th Degree tears<br><b>A&amp;P</b><br>56. Elective Recovery Activity (Grouped SPCs)<br>57. Elective Recovery Diagnostic Activity<br>60. % patients referred to long COVID service not assessed within 15 weeks<br>63. COVID-19 Recovery Cancer First Treatment<br>66. Day case (measured as an aggregate of total cases)<br><b>Finance</b><br>75. Trust Financial Position (£m)<br>81. Agency Ceiling |

\*These areas are of a concerning nature due to either indicators not meeting (failing) their set target, or due to the declining nature of the performance

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 and Activity Statement for April 2023 is attached in **Appendix 5**.

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

- CIP delivery.
- Cost pressures – the Trust was unable to fund circa £8m cost pressures and has put in a process to oversee mitigation plans and risk management.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR) - during April 2023 elective activity has underperformed against plan by c£1.2m, however this income has been assumed in the position due to the impact of industrial action.
- A&E staffing pressures.
- Additional capacity open due to the levels of no criteria to reside patients.
- Cost of industrial action.

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

### **Cash**

The cash balance at the end of April is £32.3m, which is sufficient cash for the year provided the Trust delivers the plan.

### **CIP**

At 30 April 2023, the Trust has delivered a CIP of £0.6m against a target of £0.6m. The full year CIP target is £17.9m of which £13.8m has been identified (77%). However, of the £13.8m £11.4m is non recurrent CIP which is a significant issue of concern.

### **Capital Programme**

The Trusts capital programme of £23.5m is underspent at month 1 by £1m. This is mainly due to the timing of externally funded schemes and the minor delay in the implementation of new schemes whilst waiting for full approval of the Trust Plan. This is expected to catch up in the next 3 months. **Table 3** highlights the current contingency and four emergency requests that have been approved by the Chief Finance Officer and Deputy Chief Executive during April.

**Table 3: Capital Contingency**

| DETAIL                               | £'000 | £'000      |
|--------------------------------------|-------|------------|
| Contingency balance start of month 1 |       | 300        |
| Proposed changes in month            |       |            |
| Emergency request                    |       |            |
| Mortuary Transfer Vehicle            | - 56  |            |
| MRI Coil                             | -19   |            |
| Oto Acoustic Emissions Equipment     | -7    |            |
| Tympanometer                         | -10   |            |
| <b>Sub Total</b>                     |       | <b>-92</b> |
| Contingency as at end of month 1     |       | 208        |

A letter has been received from Cheshire and Merseyside ICS, advising that Trust Boards should put in place proportionate and appropriate controls to constrain expenditure until such time that an approved plan is agreed. The Trust plan has been supported by the ICS and plans have been submitted nationally. The Trust Board has signed off a new process to ensure that revenue requests are only supported if they relate to patient and/or staff safety, result in a cost reduction or can be self-funded. Any revenue requests approved by the Executive Team on this basis are reported the Finance and Sustainability Committee. (**Table 4**):

**Table 4: Revenue Requests supported by the Executive Team**

| Revenue Request   | Approval Date | Rationale   |
|---|---------------|---|
| Research Capability   | 02/05/2023    | Continuation of the Associate Director of Research position. The post has actively contributed to the generation of income at WHH and supported the CIP programme. This is not new expenditure and is self-funding from the research income generated.  |
| Communications and Engagement                                   | 11/05/2023    | The continuation of increased capacity within the communications and engagement team, at a reduced cost due to the elimination of the use of agency staff (£2,329 monthly cost saving).   |
| Power Tools Update  | 16/05/2023    | The provision of Trauma & Orthopaedic (T&O) power tools on the grounds of patient safety. The cost of the tools was already included in the Trust's 2023/24 plan with this request being for the maintenance of those tools. The preferred supplier remains the same with the inclusion of these maintenance costs. This will be funded from within the Planned Care Group. |
| Recruitment of Internationally Educated Occupational Therapists | 16/05/2023    | The Recruitment of four Internationally Educated Occupational Therapists utilising current vacancies. This recruitment is expected to reduce locum costs in the medium term.  |

The Trust Board is asked to:

- Note the revenue requests that have been supported by the Executive Team

### **3. ACTIONS REQUIRED/RESPONSIBLE OFFICER**

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

### **4. ASSURANCE COMMITTEE**

The following committees provide assurance to the Trust Board:

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

### **5. RECOMMENDATIONS**

The Trust Board is asked to:

1. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive.
2. Note the contents of this report.

# Statistical Process Control - Assurance & Variation

## Appendix 1

Key:

- Special Cause Variation of an 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

| QUALITY   | Latest                   |         |        |           | Previous |        | Assurance |
|---|--------------------------|---------|--------|-----------|----------|--------|-----------|
|   | Plan/Target              | Actual  | Period | Variation | Actual   | Period |           |
| 1. Incidents  | 0                        | 0       | Apr-23 |           | 0        | Mar-23 |           |
| 2. Duty of Candour (serious incidents)                                | 100.00%                  | 100.00% | Apr-23 |           | 100.00%  | Mar-23 |           |
| 3. Healthcare Acquired Infections (MRSA)                              | 0                        | 0       | Apr-23 |           | 0        | Mar-23 |           |
| 4. Healthcare Acquired Infections (MSSA)                              | No target set            | 1       | Apr-23 |           | 1        | Mar-23 |           |
| 5. Healthcare Acquired Infections (CDI)                               | Less than 36 for 2023/24 | 1       | Apr-23 |           | 3        | Mar-23 |           |
| 6. Healthcare Acquired Infections (Ecoli)                             | Less than 54 for 2023/24 | 8       | Apr-23 |           | 5        | Mar-23 |           |
| 7. Healthcare Acquired Infections (Klebsiella)                        | Less than 18 - annual    | 1       | Apr-23 |           | 0        | Mar-23 |           |
| 8. Healthcare Acquired Infections (PA)                                | Less than 2 - annual     | 0       | Apr-23 |           | 2        | Mar-23 |           |
| 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks | No target set            | 1       | Apr-23 |           | 0        | Mar-23 |           |

# Statistical Process Control - Assurance & Variation

## Appendix 1

Key:

- Special Cause Variation of an 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

|    |  |  |        |        |  |        |        |  |
|----|--|--|--------|--------|--|--------|--------|--|
| 10 | 10. VTE Assessment                                   | 95.00% (quarterly position)  | 95.39% | Apr-23 |  | 96.02% | Mar-23 |  |
| 11 | 11. Inpatient Falls & harm levels                    | 20% or more decrease from previous year (590 Inpatient Falls in 2021/22) | 34     | Apr-23 |  | 36     | Mar-23 |  |
| 12 | 12. Pressure Ulcers                                  | 10% reduction based on 91 in 2021/22                                     | 15     | Apr-23 |  | 10     | Mar-23 |  |
| 13 | 13. Medication Safety Reconciliation within 24 hours | 80.00%   | 38.00% | Apr-23 |  | 44.00% | Mar-23 |  |
| 14 | 14. Staffing - Average Fill Rate                     | 90.00%   | 97.77% | Apr-23 |  | 90.43% | Mar-23 |  |
| 15 | 15. Staffing - Care Hours Per Patient Day (CHPPD)    | 7.9  | 7.8    | Apr-23 |  | 7.4    | Mar-23 |  |
| 16 | 16. Mortality ratio - HSMR                           | No target set  | 93.55  | Apr-23 |  | 93.53  | Mar-23 |  |
| 17 | 17. Mortality ratio - SHMI                           | No target set  | 99.52  | Apr-23 |  | 97.41  | Mar-23 |  |
| 18 | 18. NICE Compliance                                  | 90.00%   | 91.79% | Apr-23 |  | 91.71% | Mar-23 |  |
| 19 | 19. Complaints                                       | Zero complaints open over 6 months old/in the backlog                    | 0      | Apr-23 |  | 0      | Mar-23 |  |
| 20 | 20. Friends and Family (Inpatients & Day cases)      | 95.00%   | 97.00% | Apr-23 |  | 96.00% | Mar-23 |  |

# Statistical Process Control - Assurance & Variation

## Appendix 1

Key:

- Special Cause Variation of an 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

|     |   |                          |        |        |  |        |        |  |
|-----|---|--------------------------|--------|--------|--|--------|--------|--|
| 21  | 21. Friends and Family (ED and UCC)   | 87.00%                   | 81.00% | Apr-23 |  | 75.00% | Mar-23 |  |
| 22  | 22. Mixed Sex Accommodation Breaches (Non ITU Only)   | 0                        | 0      | Apr-23 |  | 0      | Mar-23 |  |
| 23  | 23. Sepsis - % screening for all emergency patients.  | 90.00%                   | 72.00% | Apr-23 |  | 70.00% | Mar-23 |  |
| 24  | 24. Sepsis - % screening for all inpatients   | 90.00%                   | 80.00% | Apr-23 |  | 80.00% | Mar-23 |  |
| 25  | 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag | 90.00%                   | 84.00% | Apr-23 |  | 66.00% | Mar-23 |  |
| 26  | 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis                             | 90%                      | 84.00% | Apr-23 |  | 82.50% | Mar-23 |  |
| 27  | 27. Ward Moves between 10:00pm and 06:00am  | 0                        | 67     | Apr-23 |  | 67     | Mar-23 |  |
| 28  | 28. Acute Kidney Injury   | Less than previous month | 157    | Apr-23 |  | 194    | Mar-23 |  |
| 29  | 29. Maternity Postpartum Haemorrhage  | >1500ml                  | 2.43%  | Apr-23 |  | #N/A   | Mar-23 |  |
| 30  | 30. Maternity 3rd and 4th Degree tears  | <1.85%                   | 0.48%  | Apr-23 |  | #N/A   | Mar-23 |  |
| 31a | 31a. Maternity Pregnancy Bookings before 10 weeks   | 10-week Target: >75%     | 56%    | Apr-23 |  | 59%    | Mar-23 |  |

# Statistical Process Control - Assurance & Variation

## Appendix 1

Key:

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

\*based on the last 6 datapoints/months

|     |   |                      |     |        |  |     |        |  |
|-----|---|----------------------|-----|--------|--|-----|--------|--|
| 32b | 31b. Maternity Pregnancy Bookings before 13 weeks   | 13-week Target: >90% | 81% | Apr-23 |  | 83% | Mar-23 |  |
| 32  | 32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) | Best Practice Tariff | 7%  | Feb-23 |  | 11% | Dec-22 |  |
| 33  | 33. MUST nutritional assessment completion  | above > 85%          | 58% | Apr-23 |  | 50% | Mar-23 |  |

# Statistical Process Control - Assurance & Variation

## Appendix 1

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\*based on the last 6 datapoints/months

| ACCESS & PERFORMANCE  | Latest      |        |        |           | Previous |        | Assurance |
|---|-------------|--------|--------|-----------|----------|--------|-----------|
|   | Plan/Target | Actual | Period | Variation | Actual   | Period |           |
| 34. Diagnostic Waiting Times 6 Weeks  | 95.00%      | 74.40% | Apr-23 |           | 77.69%   | Mar-23 |           |
| 35. Referral to treatment Open Pathways   | 92.00%      | 54.25% | Apr-23 |           | 56.17%   | Mar-23 |           |
| 36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.        | 75%         | 67.85% | Apr-23 |           | 63%      | Mar-23 |           |
| 37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. | 2% or less  | 19.09% | Apr-23 |           | 21.4%    | Mar-23 |           |
| 38. Average time in department ED   | No Target   | 295    | Apr-23 |           | 411      | Mar-23 |           |
| 39. Cancer 14 Days  | 93%         | 69.48% | Mar-23 |           | 89.01%   | Feb-23 |           |
| 40. Breast Symptoms 14 Days   | 93%         | 13.73% | Mar-23 |           | 75.00%   | Feb-23 |           |
| 41. 28 Day Faster Cancer Diagnosis Standard   | 75%         | 73.16% | Mar-23 |           | 75.26%   | Feb-23 |           |
| 42. Cancer 31 Days First Treatment  | 96%         | 91.55% | Mar-23 |           | 98.44%   | Feb-23 |           |

# Statistical Process Control - Assurance & Variation

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\*based on the last 6 datapoints/months

|    |   |              |         |        |  |         |        |  |
|----|---|--------------|---------|--------|--|---------|--------|--|
| 43 | 43. Cancer 31 Days Subsequent Surgery   | 94%          | 100.00% | Mar-23 |  | 100.00% | Feb-23 |  |
| 44 | 44. Cancer 31 Days Subsequent Drug  | 98%          | 100.00% | Mar-23 |  | 100.00% | Feb-23 |  |
| 45 | 45. Cancer 62 Days Urgent   | 85%          | 50.52%  | Mar-23 |  | 58.51%  | Feb-23 |  |
| 46 | 46. Cancer 62 Days Screening  | 90%          | 100.00% | Mar-23 |  | 100.00% | Feb-23 |  |
| 47 | 47. Ambulance Handovers within 15 minutes   | 65%          | 46.64%  | Apr-23 |  | 34.84%  | Mar-23 |  |
| 48 | 48. Ambulance Handovers within 30 minutes   | 95%          | 73.26%  | Apr-23 |  | 61.57%  | Mar-23 |  |
| 49 | 49. Ambulance Handovers within 60 minutes   | 100%         | 80.48%  | Apr-23 |  | 70.57%  | Mar-23 |  |
| 50 | 50. Discharge Summaries - % sent within 24hrs   | 95%          | 89.98%  | Apr-23 |  | 88.71%  | Mar-23 |  |
| 51 | 51. Discharge Summaries - Number NOT sent within 7 days   | 0            | 0       | Apr-23 |  | 51      | Mar-23 |  |
| 52 | 52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting. | Less than 2% | 0.05%   | Apr-23 |  | 0.04%   | Mar-23 |  |

# Statistical Process Control - Assurance & Variation

## Appendix 1

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\*based on the last 6 datapoints/months

|    |   |  |         |        |  |         |        |  |
|----|---|--|---------|--------|--|---------|--------|--|
| 53 | 53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting. | 0  | 0.00%   | Apr-23 |  | 0.00%   | Mar-23 |  |
| 54 | 54. Urgent Operations Cancelled for 2nd Time  | 0  | 0       | Apr-23 |  | 0       | Mar-23 |  |
| 55 | 55. Super Stranded Patients   | Trajectory   | 132     | Apr-23 |  | 147     | Mar-23 |  |
| 56 | 56. Elective Recovery Activity (Grouped SPCs)   | 104% (aggregate) % activity is against activity in the same month in 2019/20 | 76.07%  | Apr-23 |  | 112.19% | Mar-23 |  |
| 57 | 57. Elective Recovery Diagnostic Activity   | 104% (aggregate) % activity is against activity in the same month in 2019/20 | 101.69% | Apr-23 |  | 120.83% | Mar-23 |  |
| 58 | 58. Elective Outpatient Activity  | 90%  | 73%     | Apr-23 |  | 100%    | Mar-23 |  |
| 59 | 59. Patients seen in the Fracture Clinic within 72 hours  | 95%  | 75%     | Apr-23 |  | 85%     | Mar-23 |  |
| 60 | 60. % patients referred to long COVID service not assessed within 15 weeks  | No Target set  | 0       | Apr-23 |  | 0       | Mar-23 |  |
| 61 | 61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions   | No Target set  | 85%     | Apr-23 |  | 85%     | Mar-23 |  |
| 62 | 62. Reduction in Outpatient Follow Ups compared to 19/20 activity   | 75% or less based on 2019/20 activity  | 73%     | Apr-23 |  | 100%    | Mar-23 |  |

# Statistical Process Control - Assurance & Variation

## Appendix 1

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\*based on the last 6 datapoints/months

|    |  |                      |      |        |  |     |        |  |
|----|--|----------------------|------|--------|--|-----|--------|--|
| 63 | 63. COVID-19 Recovery Cancer First Treatment                         | 100%                 | #N/A | Apr-23 |  | 0%  | Mar-23 |  |
| 64 | 64. % Patients discharged to their usual place of residence          | No Current Threshold | 95%  | Apr-23 |  | 94% | Mar-23 |  |
| 65 | 65. Theatre Utilisation (measured as productive operating time only) | 85%                  | 73%  | Apr-23 |  | 74% | Mar-23 |  |
| 66 | 66. Day case (measured as an aggregate of total cases)               | 85%                  | 86%  | Apr-23 |  | 86% | Mar-23 |  |
| 67 | 67. RTT - Number of patients waiting 65+ weeks                       | No Target set        | 423  | Apr-23 |  | 401 | Mar-23 |  |

# Statistical Process Control - Assurance & Variation

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\*based on the last 6 datapoints/months

| WORKFORCE                    | Latest      |        |        |           | Previous |        | Assurance |
|------------------------------|-------------|--------|--------|-----------|----------|--------|-----------|
|                              | Plan/Target | Actual | Period | Variation | Actual   | Period |           |
| 68. Supporting Attendance    | 4.20%       | 6.11%  | Apr-23 |           | 6.28%    | Mar-23 |           |
| 69. Retention                | 86.00%      | 84.74% | Apr-23 |           | 83.79%   | Mar-23 |           |
| 70. Turnover                 | Below 13%   | 15%    | Apr-23 |           | 15%      | Mar-23 |           |
| 71. Bank and Agency Reliance | 9% or Below | 16.95% | Apr-23 |           | 15.60%   | Mar-23 |           |
| 72. Core/Mandatory Training  | 85.00%      | 88.59% | Apr-23 |           | 87.46%   | Mar-23 |           |
| 73. Safeguarding Training    | Trajectory  | 81.46% | Apr-23 |           | 79.53%   | Mar-23 |           |
| 74. PDR                      | 85.00%      | 70.64% | Apr-23 |           | 68.93%   | Mar-23 |           |

# Statistical Process Control - Assurance & Variation

## Appendix 1

Key:

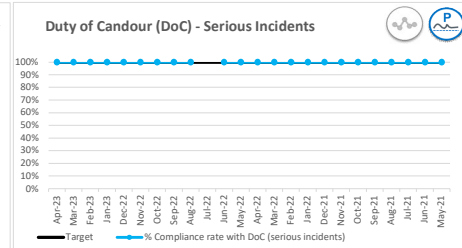
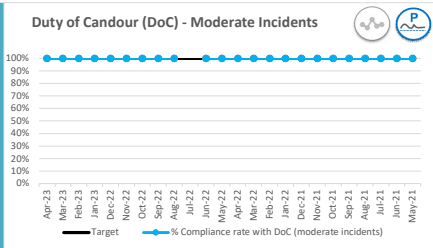
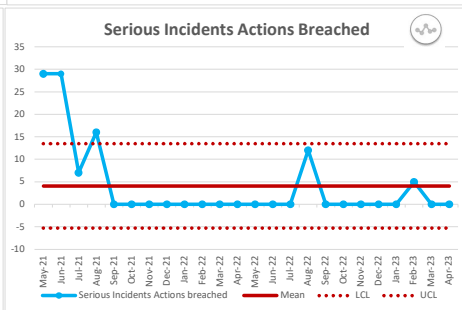
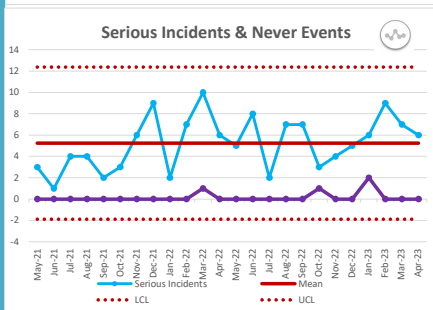
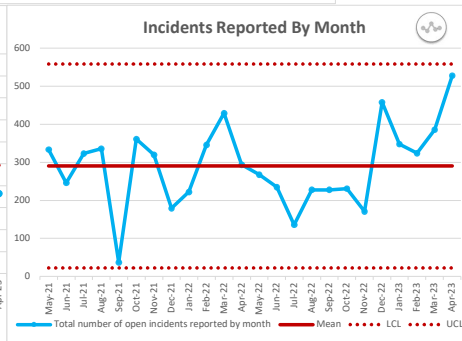
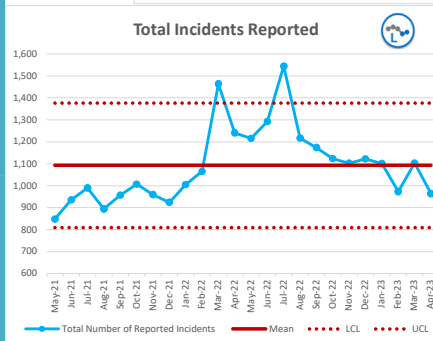
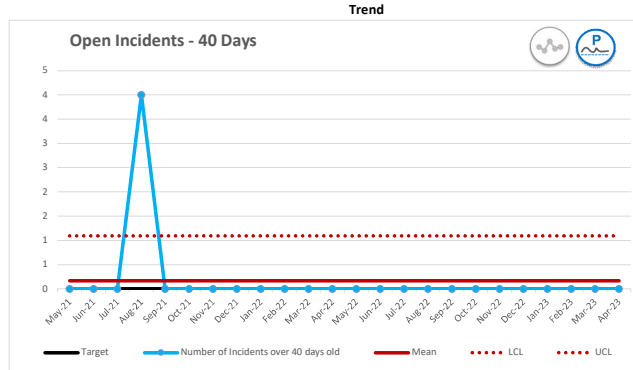
- Special Cause Variation of an improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target\*
- Inconsistently passes and fail the target\*
- Consistently fails the target\*

\*based on the last 6 datapoints/months

|   | Latest         |        |        |           | Previous |        | Assurance |
|---|----------------|--------|--------|-----------|----------|--------|-----------|
|   | Plan/Target    | Actual | Period | Variation | Actual   | Period |           |
| 75. Trust Financial Position (£m)   | 2.02           | -2.51  | Apr-23 |           | 0.19     | Mar-23 |           |
| 76. Cash Balance (£m)   | 30.30          | 32.35  | Apr-23 |           |          |        |           |
| 77. Capital Programme (£m)  | 1.56           | 0.52   | Apr-23 |           |          |        |           |
| 78. Better Payment Practice Code  | 95%            | 96%    | Apr-23 |           | 92%      | Mar-23 |           |
| 79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m) | 0.60           | 0.60   | Apr-23 |           |          |        |           |
| 80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m)          | 0.60           | 0.14   | Apr-23 |           |          |        |           |
| 81. Agency Ceiling  | Less than 3.7% | 5.3%   | Apr-23 |           | #N/A     | Mar-23 |           |

**Quality Improvement - Trust Position**

**Appendix 2** Trust Performance



1. Incidents (over 40 days)  
Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events

There were 0 incidents over 40 days old.

2. Duty of Candour (serious incidents)  
Target: 100%

The Trust achieved 100% for Duty of Candour in month.

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)?

Incident reporting remains within variation. The number of open incidents has increased when compared to last month - all have been reviewed within timeframe.

Assurance: The Trust consistently passes the target. There are 0 overdue 40-day incidents.

Variation: Common Cause (Normal) variation. There were 6 Serious Incidents reported in April 2023. A reduction of 1 when compared to March 2023. 1 Serious Incidents declared in Maternity, 2 x hospital acquired category 3 pressure ulcers (A7 and A6), 1 x ED, 1 x Breast.

There were 0 breached Serious Incident actions in April 2023.

A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each CBU is supported by a designated member of the governance team to ensure consistency.

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.

Weekly Safety Oversight Meeting continues for scrutiny and ratification.

Assurance: The Trust consistently passes the target. There is no variance, the Trust remains 100% compliant.

Variation: Common Cause (Normal) variation. Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.

**Quality Improvement - Trust Position**

**Appendix 2**

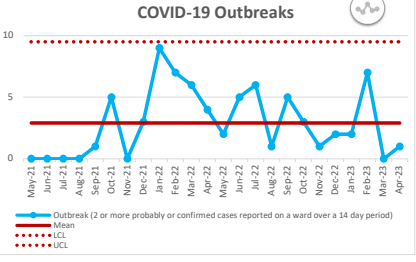
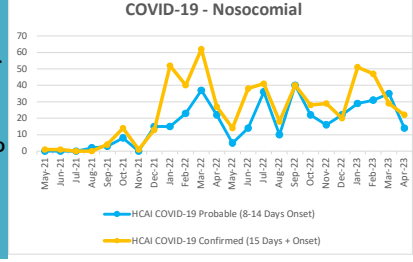
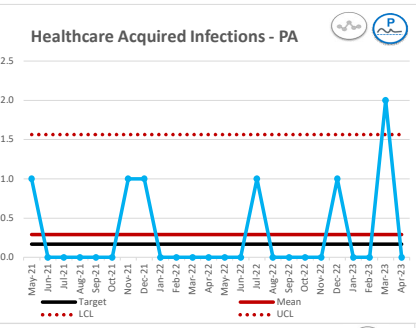
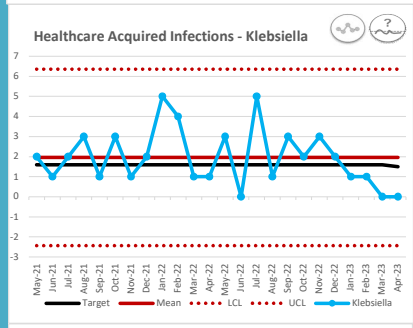
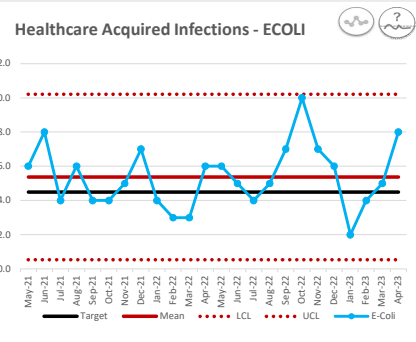
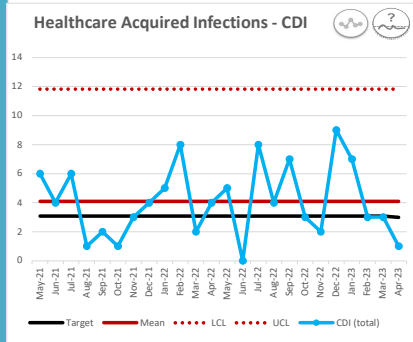
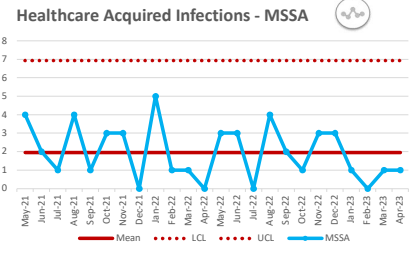
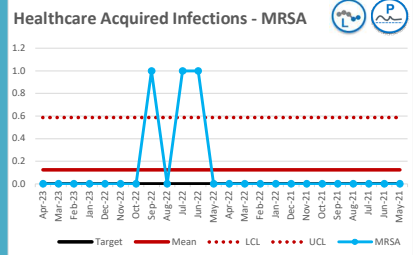
Trust Performance

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)?



**MRSA 0 cases over threshold**

**MSSA 1 cases YTD - no threshold set**

**CDI 1 cases YTD, annual threshold exceeded by 0 cases**

**E. coli 8 cases YTD (0 case(s) over the annual threshold)**

**Klebsiella spp. 0 cases YTD (0 cases over the annual threshold)**

**P. aeruginosa 0 cases YTD (0 cases over the annual threshold)**

**1 in month COVID-19 outbreak.**

**Covid-19:**  
14 day 8-14 cases probable healthcare associated cases YTD  
22 day 15+ cases definite healthcare associated YTD

**(MRSA) Assurance:**  
The Trust consistently passes the target.

**(MRSA) Variation:**  
Special Cause  
Variation of an improving nature.

**(CDI) Assurance:** N/A  
Annual Target

**(CDI) Variation:**  
Common Cause  
(Normal) variation.

**(ECOLI) Assurance:**  
N/A Annual Target

**(ECOLI) Variation:**  
Common Cause  
(Normal) variation.

**(K) Assurance:** N/A  
Annual Target

**(K) Variation:**  
Common Cause  
(Normal) variation.

**(PA) Assurance:** N/A  
Annual Target

**(PA) Variation:**  
Common Cause  
(Normal) variation.

**Assurance:** N/A - No target.

**Variation:** Common Cause  
(Normal) variation.

**MRSA:** Nil return for MRSA bacteraemia in April 23

**MSSA:** 1 Hospital onset case: Unknown source

**CDI:** Higher incidence of C. difficile across the northwest. WHH is not an outlier for case numbers/rates. Increase in antibiotic prescribing associated with respiratory infections following Covid-19/flu season.

**ECOLI:** Klebsiella: Pseudomonas aeruginosa: Mainly UTI associated, followed by hepatobiliary source cases for all GNBSI cases.

**COVID-19:** Revised national approach to testing. Winter season with increase in respiratory infections.

**MRSA:** MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise investigation template to align with PSIRF.

**CDI:** CDI prevention action plan in place. RCA investigations & review meetings will continue, approach will be aligned to PSIRF, SIGHT mnemonic education will continue, review of approach to auditing hand hygiene with NHSE, C. difficile study days in June.

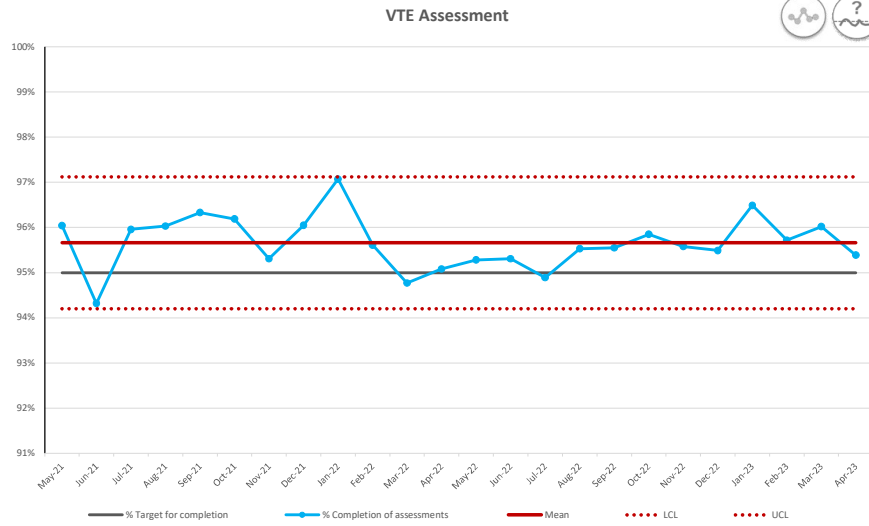
**ECOLI:** Klebsiella: Pseudomonas aeruginosa: Audit of hepatobiliary cases has commenced, revise GNBSI RCA template and re-introduce RCA investigation of hospital onset cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse removal, focus support on wards with higher UTI associated cases. Reconvene the GNBSI Prevention Group.

**COVID-19:** Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients, staff and visitors. The national requirements to report Covid-19 outbreaks remains in place.

**Quality Improvement - Trust Position**

**Appendix 2** Trust Performance

Trend



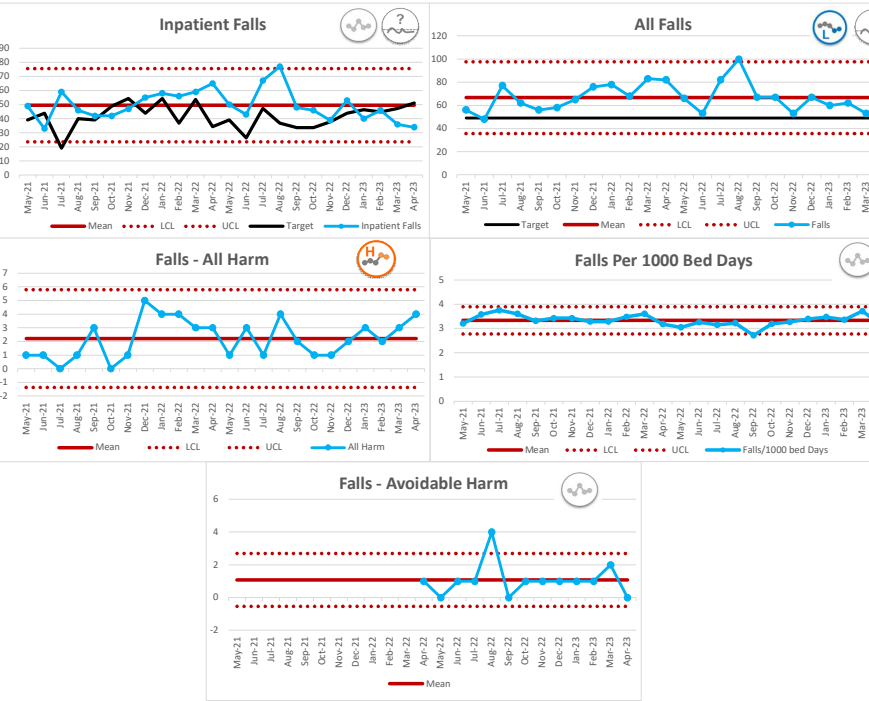
Statistical Narrative      What are the reasons for the variation and what is the impact?      How are we going to improve the position (Short & Long Term)?

10. VTE Assessment  
Target: 95% (quarterly position)

The Trust achieved the required target at 95.39% for VTE assessments in month.

**Assurance:** The Trust inconsistently passes/fails the target.  
**Variation:** Common Cause (Normal) variation.  
 Performance target threshold for financial year April 2022 - March 2023 has achieved 95.55%.

- Current systems in place to improve VTE compliance:
1. Inconsistent use of the standardised RWW CDC initial clinical assessment and ward round forms within the surgical specialties
  2. Monthly CBU VTE RA compliance data with the breakdown at the ward level has been distributed to all CBU governance meetings with the figures not completed at the ward level to sustain the performance.
  3. To continue to raise awareness of the need for VTE completion with the changeover of junior doctors into 2nd 4 month placement. Future proactive approach/plan to improve VTE compliance within 14 hours of admission:
    1. To get the feedback from all CBUs how to improve future CBU VTE risk assessment compliance.
    2. To add VTE risk assessment data to be visible at the ward level for ownership of overall VTE compliance. This was endorsed by PSCEC as an one of the improvement plans based on VTE report.



11. Inpatient Falls & harm levels  
Target: 20% or more decrease from 21/22 (590 inpatient falls in 2021/22)

60 total falls were reported in month. 34 of these were inpatient falls.

There has been a 11.67% increase from the previous month in Trust falls, and a decrease of 5.88% inpatient falls. There has been a decrease of 22 of Trust wide falls compared with same period last year.

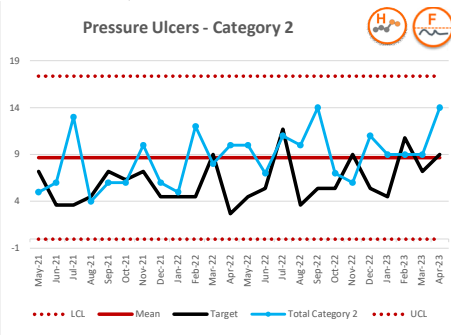
There were 4 falls in month with harm.

**Assurance:** The Trust inconsistently passes/fails the target.  
**Variation:** Common Cause (Normal) variation.  
 The 1 moderate harm fall occurred on B12 with a major fall noted on B3. B12 (wrist fracture) fall following review deemed as unavoidable. The fall on B3 was a periprosthetic fracture on a patient with a complex medical history. It is currently going through the governance investigation process.

- Actions to improve the position include:
1. 2 Falls workshops to take place in the Emergency Department in April supported by the Patient Safety Improvement Nurses (PSIN's) and Quality Academy staff.
  2. New video available to access for all staff which demonstrates falls prevention and awareness, positive feedback received.
  3. Ward reviews by the Patient Safety Improvement Nurses are undertaken to support the clinical areas.
  4. Senior oversight from the Associate Chief Nurses is in place with individual action plans monitored for areas of higher risk.

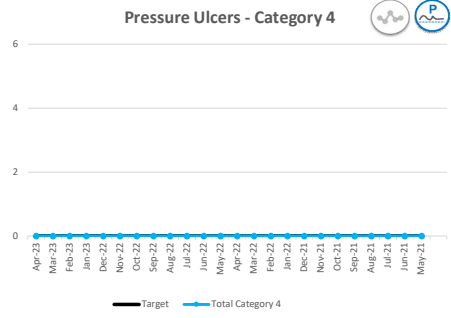
**Quality Improvement - Trust Position**

**Appendix 2** Trust Performance

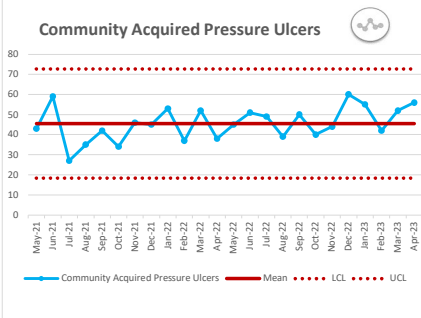
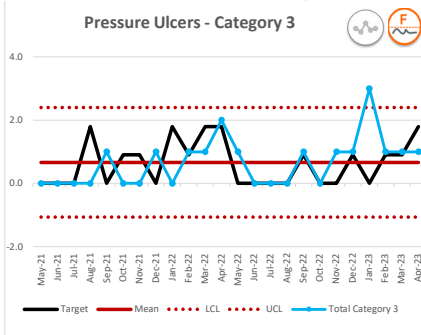


There were 14 hospital acquired category 2 pressure ulcers and 1 Category 3 pressure ulcer in month.

There were 56 community acquired pressure ulcers in month.



**Trend**



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

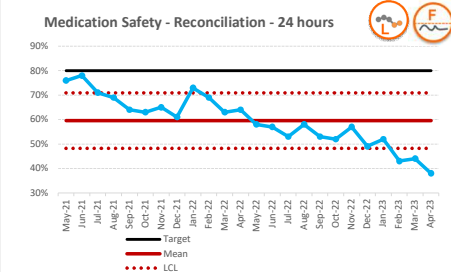
**Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of a concerning nature.

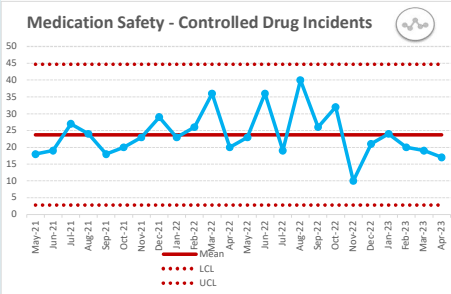
A delay in upgrading to pressure relieving mattress, incorrect risk assessment, prolonged time in ED and inadequate repositioning have been identified as contributory factors to pressure ulcer development in April. The unstageable pressure ulcer developed under a cast currently being investigated. Medical devices (TED stockings, NIV mask and nasal cannula) were a factor in 3 of the category 2 pressure ulcers.

**Actions to improve the position include:**

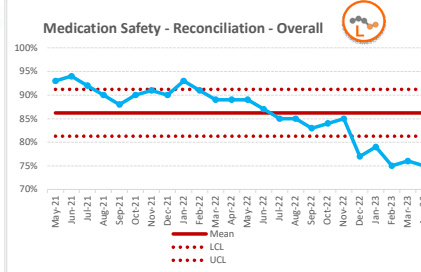
1. The Tissue Viability Nursing (TVN) Team continue to have an increased presence in the Emergency Department.
2. The QI Team support the Matrons to monitor the sustainability of the change package.
3. Face to face pressure ulcer prevention training is held monthly, the TVN Team also provide training on a monthly basis for preceptorship nurses and international nurses.
4. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management.
5. A workshop for pressure ulcer prevention to be held in May.
6. Monthly RCA meetings continue and lessons are shared with ward teams and via Operational Patient Safety Group.
7. Display posters circulated for prevention of damage to heels.
8. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.



Medicines reconciliation was completed within 24 hours of admission for 38% of patients. 75% 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:** Special Cause Variation of a concerning nature.

**Medicines reconciliation:** Performance out with national targets continues to be adversely impact by pharmacy workforce issues. Currently only 60% of established pharmacist posts filled.

**Medicines reconciliation:** Ongoing recruitment campaign and locum support. Shift from allocating pharmacists to named wards to a team based approach trialled in May 2023 to see whether delivers improvements against this metric.

**Controlled Drug Incidents:** There is no target for this metric. The most common type of incident was administration errors (n=5). No themes in the reported incidents were identified.

**Controlled Drug Incidents:** Monthly self-assessment and quarterly CD audits are undertaken. Themes identified and addressed with specific action plans. Support given to areas with poor compliance.

**Incidents with Harm:** There is no target for this metric.

**Incidents with Harm:** All medication incidents reviewed by governance and pharmacy team and lessons learned shared within the organisation.

12. Pressure Ulcers  
Target: 10% reduction based on 91 in 2021/22

13. Medication Safety  
Reconciliation within 24 hours  
Target: 80%

### Quality Improvement - Trust Position

#### Appendix 2 Trust Performance

In month, the average staffing fill rates were:

**Day (Nurses/Midwife)**  
90.5%  
**Day (Care Staff)**  
92.53%  
**Night (Nurses/Midwife)**  
95.71%  
**Night (Care Staff)**  
100.91%

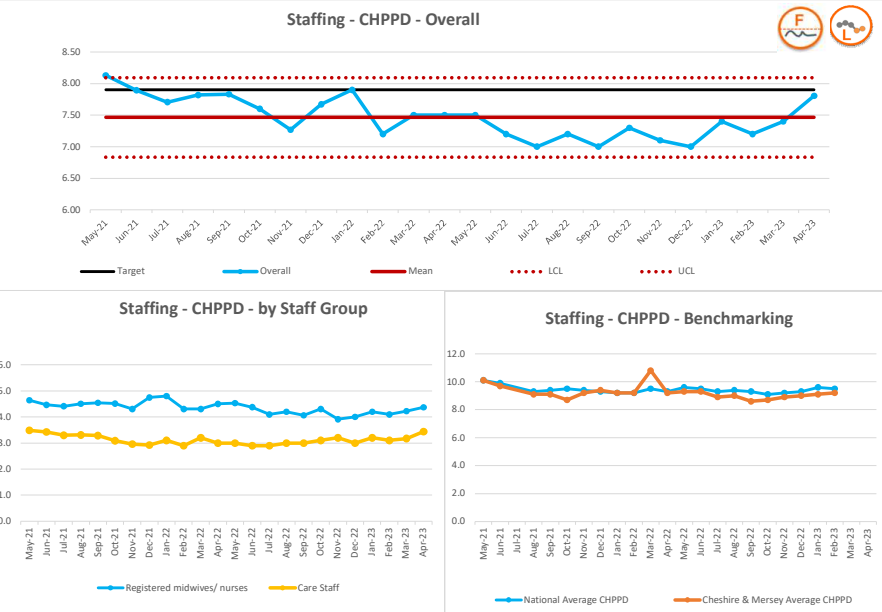
14. Staffing - Average Fill Rate  
Target: 90%



In month, the average CHPPD were:

**Nurse/Midwife: 4.4 hours**  
**Care Staff: 3.4 hours**  
**Overall: 7.8 hours**

15. Staffing - Care Hours Per Patient Day (CHPPD)  
Target: 7.9 CHPPD



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

Assurance: N/A Grouped Indicator  
Variation: N/A Grouped Indicator

Additional beds in use across the Trust due to increased demand in AED alongside acuity and a large number of super stranded patients and escalated beds open.

Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. A full staffing review has been completed overseen by the Chief Nurse, Deputy Chief Executive. A wards have senior nurse oversight by a matron and lead nurse. Vacancy trends are monitored through the Trust Workforce Review Group. Recruitment and retention plans are in place and overseas recruitment programmes continue. Specialist recruitment continues for hard to recruit areas with successes noted in Maternity. Bi-weekly shortlisting and interviews continue. A successful Trust recruitment event was held in May with 40 posts recruited to.

Assurance: The Trust consistently fails to hit the target.  
Variation: Special Cause Variation of a Concerning Nature.

The CHPPD data for April shows an improving position. Continued work on recruiting to vacancies, increased NHSP shift fill and the reduction of agency usage through the NHSP Agency Managed Service project.

Staffing is reviewed twice daily by the senior nursing team and acuity and activity is monitored to ensure safe patient care at all times. A recruitment and retention plan is in place monitored through the monthly Workforce Review Group chaired by the Deputy Chief Nurse. Registered Nurse vacancy is currently 145 with 106 in recruitment pipeline and a further 18 international nurses planned to commence induction in May. A plan to recruit a further cohort of international nurses is in place. HCSW vacancy is 51 with 37 in pipeline. 81 people attended the May recruitment event with 40 recruited.

**Quality Improvement - Trust Position**

**Appendix 2**


Trust Performance

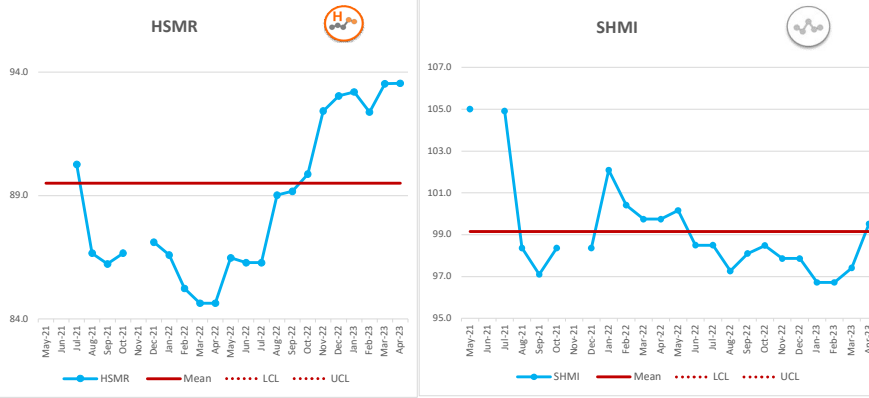
Trend

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)?

 **SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 93.55. The Summary Hospital Level Mortality Indicator (SHMI) ratio in month was 99.52.**

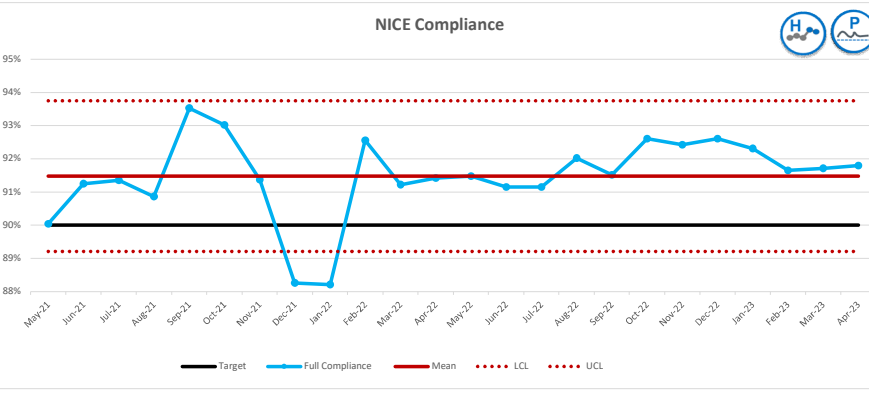


**N/A - No SPC/Target**

No variation. HSMR and SHMI remain within expected range. NB: The gaps in the SPC relate to the time periods whereby our external provider (HED) did not produce a report with the HSMR/SHMI. Standard SHMI calculations allow for out-of-hospital and in-hospital deaths but do not take recorded palliative care into account. HSMR takes recorded palliative care into account but only looks at in hospital deaths.

Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. Should an SJR be rated as poor / very poor care then an incident will be raised.

**The Trust achieved 91.79% in month.**



**Assurance: The Trust consistently passes the target.**

**Variation: Special Cause Variation of an improving nature.**

Performance against the target of 90% continues to be sustained.

The Clinical Effectiveness Manager continues to work closely with the CBUs with focus upon partial compliance and those 'under review' to ensure timeliness of progress and completion.

16. Mortality ratio - HSMR  
 Target: Plan

17. Mortality ratio - SHMI  
 Target: Plan

18. NICE Compliance  
 Target: 90%

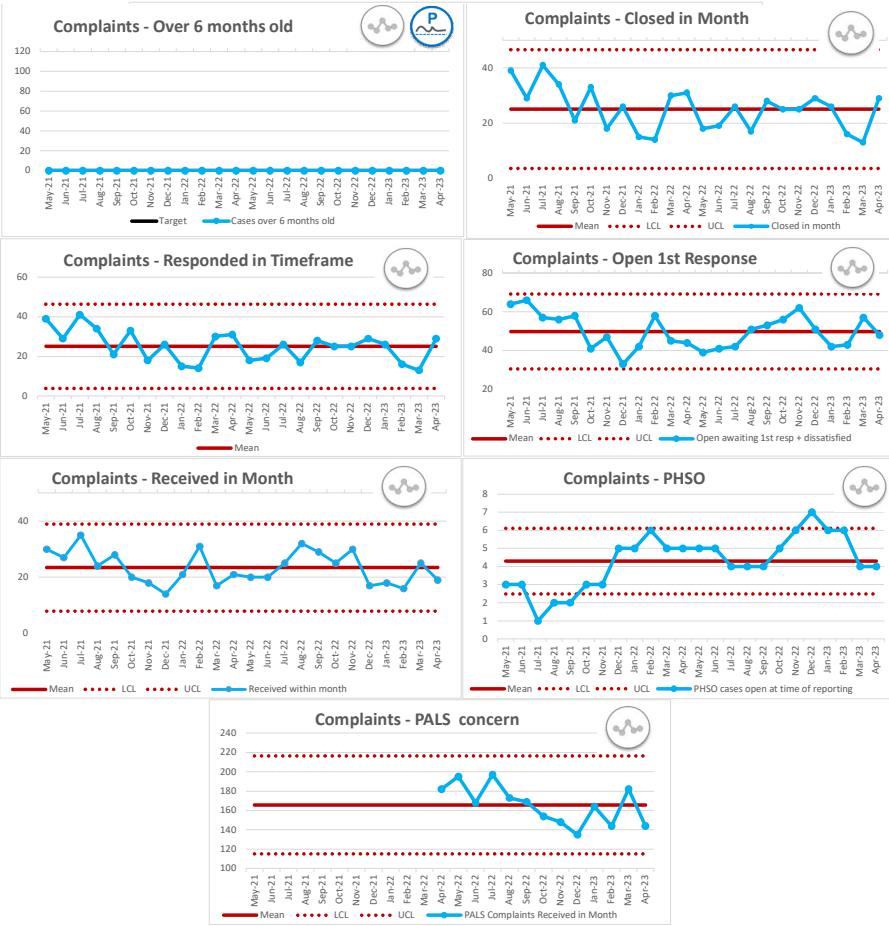
**Quality Improvement - Trust Position**

**Appendix 2** Trust Performance



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

In month, 19 new complaints were received to the Trust which was a decrease of 6 from the previous month. There were 2 dissatisfied complaints received in month, which is an increase from the previous month.



**Statistical Narrative**

**What are the reasons for the variation and what is the impact?**

**How are we going to improve the position (Short & Long Term)?**

**Assurance:** The Trust consistently passes the target. performance in the timely completion of complaints. There continues to be no complaints over 6 months old. There has been a significant increase of the number of complaints closed in month compared to the previous month and the complaints team and wider Trust are working hard to sustain this position.

**Variation:** Common Cause (Normal) variation.

**How are we going to improve the position (Short & Long Term)?** All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams. All CBUs have a designated complaints case handler to ensure consistency.

## Quality Improvement - Trust Position

### Appendix 2 Trust Performance



20. Friends and Family (Inpatients & Day cases)  
Target: 95%

21. Friends and Family (ED and UCC)  
Target: 87%

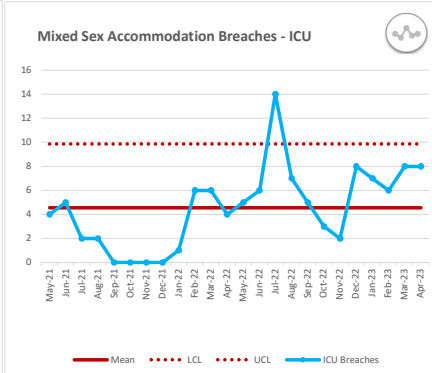
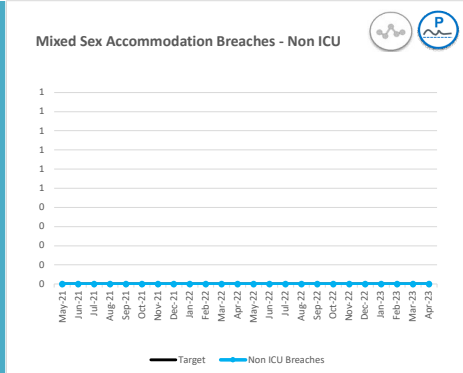
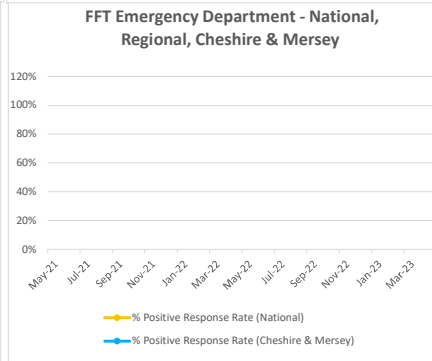
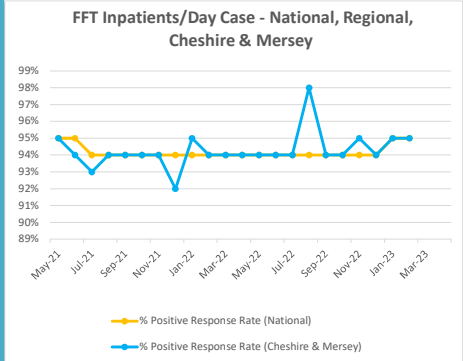
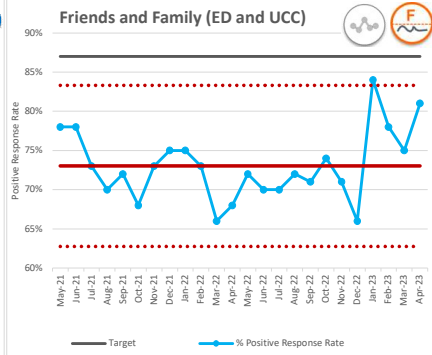
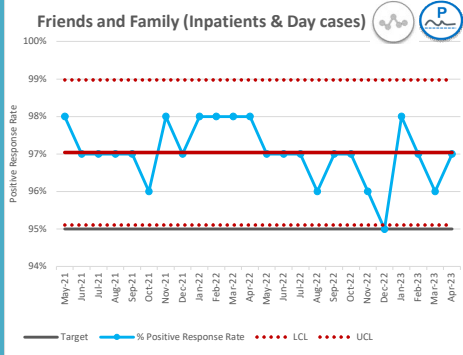
The Trust achieved 97% in month for Inpatient & Day case FFT and 81% for ED/UCC FFT.

The most recent National average for FFT was 95% and for C&M was 95%.

22. Mixed Sex Accommodation Breaches (Non ITU Only)  
Target: Zero

There were 0 mixed sex accommodation incidents outside of the ITU in month. There were 8 MSA incidents within the ITU.

#### 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)?

(IP/DC) Assurance: The Trust consistently passes the target.

(IP/DC) Variation: Common Cause (Normal) variation.

(ED/UCC) Assurance: The Trust consistently fails the target.

(ED/UCC) Variation: Common Cause (Normal) variation.

ED/UCC - The Trust achieved 81.00% positive feedback in Friends and Family Test results in April 2023. This data is within range of ED FFT performance across the Cheshire and Merseyside footprint with recent data from February 2023 of a recommendation rate of 78%. The Patient Experience and Inclusion team and the senior nursing in the emergency team are continuing to focus on communication, both written and verbal and reviewing documentation to ensure this is taking place effectively.

Inpatient/Day Case - The Trust achieved 97.00% positive recommendation rate in April 2023.

ED/UCC - Key themes for improvement in relation to positive recommendation rates continue with communication and wait times. This is perpetuated by the super stranded position within the Trust and the increased attendees. Measures taken to improve patient experience within the Emergency Department include but are not limited to:

- Work commenced to review communication on notice boards within the department with regards to what patients should expect whilst in the department and the support available.
- Donations of dignity bags for patients have been made for the Emergency Department which will commence now in June 2023. The bags will include basic hygiene products.
- The Senior Nursing Team have commenced documentation audits to ensure basic communication is satisfactory with patients e.g. use of 'Hello my name is'.

Inpatient/Day Case - Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients.

Assurance: The Trust consistently passes the target.

Variation: Common Cause (Normal) variation.

There were 8 mixed sex accommodation breach reported in April 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.

Work is underway in the Unplanned Care Group in relation to ongoing patient flow to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each bed meeting. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.

**Quality Improvement - Trust Position**

**Appendix 2** Trust Performance

Trend

Statistical Narrative

What are the reasons for the variation and what is the impact?

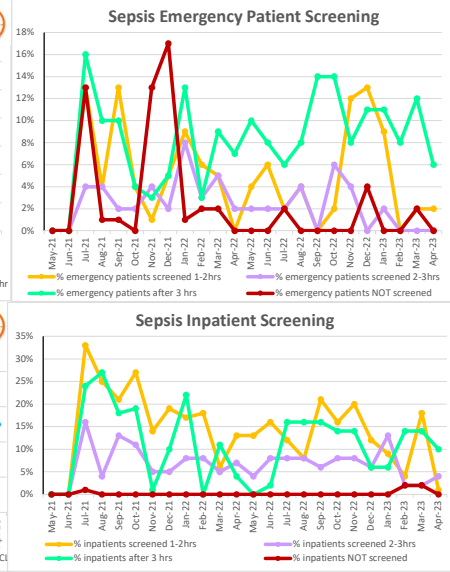
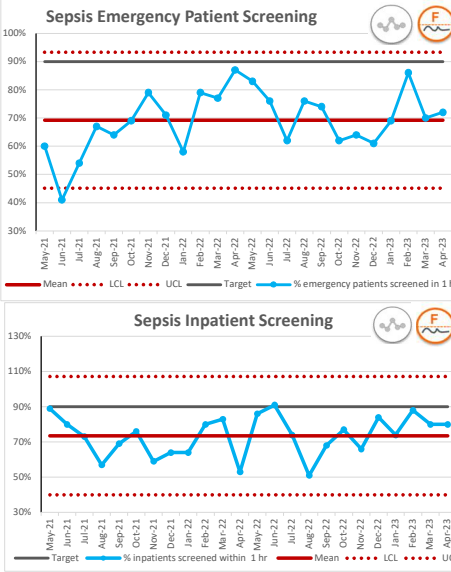
How are we going to improve the position (Short & Long Term)?

**The Trust achieved:**

- 23. Sepsis - % screening for all emergency patients. Target: 90%
- 24. Sepsis - % screening for all inpatients. Target: 90%
- 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:**

- 72% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.
- 80% screening for all inpatients with suspected sepsis within 1 hour.
- 84% 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: Common Cause (Normal) variation.

Improvements in both ED and inpatient areas for screening have been sustained during April. The increased attendances in the Emergency Department continue to be a contributory factor to the inability to achieve the 90% Trust target

**(Inpatient)**  
 Assurance: The Trust consistently fails the target.  
 Variation: Common Cause (Normal) variation.

Quality Improvement support is in place to drive improvements across the Trust. Response to compliance to NEWS 2 sepsis triggers on inpatient wards is monitored by the Patient Safety Improvement Team with an improving position reported. Sepsis management remains a focus on Safety Huddles within the Emergency Department and inpatient wards.

**(Emergency)**  
 Assurance: The Trust consistently fails the target.  
 Variation: Common Cause (Normal) variation.

Improvements in both ED and inpatient areas for antibiotic administration are noted during April. Delays in completing prescriptions is the main contributory factor for non achievement of Trust target.

**(Inpatient)**  
 Assurance: The Trust consistently fails the target.  
 Variation: Common Cause (Normal) variation.

The importance of prescribing antibiotics in a timely manner continues to be a focus for improvement. A comprehensive review of the prescribing process for antibiotics will be undertaken with the Chief Pharmacist, Medical Director, Trust Medical Lead for Sepsis and Emergency Department staff, to determine whether a more efficient digital solution can be introduced. Patient Safety Improvement Nurses (PSIN) with the Quality Improvement Team have started to process map all areas of the hospital so any gaps can be identified. The PSIN have set developed a Sepsis Group with other Trusts so best practice can be shared. The first meeting will be in June 2023.

**Quality Improvement - Trust Position**

**Appendix 2** Trust Performance

Trend

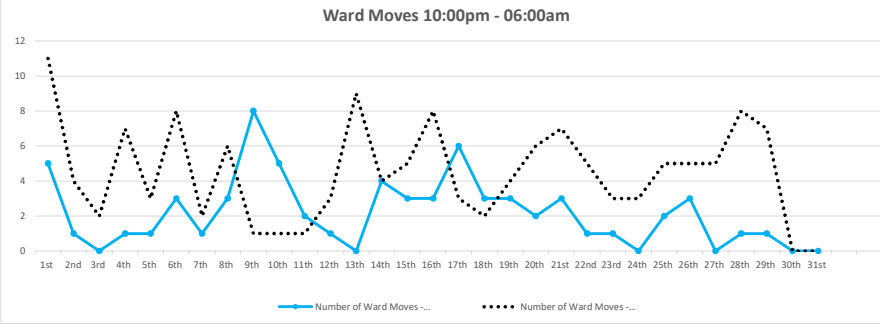
Statistical Narrative

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

27. Ward Moves between 10:00pm and 06:00am  
 No Target

There was a total of 67 ward moves between 10pm-6am in month, compared to 138 in 2022.



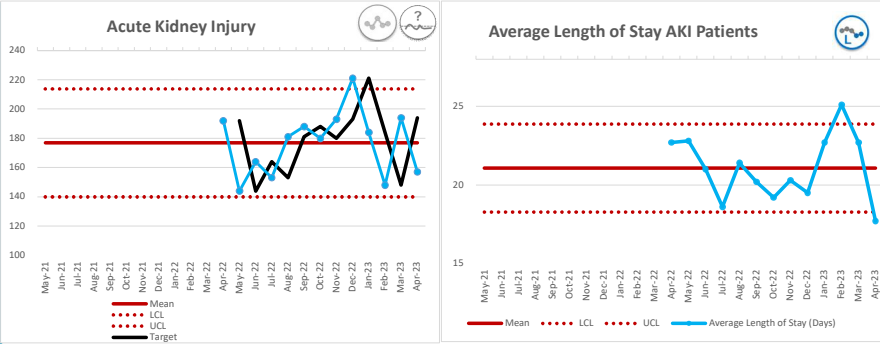
N/A - Monthly/Annual Comparison.

The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non essential clinical patient moves.

The Senior Manager on call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who undertake a welfare check.

28. Acute Kidney Injury  
 Target: Less than previous month

There were 157 acute kidney injuries reported in month.



Variation: Common Cause (Normal) variation.

There has been a decrease in the number of Hospital Acquired AKI's

AKI teaching is delivered through the AIMS course, the AKI nursing role is established within the Acute Care Team. WHH are no longer an outlier for Mortality. Hospital Acquired AKIs are also consistently down on 2019 levels.

Quality Improvement - Trust Position

Appendix 2

Trust Performance

Trend

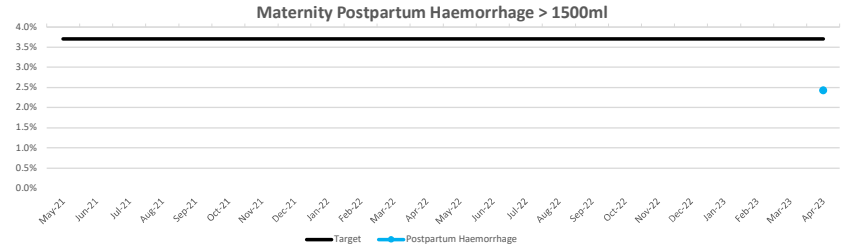
Statistical Narrative

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

29. Maternity Postpartum Haemorrhage >1500ml  
Target: < 3.7%

There were 2.43% Postpartum Haemorrhages >1500ml in month.



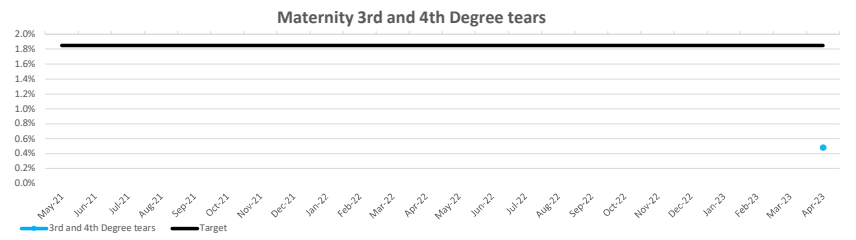
N/A - Not enough datapoints.

Rates are below target in April 2023.

Rates are below target in April 2023. WHH is however an outlier on the NWC dashboard with a 12 month average just over 99th Control line, variable monthly rate. A deep dive was presented to QAC and learning will form an action plan.

30. Maternity 3rd and 4th Degree tears  
Target: <1.85%

There were 0.48% 3rd and 4th Degree tears in month.



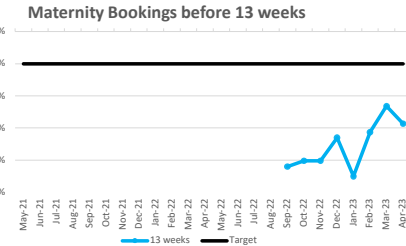
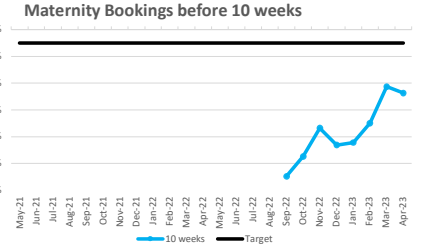
N/A - Not enough datapoints.

Rates are below target in April 2023. WHH is not an outlier compared to the NWC dashboard

We will continue to monitor our rates against internal and external datasets to ensure we promptly identify any increase in rates and act accordingly. We will also ensure we continue to adopt best practice measures to maintain low rates.

31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks  
10-week Target: >75%  
13-week Target: >90%

56.3% bookings before 10 weeks and 80.67% bookings before 13 weeks.



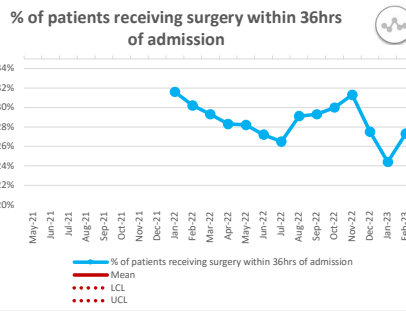
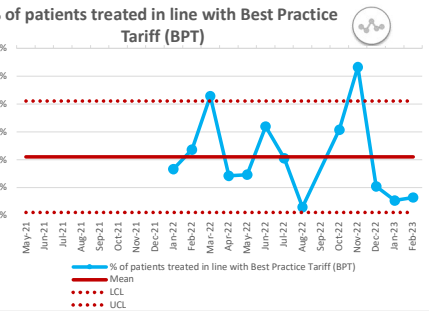
N/A - Not enough datapoints.

Delay in maternity booking is as a result of a number of factors largely related to staffing and challenges in how referrals are managed following the implementation of the new BadgerNet system. Delay in pregnancy booking can result in delay in other aspects of maternity care, particularly in relation to antenatal screening.

An action plan is in place to improve timeliness of bookings and there has been significant improvement in Q4 2022/23. North West Coast dashboard mean for March 2023 was 58.9% for bookings before <10 weeks and 80.67% for bookings before 13 weeks. Accordingly, whilst to yet meeting the stretch target WHH performance is similar to that of their providers.

32. Fractured Neck of Femur  
Target: Best Practice Tariff

6.5% of patients were treated in line with Best Practice Tariff (BPT) in Feb-23.



Variation: Common Cause (Normal) variation.

There continues to be variation in achievement of KPI's for NHFD, with a below average compliance. The KPI's that are affecting achievement of BPT and continue to show below average compliance are 'Prompt Orthogeriatric Review' and 'Prompt Surgery'. With the increase in the Orthogeriatric service from May 2023, although still provided via 'in reach', an improvement in KPI's is expected, delivered by the Orthogeriatric team.

Work continues with regards to improving capacity to aid performance of 'Prompt surgery', this includes a review of theatre availability for trauma, scheduling of an additional list, as is possible, productivity monitoring and a review of the delivery of the Trauma Consultant on Call rota'

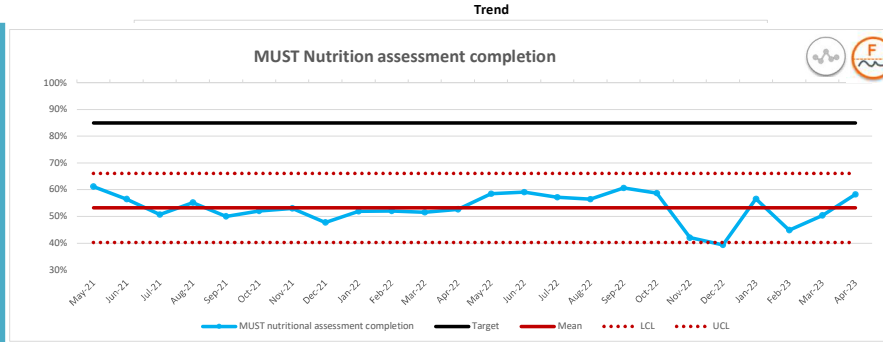
## Quality Improvement - Trust Position

### Appendix 2

#### Trust Performance

33. MUST nutritional assessment completion  
 Target: above 85%

**MUST Nutrition assessment completion was 58.22% in month.**



#### Statistical Narrative

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

**Assurance:** The Trust consistently fails the target.

**Variation:** Common Cause (Normal) variation.

The dashboard for MUST pulls data from Lorenzo regarding 6 hour, 24 hour and 7 day compliance. The impact of low compliance in assessing the nutritional needs of our patients can potentially delay appropriate intervention and can contribute to patient harm such as delayed wound healing, pressure damage to skin and increased length of stay.

A new dashboard has been developed to measure MUST compliance for Ward Managers, Matrons & Lead Nurses awareness of compliance in their areas, local Quality Improvement projects are to be developed. Ward-based interventions have been re-launched – posters for display in wards to highlight nutritional assessment and associated actions. Wards will be audited weekly regarding implementation of ward-based actions. Collaboration with QI team to analyse audit data and formulate Trust wide Quality improvement project. Compliance is monitored by monthly Nutrition, Food & Hydration Steering Group.

**Access & Performance - Trust Position**

**Trust Performance**

**Trend**

**Statistical Narrative**

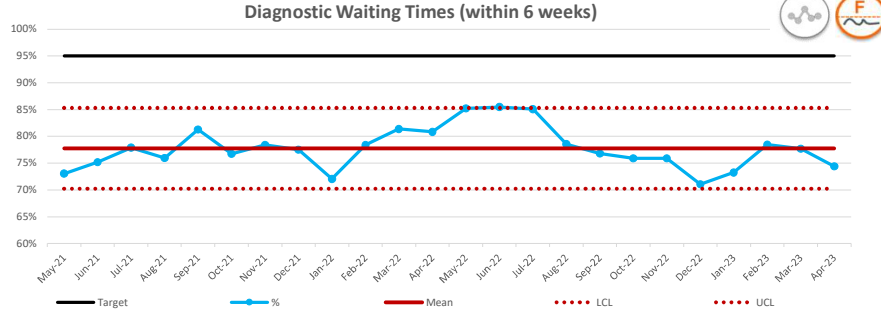
What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

34. Diagnostic Waiting Times 6 Weeks  
 Target: 95%

**The Trust achieved 74.4% in month.**





**Assurance:** The Trust consistently fails the target.

**Variation:** Common Cause (Normal) Variation.

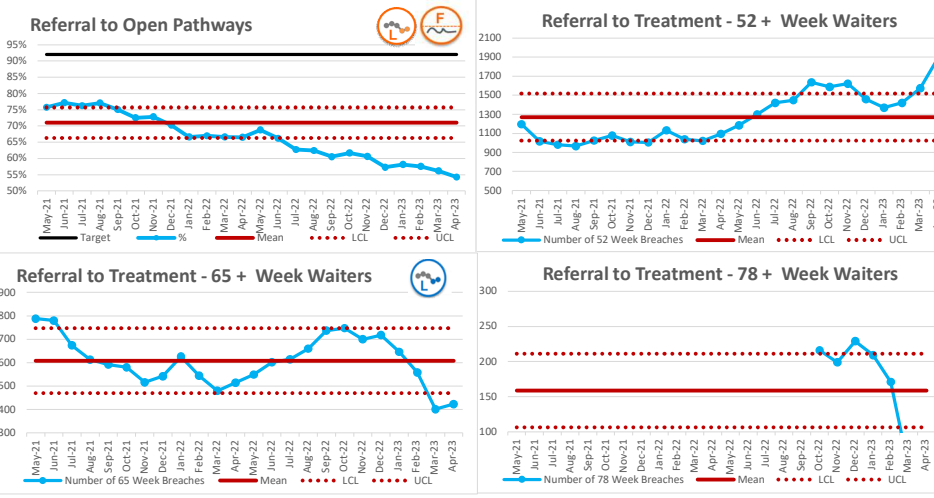
The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.

A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies.

35. Referral to treatment Open Pathways  
 Target: 92%

**The Trust achieved 54.25% in month. There were 1897, 52 week breaches, 39, 78 week breaches and 423, 104 week breaches in .**





**Assurance:** The Trust consistently fails the target.

**Variation:** There is special cause variation of a concerning nature.

Recovery of the elective programme is taking place with:

- Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.
- Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.
- Restoration and recovery plans for 2023/24 have been drawn up in line with Operational Planning Guidance.

RTT performance, 52, 65, 78 and 104 week wait performance in the reporting period was in line with the Trust's 2023/24 plan.

**Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of an improving nature.

### Access & Performance - Trust Position

#### Trust Performance

36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.  
Target: 75%

37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.  
Target: 2% or less

38. Average time in department ED  
No Target

39. Cancer 14 Days  
Target: 93%

40. Breast Symptoms 14 Days  
Target: 93%

41. 28 Day Faster Cancer Diagnosis Standard

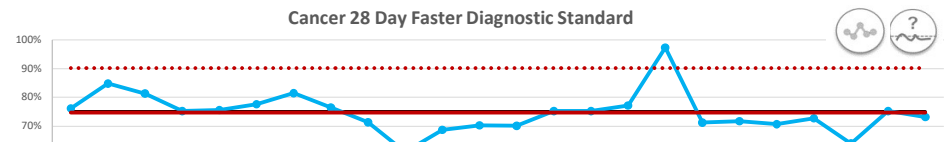
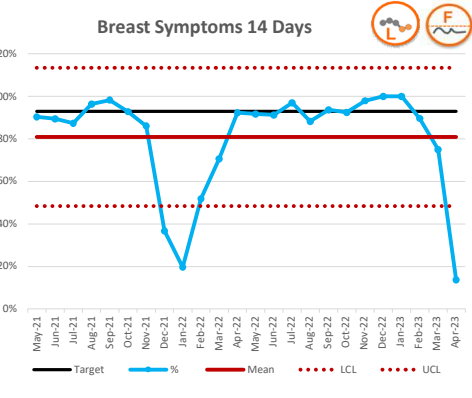
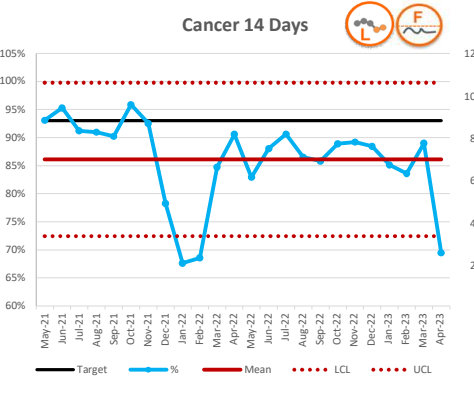
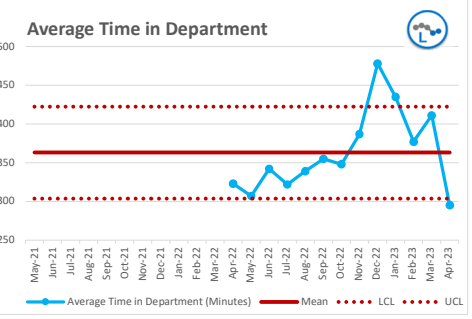
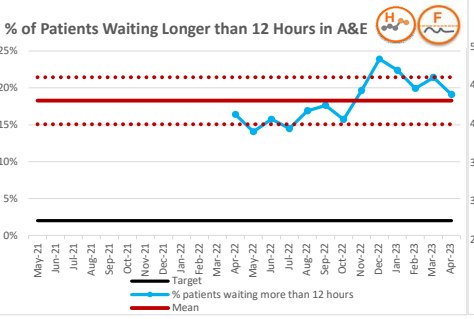
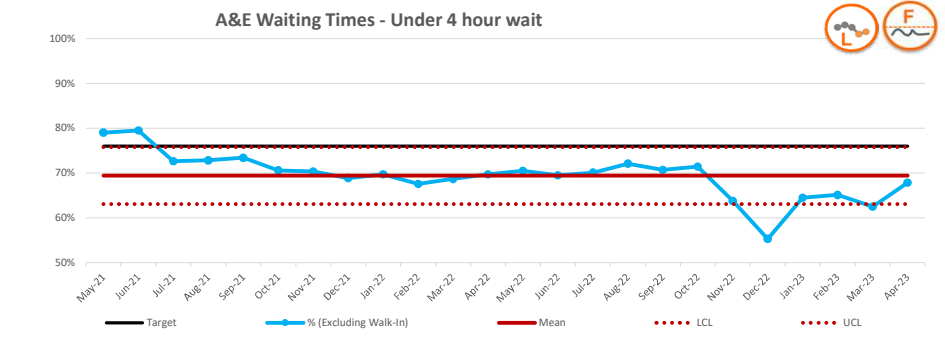
The Trust achieved **67.85% excluding Widnes walk ins** in month.

**19.09% of patients in A&E were waiting longer than 12 hours** from presentation to admission/discharge. The average time in department was **295 minutes**.

The Trust achieved **69.48% in November 2022 for Cancer 14 days** and **13.73% in month for Breast Symptomatic**.

The Trust achieved **73.16%** in month

#### Trend



#### Statistical Narrative

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

**Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of a concerning nature

Performance continues to be negatively impacted by high attends, long length of stay as a result of community discharge delays.

- System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.
- System resource investment in order to support Pathway 1 discharges.
- Additional beds remain open on the Halton site to support bed capacity and flow.
- Ward A10 opened in October (14 Beds) to support performance.

N/A - Not enough datapoints.

12 hour performance continues to be monitored. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through ED.

The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 23/24 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 23/24 is to be set up to support improvement.

**(C14) Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of a concerning nature

**(Breast) Assurance:** The Trust inconsistently passes/fails the target.

**Variation:** Special Cause Variation of a concerning nature

The 2ww standard and Breast Symptoms have seen a drop in performance through March and April due to the continued high levels of referrals coupled with reduced staffing within radiology to support the new patient clinics. There has also been some disruption caused by IA. The Breast service has taken corrective action which has seen performance improve in May.

The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard.

Performance against this standard is monitored via the Performance Review Group (PRG).

Targeted capacity and demand work has been initiated for the Breast service.

**Assurance:** The Trust inconsistently passes/fails the target.

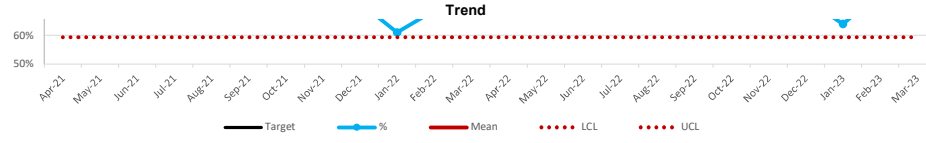
This indicator is impacted by continued high volumes of referrals into General Surgery creating pressures on 2 week wait

The Trust will continue to monitor and review performance of this standard via the

### Access & Performance - Trust Position

Trust Performance  
**75.10% in month.**

Target: 75%



**Statistical Narrative**

Variation: Common Cause (normal) variation.

What are the reasons for the variation and what is the impact?  
 capacity. Short term additional capacity continues to be put in place.

How are we going to improve the position (Short & Long Term)?  
 Performance Review Group (PRG)

### Access & Performance - Trust Position

#### Trust Performance

42. Cancer 31 Days First Treatment  
Target: 96%

43. Cancer 31 Days Subsequent Surgery  
Target: 94%

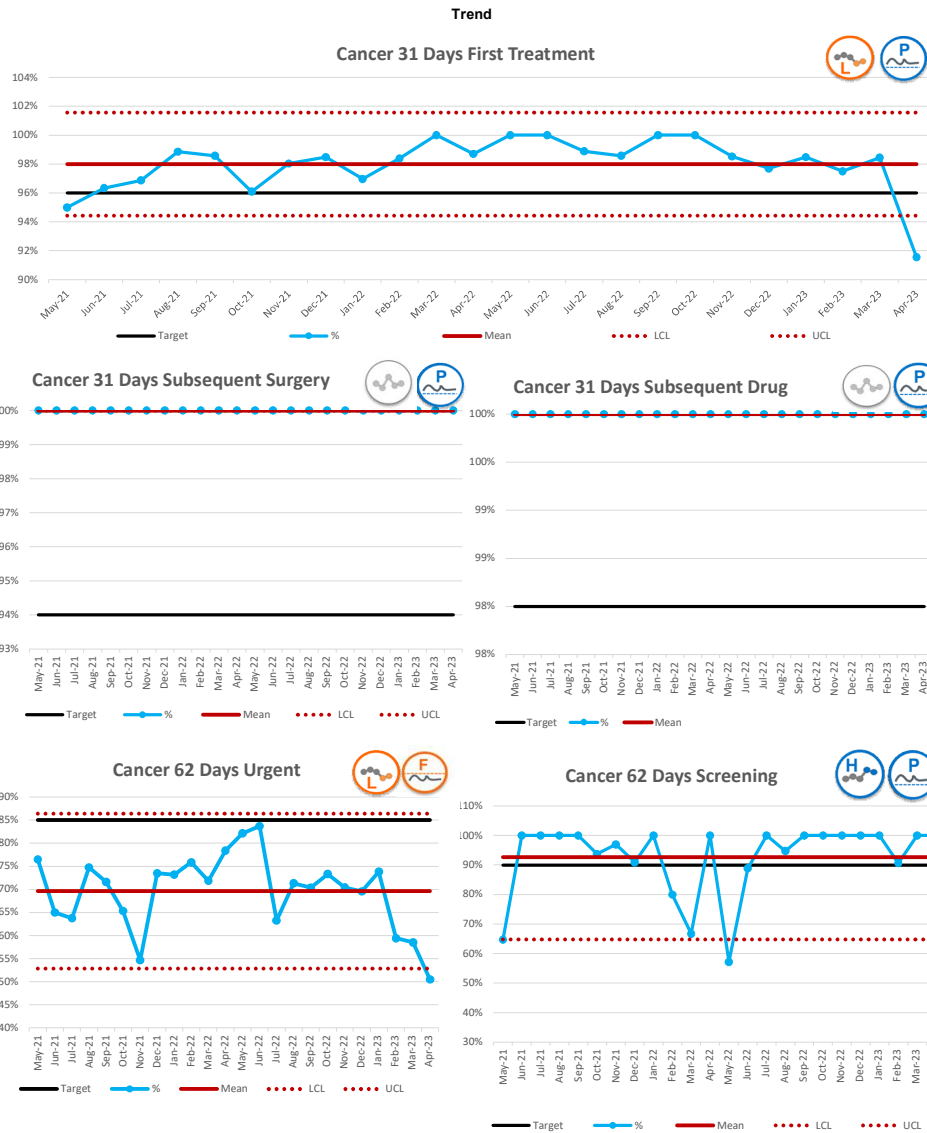
44. Cancer 31 Days Subsequent Drug  
Target: 98%

45. Cancer 62 Days Urgent  
Target: 85%

46. Cancer 62 Days Screening  
Target: 90%

**The Trust achieved 91.55% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in month.**

**The Trust achieved 50.52% for Cancer 62 Day Urgent and 100% for Cancer 62 Day Screening in month.**



#### Statistical Narrative

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

**Assurance:** The Trust consistently passes the target.

**Variation:** Special Cause Variation of a concerning nature

The 62 day and 31 day targets have both been affected by a number of longer waiting kidney patients and some breast breaches due to the 2ww issues causing overall longer pathways in this group who do not normally breach. This has remained an issue for April but is now resolving and will be reflected in May's performance.

Capacity is being reviewed in line with clinical service restoration plans.

**(Surgery) Assurance:** The Trust consistently passes the target.

**Variation:** Common Cause (Normal) variation.

**(Drugs) Assurance:** The Trust consistently passes the target.

**Variation:** Common Cause (Normal) variation.

**(Urgent) Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of a concerning nature

The 62 day urgent target was not achieved in this reporting period, this was decrease on the months previous level, the key factors driving this drop are the Urology and CR pathways which have capacity constraints due to workforce pressures, a recovery plan is in place. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.

There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

**(Screening) Assurance:** The Trust consistently passes the target.

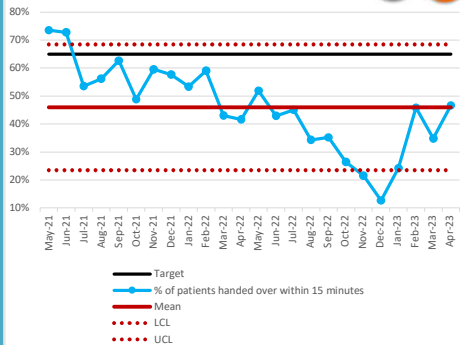
**Variation:** Special Cause Variation of an improving nature

### Access & Performance - Trust Position

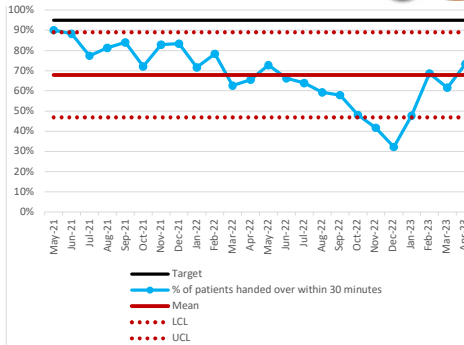
#### Trust Performance

#### Trend

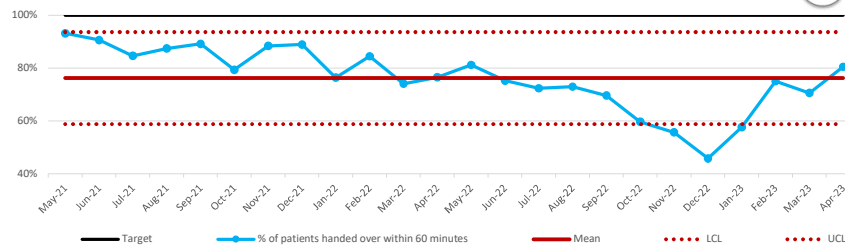
**Ambulance Handovers within 15 minutes**



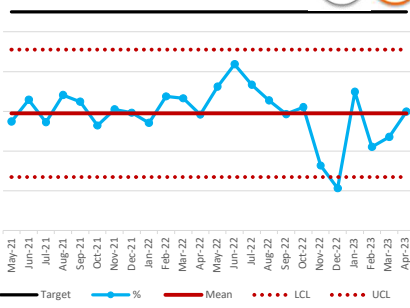
**Ambulance Handovers within 30 minutes**



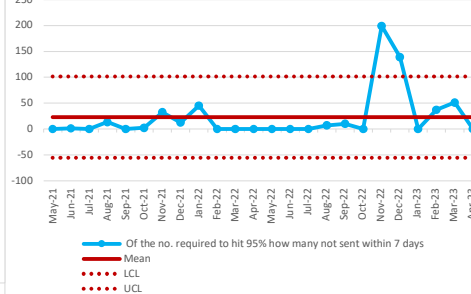
**Ambulance Handovers within 60 minutes**



**Discharge Summaries**



**Discharge Summaries - NOT sent within 7 days**



#### 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)?

**(15) Assurance: The Trust consistently fails the target.**

Variation: Common Cause (Normal) variation.

**(30) Assurance: The Trust consistently fails the target.**

Variation: Common Cause (Normal) variation.

**(60) Assurance: The Trust consistently fails the target.**

Variation: Common Cause (Normal) variation.

Handover performance has improved as a result of modest improvement in No Criteria to Reside patients and the reduction in the impact of winter. Additional staffing to support the offloading of Ambulances has also been used in this period.

The Trust will continue to work in partnership with NWAS to identify and implement improvements.

**(24 hrs) Assurance: The Trust consistently fails the target.**

Variation: Common Cause (Normal) variation.

**(7 Days) Assurance: The Trust inconsistently passes/fails the target.**

Variation: Common Cause (Normal) variation.

Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.

The Performance Review Group (PRG) continues to monitor this standard to support improvements.

47. Ambulance Handovers within 15 minutes  
Target: 65%

48. Ambulance Handovers within 30 minutes  
Target: 95%

49. Ambulance Handovers within 60 minutes  
Target: 100%

50. Discharge Summaries - % sent within 24hrs  
Target: 95%

51. Discharge Summaries - Number NOT sent within 7 days  
Target: ZERO

In month 46.64% of patients were handed over within 15 minutes, 73.26% were handed over within 30 minutes and 80.48% were handed over within 60 minutes.

The Trust achieved 89.97% in month. There was 1 discharge summary not sent within 23 days required to meet the 95.00% threshold.

### Access & Performance - Trust Position

#### Trust Performance

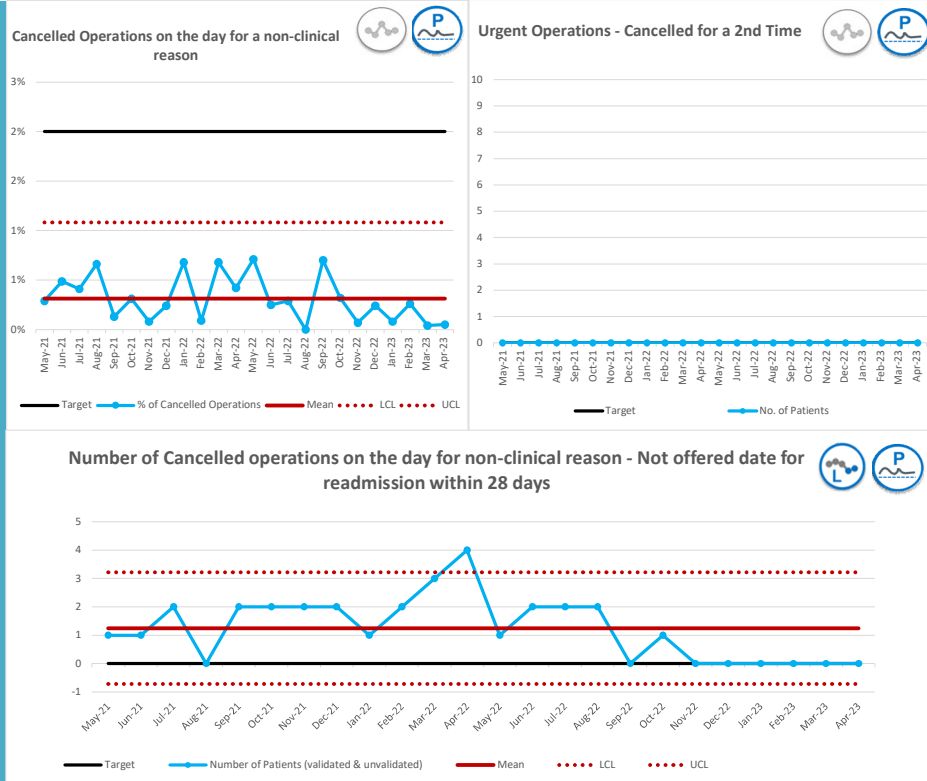
52. Cancelled Operations on the day for a non-clinical reason  
 Target: Less than 2%

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

54. Urgent Operations Cancelled for 2nd Time

Cancelled operations data validation for month is in progress.

#### 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)?

(Urgent Ops) Assurance: The Trust consistently passes the target.

Compliance against this standard remains below the monitored threshold of 2.00% (positive).

Recovery of elective activity continues to be monitored via Performance review group.

Variation: Common Cause (normal) variation.

### Access & Performance - Trust Position

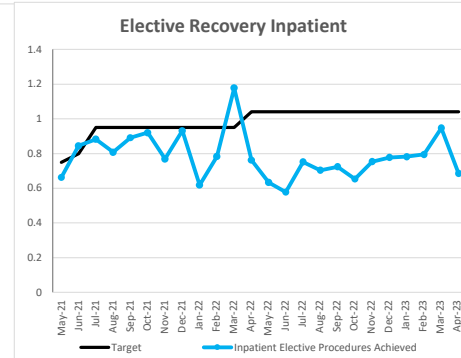
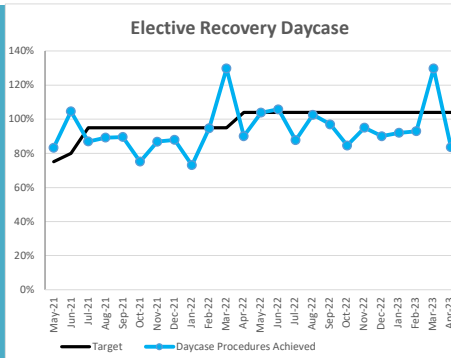
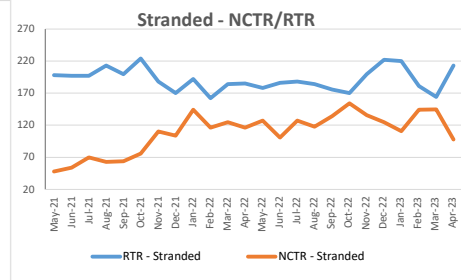
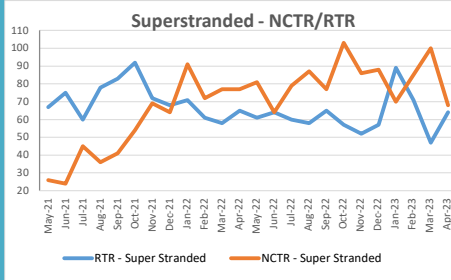
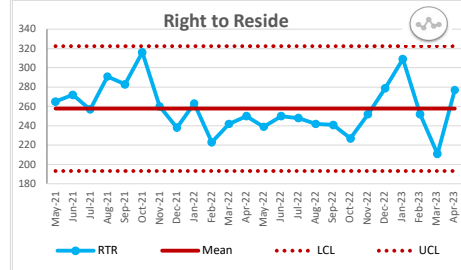
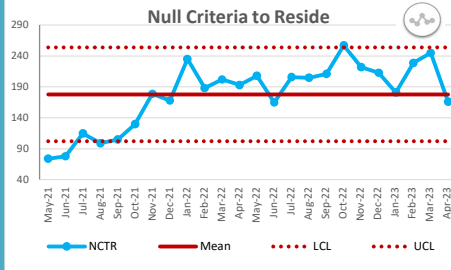
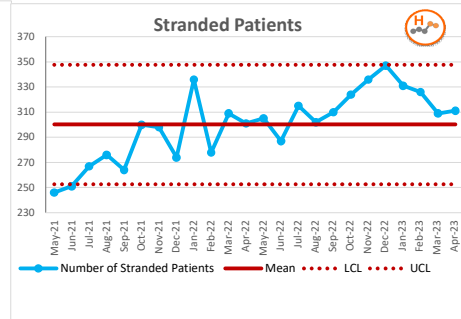
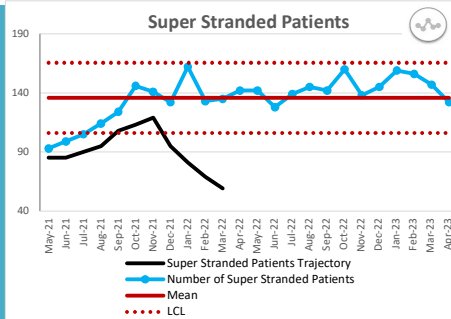
#### Trust Performance

#### 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)?



**(SS) Assurance: N/A Trajectory Not Agreed**

**Variation: Common Cause (normal) variation.**

**(SS) Assurance: N/A Trajectory Not Agreed**

**Variation: There is special cause variation of a concerning nature.**

**(NCTR) Assurance: N/A Trajectory Not Agreed**

**Variation: Common Cause (normal) variation.**

**(RTR) Assurance: N/A Trajectory Not Agreed**

**Variation: Common Cause (normal) variation.**

The number of Super Stranded patients continues to remain higher than trajectory as a result of the community and Local Authority discharge delays.

The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.

**N/A - Grouped indicator.**

Inpatient activity for the reporting period is below the Trajectory but is inline with the Month 1 plan when the cancellations for Industrial Action is taken into account.

The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

55. Super Stranded Patients  
Target: Trajectory

There were 311 stranded and 132 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.

56. Elective Recover Activity  
Aggregate Target: 104%  
% activity is against activity in the same month in 2019/20

In month, the Trust achieved the following % of activity against 2019. This included 68.54% of Daycase Procedures and 83.59% of Inpatient Elective Procedures.

### Access & Performance - Trust Position

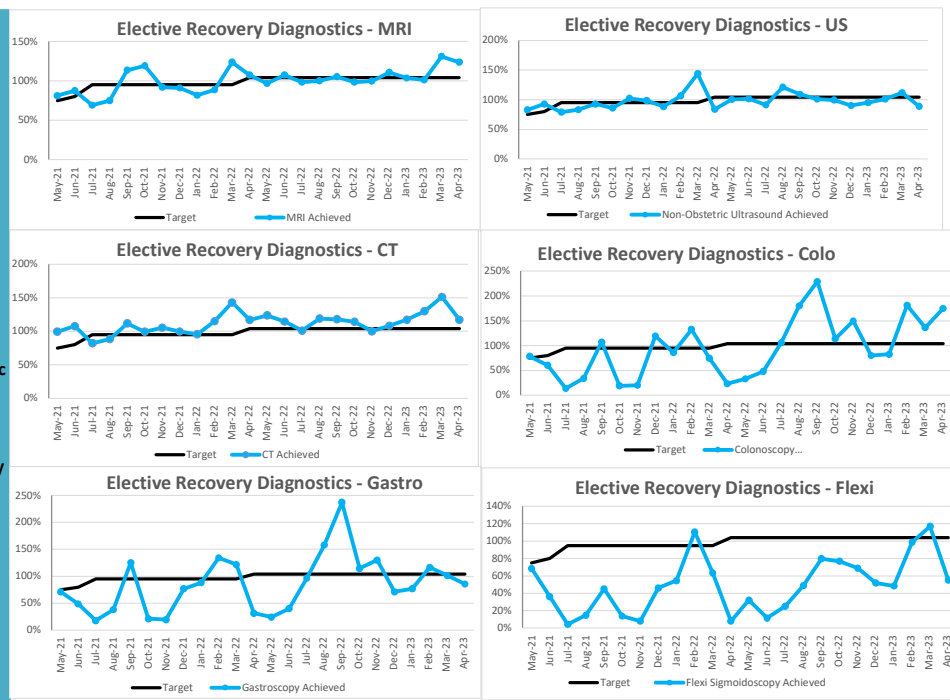
#### Trust Performance

**In month, the Trust achieved the following % of activity against 2019. This included:**  
**123.93% of MRI**  
**117.31% of CT**  
**88.78% of Non-Obstetric Ultrasound**  
**55.15% of Flexi Sigmoidoscopy**  
**174.75% of Colonoscopy**  
**85.71% of Gastroscopy**

57. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20

58. COVID-19 Outpatient Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20

#### 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)?

**N/A - Grouped indicator.**

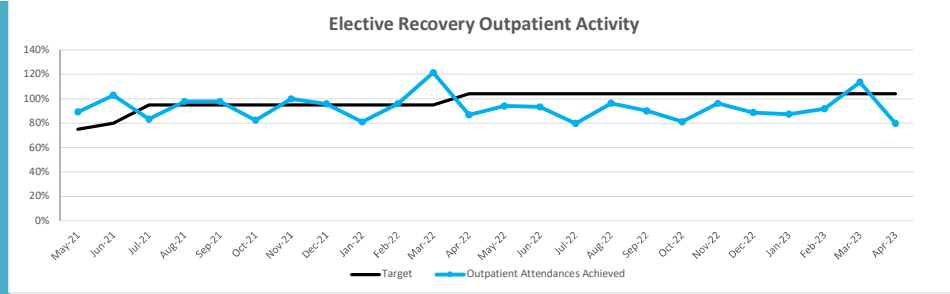
Recovery trajectories Radiological specialties and Endoscopy are in line with recovery trajectories.

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.

**In month, the Trust achieved 79.66% of Outpatient activity against 2019.**



**Assurance: The Trust consistently fails the target.**

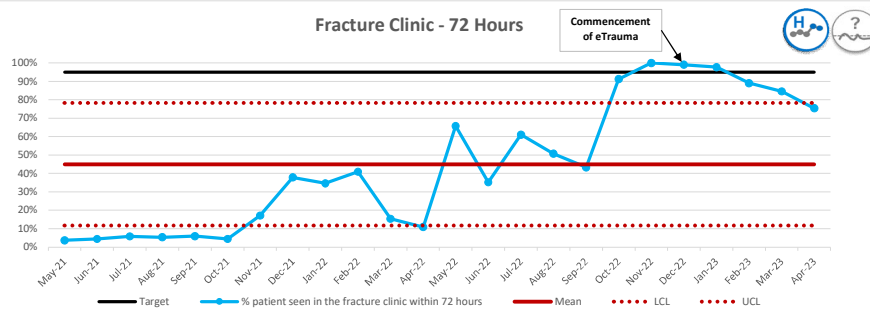
The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative services such as patient initiated follow up. April activity is impacted by Industrial Action.

The Trust continues to restore clinical services in line with the national operating guidance.

**Access & Performance - Trust Position**

**Trust Performance**

**Trend**



59. Patients seen in the Fracture Clinic within 72 hours  
 Target: 95%

The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.

**Statistical Narrative**

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

**Assurance:** The Trust inconsistently passes/fails the target.

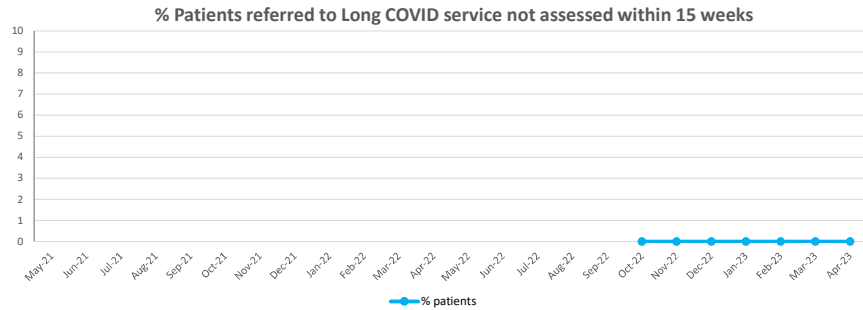
**Variation:** Special Cause  
 Variation of an improving nature

Issue of non-compliance addressed in-month.

This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.

60. % patients referred to long COVID service not assessed within 15 weeks

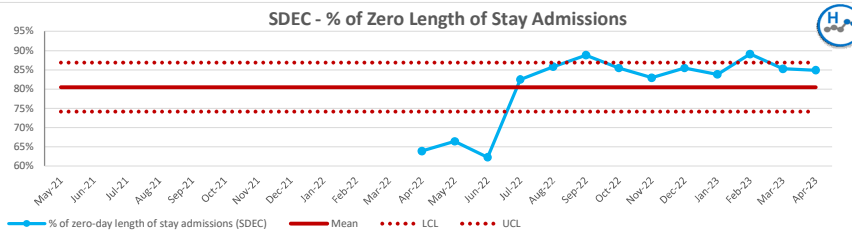
The Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks for .



N/A - Not enough datapoints.

61. 59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions  
 No Target

84.89% of SDEC Emergency Admissions had a zero day length of stay.



**Variation:** Special Cause  
 Variation of an improving nature

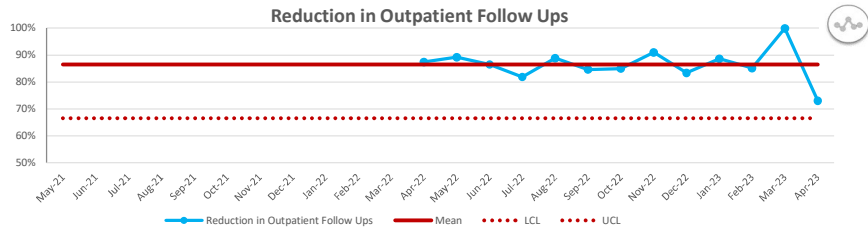
**Access & Performance - Trust Position**

**Trust Performance**

**Trend**

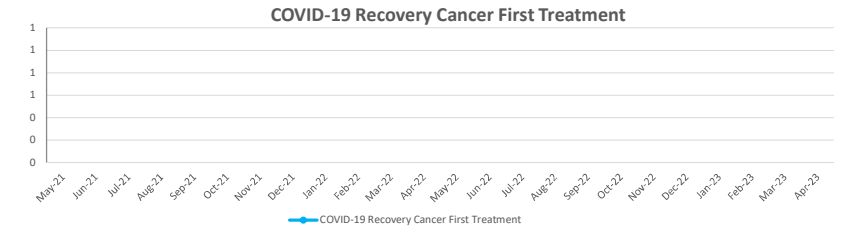
62. Reduction in Outpatient Follow Ups compared to 19/20 activity  
 Target: 75% or less based on 2019/20 activity

**Outpatient follow ups have reduced to 73.06% of 19/20 activity in month.**



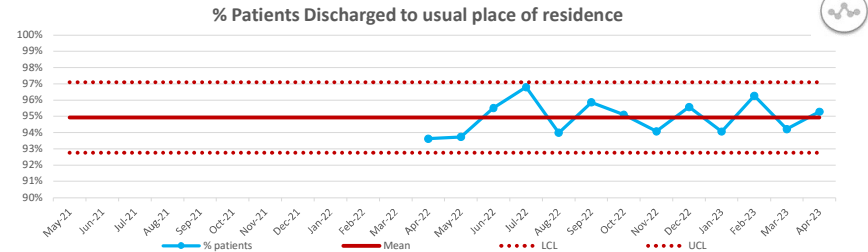
63. COVID-19 Recovery Cancer First Treatment  
 Target: 100%

**#N/A**



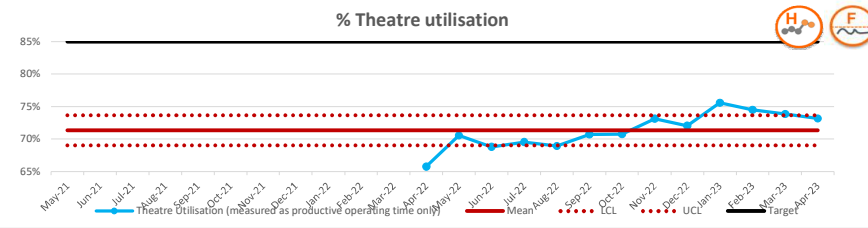
64. % Patients discharged to their usual place of residence  
 Target: No Current Threshold

**95.29% patients in month who were discharged to their usual place of residence.**

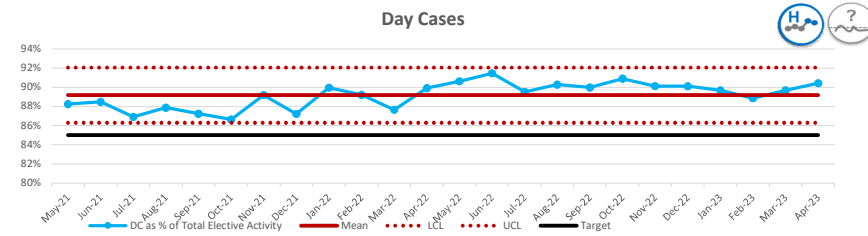


65. Theatre Utilisation (measured as productive operating time only)  
 Target: 85%

**73.16% Theatre utilisation in month (measured as productive operating time only). There were 90.43% Day cases, of total activity in month.**



66. Day case (measured as an aggregate of total cases)  
 Target: 85%



**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)?

Variation: Common Cause (Normal) variation.

N/A - Not enough datapoints.

Variation: Common Cause (Normal) variation.

Variation: There is special cause variation of a concerning nature.

Variation: Common Cause (Normal) variation.

## Workforce - Trust Position

KEY:

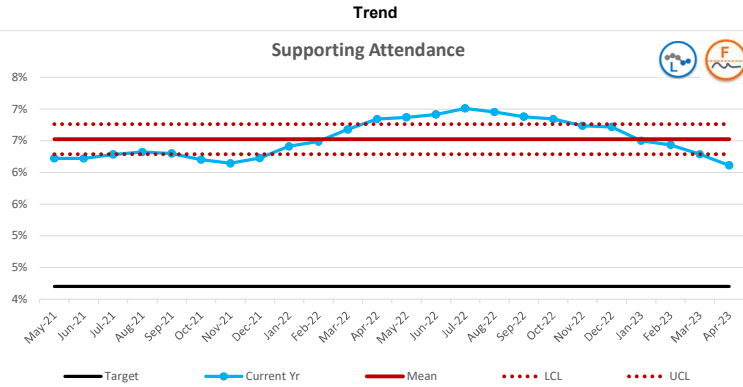
- System Oversight Framework
- Use of Resources Assessment

- Care Quality Commission
- Trust Strategy
- Risk Register

### Trust Performance

68. Supporting Attendance  
 Target: Below 4.2%

The Trust's sickness absence rate was 6.28% in month.



### 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)?

Annualised Sickness absence showing an Improving Variation

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a concerning nature.

The Annualised Sickness absence percentage in April 2023 decreased from 6.3% (March 2023) to 6.1%.

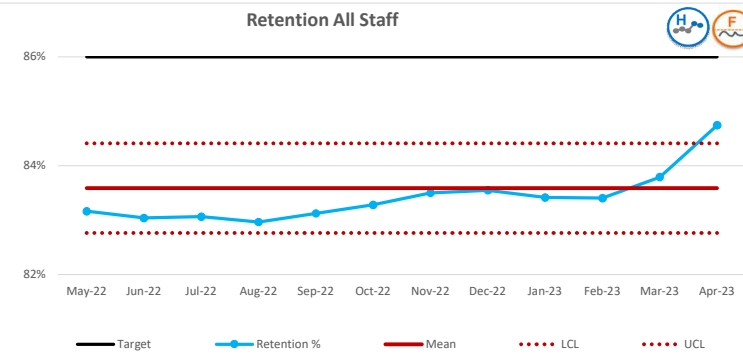
Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.

The Trust implemented an updated Supporting Attendance policy in February 2022. Consequently, the Trust continues to see a significant improvement in long term sickness absence rates reducing from 4.39% in April 2022 to 2.48% in March 2023.

The Occupational Health and Wellbeing, Mental Wellbeing Hub and HR Business Partnering team continue to meet on a regularly basis to triangulate data relating to sickness absence to support bespoke interventions such as the implementation of stress and resilience workshops for international recruits, directly responding to the feedback received within the staff survey. In addition, the People Health and Wellbeing strategy group meets regularly with line managers and leads from Care Groups to identify areas of best practice and facilitate shared learning on supporting the workforce.

69. Retention  
 Target: 86%

Retention of all staff was 84.74% and Retention of Permanent staff only was 89.21% in month.



Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a improving nature.

Retention showing an Improving Variation

Retention of all staff in April 2023 was slightly below target at 84.7% compared to 83.8% in March 2023.

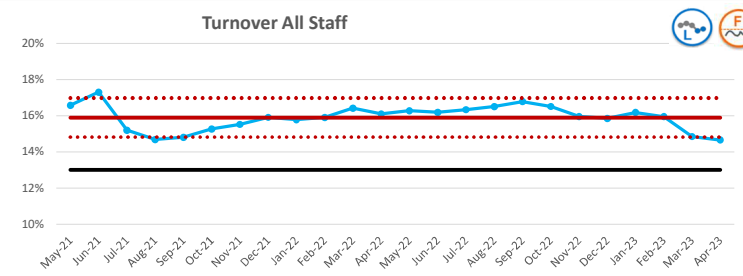
Retention for permanent staff remains above Trust target at 89.21% in April 2023.

Work-life balance continues to be the number one known reason people leave WHH, followed by retirement and relocation.

A new exit interview process has been implemented to further understand the details as to why people are leaving. Collation and analysis of this data enables themes to be identified and targeted action to be taken to address these areas. This information is now available on the Trust Workforce Information Dashboard. CBU's, supported by their HRBPs, are making use of this information to develop bespoke retention plans, which are to be reported through OPC.

70. Turnover  
 Target: Below 13%

Turnover of all staff was 14.66% and Turnover of Permanent staff only was 13.69% in month.



Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a concerning nature.

Turnover showing an Improving Variation

Turnover in April 2023 was 14.7% compared to 14.9% in March 2023.

Turnover of permanent staff in April 2023 was 13.69%

A dedicated area to supporting Agile/Flexible working is available on the extranet, and following a further discussion within June's SPC, various toolkits will be made available to support managers/employees to improve Agile/Flexible working.

There has been a significant increase in the number of individuals choosing to retire, however circa 50% of retirees do return to the workplace (retire and return), and are supported to do so. These still count as a leaver for the purposes of retention and turnover.

**Workforce - Trust Position**

**KEY:**  
 System Oversight Framework  
 Use of Resources Assessment

Care Quality Commission  
 Trust Strategy  
 Risk Register

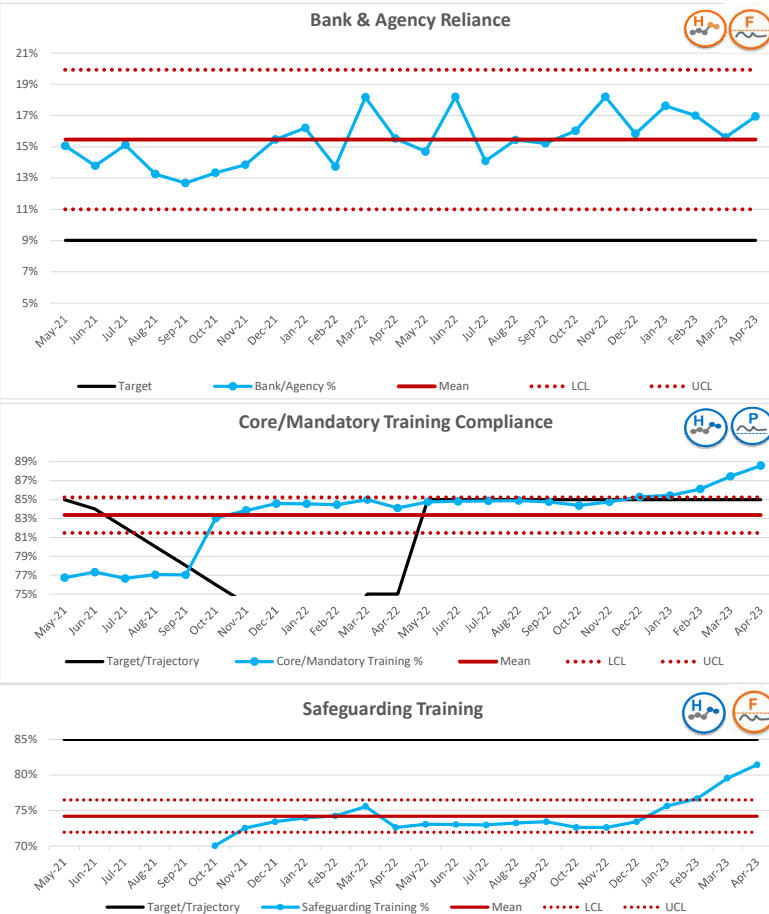
**Trust Performance**

**Bank and Agency Reliance**  
 Target: 9% or Below  
**Bank and Agency Reliance was 16.95% in month.**

**Core/Mandatory training compliance**  
 Target: 85%  
**Core/Mandatory training compliance was 88.59% in month.**

**Safeguarding Training**  
 Target: Trajectory  
**Safeguarding Training compliance was 81.46% in month.**

**Trend**



**What are the reasons for the variation and what is the impact?**

**How are we going to improve the position (Short & Long Term)?**

**Statistical Narrative**

**Bank and Agency reliance is showing a Concerning Variation**

**Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of a concerning nature.

Bank and Agency reliance in April 2023 was 16.9% compared to 15.6% in March 2022.

Reasons for the variation can be attributed to sickness absence, high turnover and additional capacity.

**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

**Core/Mandatory Training Compliance**

**Assurance:** The Trust consistently passes the target.

**Variation:** Special Cause Variation of a improving nature.

CSTF Training (inclusive of Safeguarding) is showing an Improving Variation

In April 2023, CSTF Mandatory Training compliance was 88.6%, excluding Safeguarding Training (Children's and Adults); Safeguarding (Children's and Adults) compliance was 81.5%

Trajectories continue to be monitored through workforce governance structures and QPS.

A Mandatory and Role Specific multi-disciplinary training panel has been established to support SMEs to review and identify accessibility, training needs analysis and justification for mandatory status. This has resulted in changes being made to Safeguarding mandatory training provision as well as tweaks to the delivery of Infection, Prevention and Control.

**Safeguarding Training**

**Assurance:** The Trust consistently fails the target.

**Variation:** Special Cause Variation of a improving nature.

In order to respond to staff feedback regarding access to training, two learning and development days have been developed for the 18th and 19th May to enable staff to complete their mandatory training. This will be evaluated post-event in order to establish impact on compliance figures and further developments to consider.

**Workforce - Trust Position**

KEY:

- System Oversight Framework
- Use of Resources Assessment

- Care Quality Commission
- Trust Strategy
- Risk Register

**Trust Performance**



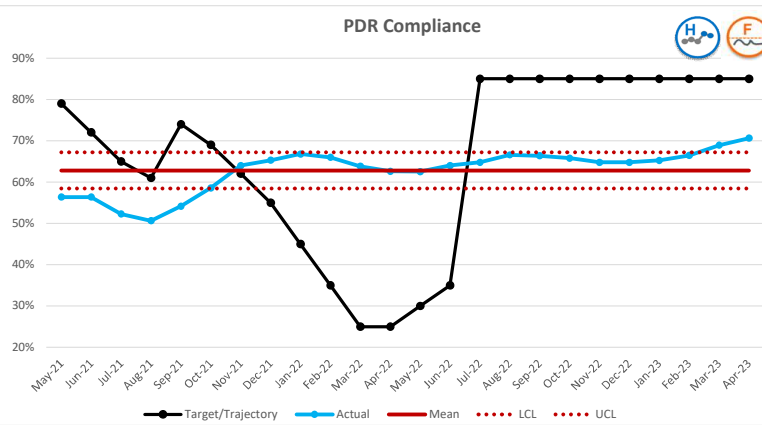
PDR compliance was 70.64% in month.

SPC - there is evidence of special cause variation for PDR compliance.

74. PDR  
 Target: 85%

**Trend**

**PDR Compliance**



**Statistical Narrative**

**What are the reasons for the variation and what is the impact?**

**How are we going to improve the position (Short & Long Term)?**

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of an improving nature.

PDRs are showing an Improving Variation

In April 2023, PDR compliance was 70.6%. In March 2023, PDR compliance was 68.9%.

Currently PDR rates are below the trajectories but higher than 2022

The CBUs and Corporate Areas have been supported to develop trajectories and associated actions to improve PDR compliance, these continue to be monitored through the workforce governance structures and QPS.

As a result of feedback from the Operational People Committee of improving appraisal compliance, updated paperwork to support career and PDR conversations has been developed aligned to the check-in conversation that was utilised during the pandemic and also the principles of the NHS Leadership Academy's Scope for Growth talent management tool. This will be implemented by the end of Q1 2023-24.

Pay progression has been implemented from 1st April with one of the criteria for pay-affecting progression being an in-date appraisal which will continue to have an impact on compliance and meeting trajectories set within departments and teams. As part of the pay progression approach training is offered to line managers with key tools and techniques to have a meaningful PDR conversation.

**Finance & Sustainability - Trust Position**

Key:

- SOF System Oversight Framework
- UoR Use of Resources Assessment
- RR116 Risk Register

- CQC Care Quality Commission
- S Trust Strategy

**Trust Performance**

**Trend**

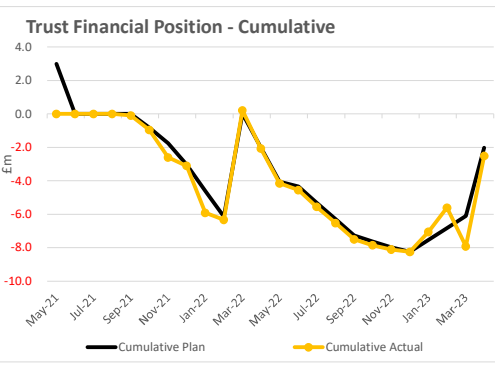
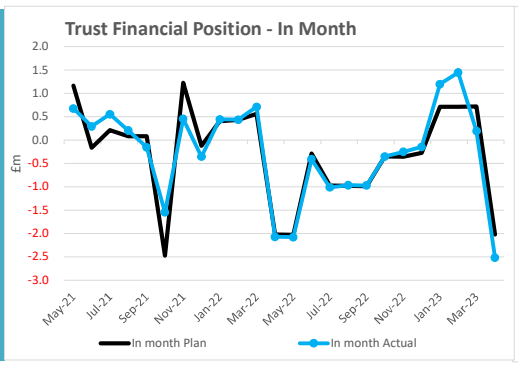
**Statistical Narrative**

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

75. Trust Financial Position  
 Target: Plan

The Trust has recorded a deficit position of £7.9m at the 31 March, the £5.4m plan was achieved and the ICS supported further expenditure of £2.5m towards the 2022/23 PLACE adaptive reserve. Month 1 for 2023/24 is worse than plan due mostly to industrial action costs



**Assurance:** The Trust inconsistently passes/fails the target.

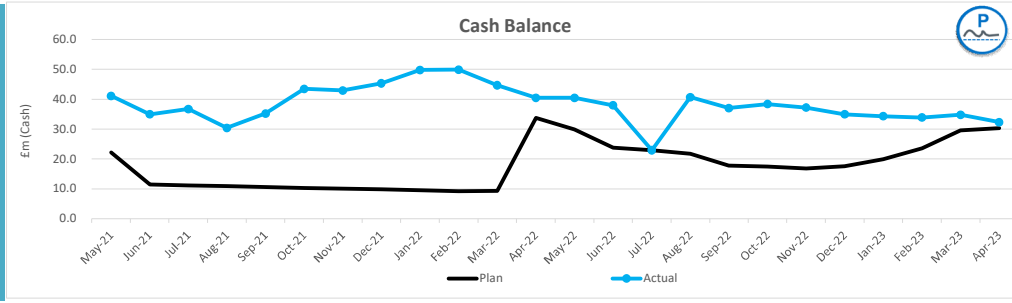
**Variation:** SPC Variance is not relevant for this metric

For the period ending 30 April 2023, the Trust has recorded a deficit of £2.5m, which is slightly worse than plan. The position includes ERF and assumes full PBR.

The Trust is forecasting delivery of the forecast £15.8m deficit, however there are significant risks to achieving this plan.

76. Cash Balance  
 Target: On or better than plan

The cash balance as at 30 April 2023 is £32.35m.



**Assurance:** The Trust consistently passes the target.

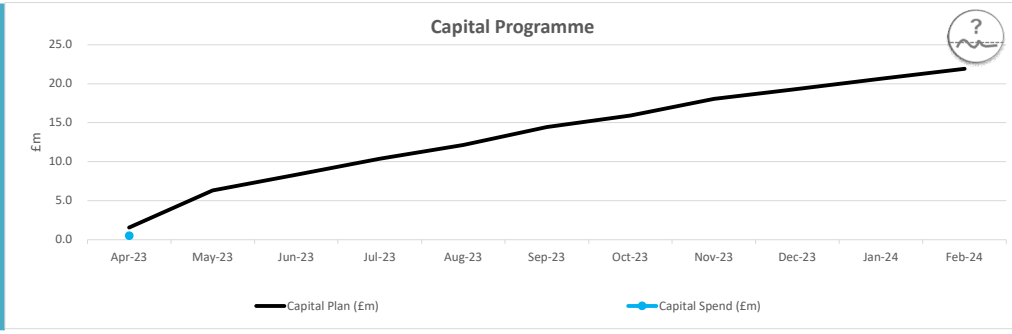
**Variation:** SPC Variance is not relevant for this metric

The current cash balance is £32.35m which is £2.0m better than the initial cash plan.

Payment of the creditors on receipt of invoices will get the cash back to plan.

77. Capital Programme  
 Target: On plan 90%-100%

Capital expenditure at the end of month 1 is £0.52m against a plan of £1.56m.



**Assurance:** The Trust inconsistently passes/fails the target.

Annual Trust capital plan of £23.5m, £1.5m oversubscribed against the £21.9m capital funding

The underspend year to date relates to some delays in IM&T and Medical Equipment schemes mainly due to confirmation of Trust plan approval. Along with timing difference between the plan and actual expenditure for Warrington Town Deal Health & Wellbeing Hub and CDC

## Finance & Sustainability - Trust Position

Key:

- System Oversight Framework
- Use of Resources Assessment
- Risk Register

- Care Quality Commission
- Trust Strategy

### Trust Performance

### Trend

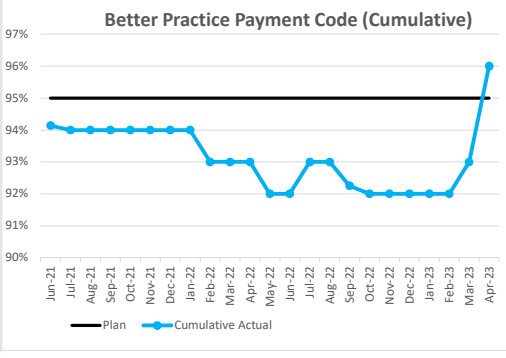
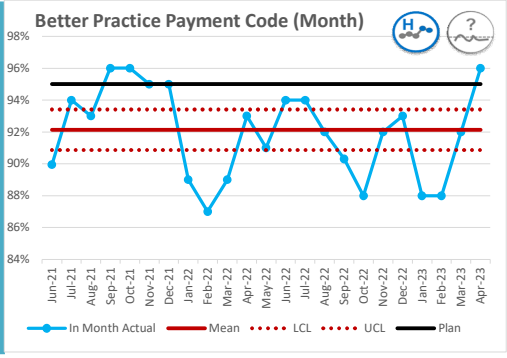
### Statistical Narrative

What are the reasons for the variation and what is the impact?

How are we going to improve the position (Short & Long Term)?

**UoR**  
The Better Payment Practice Code performance based on volume for NHS is 87% and non-NHS is 96%. The Better Payment Practice Code performance based on value for NHS is 86% and non-NHS is 98%.

78. Better Payment Practice Code  
Target: Cumulative performance 95%



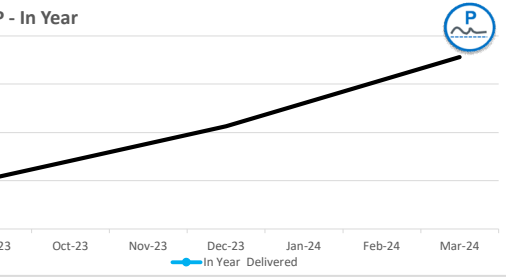
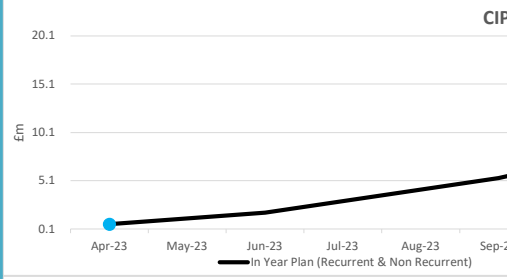
**Assurance:** The Trust consistently fails the target.  
**Variation:** Special Cause Variation of a concerning nature.

Cumulative performance is 96.00% which is above the national target of 95.00%.

Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.

**UoR**  
The month 1 CIP plan is £0.6m and £0.6m has been delivered.

79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date  
Target: >90% plan delivered YTD



**N/A - Not enough datapoints.**

77% of savings have been identified for 2023/24 which is £13.8m of the £17.9m target.

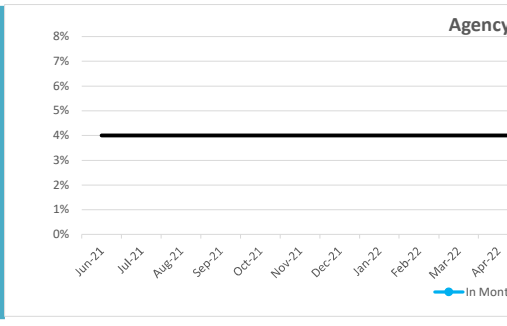
The Trust is working to identify recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust. Of the £13.8m identified £11.4m are non recurrent.

CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT conversations with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust. The plan for 2023/24 continues to be developed for the £17.9m target.

To support all CBU's and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.

**UoR**  
The Trust Agency spend in month is 5.3% against a target of 3.7%

81. Agency Ceiling  
Target: Agency spend should not exceed 3.7% of total pay (ICS)



**Assurance:** The Trust consistently fails the target.  
**Variation:** Special Cause Variation of a concerning nature.

The Trust Agency spend is above the agency ceiling due to industrial action open escalation areas and vacancies.

The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as:

- Agency controls best practice
- Rostering compliance
- Rate card compliance
- Establishment Control compliance (or an alternative approach)
- Unplanned absences
- Recruitment activity

### Appendix 3 – Trust IPR Indicator Overview

|                            | Indicator   | Detail  |
|----------------------------|---|---|
|                            | <b>Quality</b>  |   |
| 1.                         | <b>Incidents</b>  | <ul style="list-style-type: none"> <li>• Number of incidents reported in month.</li> <li>• Number of incidents open over 20 days and 40 days.</li> <li>• Number of serious incidents reported in month.</li> <li>• Number of serious incidents where actions have breached the timescale.</li> <li>• Number of never events reported in month.</li> </ul>   |
| 2.                         | <b>Duty of Candour</b>  | <ul style="list-style-type: none"> <li>• Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where the Trust contacts the patient or their family to advise of the incident; this has to be done within 10 working days.</li> </ul>   |
| 3.<br>4.<br>5.<br>6.<br>7. | <b>Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)</b> | <ul style="list-style-type: none"> <li>• Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.</li> <li>• MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.</li> <li>• Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.</li> <li>• Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.</li> <li>• 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.</li> <li>• Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.</li> </ul> |
| 9.                         | <b>Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks</b>                     | <ul style="list-style-type: none"> <li>• Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission.</li> <li>• Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).</li> </ul>   |
| 10.                        | <b>VTE Assessment</b>   | <ul style="list-style-type: none"> <li>• 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.</li> </ul>   |
| 11.                        | <b>Inpatient Falls &amp; Harm Levels</b>  | <ul style="list-style-type: none"> <li>• Total number of falls which have occurred in month.</li> <li>• Falls per 1000 bed days in month.</li> <li>• Total number of inpatient falls which have occurred in month.</li> <li>• Levels of harm reported as a result of a fall in month.</li> <li>• Level of avoidable harm which has occurred in month.</li> </ul>  |
| 12.                        | <b>Pressure Ulcers</b>  | <ul style="list-style-type: none"> <li>• Pressure ulcers, also known as pressure sores, bedsore 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 &amp; 4).</li> </ul>  |

|                          |  |  |
|--------------------------|--|--|
| 13.                      | <b>Medication Safety</b>                                   | <p>Overview of the current position in relation to medication, to include:</p> <ul style="list-style-type: none"> <li>• Medication reconciliation within 24 hours.</li> <li>• Medication reconciliation throughout the inpatient stay.</li> <li>• Number of controlled drugs incidents.</li> <li>• Number medication incidents resulting in harm.</li> </ul>   |
| 14.                      | <b>Staffing Average Fill Levels</b>                        | <ul style="list-style-type: none"> <li>• 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.</li> </ul>  |
| 15.                      | <b>Care Hours Per Patient Day (CHPPD)</b>                  | <ul style="list-style-type: none"> <li>• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.</li> </ul>  |
| 16.                      | <b>HSMR Mortality Ratio</b>                                | <ul style="list-style-type: none"> <li>• 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.</li> </ul>   |
| 17.                      | <b>SHMI Mortality Ratio</b>                                | <ul style="list-style-type: none"> <li>• 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.</li> </ul>  |
| 18.                      | <b>NICE Compliance</b>                                     | <ul style="list-style-type: none"> <li>• 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.</li> </ul>  |
| 19.                      | <b>Complaints</b>  | <p>Overall review of the current complaints position including;</p> <ul style="list-style-type: none"> <li>• Number of complaints received in month.</li> <li>• Number of dissatisfied complaints in month.</li> <li>• Total number of open complaints in month.</li> <li>• Total number of cases over 6 months old in month.</li> <li>• Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month.</li> <li>• Number of complaints responded to within timeframe in month.</li> <li>• Number of PALS complaints received and closed in month.</li> </ul> |
| 20.                      | <b>Friends and Family Test (Inpatient &amp; Day Cases)</b> | <ul style="list-style-type: none"> <li>• Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?</li> </ul>  |
| 21.                      | <b>Friends and Family (ED and UCC)</b>                     | <ul style="list-style-type: none"> <li>• 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?</li> </ul>  |
| 22.                      | <b>Mixed Sex Accommodation Breaches (Non-ITU)</b>          | <ul style="list-style-type: none"> <li>• Number of MSA Breaches in month (outside of ITU).</li> </ul>  |
| 23.<br>24.<br>25.<br>26. | <b>Sepsis</b>  | <ul style="list-style-type: none"> <li>• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.</li> </ul>   |

|                                 |  |   |
|---------------------------------|--|---|
| 27.                             | <b>Ward Moves Between 10pm and 6am</b>           | <ul style="list-style-type: none"> <li>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.</li> </ul>  |
| 28.                             | <b>Acute Kidney Injury</b>                       | <ul style="list-style-type: none"> <li>Number of hospital acquired Acute Kidney Injuries (AKI) in month.</li> <li>Average Length of Stay (LoS) of patients within a AKI.</li> </ul>   |
| 29.                             | Postpartum Haemorrhage >1500ml                   | <ul style="list-style-type: none"> <li>To monitor rates of PPH (Postpartum haemorrhage) &gt;1500mls against North West Coast Regional Dashboard.</li> <li>PPH&gt;1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH&gt;1500mls when compared to the North West Coast Maternity Dashboard.</li> </ul>  |
| 30.                             | 3 <sup>rd</sup> and 4 <sup>th</sup> Degree tears | <ul style="list-style-type: none"> <li>To monitor rates of 3<sup>rd</sup> &amp; 4<sup>th</sup> degree tears against North West Coast Regional Dashboard.</li> <li>WHH are not currently an outlier for 3<sup>rd</sup> &amp; 4<sup>th</sup> degree when compared to the North West Coast Maternity Dashboard, but 3<sup>rd</sup> and 4<sup>th</sup> degree tears are a significant outcome with the potential for long term impact of women's health and wellbeing.</li> </ul> |
| 31.                             | 3 <sup>rd</sup> and 4 <sup>th</sup> Degree tears | <ul style="list-style-type: none"> <li>To monitor pregnancy bookings met within the 10 and 13 week target.</li> <li>Timeliness of pregnancy booking is a key performance indicator.</li> <li>WHH is currently an outlier for bookings before 10 weeks when compared to the North West Coast Maternity Dashboard.</li> <li>WHH is also currently an outlier for bookings before 13 weeks gestation when compared to the North West Coast Maternity Dashboard</li> </ul>        |
| 32.                             | Fractured Neck of Femur                          | <ul style="list-style-type: none"> <li>The % of patients treated in line with Best Practice Tariff (BPT).</li> <li>The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)).</li> <li>Shorter time to theatres significantly reduces risk of mortality and improves pain.</li> </ul>  |
| 33.                             | <i>MUST nutritional assessment completion</i>    | <ul style="list-style-type: none"> <li>To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE)</li> <li>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</li> </ul>  |
| <b>Access &amp; Performance</b> |  |   |
| 34.                             | <b>Diagnostic Waiting Times – 6 weeks</b>        | <ul style="list-style-type: none"> <li>All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.</li> </ul>  |

|            |  |  |
|------------|--|--|
| 35.<br>67. | <b>RTT Open Pathways and 52 &amp; 65 week waits</b>  | <ul style="list-style-type: none"> <li>Percentage of incomplete pathways waiting within 18 weeks.</li> <li>Number of patients waiting over 52 weeks.</li> <li>Number of patients waiting over 104 weeks.</li> </ul>  |
| 36.        | <b>Four hour A&amp;E Target and ICS Trajectory</b>   | <ul style="list-style-type: none"> <li>All patients who attend A&amp;E should wait no more than 4 hours from arrival to admission, transfer or discharge.</li> </ul>   |
| 37.        | <b>A&amp;E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.</b> | <ul style="list-style-type: none"> <li>% of patients who has experienced a wait in A&amp;E longer than 12 hours from arrival to admission, transfer or discharge.</li> </ul>   |
| 38.        | <b>Average Time in Department (ED)</b>   | <ul style="list-style-type: none"> <li>How long on average a patient stays within the emergency department (ED).</li> </ul>  |
| 39.        | <b>Cancer 14 Days</b>  | <ul style="list-style-type: none"> <li>All patients need to receive their first appointment for cancer within 14 days of urgent referral.</li> </ul>   |
| 40.        | <b>Breast Symptoms – 14 Days</b>   | <ul style="list-style-type: none"> <li>All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.</li> </ul>   |
| 41.        | <b>Cancer – 28 Day Faster Diagnostic Standard</b>  | <ul style="list-style-type: none"> <li>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.</li> </ul>  |
| 42.        | <b>Cancer 31 Days - First Treatment</b>  | <ul style="list-style-type: none"> <li>All patients to receive first treatment for cancer within 31 days of decision to treat.</li> </ul>  |
| 43.        | <b>Cancer 31 Days - Subsequent Surgery</b>   | <ul style="list-style-type: none"> <li>All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.</li> </ul>   |
| 44.        | <b>Cancer 31 Days - Subsequent Drug</b>  | <ul style="list-style-type: none"> <li>All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments.</li> </ul>   |
| 45.        | <b>Cancer 62 Days - Urgent</b>   | <ul style="list-style-type: none"> <li>All patients to receive first treatment for cancer within 62 days of an urgent referral.</li> </ul>   |
| 46.        | <b>Cancer 62 Days – Screening</b>  | <ul style="list-style-type: none"> <li>All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers.</li> </ul>   |
| 47.        | <b>Ambulance Handovers 15</b>  | <ul style="list-style-type: none"> <li>% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).</li> </ul>   |
| 48.        | <b>Ambulance Handovers 30 – 60 minutes</b>   | <ul style="list-style-type: none"> <li>% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).</li> </ul>   |
| 49.        | <b>Ambulance Handovers – more than 60 minutes</b>  | <ul style="list-style-type: none"> <li>% of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).</li> </ul>   |
| 50.        | <b>Discharge Summaries – Sent within 24 hours</b>  | <ul style="list-style-type: none"> <li>The Trust is required to issue and send electronically a fully contractually compliant Discharge Summary within 24 hrs of the patient’s discharge. This metric relates to Inpatient Discharges only.</li> </ul>                         |
| 51.        | <b>Discharge Summaries – Not sent within 7 days</b>  | <ul style="list-style-type: none"> <li>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.</li> </ul> |
| 52.        | <b>Cancelled operations on the day for non-clinical reasons</b>  | <ul style="list-style-type: none"> <li>% of operations cancelled on the day or after admission for non-clinical reasons.</li> </ul>  |
| 53.        | <b>Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days</b>                    | <ul style="list-style-type: none"> <li>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.</li> </ul>   |
| 54.        | <b>Urgent Operations – Cancelled for a 2<sup>nd</sup> Time</b>   | <ul style="list-style-type: none"> <li>Number of urgent operations which have been cancelled for a 2<sup>nd</sup> time.</li> </ul>   |

|                  |   |   |
|------------------|---|---|
| 55.              | <b>Super Stranded Patients</b>  | <ul style="list-style-type: none"> <li>Stranded Patients are patients with a length of stay of 7 days or more.</li> </ul> <p>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.</p>  |
| 56.              | <b>Elective Recovery Activity</b>                                       | <ul style="list-style-type: none"> <li>% of Elective Activity (Inpatients &amp; Day Cases) against the same period in 2019/20.</li> </ul>   |
| 57.              | <b>Elective Recovery Diagnostics</b>                                    | <ul style="list-style-type: none"> <li>% of Diagnostic Activity against the same period in 2019/20.</li> </ul>  |
| 58.              | <b>Elective Recovery Outpatients</b>                                    | <ul style="list-style-type: none"> <li>% of Outpatient Activity against the same period in 2019/20.</li> </ul>  |
| 59.              | <b>Fracture Clinic</b>  | <ul style="list-style-type: none"> <li>The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.</li> </ul>   |
| 60.              | <b>% Outpatient referred to long covid service within 15 weeks</b>      | <ul style="list-style-type: none"> <li></li> </ul>  |
| 61.              | <b>% of zero-day length of stay admissions (SDEC)</b>                   | <ul style="list-style-type: none"> <li>% of zero length of stay admission (SDEC).</li> </ul>  |
| 62.              | <b>Reduction in Outpatient Follow Ups</b>                               | <ul style="list-style-type: none"> <li>% reduction of Outpatient follow ups compared to 19/20 activity.</li> </ul>  |
| 63.              | <b>COVID-19 Recovery Cancer First Treatment</b>                         | <ul style="list-style-type: none"> <li>% of people who received their first treatment for cancer compared to the equivalent month in 19/20.</li> </ul>  |
| 64.              | <b>% Patients discharged to their usual place of residence</b>          | <ul style="list-style-type: none"> <li>% of patients who were discharged to their usual place of residence.</li> </ul>  |
| 65.              | <b>Theatre Utilisation (measured as productive operating time only)</b> | <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul> |
| 66.              | <b>Day case (measured as an aggregate of total cases)</b>               |   |
| <b>Workforce</b> |   |   |
| 68.              | <b>Supporting Attendance</b>  | Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.  |
| 69.              | <b>Retention</b>  | Staff retention rate % over the last 12 months.   |
| 70.              | <b>Turnover</b>   | A review of the turnover % over the last 12 months.   |
| 71.              | <b>Bank &amp; Agency Reliance</b>                                       | The Trust reliance on bank/agency staff.  |
| 72.              | <b>Core/Mandatory Training</b>  | A summary of the Core/Mandatory Training Compliance, this includes:<br>Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.  |
| 73.              | <b>Safeguarding Training</b>  | A summary of safeguarding training compliance.  |
| 74.              | <b>Performance &amp; Development Review (PDR)</b>                       | A summary of the PDR compliance rate.   |
| <b>Finance</b>   |   |   |
| 75.              | <b>Trust Financial Position</b>   | The Trust operating surplus or deficit compared to plan.  |
| 76.              | <b>Cash Balance</b>   | The cash balance at month end compared to plan.   |

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

## Appendix 4 - Statistical Process Control

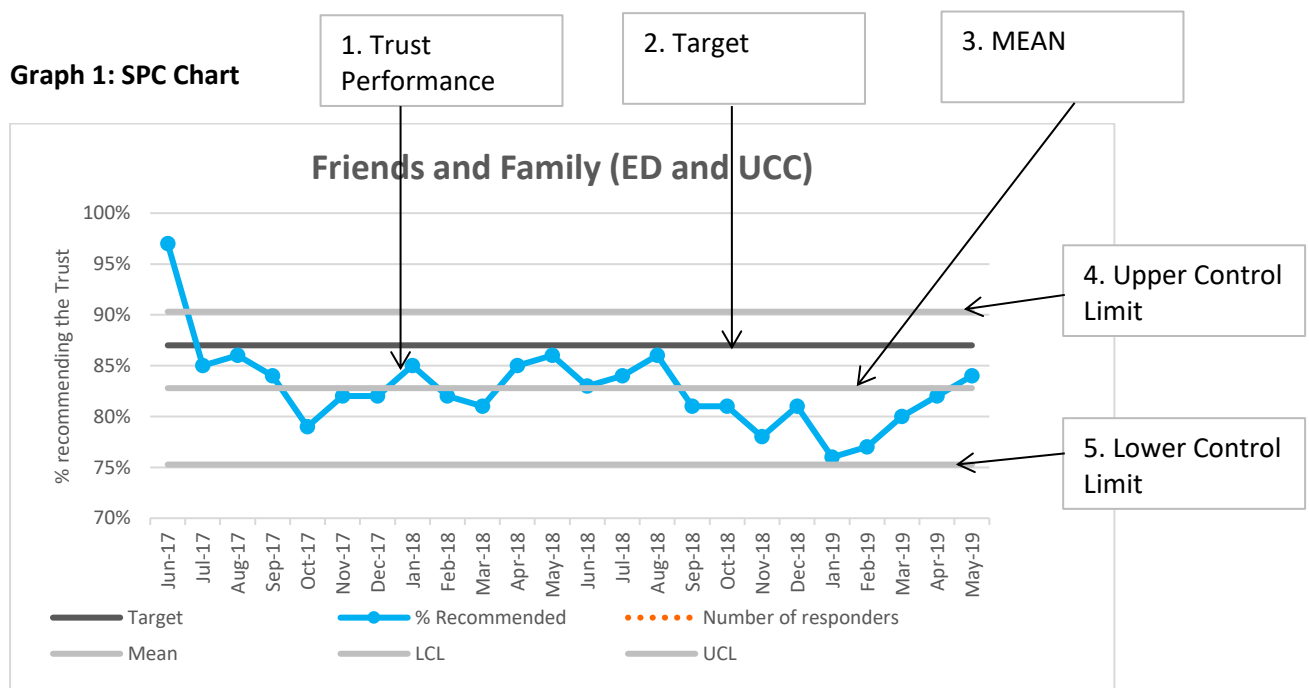
### 1.0 What is SPC?

Statistical Process Control (SPC) is a 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 as 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.

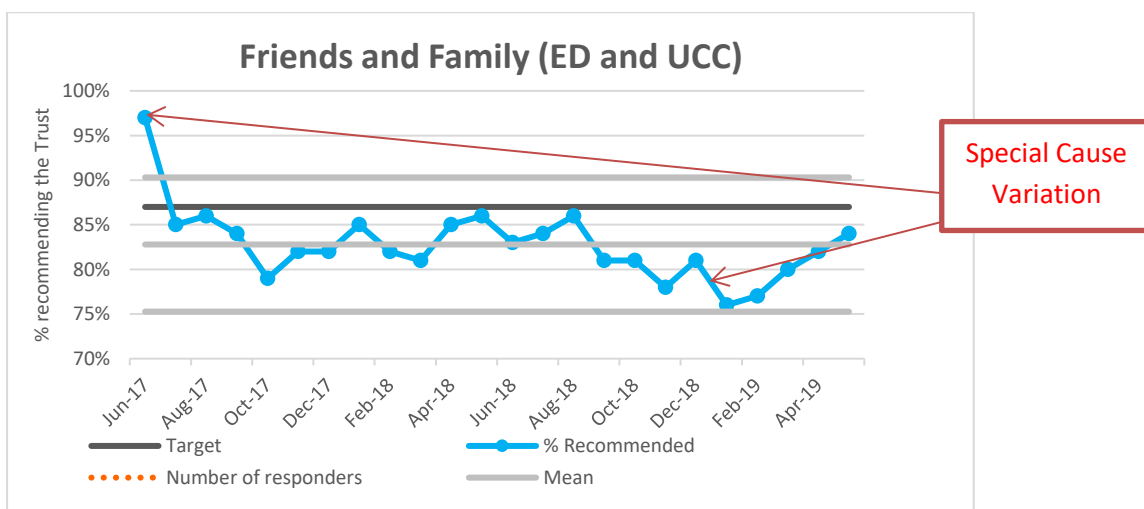


## 2.1 Interpreting a SPC Chart

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 30 April 2023

| Income Statement                                       | Annual          | Month          |                |                  | Year to date   |                |                  |
|--|-----------------|----------------|----------------|------------------|----------------|----------------|------------------|
|  | Budget<br>£000  | Budget<br>£000 | Actual<br>£000 | Variance<br>£000 | Budget<br>£000 | Actual<br>£000 | Variance<br>£000 |
| <b>Operating Income</b>                                |                 |                |                |                  |                |                |                  |
| <b>NHS Clinical Income</b>                             |                 |                |                |                  |                |                |                  |
| Elective Spells  | 38,334          | 2,680          | 2,041          | -639             | 2,680          | 2,041          | -639             |
| Elective Excess Bed Days                               | 80              | 6              | 0              | -6               | 6              | 0              | -6               |
| Non Elective Spells                                    | 77,289          | 6,628          | 6,448          | -180             | 6,628          | 6,448          | -180             |
| Non Elective Bed Days                                  | 0               | 0              | 200            | 200              | 0              | 200            | 200              |
| Non Elective Excess Bed Days                           | 3,140           | 269            | 0              | -269             | 269            | 0              | -269             |
| Outpatient Attendances                                 | 43,649          | 3,356          | 2,717          | -639             | 3,356          | 2,717          | -639             |
| Accident & Emergency Attendances                       | 17,017          | 1,389          | 1,433          | 44               | 1,389          | 1,433          | 44               |
| Other Activity   | 97,777          | 8,615          | 9,885          | 1,270            | 8,615          | 9,885          | 1,270            |
| ERF  | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| COVID Block and System Top Up                          | 24,744          | 2,062          | 2,062          | 0                | 2,062          | 2,062          | 0                |
| <b>Sub total</b>                                       | <b>302,030</b>  | <b>25,005</b>  | <b>24,786</b>  | <b>-219</b>      | <b>25,005</b>  | <b>24,786</b>  | <b>-219</b>      |
| <b>Non NHS Clinical Income</b>                         |                 |                |                |                  |                |                |                  |
| Private Patients                                       | 8               | 1              | 1              | 0                | 1              | 1              | 0                |
| Non NHS Overseas Patients                              | 60              | 5              | 9              | 4                | 5              | 9              | 4                |
| Other non protected                                    | 728             | 61             | 54             | -6               | 61             | 54             | -6               |
| <b>Sub total</b>                                       | <b>796</b>      | <b>66</b>      | <b>64</b>      | <b>-2</b>        | <b>66</b>      | <b>64</b>      | <b>-2</b>        |
| <b>Other Operating Income</b>                          |                 |                |                |                  |                |                |                  |
| Training & Education                                   | 9,093           | 758            | 758            | 0                | 758            | 758            | 0                |
| Donations and Grants                                   | 2,095           | 349            | 42             | -307             | 349            | 42             | -307             |
| Miscellaneous Income                                   | 14,620          | 1,217          | 1,297          | 80               | 1,217          | 1,297          | 80               |
| <b>Sub total</b>                                       | <b>25,808</b>   | <b>2,324</b>   | <b>2,097</b>   | <b>-227</b>      | <b>2,324</b>   | <b>2,097</b>   | <b>-227</b>      |
| <b>Total Operating Income</b>                          | <b>328,634</b>  | <b>27,395</b>  | <b>26,947</b>  | <b>-448</b>      | <b>27,395</b>  | <b>26,947</b>  | <b>-448</b>      |
| <b>Operating Expenses</b>                              |                 |                |                |                  |                |                |                  |
| Employee Benefit Expenses                              | -242,246        | -20,695        | -21,023        | -328             | -20,695        | -21,023        | -328             |
| Drugs  | -20,191         | -1,711         | -1,455         | 256              | -1,711         | -1,455         | 256              |
| Clinical Supplies and Services                         | -22,298         | -1,946         | -2,085         | -139             | -1,946         | -2,085         | -139             |
| Non Clinical Supplies                                  | -38,134         | -3,221         | -3,443         | -222             | -3,221         | -3,443         | -222             |
| Depreciation and Amortisation                          | -14,542         | -1,175         | -1,120         | 55               | -1,175         | -1,120         | 55               |
| Net Impairments (DEL)                                  | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| Net Impairments (AME)                                  | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| Restructuring Costs                                    | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| <b>Total Operating Expenses</b>                        | <b>-337,411</b> | <b>-28,748</b> | <b>-29,125</b> | <b>-377</b>      | <b>-28,748</b> | <b>-29,125</b> | <b>-377</b>      |
| <b>Operating Surplus / (Deficit)</b>                   | <b>-8,777</b>   | <b>-1,353</b>  | <b>-2,178</b>  | <b>-825</b>      | <b>-1,353</b>  | <b>-2,178</b>  | <b>-825</b>      |
| <b>Non Operating Income and Expenses</b>               |                 |                |                |                  |                |                |                  |
| Profit / (Loss) on disposal of assets                  | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| Interest Income  | 518             | 136            | 151            | 15               | 136            | 151            | 15               |
| Interest Expenses                                      | -191            | -16            | -9             | 7                | -16            | -9             | 7                |
| PDC Dividends  | -5,679          | -473           | -473           | 1                | -473           | -473           | 1                |
| <b>Total Non Operating Income and Expenses</b>         | <b>-5,352</b>   | <b>-353</b>    | <b>-331</b>    | <b>22</b>        | <b>-353</b>    | <b>-331</b>    | <b>22</b>        |
| <b>Surplus / (Deficit) - as per Accounts</b>           | <b>-14,129</b>  | <b>-1,706</b>  | <b>-2,509</b>  | <b>-803</b>      | <b>-1,706</b>  | <b>-2,509</b>  | <b>-803</b>      |
| <b>Adjustments to Financial Performance</b>            |                 |                |                |                  |                |                |                  |
| Less Impact of I&E (Impairments)/Reversals DEL         | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| Less Impact of I&E (Impairments)/Reversals AME         | 0               | 0              | 0              | 0                | 0              | 0              | 0                |
| Less Donations & Grants Income                         | -2,095          | -349           | -42            | 307              | -349           | -42            | 307              |
| Add Depreciation on Donated & Granted Assets           | 475             | 40             | 37             | -3               | 40             | 37             | -3               |
| <b>Total Adjustments to Financial Performance</b>      | <b>-1,620</b>   | <b>-310</b>    | <b>-5</b>      | <b>304</b>       | <b>-310</b>    | <b>-5</b>      | <b>304</b>       |
| <b>Adjusted Surplus / (Deficit) as per NHSI Return</b> | <b>-15,748</b>  | <b>-2,015</b>  | <b>-2,514</b>  | <b>-499</b>      | <b>-2,015</b>  | <b>-2,514</b>  | <b>-499</b>      |

### BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

|                          |                 |  |             |                        |                           |
|--------------------------|-----------------|--|-------------|------------------------|---------------------------|
| <b>AGENDA REFERENCE:</b> | BM/23/06/56a(i) |  | Trust Board | <b>DATE OF MEETING</b> | 7 <sup>th</sup> June 2023 |
|--------------------------|-----------------|--|-------------|------------------------|---------------------------|

|                          |  |
|--------------------------|--|
| Date of Meeting          | 11 April 2023  |
| Name of Meeting & Chair  | Quality Assurance Committee, Chaired by Cliff Richards |
| Was the meeting quorate? | Yes  |

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

| Ref          | Agenda Item  | Issue And Lead Officer   | Recommendation / Assurance/ mandate to receiving body   | Follow up/ Review date          |
|--------------|--|--|---|---------------------------------|
| QAC/23/04/72 | <b>Paediatric Audiology Incident - Progress Report</b> | <p>The Committee received the report providing an update on the incident including the confirmation of commissioning arrangements with Northern Care Alliance (NCA).</p> <p>The Committee received assurance around the clinics being supported by NCA and note that the backlog had been cleared and the ongoing training for WHH staff at sites across the NCA.</p> <p>A full ABR service review commenced on 6<sup>th</sup> March and all cases received back, including queries. Several cases had been identified outside of the review scope; these would be reviewed by NCA.</p> <p>The Committee received details on the next steps, including communication with affected families, consideration of a further look back (prior to 2018) and working with Bridgewater Community Trust (BCT), ICB and work with the National Team around pathway issues.</p> | The Committee discussed the update and received moderate assurance on the position, noting that further work was underway to review cases outside of the peer review scope. | QAC to receive monthly updates. |
| QAC/23/04/74 | <b>Maternity Update – Ockenden Review Update</b>       | The Committee received a comprehensive report providing an update around Ockenden recommendations.   | The Committee discussed the report and received acceptable assurance on the   | Quality Committee Monthly       |

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|              |  | <p>The Committee noted that the Trust had 3 Ockenden action plans:</p> <ul style="list-style-type: none"> <li>• <b>Ockenden Part 1a:</b> WHH is 100% compliant.</li> <li>• <b>Ockenden 1b:</b> WHH is 94.91% compliant and on trajectory to be 100% compliant by 31<sup>st</sup> May 2023.</li> <li>• <b>Ockenden 2:</b> WHH is 60.81% compliant and was on trajectory to be 100% compliant by 30<sup>th</sup> June 2023. This trajectory has been impacted by cancellation of a 6-month High Dependency Training Programme scheduled for Band 7 staff, training had been rescheduled. It was noted that there were no national timelines for Ockenden 2. WHH had set internal compliance timelines.</li> </ul> <p>The Committee took assurance from the final report received by the CBU on 13 March 2023 following the MIAA audit of Ockenden 2 actions. The report gave a rating of Substantial Assurance.</p> | progress against the Ockenden action plans.  | Assurance Reporting                        |
| QAC/23/04/76 | <b>Perinatal Mortality Annual Report</b> | <p>The Committee received the report which provided an analysis of still births and neonatal deaths from 1/1/2022 – 31/12/2022 along with an overview of the key findings, learning and good practice for each of the cases.</p> <p>The Committee took assurance from the data which did not identify WHH as an outlier, and confirmed that robust reviews of each of the cases had taken place using the Perinatal Review Tool which had been developed to standardise reviews of stillbirths and neonatal deaths across England, Scotland and Wales. The committee noted the evidence of good practice and lessons learned during the mortality reviews.</p>  | The Committee discussed the report and received acceptable assurance on the data reported and learning identified. | Annual Reports to the Committee            |
| QAC/23/02/77 | <b>Arbury Court Update</b>               | <p>The Committee received an update on the escalations and the agreed system approach in relation to the issues and concerns raised at Arbury Court.</p> <p>Meetings had taken place with system partners (PLACE, Adult Safeguarding Board representation, Local Authority, Specialist Commissioners, NHSE/I, Director of Arbury Court, CQC also informed of concerns raised by WHH) to discuss and review the concerns. A number of actions had been identified,</p>   | The Committee discussed the update and received moderate assurance on the progress to date.                        | May 2023 – QAC to receive a further update |



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|  |  | <p>with a commitment to taking forward prior to the next meeting 24<sup>th</sup> April 2023.</p> <p>The Committee agreed monthly updates would continue until sufficient assurance was received.</p> |  |  |
|--|--|--|--|--|

**The Committee also received the following items:**

**QAC/23/04/68** Hot Topic – Patient Story – Patient Safety Incident Response Framework “A Patients Perspective”

**QAC/23/04/69** Hot Topic – AMD Ophthalmology

**QAC/23/04/70** Deep Dive – Third- & Fourth-Degree Tears

**Matters for Approval**

**QAC/23/04/71** Board Assurance Framework & Risk Register

**Papers to Discuss and Note for Assurance**

**QAC/23/04/73** Arthroplasty SSI Audit & External Review Update

**QAC/23/04/75** Digital Maternity Update

**QAC/23/04/78** Clinical Audit Bi-Annual Report

**QAC/23/04/79** Quality Improvement Progress Bi-Annual Report

**Papers to Note for Assurance**

**QAC/23/04/80** Patient Safety & Clinical Effectiveness Sub Committee Exception Report

**QAC/23/04/81** Committee Effectiveness Review Results

**QAC/23/04/82** Patient Experience Sub-Committee Bi-Annual report

**QAC/23/04/83** Patient Equality, Diversion & Inclusion Sub Committee Bi-Annual report

**QAC/23/04/84** Ward Accreditation Bi-Annual Report

**QAC/23/04/85** High level enquiries & External Assessment / Inspections (when notified)

**BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT**

|                          |                   |  |             |                        |                           |
|--------------------------|-------------------|--|-------------|------------------------|---------------------------|
| <b>AGENDA REFERENCE:</b> | BM/23/06/56a (ii) |  | Trust Board | <b>DATE OF MEETING</b> | 7 <sup>th</sup> June 2023 |
|--------------------------|-------------------|--|-------------|------------------------|---------------------------|

|                          |  |
|--------------------------|--|
| Date of Meeting          | 9 <sup>th</sup> May 2023                               |
| Name of Meeting & Chair  | Quality Assurance Committee, Chaired by Cliff Richards |
| Was the meeting quorate? | Yes  |

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

| Ref          | Agenda Item   | Issue And Lead Officer  | Recommendation / Assurance/ mandate to receiving body                                       | Follow up/ Review date |
|--------------|---|---|---|------------------------|
| QAC/23/05/91 | <b>Hot Topic – Intensive Care Unit (ICU) Length of Stay</b> | <p>The Committee received a presentation which provided background on the Guidelines for the Provision of Intensive Care Services (GPICS), specifically that Level 1 patients should be discharged from ITU to a ward area within 4 hours of the decision, noting that due to capacity challenges across the Trust delays had been experienced in these transfers.</p> <p>The Committee noted the current estate issues and the negative impact on patients and their families/carers during a prolonged ITU stay.</p> <p>The Committee took some assurance on the actions in place and next steps to improve the position.</p> | The Committee received moderate assurance noting the actions in place and next steps        |                        |
| QAC/23/05/92 | <b>Deep Dive – Post Partum Haemorrhage (PPH)</b>            | <p>The Committee received the presentation which had been requested due WHHs underperformance (3.9%) against the NW benchmark (3.5%) in January and February 2023.</p> <p>The Committee received assurance on the processes in place to robustly record weighed blood loss, and noted the areas identified for improvement in both digital reporting and clinical practice.</p>   | The Committee received moderate assurance noting the recommendations and completed actions. |                        |

|                     |  |  |  |  |
|---------------------|--|--|--|--|
|                     |  | The Committee noted the recommendations to improve which had been actioned, and the further work identified to drive further improvements.   |  |  |
| <b>QAC/23/05/94</b> | <b>Update report for the management of patients with Sepsis at WHH</b> | <p>The Committee received the report which provided a progress update on improving compliance with Sepsis Assessment and Treatment for patients at WHH.</p> <p>The Committee noted that while improvements in compliance for screening and administration of antibiotics within the hour for both the ED and inpatient position has been observed from Q4 to Q3, the improvements were not consistently maintained.</p> <p>The Committee took some assurance from the progress against actions noting the challenges around high number of attendances through the ED, staffing capacity and the continued position of high numbers of patients with no right to reside/ super stranded, accepting that this was a system wide issue, evidenced from the benchmarking data provided.</p> | The Committee discussed the update and received moderate assurance on the position, noting the system wide and national pressures. | Continued progress reporting to QAC through the Quality governance reporting structure.          |
| <b>QAC/23/05/95</b> | <b>Draft Quality Account</b>   | <p>The Committee received the draft Quality Account which was supported, it was noted that the committee had the opportunity to provide further comments/feedback up until 16<sup>th</sup> May, following which the final version would be circulated to digitally for Committee approval</p> <p>It was noted that the Final approved Quality Account would be presented to the Audit Committee in at its June meeting.</p>  | The Committee supported the draft Quality Account.   | Final approved Quality Account would be presented to the Audit Committee in at its June meeting. |
| <b>QAC/23/05/96</b> | <b>Arbury Court Update</b>   | <p>The Committee received an update on the escalations and the agreed system approach in relation to the issues and concerns raised at Arbury Court.</p> <p>The Committee received assurance on the progress against the actions identified and noted the completion of the Grand Round training session, with a presentation to Arbury Court and WHH staff. It had been agreed that Arbury Court would attend a Nursing and Midwifery Forum/</p>  | The Committee discussed the update and received moderate assurance on the progress to date.  | Bi-monthly reporting to QAC until sufficient assurance was received and reviews concluded.       |

|                      |  |  |   |  |
|----------------------|--|--|---|--|
| <b>QAC/23/05/97</b>  | <b>Paediatric Audiology Incident - Progress Report</b> | <p>The Committee received the report providing an update on the incident including the confirmation of commissioning arrangements with Northern Care Alliance (NCA) which ensures the WHH ABR pathway is safe.</p> <p>The Committee noted that WHH were to be part of a wider peer review group from May. It was further noted that there were 48 cases Identified cases with a shared WHH and Bridgewater Community Trust (BWCHT), the Trust working with BCT to map the pathway for these cases.</p> <p>The Committee received details on the next steps, including the Incident Response Group and Task and Finish Group, continued work with the NCA team and maintain service safety, communications with families, commissioning new equipment purchased for audiology services and commencing the IQPS business case.</p> | The Committee discussed the update and received moderate assurance on the position, noting the ongoing work.  | QAC to receive a final update in June.         |
| <b>QAC/23/05/100</b> | Liberty Protection Services Update                     | <p>The Committee received an update on the position, noting that LPS would form part of the Mental Capacity Framework and that this was the most significant change in health and social care since the Care Act began.</p> <p>The Committee were informed that following consultation LPS was now paused for the remainder of government term in office (another 12 months). The committee took assurance that the current scheme continues to remain unchanged and in place until the new scheme comes into effect which would be supported by a national training programme.</p>  | The Committee discussed the update and received moderate assurance on the continuation of the current scheme. | Updates to be reported into QAC in due course. |

**The Committee also received the following items:**

- QAC/23/05/93** Move to Outstanding Update Q4
- QAC/23/05/98** DNACPR 6 Month position Report
- QAC/23/05/99** CIP/GIRFT Quality Impact Assessment
- QAC/23/05/101** Maternity Update
  - i. Ockenden Review Update
  - ii. Perinatal Mortality Update Q4



**QAC/23/05/102** Maternity Governance Quarterly Update

**QAC/23/05/103** Learning from Experience Q4

**QAC/23/05/104** DIPC Infection Control Update Q4

**QAC/23/05/105** Violence Reduction Strategy – Bi-Annual Update to Board

**QAC/23/05/106** Dementia Strategy Annual Review

**Papers to Discuss and Note for Assurance**

**QAC/23/05/108** Patient Safety & Clinical Effectiveness Sub Committee Exception Report

**QAC/23/05/109** IG & Corporate Records Update Q4

**QAC/23/05/110** High level enquiries & External Assessment / Inspections (when notified)

### BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

|                          |                  |                 |             |                        |                           |
|--------------------------|------------------|-----------------|-------------|------------------------|---------------------------|
| <b>AGENDA REFERENCE:</b> | BM/23/06/56b (i) | <b>MEETING:</b> | Trust Board | <b>DATE OF MEETING</b> | 7 <sup>th</sup> June 2023 |
|--------------------------|------------------|-----------------|-------------|------------------------|---------------------------|

|                          |  |
|--------------------------|--|
| Date of Meeting          | 19 <sup>th</sup> April 2023              |
| Name of Meeting & Chair  | Strategic People Committee, Julie Jarman |
| Was the meeting quorate? | Yes                                      |

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

| REF          | AGENDA ITEM                             | ISSUE AND LEAD OFFICER  | Recommendation / Assurance/ mandate to receiving body  | Follow up/ Review date              |
|--------------|---|---|--|-------------------------------------|
| SPC/23/04/48 | <b>Job Planning</b>                     | The Committee received a presentation which provided the background to job plans, programmed activities (PAs) and the job planning process. It explained the current position, and the top five actions. It was noted that WHH was not in a bad position, however there was a need to improve on current completed job plans.   | <b>The Strategic People Committee noted the Deep Dive in relation to Job Planning and received a good level of assurance.</b>                          | <b>Not applicable</b>               |
| SPC/23/04/50 | <b>Chief People Officer Report</b>      | The Committee received the report which included an update on industrial action. The industrial action which took place over Easter was more difficult than previously, but there had been no reported clinical incidents associated with the action. It was noted that if this was to take place again, there was confidence that robust processes were now in place. A thank you was asked to be recorded to all those that helped out over the period of the strike. For AfC, Staff Council meeting scheduled 2 <sup>nd</sup> May, should know more regarding approach after this. | <b>The Strategic People Committee noted the contents of the report and received a good level of assurance regarding approach to industrial action.</b> | <b>SPC 17<sup>th</sup> May 2023</b> |
| SPC/23/04/51 | <b>Annual Hospital Volunteer Report</b> | The Committee received the report which included details of activity and achievements within the period of April 2022 to March 2023. The report provided an update on the insourcing of the (WHH) Volunteer Service and its development, and key statistics on recruitment including 86 new Volunteers recruited to support   | <b>The Strategic People Committee noted the contents of the report</b>   | <b>SPC April 2024</b>               |

|              |                               |  |  |                                |
|--------------|-------------------------------|--|--|--------------------------------|
|              |                               | the Trust, 31 existing Volunteers returning to support the Trust and 5,999 hours of support provided to the Trust by Volunteers.   | and received a good level of assurance.  |                                |
| SPC/23/04/52 | National Staff Opinion Survey | <p>The Committee received the findings of the 2022 Staff Survey. The organisation's response rate was 35%. The organisation is better than the average score in 5 areas and in line with the average score in 3 areas. The results show three themed areas of statistically significant decline when compared with the 2021 results:</p> <ul style="list-style-type: none"> <li>• We are recognised and rewarded</li> <li>• We each have a voice that counts</li> <li>• Staff engagement</li> </ul> <p>A breakdown of the survey results relating to Workforce Race Equality Standard and Workforce Disability Equality Standard were also included.</p> <p>Agreed to present to SPC a summary of Care Group and CBU level scores to ensure sufficient overview at department level.</p> | The Strategic People Committee noted the contents of the report and received moderate assurance. | SPC 21 <sup>st</sup> June 2023 |

The Committee also received the following items:

**Matters to Note for Assurance:**

SPC/23/04/45 - Committee Effectiveness Review Results

SPC/23/04/46 - Board Assurance Framework

SPC/23/04/47 – Hot Topic – CMAST Workforce Priorities 2023/24

SPC/23/04/49 – Certificate of Eligibility for Specialist Registration (CESR) for Substantive Consultants

SPC/23/04/53 – WHH People Strategy Update

**Sub-Committee Chairs Logs:**

SPC/23/04/54 – Nursing and AHP Workforce Resourcing Group (06.04.2023)

### BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

|                          |                   |                 |             |                        |                           |
|--------------------------|-------------------|-----------------|-------------|------------------------|---------------------------|
| <b>AGENDA REFERENCE:</b> | BM/23/06/56b (ii) | <b>MEETING:</b> | Trust Board | <b>DATE OF MEETING</b> | 7 <sup>th</sup> June 2023 |
|--------------------------|-------------------|-----------------|-------------|------------------------|---------------------------|

|                          |  |
|--------------------------|--|
| Date of Meeting          | 17 <sup>th</sup> May 2023                |
| Name of Meeting & Chair  | Strategic People Committee, Julie Jarman |
| Was the meeting quorate? | Yes                                      |

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

| REF          | AGENDA ITEM  | ISSUE AND LEAD OFFICER   | Recommendation / Assurance/ mandate to receiving body  | Follow up/ Review date |
|--------------|--|--|--|------------------------|
| SPC/23/05/59 | Staff Story – Theatres                                 | The Committee received a presentation on the Staff Story in Theatres and the positive progress that had been made to achieve People IPR targets. Building leadership capacity has made a huge difference and seen a very positive cultural change which is clearly visible. The Committee congratulated the work that had been undertaken and achievements of Theatres.  | The Strategic People Committee noted the Staff Story in relation to Theatres and received a good level of assurance. | Not applicable         |
| SPC/23/05/60 | Hot Topic – Industrial Action Update and Impact on WHH | The Committee received a presentation on industrial action and the impact at WHH. Included updates regarding AfC pay dispute, 4 TUs accepted, 2 not. Staff Council meeting 2 <sup>nd</sup> May, majority accepted offer. Communications have been issued to staff regarding payment in June. BMA and RCN out to ballot. Reviewed costs to the organisation for staffing and loss of activity due to IA. No safety incidents identified as a result of IA, been well managed across the organisation. | The Strategic People Committee noted the presentation and received a good level of assurance.                        | As requested,          |
| SPC/23/05/63 | Committee Chairs Annual Report to Trust Board          | The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presented the Strategic People Committee Annual Report  | The Strategic People Committee noted the contents of the report  | SPC May 2024           |

|              |  |  |   |                                    |
|--------------|--|--|---|------------------------------------|
|              |  | which covers the reporting period 1 <sup>st</sup> April 2022 – 31 <sup>st</sup> March 2023. The Committee approved the report.   | and received a good level of assurance.   |                                    |
| SPC/23/05/65 | <b>Improving People Practices Report</b>           | The Committee received the report provides an overview of the employee relations case management activity ongoing between October 2022 – March 2023 across the Trust. The report provided an overview of the level of activity, areas of risks, strategies to mitigate any identified risks, and wider actions to improve employee relations case management performance.  | The Strategic People Committee noted the contents of the report and received a good level of assurance. | SPC 22 <sup>nd</sup> November 2023 |
| SPC/23/05/66 | <b>Health and Wellbeing Guardian Annual report</b> | The Committee received the annual report which provides an overview of the annual activity that has supported the national Wellbeing Guardian principles and the assurances provided to the Wellbeing Guardian regarding how the organisation are responding to the needs of the workforce.<br><br>Further additional highlights were provided by way of a presentation which explained in more detail about the HWB Guardian and what is available to support WHH staff in relation to their wellbeing. | The Strategic People Committee noted the contents of the report and received a good level of assurance. | SPC May 2024                       |

The Committee also received the following items:

***Matters to Note for Assurance:***

- SPC/23/05/61 – HEE Funded Education Activity
- SPC/23/05/62 – Chief People Officer Report
- SPC/23/05/64 – Workforce IPR
- SPC/23/05/67 – Trust Board Monthly Staffing Report
- SPC/23/05/68 – Guardian of Safe Working Hours Report – Q4

***Sub-Committee Chairs Logs:***

- SPC/23/05/69 – Nursing and AHP Workforce Resourcing Group (04.05.2023)
- SPC/23/05/70 – Workforce Equality, Diversity and Inclusion Sub-Committee (05.05.2023)



**BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT**

|                          |                   |  |             |                        |               |
|--------------------------|-------------------|--|-------------|------------------------|---------------|
| <b>AGENDA REFERENCE:</b> | BM 23 06 56c (ii) |  | Trust Board | <b>DATE OF MEETING</b> | 26 April 2023 |
|--------------------------|-------------------|--|-------------|------------------------|---------------|

|                          |  |
|--------------------------|--|
| Date of Meeting          | 26 April 2023  |
| Name of Meeting & Chair  | Finance and Sustainability Committee, Chaired by John Somers |
| Was the meeting quorate? | Yes  |

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

| REF                 | AGENDA ITEM                         | ISSUE AND LEAD OFFICER   | Recommendation / Assurance/ mandate to receiving body                                | Follow up/ Review date |
|---------------------|-------------------------------------|--|--|------------------------|
| <b>FSC/23/04/03</b> | <b>Matters arising</b>              |  |  |                        |
| <b>FSC/23/04/06</b> | <b>Corporate Performance Report</b> | The Committee received the presentation noting:- <ul style="list-style-type: none"> <li>• Report to now be presented to FSC given CROC has been stepped down</li> <li>• Urgent care – 62.52% against 95% standard due to high NCTR and super stranded patients</li> <li>• Elective – 56.17% against 92% standard, in line with RTT improvement trajectory</li> <li>• Outpatient DNAs suggested as a deep dive</li> <li>• Diagnostics – 22.31% against a target of &lt;1% driven by Cardio Respiratory, mainly Sleep and Echo, insourcing being used to improve Echo</li> <li>• Cancer – 62 day 58.1% against 85% target, 31 day 98.44% vs 96% target, 2 week wait 89% against 93% and Symptomatic Breast Patients 75% against 93%</li> <li>• 78 week delivery – Finished March 23 with 49 patients breaching. 8 out of 12 providers in C&amp;M had breaches declared in March</li> </ul> | The Committee <b>noted</b> the presentation receiving <b>good</b> assurance          | <b>FSC May 2023</b>    |
| <b>FSC/23/04/07</b> | <b>Pay Assurance Report</b>         | The Committee received the report noting:- <ul style="list-style-type: none"> <li>• Letter to Chief Executives expected to state that a deficit organisation can't add to their establishment</li> </ul>   | The Committee <b>noted</b> and discussed the report, receiving <b>good</b> assurance | <b>FSC May 2023</b>    |

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|---------------------|--------------------------------------|---|--|---------------------|
|                     |                                      | <ul style="list-style-type: none"> <li>• Need to work as system re: bank and agency, agency cap still not provided for agency, expecting bank will go up to compensate</li> <li>• Controls around bank and agency are in place and will be strengthened with review at Finance Wednesday Executive Team meeting</li> </ul>  |  |                     |
| <b>FSC/23/04/08</b> | <b>Monthly CIP report</b>            | <p>The Committee received the report noting:-<br/><u>CIP</u></p> <ul style="list-style-type: none"> <li>• £14.9m achieved against a target of £15.7m for 2022/23</li> <li>• Significant level of non-recurrent CIP (£13.3m) and the risk this presents to 2023/24</li> <li>• £11.2m identified against £17.9m target for 2023/24</li> <li>• Planned Care identified £2.6m against a target of £4.6m</li> <li>• CSS identified £2.2m of £2.7m target</li> <li>• £1.1m of the £11.2m relates to GIRFT but this is contingent on delivery of activity above the 104% target</li> </ul> <p><u>GIRFT</u></p> <ul style="list-style-type: none"> <li>• Unplanned Care – two main focus areas, achievement of 76% ED targets, SAFER bundle and LoS</li> <li>• Planned Care – five high level projects – Theatre List planning, increase daycase activity (High Volume Low Complexity cases), Theatre 42 week capacity and job plans, Improve Neck of Femur Pathway, Theatre late starts</li> <li>• CSS – proposed as a deep dive next month</li> </ul> | The Committee discussed and <b>noted</b> the report and presentation receiving <b>moderate</b> assurance.                                      | <b>FSC May 2023</b> |
| <b>FSC/23/04/09</b> | <b>Covid pay related expenditure</b> | <p>The Committee received the report noting:-</p> <ul style="list-style-type: none"> <li>• Expenditure of £8.97m against a plan of £10.53m</li> <li>• COVID-19 schemes are now classed as business as usual and therefore monitoring to cease</li> </ul>  | The Committee discussed and <b>noted</b> the report and <b>approved</b> that monitoring will now cease. The Committee received good assurance. |                     |
| <b>FSC/23/04/10</b> | <b>Finance Report</b>                | The Committee received a report noting:-  | The Committee discussed the paper considering the review of capital  | <b>FSC May 2023</b> |

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|---------------------|-------------------------|--|---|--|
|                     |                         | <ul style="list-style-type: none"> <li>The Trust has delivered a deficit of £7.9m against the control total of £5.4m in relation to support from the ICS to contribute to the Adaptive Reserve supporting flow</li> <li>Updated capital spend £25.4m against a target of £25.6m (£162k under plan)</li> <li>Items for escalation from FRG and CPG</li> </ul>   | underspend and <b>approved</b> the capital requests. Moderate assurance received.   |  |
| <b>FSC/23/04/11</b> | <b>Capital Position</b> | <p>The Committee received a presentation noting:-</p> <ul style="list-style-type: none"> <li>£162k underspend, updated from the position on the slides during accounts preparation</li> <li>Schemes over £500k reviewed in detail including Catering, Town Deal, CDC and TIF.</li> <li>MIAA has concluded the review of the mortuary scheme, next step being to submit their report for Executive review</li> <li>Capital plan for 2023/24 currently oversubscribed by £1.1m, further suggested schemes will increase this to £1.5m oversubscribed. The schemes will be managed throughout the year to ensure envelope is not exceeded, supported to go to Board for approval</li> </ul> | The Committee <b>noted</b> the update and the risks and <b>supported</b> capital programme to the Trust Board. Moderate assurance received.                   | <b>FSC May 2023 &amp; Trust Board May 2023</b> |
| <b>FSC/23/04/12</b> | <b>Operational Plan</b> | <p>The Committee received a presentation noting:-</p> <ul style="list-style-type: none"> <li>Submission due noon 4<sup>th</sup> May and deficit needs to improve</li> <li>A number of improvements have been made from the previous submissions including a reduction in inflationary pressures now prices confirmed</li> <li>Revised position of £18.7m deficit</li> <li>C&amp;M currently system deficit and asked to improve overall position, therefore further improvements required from the Trust plan, with an ambition to improve by c£2-3m</li> </ul>  | The Committee <b>approved</b> the draft submission of £18.7m subject to further changes requested by the ICS. Moderate assurance received.                    | <b>Trust Board May 2023</b>                    |
| <b>FSC/23/04/13</b> | <b>Capital Requests</b> | <p>The Committee received a paper noting:-</p> <ul style="list-style-type: none"> <li>Maternity scheme, secured funding of £300k for triage and induction of labour bay</li> <li>Estimated costs for both elements currently exceed the funding secured therefore propose splitting schemes into Phase 1: Triage and Phase 2: Induction of Labour</li> </ul>   | The Committee <b>supported</b> the change to the Capital Programme, to split scheme into two phases and for phase 1 to progress. Moderate assurance received. | <b>Trust Board May 2023</b>                    |

|                     |                            |  |  |                              |
|---------------------|----------------------------|--|--|------------------------------|
|                     |                            | <ul style="list-style-type: none"> <li>• Funding available in 2023/24 to complete, Phase 1: Triage</li> <li>• Solution being worked on to address fully Phase 2: Induction of Labour</li> </ul>  |  |                              |
| <b>FSC/23/04/14</b> | <b>Elective TIF Update</b> | <p>The Committee received a presentation noting:-</p> <ul style="list-style-type: none"> <li>• Activity reducing from 1,440 to 1,890 due to 2 month delay in national approval</li> <li>• Activity is incorporated in the 103.8% activity plan</li> <li>• Income is now not additional to what is included in the baseline</li> <li>• Cost pressure of £965k, mitigations include reducing expenditure (workforce transformational review), deliver activity above the 103.8% target or increase CIP generation</li> <li>• Change request form to be submitted to NHS England detailing changes since submission of initial business case</li> </ul> | <p>The Committee <b>supported</b> the TIF update. Final approval will be requested in the Trust Board meeting in June 2023. Moderate assurance received.</p> | <b>Trust Board June 2023</b> |

The Committee also received the following items:

***Papers for Approval***

**FSC/23/04/15** Terms of Reference

**FSC/23/04/16** Cycle of business

***Papers to Discuss and Note for Assurance***

**FSC/23/04/04** Board Assurance Framework

**FSC/23/04/05** Committee Effectiveness Review

**FSC/23/04/17** Digital Strategy Group

### BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

|                          |                   |  |             |                        |             |
|--------------------------|-------------------|--|-------------|------------------------|-------------|
| <b>AGENDA REFERENCE:</b> | BM/23/01/56c (ii) |  | Trust Board | <b>DATE OF MEETING</b> | 24 May 2023 |
|--------------------------|-------------------|--|-------------|------------------------|-------------|

|                          |  |
|--------------------------|--|
| Date of Meeting          | 24 May 2023  |
| Name of Meeting & Chair  | Finance and Sustainability Committee, Chaired by John Somers |
| Was the meeting quorate? | Yes  |

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

| REF          | AGENDA ITEM                  | ISSUE AND LEAD OFFICER   | Recommendation / Assurance/ mandate to receiving body                       | Follow up/ Review date |
|--------------|------------------------------|--|---|------------------------|
| FSC/23/05/24 | Hot Topic - Activity         | <p>The Committee received the presentation noting: -</p> <ul style="list-style-type: none"> <li>• Easter, Industrial action, covid swabbing in plan, counting, and coding all impacting on month 1 activity.</li> <li>• Urology, ENT, Gynae and T&amp;O highlight on impact of delivery</li> <li>• Month 2 is looking much closer to plan at this point but still specific areas of concern.</li> <li>• Deep dive in surgical specialties for June FSC</li> </ul>  | The Committee <b>noted</b> the presentation receiving <b>good</b> assurance |                        |
| FSC/23/05/25 | Deep Dive - DNA              | <p>The Committee received the presentation noting: -</p> <ul style="list-style-type: none"> <li>• A group has been set up which reviews DNA and a target of 8.5% has been set – the committee asked for this to be reviewed and consideration to be given to a more stretching target.</li> <li>• Hospital cancellations impacts on DNAs and process have been implemented to reduce cancellations with fortnightly monitoring with CBUs.</li> <li>• Financial improvement is anticipated if the target is achieved</li> </ul> | The Committee <b>noted</b> the presentation receiving <b>good</b> assurance |                        |
| FSC/23/05/28 | Corporate Performance Report | <p>The Committee received the presentation noting: -</p> <ul style="list-style-type: none"> <li>• ED performance is at 69.8% which is an increase on last month. The Trust is 25<sup>th</sup> out of 40 NW Trusts</li> <li>• Staffing corridors improve Ambulance turnaround but at a cost to the Trust.</li> </ul>  | The Committee <b>noted</b> the presentation receiving <b>good</b> assurance | FSC June 2023          |

|                     |                             |  |   |                      |
|---------------------|-----------------------------|--|---|----------------------|
|                     |                             | <ul style="list-style-type: none"> <li>• Waiting List has stabilised at 38,000 patients</li> <li>• 65-week trajectory is on track</li> <li>• 62-day cancer is at 50.5% which is a reduction on previous month</li> <li>• 28-day cancer is at 73.2%</li> <li>• 2-week wait is at 69.48% which is worse due to industrial action</li> <li>• 144 super stranded today (higher than previous weeks) of which 120 NCTR (plan is 110)</li> <li>• Patient safety issues are being picked up in Quality Committee and some of the concerns were discussed.</li> <li>• As a Tier 1 Trust WHH will receive support on performance</li> <li>• Discussion on patients' suitability to go to the discharge lounge compared to the need of patients on the corridor</li> </ul> |   |                      |
| <b>FSC/23/05/29</b> | <b>Pay Assurance Report</b> | <p>The Committee received the report noting.</p> <ul style="list-style-type: none"> <li>• Agency – continue to manage / review processes. Climate of industrial action is driving the usage of agency.</li> <li>• High-cost locum - regular triangulation with Senior Medical Team and the Trust continues to support recruitment, considering Just R campaign for the difficult to recruit areas</li> <li>• Collaborative bank – report showing benefits had been circulated by the Trust Chair and the content was discussed including the fact it is an administrative collaborative approach rather than a financial collaborative approach.</li> </ul>  | The Committee <b>noted</b> and discussed the report, receiving <b>good</b> assurance                      | <b>FSC June 2023</b> |
| <b>FSC/23/05/30</b> | <b>Monthly CIP report</b>   | <p>The Committee received the report noting: -</p> <ul style="list-style-type: none"> <li>• CIP overview at month 1 the £0.6m target was achieved.</li> <li>• GIRFT overview of key schemes including:</li> <li>• Job planning a baseline of 85% - 90% by March 2024</li> <li>• Points system for theatre list is being progressed.</li> <li>• LOS / safer working, NCTR are a key focus.</li> <li>• Review of Top 10 LOS, with twice a week ward round, which is supporting Consultant decision for complex patients with Executive/ senior presence.</li> <li>• Highlighted next steps for monitoring of the schemes</li> </ul>  | The Committee discussed and <b>noted</b> the report and presentation receiving <b>moderate</b> assurance. | <b>FSC June 2023</b> |

|              |                  |  |   |   |
|--------------|------------------|--|---|---|
| FSC/23/05/30 | Cost Pressures   | <p>The Committee received the report noting: -</p> <ul style="list-style-type: none"> <li>• The risk of overspending on cost pressures and development on the Trust financial plan</li> <li>• The risk to patient care and the assessment to manage any risk</li> </ul>  | <p>The Committee discussed and <b>noted</b> the report and presentation receiving <b>moderate</b> assurance.</p>  | FSC June 2023                                     |
| FSC/23/05/34 | Finance Report   | <p>The Committee received a report noting: -</p> <ul style="list-style-type: none"> <li>• The month 1 position off plan by £500k with deficit £2.5m</li> <li>• Assumption the Trust retains all income due to the impact of Industrial Action (as the activity plan was not achieved) therefore c£1.2m income risk.</li> <li>• Key driver to overspend is industrial action and corridor care.</li> <li>• 2023/24 plan of £15.8m deficit was accepted and a system recovery plan is required by September</li> <li>• Revenue requests supported by the Executive Team were discussed and noted</li> <li>• Capital spend is below plan mainly linked to externally funded schemes.</li> <li>• Risks include CIP in particular proportion of non-recurrent and the pace of unplanned care CIP schemes. Cost Pressures and income linked to activity are also a concern.</li> </ul> | <p>The Committee discussed the paper <b>noting</b> the emergency capital requests.</p>                            | FSC June 2023                                     |
| FSC/23/05/35 | Capital Position | <p>The Committee received a presentation noting: -</p> <ul style="list-style-type: none"> <li>• Schemes over £500k reviewed Catering, ED CT Scanner, Pharmacy Robot (Warrington completed Halton date to be confirmed), Network IT, Warrington Town Deal is about to be signed.</li> <li>• CDC has had an increase in costs per square metre for phase 2 shopping city. The Committee considered mitigations and supported a pause due to the increased costs. Risks to the whole project were discussed.</li> <li>• Mortuary – MIAA have met with cost advisors and provided some further detail. MIAA have shared an update, the report will be finalised to include this additional information and brought to the next Committee.</li> </ul>   | <p>The Committee <b>noted</b> the update and the risks.</p> <p>FSC <b>supported</b> taking CDC to Trust Board</p> | <p>FSC June 2023</p> <p>Trust Board June 2023</p> |



|                     |   |   |   |                              |
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| <b>FSC/23/05/36</b> | <b>Trust Strategy – measures of success</b> | The Committee received a paper noting:- <ul style="list-style-type: none"> <li>• The sustainability KPIs were discussed and the practicality of their monitoring</li> </ul> | <b>The Committee supported the approach to present progress to FSC twice a year</b> | <b>Trust Board June 2023</b> |
|---------------------|---|---|---|------------------------------|

***Papers for Approval***

N/A

***Papers to Discuss and Note for Assurance***

**FSC/23/05/26** Board Assurance Framework

**FSC/23/05/27** Annual review of risk registers

**FSC/23/05/31** Cost of harm

**FSC/23/05/32** Benefits realisation

**FSC/23/05/33** Committee Chair’s Annual Report to Board

**FSC/23/05/37** Senior Information Risk Owner (SIRO) Report

**FSC/23/05/38** Digital Strategy Group

**BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT**

|                          |                 |                            |             |                        |              |
|--------------------------|-----------------|----------------------------|-------------|------------------------|--------------|
| <b>AGENDA REFERENCE:</b> | BM 23 06 56 (d) | <b>COMMITTEE OR GROUP:</b> | Trust Board | <b>DATE OF MEETING</b> | 07 June 2023 |
|--------------------------|-----------------|----------------------------|-------------|------------------------|--------------|

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| Date of Meeting          | 27 April 2023                                 |
| Name of Meeting & Chair  | Audit Committee, Chaired by Michael O’ Connor |
| Was the meeting quorate? | Yes   |

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

| Agenda Reference | Agenda Item                           | Issue and Lead Officer  | Recommendation / Assurance/mandate to receiving body  | Follow up/ Review date            |
|------------------|---------------------------------------|---|---|-----------------------------------|
| AC/23/04/28      | <b>Internal Audit Progress Report</b> | <p>The Committee received the report setting out the outcomes of the reviews that had been completed since the last Audit Committee. The Committee noted:</p> <p>4 reports had been issued since the last Audit Committee;</p> <ul style="list-style-type: none"> <li>• Waiting List Initiative Review - substantial assurance</li> <li>• Ockenden Review Pt 2 – substantial assurance</li> <li>• Risk management Core Controls -</li> <li>• Assurance Framework Review – met all NHS requirements</li> </ul> <p>2 reviews were in progress.</p> <ul style="list-style-type: none"> <li>• Sickness Absence Review (Draft report issued for management responses)</li> <li>• Data Security Protection Toolkit (DPST) (Phase 1 complete)</li> </ul> | <b>The Committee noted the assurances in the report that had been finalised and were assured of the adequacy in the response to the actions identified where appropriate.</b> | <b>Audit Committee June 2023</b>  |
| AC/23/04/30      | <b>Head of internal Audit Opinion</b> | <p>The Committee received a report detailing the Head of Internal Audit Opinion. It was noted that the opinion was provided in the context that the Trust like other organisations across the NHS is facing a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic recovery response, financial challenges and increasing collaboration across organisations and systems.</p>  | <b>The Committee reviewed the report, noting the overall opinion of Substantial Assurance.</b>  | <b>Audit Committee April 2024</b> |

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|                    |  | The Committee took assurance that the overall opinion for the period 1st April 2022 to 31st March 2023 was <b>Substantial Assurance</b> : confirming that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.  |  |                                  |
| <b>AC/23/04/32</b> | <b>External Audit Plan &amp; Fees 2022/23</b>              | The Committee received the 2022/23 audit plan, setting out Grant Thornton's approach and fees for the external audit, including the financial statements audit, the value for money approach, and other work in respect of the annual report, remuneration report and whole of government accounts consolidation schedules.<br><br>The Committee further noted the identified risks and the progress against audit recommendations.                   | <b>The Committee approved the plan &amp; fees.</b>                                     | n/a                              |
| <b>AC/23/04/33</b> | <b>FINAL Counter Fraud Plan</b>                            | The Committee received and approved the plan presented by MIAA.<br><br>The Committee supported the amendments to the Conflict-of-Interest Policy (also discussed under item <b>AC/23/04/42</b> ) specifically the uplift of identified decision makers from Band 7 to Band 8a and above. It was noted that there was some further improvement work to be undertaken in regard to Declarations of Interest, which would be actioned during Q1 2023/24. | <b>The Committee approved the plan</b>   |                                  |
| <b>AC/23/04/37</b> | <b>Going Concern Report</b>                                | The Committee received and approved the preparation of the accounts on the Going Concern basis statement in Section 7 of the report.  | <b>The Committee approved the Going Concern Statement and received good assurance.</b> | <b>Audit Committee June 2023</b> |
| <b>AC/23/04/38</b> | <b>Draft Annual Governance Statement</b>                   | The Committee received the draft Annual Governance Statement, it was noted this was the first iteration to be included in the Annual Report.  | <b>The Committee noted the draft statement.</b>  | <b>Audit Committee June 2023</b> |
| <b>AC/23/04/40</b> | <b>Draft Unaudited Accounts &amp; Financial Statements</b> | The Committee received the draft of the Unaudited Accounts and Financial Statements which would be reviewed and approved at the year-end Audit Committee meeting in June.   | <b>The Committee noted the draft accounts and financial statements.</b>                | <b>Audit Committee June 2023</b> |



|                    |  |   |   |  |
|--------------------|--|---|---|--|
| <b>AC/23/04/42</b> | <b>Fit and Proper Persons Assurance Report 2022/23</b> | The Committee received assurance on the Trusts robust processes in place to ensure the suitability of all Board members in line with the Care Quality Commission (CQC) Fit and Proper Person Requirements (FPPR), | <b>The Committee noted that all current WHH directors satisfy the Fit and Proper Persons Requirement.</b> | <b>Annually to Audit Committee April 2024.</b> |
|--------------------|--|---|---|--|

Other items included on the agenda were:

**AC/23/04/25** - Changes or updates to the BAF

**AC/23/04/26** – Committee Assurance update from Chairs of FSC, SPC, QAC & CFC

**AC/23/04/27** - Internal Audit Progress Report on Follow-up Actions

**AC/23/04/29**– Internal Audit Charter Annual Report

**AC/23/04/31** - MIAA & 360 Assurance Financial Sustainability Outcomes & Insights

- TIAN Monthly Insight Report

**AC/23/04/34** – Annual Counter Fraud Report

**AC/23/04/35** - Review Losses & Special Payments Q2 2022/23

**AC/23/04/36** - Review of Quotation + Tender Waivers Q2 2022/23

**AC/23/04/39** – Draft Annual Report

**AC/23/04/41** - Review of Schemes of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)

**AC/23/04/42** - Review of Trust Registers (Conflicts of Interest)

**REPORT TO TRUST BOARD**

|   |   |                             |              |          |
|---|---|-----------------------------|--------------|----------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/57 (i)</b>  |                             |              |          |
| <b>SUBJECT:</b>   | <b>Maternity Update – Ockenden Review Updates</b>   |                             |              |          |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |                             |              |          |
| <b>AUTHOR(S):</b>   | Ailsa Gaskill-Jones, Deputy Director of Midwifery   |                             |              |          |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive   |                             |              |          |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.   |                             |              | x        |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | All   |                             |              |          |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>The Ockenden recommendations require the Trust Board to be informed and have oversight of maternity safety updates.</p> <p>In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update for end March 2023 is:</p> <ul style="list-style-type: none"> <li>• <b>Ockenden Part 1a:</b> WHH is 100% compliant.</li> <li>• <b>Ockenden 1b:</b> WHH is 94.91% compliant and on trajectory to be 100% compliant by 30<sup>th</sup> December 2023.</li> <li>• <b>Ockenden 2:</b> WHH is 68.53% compliant and was on trajectory to be 100% compliant by 30<sup>th</sup> November 2023. This trajectory has been impacted by cancellation of a 6-month High Dependency Training Programme scheduled for Band 7 staff. Training is rescheduled to commence May 2023 for 6 months to end November 2023.</li> <li>• Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30<sup>th</sup> November 2023.</li> </ul> |                             |              |          |
| <b>PURPOSE: (please select as appropriate)</b>  | Information<br>X  | Approval                    | To note<br>X | Decision |
| <b>RECOMMENDATION:</b>  | The Trust Board is asked to note the contents of the report.  |                             |              |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>  | <b>Committee</b>  | Quality Assurance Committee |              |          |
|   | <b>Agenda Ref.</b>  | QAC/23/05/101               |              |          |
|   | <b>Date of meeting</b>  | 11 May 2023                 |              |          |
|   | <b>Summary of Outcome</b>   | The report was noted        |              |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full  |                             |              |          |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>   | None  |                             |              |          |

## TRUST BOARD

|                 |   |                    |                        |
|-----------------|---|--------------------|------------------------|
| <b>SUBJECT:</b> | <b>Maternity Update Ockenden Report</b> | <b>AGENDA REF:</b> | <b>BM/23/06/57 (i)</b> |
|-----------------|---|--------------------|------------------------|

### 1. BACKGROUND/CONTEXT

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

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

#### KEY

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

### 2. KEY ELEMENTS

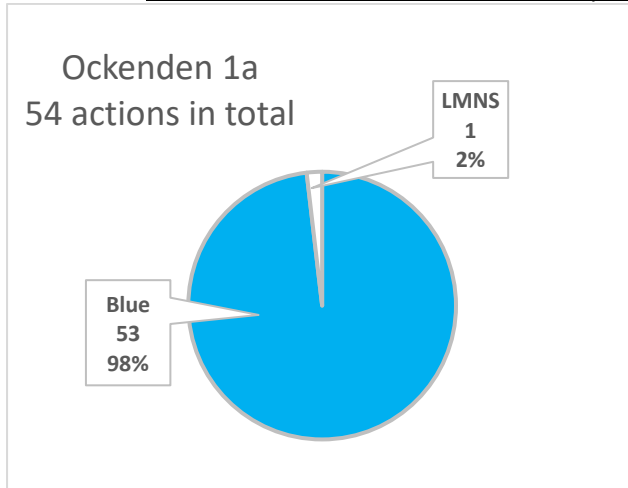
#### 2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report

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

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

#### 2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

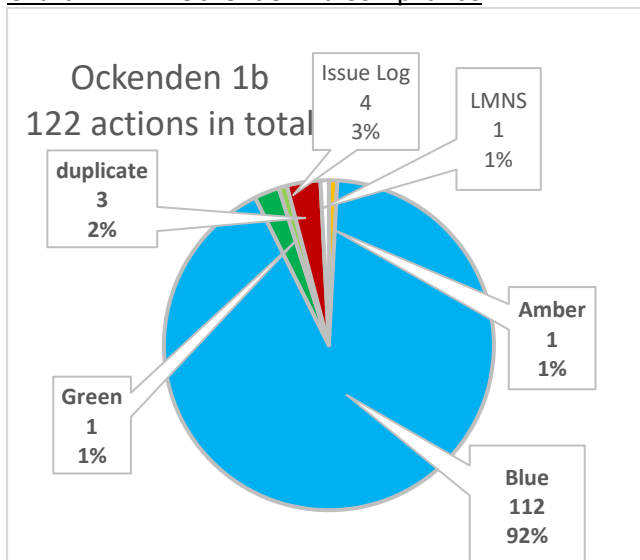
No change from previous month.

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

**2.1.3 WHH Compliance with Ockenden 1b Report**

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

Chart 2: WHH Ockenden 1b Compliance



Update

1 Amber (previously 1): -  
On track to move to green by end Dec 2023

1 Green (previously 1): - -  
On track to move to blue by end April 2023

112 blue (previously 112)

1 – action not for WHH

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

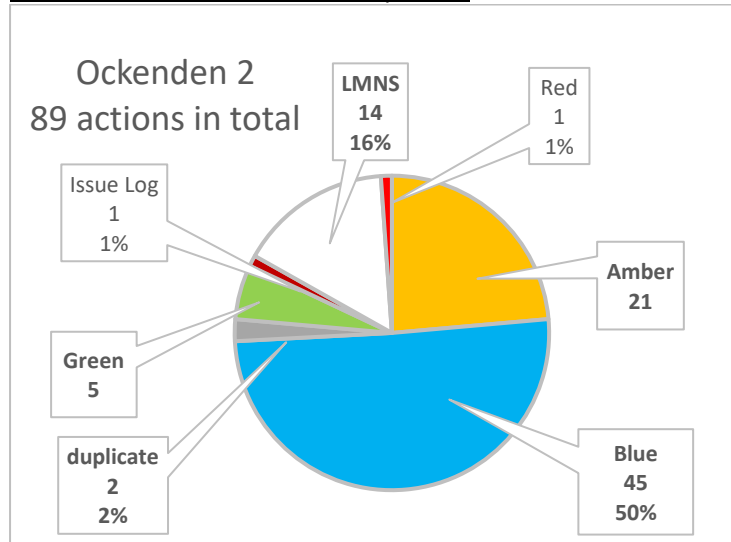
4 actions have been transferred to a BadgerNet Specific Issue Log.

Excluding the 1 LMNS and 3 duplicate actions, Ockenden Part 1b action plan is currently 94.91% compliant (no change from previous), with a trajectory to be 100% compliant by end Dec 2023.

**1.4 WHH Compliance with Ockenden 2 Report**

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

Chart 3: WHH Ockenden 2 Compliance



### Update

1 Red (previously 1)

21 Amber (previously 22)

On track to move to green by end Aug 2023

5 Green (previously 5)

On track to move to blue by end April 2023

45 blue (previously 45)

14 – actions not for WHH (previously 13)

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

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

1 Red action relates to:-

- Cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.

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

Excluding the 14 LMNS and 2 duplicate actions, Ockenden 2 action plan is 68.53% compliant (previously 60.81%), with a trajectory to be 100% compliant by end November 2023.

## 2.2 WHH Risks for Escalation

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

There is also requirement for an Audit Midwife and an Education Midwife and additional supernumerary clinical skills facilitators. In addition, the Ockenden Insight visit in July 2022 identified the need for a Failsafe Clerk to support screening compliance.

Recruitment of an Audit and Assurance Midwife has now been completed with a likely start date of the successful candidate in June 2023.

The Practice Development Midwife role has been reviewed following the retirement of the current postholder. As part of this, and funded via reallocation of funds from a vacant post, the role has been increased from 0.8fte to 1.0fte. The review of the job description has also taken account of the need for additional clinical visibility.

Other options are also being explored to use a temporarily vacant post to fund as a pilot project, additional hours for existing, experienced, clinically expert staff to work ad-hoc extra hours as part of a rota of clinical skills facilitators. This would provide the supernumerary aspect of the requirement whilst also providing a development opportunity for midwifery colleagues.

The Failsafe Clerk job description is awaiting approval of grading. This is scheduled to take place at the May panel.

Once this role is recruited to, these recommendations can be removed as a risk to meeting compliance.

## 2.3 Ockenden Summary

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

- Ockenden 1a is 100% compliant.
- Ockenden 1b is 94.91% compliant and on trajectory to be 100% compliant by 30th December 2023.

- Ockenden 2 is 68.53% compliant and was on trajectory to be 100% compliant by 30<sup>th</sup> November 2023. This trajectory has been impacted by cancellation of a 6-month High Dependency Training Programme scheduled for Band 7 staff. Training is rescheduled to commence May 2023 for 6 months to end November 2023. to commence a 6-month course in October 22, this has now been postponed until May 2023.
- Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30<sup>th</sup> November 2023.

### 3. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This Report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting on 31 May 2023.

### 4. RECOMMENDATIONS

The Trust Board are requested to receive and discuss the findings of this paper for as per Ockenden recommendations.

REPORT TO TRUST BOARD

|   |   |   |
|---|---|---|
| <b>AGENDA REFERENCE:</b>  | BM/23/06/57 (ii)  |   |
| <b>SUBJECT:</b>   | Perinatal Mortality Surveillance  |   |
| <b>DATE OF MEETING:</b>   | 9 <sup>th</sup> June 2023   |   |
| <b>AUTHOR(S):</b>   | Deborah Carter, Project Director Patient Safety   |   |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive   |   |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.   | X |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | All   |   |
| <b>EXECUTIVE SUMMARY</b><br><i>(KEY ISSUES):</i>  | <p>The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025.</p> <p>The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales.</p> <p>NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 4) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports.</p> <p>This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 4 (Q4.) PMRT report for the period covering 01/01/2023 – 31/03/2023.</p> <p>During Q4, WHH reported six babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK):</p> <p><b>Four Late Fetal Loss:</b></p> <ul style="list-style-type: none"> <li>• One baby born at 23+3 weeks</li> <li>• Demise of one twin at 23+4 (<i>Born with second twin at C/S at 38+1 weeks</i>)</li> <li>• Demise of twins born at 22+3 weeks</li> </ul> <p><b>One Stillbirth:</b></p> <ul style="list-style-type: none"> <li>• One baby born at 31+4 weeks</li> </ul> <p><b>One Early Neonatal Death:</b></p> <ul style="list-style-type: none"> <li>• One live baby born at 22+6 weeks</li> </ul> <p>The key findings, learning, good practice, and action plan for three of these cases will be reported in the Quarter 1 2023/24 QAC following a PMRT review panel for each case. Two of the cases are reported in this quarter.</p> |   |

|  |  |          |                             |          |
|--|--|----------|-----------------------------|----------|
|  | <p>WHH stillbirth rate for Q4 2022/23 was 1.58 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.88 per 1000 births. The MBRRACE-UK national rate is 3.51 per 1000 births.</p> <p>WHH Neonatal mortality rate during Q4 2022/2023 was 0.62 per 1000 live births. This includes one baby who was born at the threshold of viability where standard practice was followed, and resuscitation was not carried out. The figure adjusted to exclude these neonatal deaths is 0 per 1000 live births. The MBRRACE-UK national rate is 1.64/1000 live births.</p> <p>During Q4, WHH undertook five PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed:</p> <p><b>Three late fetal loss:</b></p> <ul style="list-style-type: none"> <li>• One baby born at 22+6 weeks</li> <li>• One baby born at 23+3 weeks</li> <li>• One baby born at 23+4 weeks</li> </ul> <p><b>Two stillbirths:</b></p> <ul style="list-style-type: none"> <li>• One baby born at 25+1 weeks</li> <li>• One baby born at 41+0 weeks.</li> </ul> <p>In two of the cases, no issues with care of the mother and baby up to the point that the baby was born were identified which may have or were likely to make a difference to the outcome for the baby.</p> <p>In two of the cases, issues with care of the mother and baby up to the point that baby was born were identified which would have made no difference to the outcome for the baby.</p> <p>In one case, issues with care of the mother and baby up to the point that the baby was confirmed to have died were identified which may have made a difference to the outcome for the baby.</p> <p>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.</p> <p>Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.</p> |          |                             |          |
| <b>PURPOSE: (please select as appropriate)</b> | <b>Information</b><br>X  | Approval | To note                     | Decision |
| <b>RECOMMENDATION:</b>                         | The Trust Board is asked to note the contents and recommendations within the report.   |          |                             |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>               | <b>Committee</b>   |          | Quality Assurance Committee |          |



|   |                           |   |
|---|---------------------------|---|
|   | <b>Agenda Ref.</b>        | QAC/23/05/101   |
|   | <b>Date of meeting</b>    | 9 <sup>th</sup> May 2023 2023   |
|   | <b>Summary of Outcome</b> | The Quality Assurance Committee noted the contents of the report and the recommendations. |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full  |   |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b> | Choose an item.           |   |

## TRUST BOARD

|                |  |                    |                  |
|----------------|--|--------------------|------------------|
| <b>SUBJECT</b> | Warrington and Halton Teaching Hospital Quarter 4 Perinatal Mortality Review Audit | <b>AGENDA REF:</b> | BM/23/06/57 (ii) |
|----------------|--|--------------------|------------------|

### 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 4 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 2022/2023 and highlights good practice and lessons learned during the mortality reviews. Q4 covers the reporting period from 01/01/2023 to 31/03/2023.

#### Definitions:

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

### 2. KEY ELEMENTS

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

During Q4 reporting period 6 cases were reported to MBRRACE-UK:



**Four late fetal loss:**

One baby born at 23+3 weeks. Their death was notified to MBRRACE, and surveillance completed within the specified timescale. The PMRT review panel for this case was completed on 10<sup>th</sup> March 2023 and is included in this report.

One baby born at 23+4 weeks. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case was completed on 10<sup>th</sup> March 2023 and is included in this report.

Two babies (twins) born at 22+3 weeks gestation. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case is scheduled for 26<sup>th</sup> May 2023 and will be included in the Q1 2023/24 Perinatal Mortality Review Audit report to QAC.

**One Stillbirth:**

One baby born at 31+4 weeks. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case is scheduled for 26<sup>th</sup> May 2023 and will be included in the Q1 2023/24 Perinatal Mortality Review Audit report to QAC.

**One Neonatal Death:**

One live baby born at 22+6 weeks. Their death was notified to MBRRACE, and surveillance completed within the specified timescale. The PMRT review panel for this case is scheduled for 26<sup>th</sup> May 2023 and will be included in the Q1 2023/24 Perinatal Mortality Review Audit report to QAC.

**2.1 Quarter 4. WHH Stillbirth Rate:**

- WHH Q4 stillbirth rate for 2022/2023 1.58 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2021 is 4.2/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH current annual stillbirth rate for Q1-Q4 2022/23 is 2.88 per 1000 births. The MBRRACE-UK national rate is 3.51 per 1000 births.

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

| Metric  | Q1 22/23    | Q2 22/23    | Q3 22/23    | Q4 22/23    | 12-month total |
|---|-------------|-------------|-------------|-------------|----------------|
| Number of live births                                       | 573         | 577         | 641         | 633         | 2424           |
| Total number of stillbirths >24 weeks                       | 3           | 1           | 2           | 1           | 7              |
| <b>Total Stillbirth Rate &gt;24 weeks (per 1000 births)</b> | <b>5.20</b> | <b>3.59</b> | <b>3.11</b> | <b>1.58</b> | <b>2.88</b>    |
| Number of intrapartum still birth rate                      | 0           | 0           | 0           | 0           | 0              |
| Number of stillbirths >37 weeks                             | 0           | 1           | 1           | 0           | 2              |

## 2.2 Q3. WHH Neonatal Mortality Rate:

There was one early neonatal death reported in Q4 2022/2023.

WHH Neonatal mortality rate during Q4 2022/2023 was 0.62 per 1000 live births. This baby was born at the threshold of viability where standard practice was followed, and resuscitation was not carried out. The figure adjusted to exclude this neonatal death is 0 per 1000 live births. MBRRACE-UK national rate of 1.64/1000 live births. MBRRACE data does not include neonatal deaths before 24 weeks. The key findings, learning, good practice, and action plan for this case will be reported in the Q1 2023/24 QAC report following a PMRT review panel.

## 2.3 Quarter 4 PMRT Review Panel Key Findings

### Synopsis of Findings

One baby born at 22+6 weeks gestation was a neonatal death. The cause of death identified at post-mortem was neonatal sepsis, congenital pneumonia, acute necrotising chorioamnionitis, acute placental haemorrhage

One baby born at 25+2 weeks gestation was a late fetal loss. The post-mortem results are awaited.

One baby born at 41+0 weeks gestation was a stillbirth. The cause of death identified was chronic villitis caused by villitis of unknown aetiology (VUE).

One baby born at 23+3 weeks gestation was a late fetal loss. The placental histology reports chorangiosis.

One baby born at 23+4 weeks gestation was a late fetal loss. The baby was a twin pregnancy and remained in utero with the surviving twin until 38+1 weeks gestation. The parents declined any investigations.

#### **Surveillance Findings:**

- Three babies were of a singleton pregnancy.  
Two babies were from a twin pregnancy.
- Two women were aged between 30-34.  
Three women were aged between 35-37.
- All women were identified as white ethnicity.
- All women spoke English as their first language.
- None of the women had any communication problems as a consequence of learning difficulties/hearing problems.
- Two women were of a healthy BMI between 18.5 - 24.9.  
Two women had an increased BMI between 25 - 29.9.  
One woman had a BMI of greater than 30 (associated with an increased risk of complications in pregnancy.)
- All women were non-smokers and had a carbon monoxide (CO) level below 3 parts per million (PPM).
- In one case the woman booked late at 17+5 weeks gestation.
- In all cases there were no issues identified with the care provided in relation to safeguarding.

## 2.4 PMRT Grading of Care

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

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

During Q4 four PMRT stillbirth review panels took place. Parental perspective of the care they received were sought in both cases.

In one case issues with care of the mother and her baby up to the point of the birth of the baby were identified which would have made no difference to the outcome for the baby.

In two cases issues with care were identified from birth up to the death of the baby which would have made no difference to the outcome for the baby.

| 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 |
|---|--|---|
| <b>PMRT grade A</b><br>The review group concluded that there were no issues with care identified  | 2  | 2   |
| <b>PMRT grade B</b><br>The review group identified care issues which they considered would have made no difference to the outcome         | 1  | 2   |
| <b>PMRT grade C</b><br>The review group identified care issues which they considered may have made a difference to the outcome            | 1  | -   |
| <b>PMRT grade D</b><br>The review group identified care issues which they considered were likely to have made a difference to the outcome | -  | -   |
| <b>Not Graded</b>   | -  | -   |
| <b>Total Cases</b>  | Four cases   | Four cases  |

In one case issues with care of the mother and baby up to the point that the birth of the baby was identified that may have made a difference to the outcome for the baby. An action plan has been implemented (Table 7).

**Table 3: Q4 PMRT Grading of Stillbirth:**

During Q4 one neonatal death PMRT review panels took place. Parental perspective of the care they received was sought.

In this case issues with care up to the point of birth of the baby were identified that would have made no difference to the outcome for the baby. Issues with care from the birth up to the death of the baby were also identified which would have made no difference to the outcome for the baby. An action plan has been implemented (Table 7).

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

## 2.5 Q4. WHH PMRT Panel Attendance

There have been five PMRT panel reviews in Q4 which were attended by multidisciplinary internal and external panel members.

**Table 5: Q4 WHH PMRT Panel Attendance**

| Number of participants involved in PMRT reviews.<br>Total number of reviews from 01/01/2023 – 31/03/2023 = 5 |                                  |                                      |  |
|--|----------------------------------|--------------------------------------|--|
| Role   | Total Stillbirth Review Sessions | Total Neonatal Death Review Sessions | Reviews with a least one in attendance |
| Chair  | 4                                | 1                                    | 5                                      |
| Vice Chair   | 0                                | 0                                    | 0                                      |
| Admin/Clerical   | 0                                | 0                                    | 0                                      |
| Bereavement Midwife  | 4                                | 1                                    | 5                                      |
| External Rep   | 3                                | 0                                    | 3                                      |
| Management Team  | 2                                | 0                                    | 2                                      |
| Midwife  | 4                                | 1                                    | 5                                      |
| Neonatal Nurse   | n/a                              | 0                                    | 0                                      |
| Neonatologist/Paediatrician  | n/a                              | 0                                    | 0                                      |
| Obstetrician   | 4                                | 1                                    | 5                                      |
| Other  | 4                                | 0                                    | 4                                      |
| Governance Manager   | 4                                | 1                                    | 5                                      |
| Safety Champion  | 0                                | 0                                    | 0                                      |

## 2.6 Maternity Incentive Scheme Year 4 Compliance

Table 6: 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? |   | Compliant Y/N |
|--|---|---------------|
| Standard Required  |   |               |
| a) i   | All perinatal deaths eligible to be notified to MBRRACEUK from 1 September 2021 onwards must be and the <b>surveillance information</b> where required must be <b>completed within one month of the death.</b>  | Yes           |
| a) ii  | A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 <b>will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust</b>  | Yes           |
| b)   | At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from <b>8 August 2021</b> will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool <b>within four months of each death and the report published within six months of each death.</b>   | Yes           |
| c)   | For at least 95% of all deaths of babies who died in your Trust from <b>8 August 2021</b> , the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. <b>This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust.</b> If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. | Yes           |
| d)   | Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. <b>The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.</b>  | Yes           |

## 2.7 Learning and Good Practice

- The cases have all been notified and surveillance completed within the required timescale.
- Antenatal care was graded A at two of the PMRT panel meetings, which included feedback from the parents.
- Postnatal care was graded A at three of the PMRT panel meetings, which included feedback from the parents.
- Parental involvement was sought in all cases as part of PMRT panel review.
- Midwifery care was commended in two cases.
- Bereavement care was commended in all five cases.

### 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 are three Q4 2022/23 PMRT actions in progress:

**Table 7: PMRT Action Plan**

| Action  | Lead                       | Start date | Due Date | RAG rating |
|---|----------------------------|------------|----------|------------|
| A reminder to be sent by the digital midwife with a guide on how to use the electronic partogram for women who experience pregnancy loss. | Digital Midwife            | 10.03.23   | 31.05.23 | Yellow     |
| Midwife to undertake a reflection with line manager regarding inappropriate comment made to the woman following a pregnancy loss.         | Birth Suite Manager        | 10.03.22   | 31.03.23 | Green      |
| All women awaiting transfer to a tertiary unit for ongoing antenatal care require transfer to the birth suite                             | Birth Suite Manager        | 10.03.23   | 31.05.23 | Yellow     |
| Review out of area pathway to ensure regular and robust communication between care providers is initiated and maintained                  | Antenatal Services Manager | 10.03.23   | 31.05.23 | Yellow     |

MIAA undertook an external audit of PMRT on the 13<sup>th</sup> and 14<sup>th</sup> of June 2022 and were assured by the processes and governance of the PMRT process and pathways at WHH. This has been previously reported in Maternity Update papers presented to QAC.

### 2.8 Summary

WHH Q4 PMRT audit recorded six babies reported to MBRRACE that were born between 01/01/2023 and 31/03/2023.

- One baby born at 23+3 weeks
- One twin at 23+4
- Twins born at 22+3 weeks
- One baby born at 31+4 weeks
- One live baby born at 22+6 weeks

The key findings, learning, good practice, and action plan for two of the five cases has been shared in this report. A further three cases will be reported in the Quarter 1 2023/24 QAC report following the PMRT review panels due to be held on 26<sup>th</sup> May 2023.

- WHH stillbirth rate for Q4 2022/23 was 1.58 per 1000 births. WHH annual Mean stillbirth rate is 2.88 per 1000 births which is below the 2021 MBRRACE-UK national rate 4.2 per 1000 births.

- WHH Neonatal mortality rate during Q4 2022/2023 was 0.62 per 1000 live births. This includes one baby who was born at the threshold of viability where standard practice was followed, and resuscitation was not carried out. The figure adjusted to exclude these neonatal deaths is 0 per 1000 live births.
- Five 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 of the cases there were no issues with care of the mother and baby up to the point that the baby was born which may have or were likely to make a difference to the outcome for the baby.
- In three of the cases there were issues with the care of the mother and baby up to the point where the baby was born that may have made no difference to the outcome for the baby.
- In one case issues were identified with care up to the point that the baby was confirmed to have died which may have made a difference to the outcome.
- Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee and there are three outstanding Q4 PMRT actions in progress.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

### 3 RECOMMENDATIONS

The Trust Board is asked to note the findings of this paper as per MIS year 4 recommendations.

## REPORT TO BOARD OF DIRECTORS

|   |  |   |
|---|--|---|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/58</b>   |   |
| <b>SUBJECT:</b>   | <b>Staff Opinion Survey</b>  |   |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023  |   |
| <b>AUTHOR(S):</b>   | Rebecca Patel, Associate Chief People Officer<br>Adam Harrison-Moran, Head of Workforce Equality, Diversity and Inclusion  |   |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Michelle Cloney, Chief People Officer  |   |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.   |   |
|   | SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.  | X |
|   | SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.  |   |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | 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.  |   |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>This paper provides an overview of the annual NHS Staff Survey results for the organisation from 2022, which are aligned to the NHS People Promises as set out in the NHS People Plan.</p> <p>The survey took place between September – November 2022, with a 35% participation rate equating to 1,520 members of staff having their say.</p> <p>The results show that the organisation is better than the Acute Trust average in the following five themes:</p> <ol style="list-style-type: none"> <li>1. We are compassionate and inclusive.</li> <li>2. We are recognised and rewarded.</li> <li>3. We each have a voice that counts.</li> <li>4. We are safe and healthy.</li> <li>5. Morale.</li> </ol> <p>The organisation has remained the same as the Acute Trust average score in the following three themes:</p> <ol style="list-style-type: none"> <li>1. We work flexibly.</li> <li>2. Staff engagement.</li> <li>3. We are a team.</li> </ol> <p>There is one theme where the organisation has scored worse than the Acute Trust average score which is in relation to the theme ‘we are always learning’. There is also a difference in experiences at WHH from a protected characteristic perspective which is highlighted in this report.</p> |   |

|   |  |          |              |          |
|---|--|----------|--------------|----------|
|   | The paper provides an overview of the engagement with the wider organisation to prioritise and enable meaningful change as a result of staff feedback. |          |              |          |
| <b>PURPOSE:</b> <i>(please select as appropriate)</i>   | Information  | Approval | To note<br>X | Decision |
| <b>RECOMMENDATION:</b>                                  | Trust Board are asked to note the annual Staff Survey results for 2022 and the actions to enable meaningful change as a result of staff feedback.      |          |              |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>                        | <b>Committee</b>   | N/A      |              |          |
|   | <b>Agenda Ref.</b>   | N/A      |              |          |
|   | <b>Date of meeting</b>   | N/A      |              |          |
|   | <b>Summary of Outcome</b>  | N/A      |              |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>            | Release Document in Full   |          |              |          |
| <b>FOIA EXEMPTIONS APPLIED:</b><br><i>(if relevant)</i> | None   |          |              |          |

## REPORT TO BOARD OF DIRECTORS

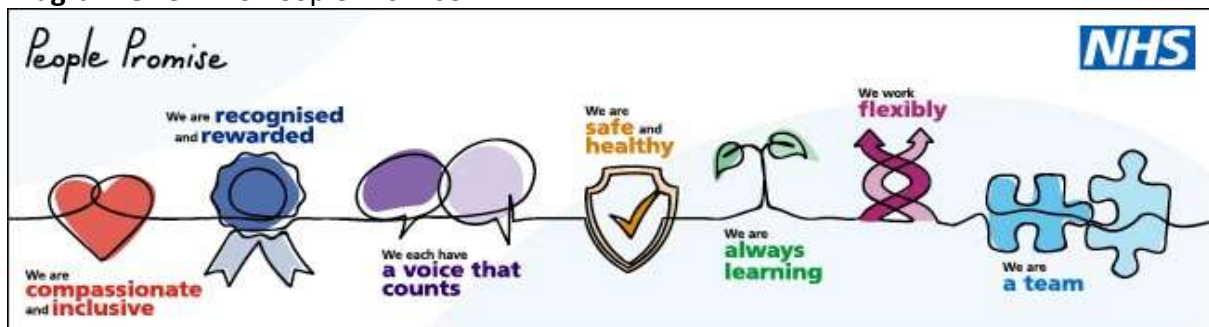
|                |                               |                    |             |
|----------------|-------------------------------|--------------------|-------------|
| <b>SUBJECT</b> | National Staff Opinion Survey | <b>AGENDA REF:</b> | BM/23/06/58 |
|----------------|-------------------------------|--------------------|-------------|

### 1. BACKGROUND/CONTEXT

The NHS Staff Survey is a nationally mandated survey across all NHS organisations to inform local improvement in staff experience and wellbeing. It is a national measure of staff experience within the NHS and provides useful intelligence to the Care Quality Commission and local commissioners.

The Staff Survey is made up of a number of questions which are aligned to the themes set out in the NHS People Promise within the NHS People Plan, illustrated in **diagram one**, as well as additional themes of ‘Staff Engagement’ and ‘Morale’.

**Diagram One:** NHS People Promise



The results of the survey provide the organisation with the opportunity to understand staff experience in terms of what is going well and the areas that may require further improvement.

**Diagram two** provides an overview of the results for 2022 when compared with the Acute Trust average score. On an organisational basis, WHH is better than the Acute Trust average in the following People Promise themes:

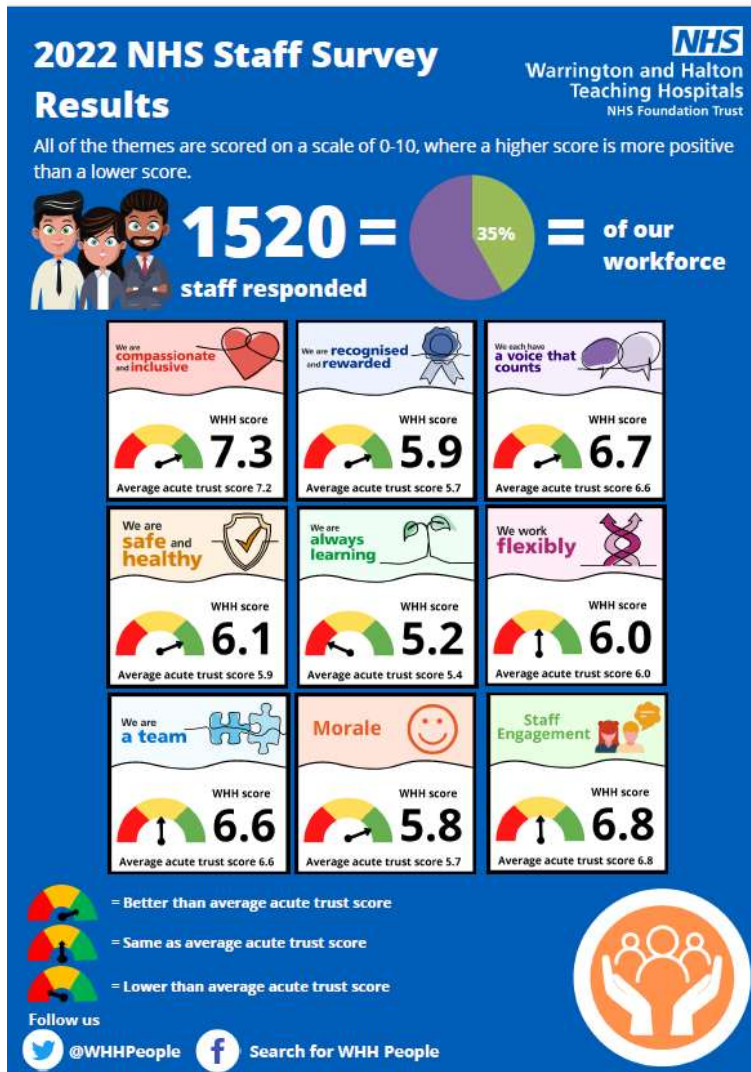
- We are compassionate and inclusive.
- We are recognised and rewarded.
- We each have a voice that counts.
- We are safe and healthy.
- Morale.

The themes that are the same as the Acute Trust average score are:

- We work flexibly.
- Staff engagement.
- We are a team.

The theme which is worse than the overall Acute Trust average score relates to ‘we are always learning’ which focuses on development and appraisals within the organisation.

**Diagram Two: NHS Staff Survey Results 2022 Overview**



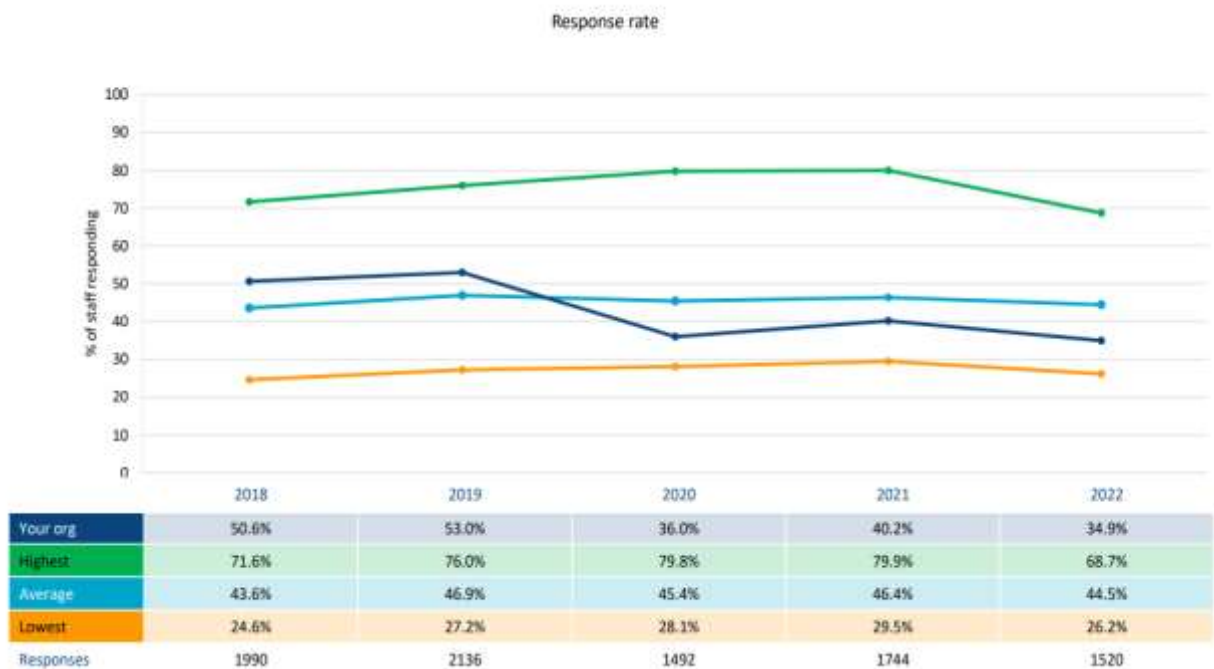
In addition to the publication and dissemination of results, organisations are required to develop local priority work streams to address the results from both an organisational and directorate / team perspective, to demonstrate how the organisation is listening to and responding to staff feedback. This paper provides an overview of key highlights from the Staff Survey results and our approach to developing priorities to respond to feedback.

## 2. KEY ELEMENTS

### 2.1 Response Rate

In the 2022 Staff Survey, the organisation's response rate was 34.9% which is 9.6% less than the Acute Trust average score, and a deterioration of 5.3% when compared with the respondent rates from 2021, as illustrated in **diagram three**.

**Diagram Three:** Response Rate Overview



### 2.2 Significance Testing

Statistical significance is tested by the survey provider, using a two-tailed t-test with a 95% level of confidence. The results, as illustrated in **table one**, demonstrate that there has not been a statistically significant change in the majority of the themes, however the results show three areas of statistical decline when compared with the 2021 results:

- We are recognised and rewarded.
- We each have a voice that counts.
- Staff engagement.

When compared with the overall Acute Trust average score, the recognition and voice themes are higher than the Acute Trust average, with staff engagement remaining the same as the Acute Trust average score.

**Table One:** Statistical Significance Testing

| People Promise elements            | 2021 score | 2021 respondents | 2022 score | 2022 respondents | Statistically significant change? |
|------------------------------------|------------|------------------|------------|------------------|-----------------------------------|
| We are compassionate and inclusive | 7.3        | 1736             | 7.3        | 1515             | Not significant                   |
| We are recognised and rewarded     | 6.1        | 1733             | 5.9        | 1508             | Significantly lower               |
| We each have a voice that counts   | 6.9        | 1718             | 6.7        | 1497             | Significantly lower               |
| We are safe and healthy            | 6.1        | 1725             | 6.1        | 1506             | Not significant                   |
| We are always learning             | 5.1        | 1618             | 5.2        | 1430             | Not significant                   |
| We work flexibly                   | 6.1        | 1726             | 6.0        | 1503             | Not significant                   |
| We are a team                      | 6.7        | 1732             | 6.6        | 1514             | Not significant                   |
| <b>Themes</b>                      |            |                  |            |                  |                                   |
| Staff Engagement                   | 6.9        | 1741             | 6.8        | 1515             | Significantly lower               |
| Morale                             | 5.9        | 1740             | 5.8        | 1516             | Not significant                   |

The results have illustrated some disparity in terms of experience and disproportionate impacts, meaning that specific groups of the workforce experience less favourable outcomes in comparison to others. Analysis of the Staff Survey demonstrates disproportionate results for race, disability and sexual orientation.

In addition, through the analysis of age, those aged 16-30 reported lower satisfaction in comparison to those aged older for the themes of:

1. Pay
2. Work / life balance
3. Reporting of discrimination
4. Discrimination based on age
5. Retention

Section 2.3 outlines the analysis of the results for race, disability, sexual orientation and age for key questions of the Staff Survey. It is noted that the results of the survey only represent those who declared a protected characteristic when completing the survey.

### 2.3 Staff Survey Analysis by Protected Characteristic

On an annual basis, the Trust is required by contract to complete the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Part of the reporting for each standard includes the Trusts performance in the annual Staff Survey as detailed in **tables two and three**. **Tables four and five** highlight the question responses based on sexual orientation and age (which are not currently reportable contractually).

### 2.3.1 Workforce Race Equality Standard Staff Survey Analysis

**Table Two:** Workforce Race Equality Standard Staff Survey Questions

| Question   | All Other Ethnic Groups |       | White |       | Improvement From Last Year? |
|--|-------------------------|-------|-------|-------|-----------------------------|
|  | 2021                    | 2022  | 2021  | 2022  |                             |
| Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months  | 25.6%                   | 25.5% | 21.0% | 21.2% | Yes                         |
| Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months                              | 21.5%                   | 30.9% | 17.6% | 21.8% | No                          |
| Q15) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion          | 49.7%                   | 40.8% | 64.3% | 61.7% | No                          |
| Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months | 11.9%                   | 18.9% | 5.0%  | 4.7%  | No                          |

The results highlighted in **table two** demonstrate that there is a significant difference between the results of our colleagues who have declared their race as 'white' and those of 'all other ethnic groups'. Particularly of the four metrics reported in the WRES, three show a deterioration in comparison to the Staff Survey results for 2021. The result for staff experiencing harassment, bullying or abuse from patients shows a slight improvement in comparison to the 2021 survey, however there is still a 4.3% difference between the results of the Trust 'white' workforce and those from 'all other ethnic groups'. The percentage of staff who declared 'all other ethnic group', for harassment, bullying or abuse from other staff and their managers / team leaders has risen in 2022.

### 2.3.2 Workforce Disability Equality Standard Staff Survey Analysis

**Table Three:** Workforce Disability Equality Standard Staff Survey Questions

| Question  | Staff With a LTC or Illness |       | Staff Without a LTC or Illness |       | Improvement From Last Year? |
|---|-----------------------------|-------|--------------------------------|-------|-----------------------------|
|   | 2021                        | 2022  | 2021                           | 2022  |                             |
| Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months           | 26.4%                       | 26.8% | 20.2%                          | 19.9% | No                          |
| Q14b) Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months                                    | 19.3%                       | 17.9% | 9.1%                           | 8.0%  | Yes                         |
| Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months                            | 26.7%                       | 24.4% | 15.3%                          | 15.7% | Yes                         |
| Q14d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | 44.4%                       | 43.0% | 48.2%                          | 49.5% | No                          |
| Q15) Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion               | 52.3%                       | 54.0% | 66.2%                          | 61.0% | Yes                         |

| Question   | Staff With a LTC or Illness |       | Staff Without a LTC or Illness |       | Improvement From Last Year? |
|--|-----------------------------|-------|--------------------------------|-------|-----------------------------|
|  | 2021                        | 2022  | 2021                           | 2022  |                             |
| Q11e) Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | 31.8%                       | 26.9% | 22.3%                          | 18.3% | Yes                         |
| Q4b) Percentage of staff satisfied with the extent to which their organisation values their work   | 36.3%                       | 34.1% | 46.7%                          | 45.6% | No                          |

The results of the Staff Survey analysed by the metrics reported for the WDES found in **table three**, highlight that of the seven questions analysed, four show improvements in comparison to the 2021 results, with three areas deteriorating. When compared against the WRES performance, the areas for deterioration for race were areas of improvement for disability. Specifically, this includes the percentage of staff experiencing harassment, bullying or abuse from managers and other colleagues in the last 12 months.

Although there were improvements in comparison to the previous year, there are still disproportionate gaps in results for staff with a disability / long-term health condition and those without. In addition, there was an increase in staff experiencing harassment, bullying or abuse from patients, relatives or the public with 26.8% reporting that they did.

### 2.3.3 Staff Survey Results by Sexual Orientation

In addition to the WRES and WDES, the Trust is currently reviewing data based on 'Sexual Orientation', although not mandated to report on as an equality standard. The aim of this is to review any disproportionate impact based on an individual's sexual orientation, this is monitored for assurance at the Workforce Equality, Diversity and Inclusion Sub-Committee. **Table four** highlights the Trusts performance analysed by sexual orientation for the Staff Survey based on the questions reviewed for WRES.

**Table Four:** Sexual Orientation Staff Survey Results

| Question   | Heterosexual | Gay / Lesbian | Bisexual | Prefer Not to Say |
|--|--------------|---------------|----------|-------------------|
| Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months  | 20.7%        | 23.8%         | 42.3%    | 31.5%             |
| Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months                   | 16.7%        | 28.6%         | 30.8%    | 37.0%             |
| Q15) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion          | 60.8%        | 66.7%         | 65.4%    | 30.1%             |
| Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months | 5.4%         | 14.3%         | 11.5%    | 15.3%             |

### 2.3.4 Staff Survey Results by Age (16-30)

**Table five** provides a breakdown of the key questions where there was a significant score variation broken down by the age range 16-30, compared to the organisational score.

**Table Five:** Age (16-30) Staff Survey Results

| Question   | Trust Score | Score (16-30) | Score Variation |
|--|-------------|---------------|-----------------|
| Q2a) I look forward to going to work (Often/Always).   | 55.2%       | 44.6%         | -10.6%          |
| Q4c) My level of pay (Satisfied/Very satisfied).   | 30.6%       | 20.7%         | -9.9%           |
| Q4d) The opportunities for flexible working patterns (Satisfied/Very satisfied).                                   | 51.7%       | 43.7%         | -8.0%           |
| Q6b) My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).              | 46.2%       | 35.6%         | -10.6%          |
| Q12d) How often, if at all, are you exhausted at the thought of another day/shift at work (Often/Always).          | 29.1%       | 40.0%         | +10.9%          |
| Q14d) The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it (Yes). | 47.0%       | 30.4%         | -16.6%          |
| Q24b) I will probably look for a job at a new organisation in the next 12 months (Agree/Strongly agree).           | 22.4%       | 33.3%         | +10.9%          |

## 2.4 Staff Survey Priorities

The Staff Survey results were released at the end of March 2023 and have been shared with the wider organisation in a variety of accessible methods that capture all staff by utilising existing engagement approaches and communication channels. **Diagram four** provides an overview of the steps that have been taken to respond to the Staff Survey and develop robust actions to respond to staff.

**Diagram Four:** Steps Taken to Respond to Staff Survey Feedback



### 2.4.1 Organisation Priorities

At the Start of the Year Conference on 18<sup>th</sup> May 2023 which over 200 WHH leaders attended, the afternoon session focused on the results of the Staff Survey and asked staff to identify three key priorities to implement within each of the Staff Survey themes to drive forward positive organisation change. The results are currently being collated and will form part of the organisational action plan which will be available by the end of Q1 2023-24.

In response to the three areas of statistical decline (which still remain better than Acute Trust average / remain the same as Acute Trust average), and 'we are always learning' which is worse than the overall Acute Trust average score, current organisation actions identified and in progress are:

- We are recognised and rewarded – it is acknowledged that the current cost of living crisis and NHS and Trade Union pay negotiations may have impacted this score and nationally the score has declined. At WHH, there are a number of recognition initiatives in place including You made a Difference, Long Service Awards, values badges and gratitude and appreciation cards. All of our offers are currently being

evaluated to ensure they meet the needs of the workforce, including ensuring effective communication and engagement with initiatives across the organisation.

- We each have a voice that counts – in response to the feedback from the Staff Survey, a Staff Voice Group is being established which will provide an opportunity for all staff, irrespective of staff group or banding, to have a real opportunity to influence the organisation and have a voice. Staff attending the Start of the Year conference were asked to express an interest if they wanted to participate and staff across the organisation are also being invited to volunteer.
- Staff engagement – this theme focuses on motivation, involvement and advocacy which has seen a decrease across all areas in comparison with 2021, which is reflective of the national downtrend trend. Although there has been deterioration, 72.4% of respondents felt that there are frequent opportunities to show initiative in their role however, only 55.2% of respondents look forward to going to work. Actions to address include use of exit interview data to support CBUs in addressing potential turnover issues and the development of Care Group specific workforce plans to address workforce gaps and minimise vacancies and the resulting impact on staff in work.
- We are always learning – this focuses on development and appraisals within the organisation. There is currently a review of data from a range of sources including Staff Survey, WRES, WDES and equality impact assessments to evaluate current accessibility of training. Approach to appraisals has also been reviewed following feedback from Care Groups with revised streamlined paperwork to be implemented to support effective appraisal discussions for staff.

Additional current organisation actions identified and in progress are:

- Increase in response rates - a recent pilot of using paper surveys for the quarterly People Pulse Survey did result in an uptake of responses. Accessibility options are being considered for the Staff Survey in 2023 including the viability of paper returns, use of I-pads and roaming teams to support staff in completing the survey, and a focus on effective communications to staff to demonstrate that staff have been listened to and change implemented as a result of their feedback, encouraging staff to respond to future Staff Surveys knowing they have been listened to previously.
- Agile working - following the principles of the NHS Flex for the Future, an NHSE initiative supported by Timewise, a review has been undertaken to understand where agile working is working well within WHH. Next steps are to launch flexible and agile working toolkits and guides for leaders and employees, and to develop a communication plan that engages with the Trusts leaders, enabling leaders to be supported to make informed decisions regarding flexible and agile working.
- Career development – in 22/23, a career development programme was implemented with Staff Networks leading to individuals securing promotions internally. The learnings from this first cohort are currently being reviewed to inform future approach. Engagement across the organisation is currently taking place to identify career progression and learning barriers so that actions can be put in place to address and overcome.

#### **2.4.2 Care Group / CBU Priorities**

To support the organisation to respond to the findings within the annual Staff Survey, the Staff Engagement and Wellbeing team have collaborated with WHH Staff Networks and Care Groups to identify key actions and priorities that can be implemented within areas to respond to the direct feedback and experience of their teams. A range of Care Group clinics have taken place with key priorities identified through action plans, which will be presented and monitored through the People Directorate governance processes at Operational and Strategic People Committee. All Care Groups will have priority actions in place by mid Q2 2023-24 in order to make reasonable strides towards completion in preparation for the opening of the 2023-24 survey in Q3.

Some of the action themes that have been identified through Care Groups include:

1. Dedicated internal communication mechanisms.
2. Clearer support of learning and development opportunities with opportunities to share opportunities across wider internal teams.
3. Awareness of raising concerns and feedback to individuals / teams on changes made as a result of raising concerns.
4. Development of focused health and wellbeing days to support teams.

As part of this approach, teams have also been reminded of what is currently in place within the organisation from a wellbeing, learning and development perspective, and initiatives are already underway in order to address the key objectives within the organisation's People Strategy.

#### **2.4.3 Protected Characteristics Priorities**

Following analysis of the Staff Survey 2022 by protected characteristic, discussions have been held and reported through the Workforce Equality, Diversity and Inclusion Sub-Committee on next steps and recommendations to address the findings of the results. This has been completed in conjunction with the Chairs and Vice Chairs of the WHH Staff Networks which represent:

- Multi-Ethnic Staff Network
- PROGRESS Staff Network (LGBTQ+)
- Disability Awareness Network
- Armed Forces and Military Veterans Community Network

Throughout the months of June and July 2023, the Workforce Equality, Diversity and Inclusion Team in conjunction with Staff Network leads will be holding listening forums with focused topics of race, disability and sexual orientation. These events are aimed at understanding the experiences of our colleagues who share different protected characteristics, or who may be underrepresented across the workforce. The events will be an opportunity to collate qualitative dialogue to drive forward change, based on quantitative data from the Staff Survey. Feedback from the events will feed into the Workforce Equality, Diversity and

Inclusion Sub-Committee to support both the organisation and Care Group / Clinical Business Unit level priorities and action plans.

Actions to inform improvement for the results of the survey by race and disability will also form part of the annual WRES and WDES action plans, which will be presented to the Strategic People Committee for ratification in August 2023 for submission and publication in October 2023.

In addition, the Workforce Equality, Diversity and Inclusion Team and Staff Engagement and Wellbeing Team will be holding a 16-29 Listening Event at both Halton and Warrington Hospitals with a view of understanding the needs, ways of thinking and priorities of our workforce aged 29 and under. The 16-29 Listening Events will be chaired by Simon Constable, Chief Executive and Michelle Cloney, Chief People Officer, with themes and learning identified at the events feeding into the organisational Staff Survey response plan. The themes will also feed into other workstreams associated with Staff Engagement, Recruitment, Workforce Wellbeing and Equality, Diversity and Inclusion.

### 3. RECOMMENDATIONS

Trust Board are asked to note the 2022 Staff Opinion Survey results and priorities to respond to staff feedback and experience.

## REPORT TO TRUST BOARD

|   |   |          |                            |          |
|---|---|----------|----------------------------|----------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/59</b>  |          |                            |          |
| <b>SUBJECT:</b>   | <b>WHH Strategy – Governance and delivery progress summary</b>  |          |                            |          |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |          |                            |          |
| <b>AUTHOR(S):</b>   | Carl Mackie, Halton Healthy New Town and Strategy Manager   |          |                            |          |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Lucy Gardner, Director of Strategy and Partnerships   |          |                            |          |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.   |          |                            | X        |
|   | SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future   |          |                            | X        |
|   | SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.  |          |                            | X        |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><br><i>(Please DELETE as appropriate)</i> | <p><b>#115</b> 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.</p> <p><b>#134</b> 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 &amp; Halton</p> <p><b>#1134</b> 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</p> <p><b>#1114</b> 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.</p> <p><b>#125</b> 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</p> <p><b>#145</b> If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire &amp; 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.</p> |          |                            |          |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>This paper provides an update on the governance and delivery of the Trust’s strategic objectives, included in the Trust’s strategy which was approved in May 2018 and refreshed in July 2021. The report is provided twice yearly to assess progress against the Trusts strategic priorities within our 3 - 5 year strategy.</p> <p>This report shows that at the end of Q4 2022/23 the Trust is ahead of plan or on track to deliver the outcome/KPI on 16 indicators, behind plan with mitigation on 20 indicators, and behind plan with significant challenges to recovery on 0 indicators.</p>   |          |                            |          |
| <b>PURPOSE: (please select as appropriate)</b>  | Information   | Approval | <b>To note</b><br><b>X</b> | Decision |

|   |  |                 |
|---|--|-----------------|
| <b>RECOMMENDATION:</b>                        | The Trust Board is asked to note the progress made against delivery of the strategic objectives. |                 |
| <b>PREVIOUSLY CONSIDERED BY:</b>              | <b>Committee</b>   | Choose an item. |
|   | <b>Agenda Ref.</b>   |                 |
|   | <b>Date of meeting</b>   |                 |
|   | <b>Summary of Outcome</b>  |                 |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full   |                 |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b> | None   |                 |

## REPORT TO BOARD OF DIRECTORS

|                |  |                    |                    |
|----------------|--|--------------------|--------------------|
| <b>SUBJECT</b> | <b>WHH Strategy – Governance and delivery progress summary</b> | <b>AGENDA REF:</b> | <b>BM/23/06/59</b> |
|----------------|--|--------------------|--------------------|

### 1. BACKGROUND/CONTEXT

At the start of the 2021/22, the Trust board reviewed and refreshed the overall strategy for the organisation. Quality Assurance Committee and Strategic People Committee have reviewed and refreshed the Quality and People priorities and key performance indicators (KPIs) respectively in 2022/23. The Sustainability priorities and KPIs have not been refreshed.

The latest priorities and their KPIs are set out below:

#### Quality

| QPS Domain   | Objectives  | Required Outcomes                                  | 22/23 Priorities  | KPIs   | Committee                   | Frequency of Monitoring | In IPR |
|--|---|--|---|--|-----------------------------|-------------------------|--------|
| <b>Quality - We will...always put our patients first delivering safe and effective care and an excellent patient experience.</b> | Patient Safety<br>- We are committed to developing and enhancing our patients' safety and learning culture where quality and safety is everyone's top priority. | We will have safe systems of work in place.        | We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority. | 1. Early recognition of deteriorating patients in ED and Inpatients.<br>2. 90% of patients who meet criteria are screened for sepsis within 1 hour.<br>3. 90% of patients receive IV antibiotics within 1 hour where red flag sepsis is diagnosed. | Quality Assurance Committee | Quarterly               | Yes    |
|  |   | We will ensure that we minimise harm for patients. | Continue to develop models of waiting list management in line with national guidance ensuring appropriate clinical prioritisation.                | 1. Continue to undertake clinical triage process.<br>2. Continue to undertake harm review process<br>3. Continue to report for assurance via Clinical Oversight Group and Quality Assurance Committee.   | Quality Assurance Committee | Bi-Annually             | No     |

| QPS Domain | Objectives  | Required Outcomes   | 22/23 Priorities  | KPIs  | Committee   | Frequency of Monitoring     | In IPR    |    |
|------------|---|---|---|---|---|-----------------------------|-----------|----|
|            |   |   | Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework                             | <ol style="list-style-type: none"> <li>1. Ensure a patient safety culture continues to be embedded across the organisation in accordance with the requirements of the patient safety strategy and alterations to the investigation process utilising new methodologies.</li> <li>2. Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance.</li> <li>3. Evidenced through implementation of a learning framework.</li> </ol> | Quality Assurance Committee   | Quarterly                   | Yes       |    |
|            | Clinical Effectiveness is about ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients. | We will ensure that we providing care that is evidence based.   | We will ensure that we are focused on outcomes for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'. | Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.   | <ol style="list-style-type: none"> <li>1. Implementation and Audit of LOCSIP safety standards which apply to invasive procedures</li> <li>2. Audit of WHO checklist effectiveness and with evidence of effective operative debriefs delivering effective learning, team culture and improvement.</li> <li>3. Improve patient safety through the delivery and evaluation of human factors training.</li> </ol>                           | Quality Assurance Committee | Quarterly | No |
|            |   | We will ensure that we foster a culture of Quality Improvement. | Every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services.  | 'Get It Right First Time' Clinical Productivity programme to be implemented across all specialities to deliver enhanced quality and productivity.   | <ol style="list-style-type: none"> <li>1. Each speciality to identify and commit to deliver 2 Clinical Productivity priorities as agreed with an Exec led GIRFT Steering Group.</li> <li>2. Improvement to be measured with agreed productivity metrics utilising internal data for assurance.</li> <li>3. To be monitored by GIRFT Steering Group reporting to the Patient Safety and Clinical Effectiveness Sub Committee.</li> </ol> | Quality Assurance Committee | Quarterly | No |

| QPS Domain | Objectives   | Required Outcomes  | 22/23 Priorities  | KPIs   | Committee                   | Frequency of Monitoring | In IPR |
|------------|--|--|---|--|-----------------------------|-------------------------|--------|
|            |  |  | Discharge processes will be strengthened to improve the quality of discharge to home and community providers.   | <ol style="list-style-type: none"> <li>1. Ensuring early measures are in place to facilitate timely discharge, improving length of stay, with data presented by each ward.</li> <li>2. Patients will be partners in their care through communication and information sharing, measured through survey feedback.</li> <li>3. Plan for discharge from the point of admission with effective management of EDDs identified at Board rounds and high quality discharge summaries. <ul style="list-style-type: none"> <li>• Increase in incident reporting to show a culture of openness and transparency.</li> </ul> </li> </ol> | Quality Assurance Committee | Quarterly               | Yes    |
|            | <p>Patient Experience - By focusing on patient experience we want to place the quality of patient experience at the heart of all we do where "seeing the person in the patient" is the norm.</p> | <p>We will communicate in line with our values.</p> <p>We will ensure partnership working and needs based care.</p> <p>We will simplify patient focused processes.</p> | <p>By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.</p> | <ol style="list-style-type: none"> <li>1. Implement and monitor the action plan to deliver the outlined recommendations of the 2020 'Independent Review of NHS Hospital Food' report ensuring access to high quality food and choice supported by an independent industry expert.</li> <li>2. To ensure all patients hydration needs are met and monitored in accordance with their health needs, utilising ward-based quality metrics.</li> <li>3. Refresh and implement the Nutritional Care Strategy in collaboration with patients.</li> </ol>   | Quality Assurance Committee | Quarterly               | No     |

| QPS Domain | Objectives | Required Outcomes | 22/23 Priorities   | KPIs  | Committee                   | Frequency of Monitoring | In IPR |
|------------|------------|-------------------|--|---|-----------------------------|-------------------------|--------|
|            |            |                   | Ensure the Mental Health and Learning Disability Strategies are implemented Trust wide.                  | <ol style="list-style-type: none"> <li>1. Audit the use of patient's passports by Care Group via the Learning Disability and Mental Health Steering Groups.</li> <li>2. Evidence effective and robust alert processes for the Trust EPR system.</li> <li>3. Competency based training for Learning Disability, Autism and Mental Health available for all staff groups in the Trust.</li> </ol>   | Quality Assurance Committee | Quarterly               | No     |
|            |            |                   | Through patient centred communication and service development address inequalities for access to health. | <ol style="list-style-type: none"> <li>1. Work with partners to support our population to access preventative and early intervention services specific to the needs of each person through the co-design of digitally enabled services.</li> <li>2. Deploy and audit the accessible information standards policy across WHH.</li> <li>3. Monitor and deliver against the First Impressions project – listening and improving the experience for patients, service users, their families, carers and our workforce.</li> </ol> | Quality Assurance Committee | Quarterly               | No     |

## People

| QPS Domain   | Objectives   | Required Outcomes   | 22/23 Priorities   | KPIs                            | Committee                  | Frequency of Monitoring | In IPR                     |
|--|--|---|--|---------------------------------|----------------------------|-------------------------|----------------------------|
| <b>People - We will...be the best place to work with a diverse and engaged workforce that is fit for now and the future.</b> | Looking After Our WHH People                             | Prioritising the health and wellbeing of all our people   | All leaders have the skills, competencies, and behaviours to support staff's health and wellbeing  | • Reduction in sickness absence | Strategic People Committee | Quarterly               | Yes                        |
|  |  |   | WHH staff are supported to remain in work and be present through the adoption of best practice as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework |                                 |                            |                         |                            |
|  |  |   | Bespoke health promotion programmes offered to our workforce to address population health inequalities impacting on their health and wellbeing                                     |                                 |                            |                         |                            |
|  | Looking After Our WHH People                             | Looking After Our WHH People  | Line managers are equipped to use person centred engagement practices which improve employee experience.   | • Reduction in time to hire     | Strategic People Committee | Quarterly               | Yes                        |
|  |  |   | Employee recognition and appreciation schemes accessible which are valued by our staff.  |                                 |                            |                         |                            |
|  |  |   | Onboarding process consistently applied to the recruitment of our leaders ensuring they have a personal priority to establish a great first impression for our patients and staff. |                                 |                            |                         |                            |
| Innovating the Way we Work   | Enabling new ways of working and planning for the future | Annual workforce plans which are reflective of the needs of WHH and the wider health and social care system to meet the changing health needs of our patients and which create new health care roles within clinical and non-clinical teams.                      | • Reduction in Vacancy Rate  | Strategic People Committee      | Quarterly                  | Yes                     |                            |
|  |  | System wide process of workforce planning aligned to workforce supply and demand across the wider health and social care system, leading to recruitment and retention campaigns, and informed commissioned, resourced and funded external education and training. | • Reduced Staff Turnover   |                                 |                            |                         | Strategic People Committee |

| QPS Domain | Objectives   | Required Outcomes   | 22/23 Priorities  | KPIs  | Committee  | Frequency of Monitoring    | In IPR    |
|------------|--|---|---|---|--|----------------------------|-----------|
|            |  |   | New roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams. | • Improved Retention  | Strategic People Committee                                 | Quarterly                  | Yes       |
|            |  |   | Attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.  |   |  |                            |           |
|            |  | Empower the workforce to improve, change and innovate within WHH and across the healthcare system | Workforce equipped to shape and deliver effective and changing models of care.  | • Reduction in bank/agency reliance   | Strategic People Committee                                 | Quarterly                  | Yes       |
|            |  |   | Enhanced digital capability, skills and leadership which embraces digitally enabled services.   |   |  |                            |           |
|            |  |   | Attract and retain a transformed and responsive workforce that can deliver care to patients in new and different ways.  |   |  |                            |           |
|            |  | Growing our WHH Workforce for the Future  | Support and develop our teams and individuals   | Managers and leaders recruited and developed using the WHH Line Management standards within the Line Management Training Framework. | • Improved mandatory and role-specific training compliance | Strategic People Committee | Quarterly |
|            | Pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans. |   |   |   |  |                            |           |
|            | Accessible development programmes, including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.   |   |   |   |  |                            |           |

| QPS Domain       | Objectives   | Required Outcomes  | 22/23 Priorities   | KPIs   | Committee                  | Frequency of Monitoring | In IPR |
|------------------|--|--|--|--|----------------------------|-------------------------|--------|
|                  |  | Harness the talents of all our staff   | NHS Talent Management and Succession Planning framework - Scope for Growth implemented and line managers clear about their responsibilities for their staff.                                   | <ul style="list-style-type: none"> <li>Improved mandatory and role-specific training compliance</li> </ul> | Strategic People Committee |                         |        |
|                  |  |  | All staff seeking career progression have a range of options available, including professional education, training, shadowing, mentoring, coaching, and secondments.                           |  |                            |                         |        |
|                  |  |  | Team leaders equipped to use structured tools and techniques to develop effective team working, within their Care Groups, across Care Groups and with the wider health and social care system. |  |                            |                         |        |
|                  | Belonging in WHH   | Develop a culture that values the voice of our staff   | Staff able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.   | <ul style="list-style-type: none"> <li>Improved PDR Compliance</li> </ul>                                  | Strategic People Committee | Quarterly               | Yes    |
|                  |  |  | All leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.                    |  |                            |                         |        |
|                  |  |  | Compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination                                   |  |                            |                         |        |
| Belonging in WHH | Develop a learning culture that encourages compassionate leadership and values diversity and inclusion | Leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices. | <ul style="list-style-type: none"> <li>Increased rate of Welcome Back conversations</li> </ul>   | Strategic People Committee   | Quarterly                  | Yes                     |        |
|                  |  | Principles of a restorative and just culture evident in all workforce policies and procedures.   |  |  |                            |                         |        |
|                  |  | Behavioural framework embedded in WHH appraisal process for each Trust Values which promotes civility, kindness, and respect for all staff.    |  |  |                            |                         |        |

## Sustainability

| QPS Domain  | Objectives   | Required Outcomes  | 22/23 Priorities   | KPIs  | Committee                          | Frequency of Monitoring | In IPR |
|---|--|--|--|---|------------------------------------|-------------------------|--------|
| <b>Sustainability - We will...work in partnership with others to achieve social and economic wellbeing in our communities</b> | Enhance our role as an anchor institution by building on the provision of integrated place-based care and addressing health inequalities within our populations, being guided by the principles of social value. | Provider of integrated services. Improved pathways for local residents to ensure that everyone receives the right support, care and treatment at the right time. | Further development of out-of-hospital services with partner organisations.  | <ul style="list-style-type: none"> <li>Opening of Health Hub in Runcorn Shopping City and Warrington and Runcorn Town Deal Hubs</li> </ul>  | Finance & Sustainability Committee | Quarterly               | No     |
|   |  | Strong relationships and collaborative working with all partners, including councils, CCGs, mental health and community  | Play a key role in the development of Cheshire & Merseyside Integrated Care System as an enabler to the development of local place-based integrated care models. | <ul style="list-style-type: none"> <li>ICS Partnership Board created with WHH having representation alongside representation at C&amp;M Acute and Specialist Provider Collaborative.</li> <li>Trust strategic priorities reflected in ICP strategies and implementation plans.</li> </ul> | Finance & Sustainability Committee | Quarterly               | No     |
|   |  |  | Full roll-out of new Continuity of Carer model across maternity services and integration of Halton community midwifery services.                                 | <ul style="list-style-type: none"> <li>75% of BAME community will be in receipt of CoC by 2024.</li> <li>51% of women in receipt of CoC</li> </ul>  | Finance & Sustainability Committee | Quarterly               | Yes    |

| QPS Domain | Objectives | Required Outcomes  | 22/23 Priorities  | KPIs  | Committee                          | Frequency of Monitoring | In IPR |
|------------|------------|--|---|---|------------------------------------|-------------------------|--------|
|            |            | <p>services providers and the voluntary sector.</p> <p>Develop the Trust as an anchor institution within the locality.</p> | <p>Develop partnerships with other local anchor institutions</p>  | <ul style="list-style-type: none"> <li>Develop partnership with St Rocco's Hospice and formulate agreed workplan to address partnership opportunities.</li> <li>Develop partnership with University of Chester and formulate agreed workplan to address partnership opportunities.</li> <li>Develop partnership with Warrington and Vale Royal College                             <ul style="list-style-type: none"> <li>Submit application for Institute of Technology</li> <li>Completion of business case for Health &amp; Social Care Academy                                     <ul style="list-style-type: none"> <li>Ensure syllabus for H&amp;SA Academy reflects Trust priorities</li> </ul> </li> </ul> </li> </ul> | Finance & Sustainability Committee | Quarterly               | No     |
|            |            |  | <p>Exploit future opportunities to access central government funding for town regeneration and schemes to address health inequalities via national "levelling up" scheme.</p>             | <ul style="list-style-type: none"> <li>Secure initial funding commitment from MHCLG for Runcorn Town Deal programme.</li> <li>Submit bids for any future levelling up funding for both Halton &amp; Warrington.</li> </ul>  | Finance & Sustainability Committee | Quarterly               | No     |
|            |            |  | <p>Lead the implementation of a Health &amp; Wellbeing Hub in Warrington Town Centre and a Health &amp; Education Hub in Runcorn Town Centre under the national Town Deal initiative.</p> | <ul style="list-style-type: none"> <li>Secure funding for Warrington Town Deal Health &amp; Wellbeing Hub via business case to MHCLG.</li> <li>Establish governance and delivery infrastructure for Runcorn Town Deal project following confirmation of commitment to funding.</li> </ul>   | Finance & Sustainability Committee | Quarterly               | No     |

| QPS Domain | Objectives  | Required Outcomes   | 22/23 Priorities   | KPIs   | Committee                          | Frequency of Monitoring | In IPR |
|------------|---|---|--|--|------------------------------------|-------------------------|--------|
|            |   |   | Embedding the principles of supporting the prevention agenda and enhancing social value across the organisation.   | <ul style="list-style-type: none"> <li>Complete baseline assessment of local health inequalities and opportunities to add social value, identify gaps and establish workplan to address gaps.</li> <li>Establish Strategy &amp; Sustainability sub-committee as primary mechanism for governance.</li> </ul> | Finance & Sustainability Committee | Quarterly               | No     |
|            | Work with other acute care providers to ensure that those services which need to be provided by an acute environment are the best they can be and are clinically and financially sustainable. | Ensure services meet the demand of our populations.<br><br>Provide services on behalf of others where our services are clinically and financially superior. | Work collaboratively with acute and specialist providers through the Provider Collaboration to ensure delivery of sustainable services which meet the needs of our population. | <ul style="list-style-type: none"> <li>Development and implement of optimal pathways for Cardiology patients with LHCH.</li> <li>Development of out-of-hospital pathways for management of follow up appointments in community settings</li> </ul>   | Finance & Sustainability Committee | Quarterly               | No     |
|            |   | Disinvest in or transform services which are not financially sustainable and do not currently provide high quality outcomes.                                | Collaboration with St Helens and Knowsley and across Cheshire and Merseyside to deliver sustainable Pathology services on a regional footprint.                                | <ul style="list-style-type: none"> <li>Develop agreed operational plan for regional Pathology service</li> </ul>   | Finance & Sustainability Committee | Quarterly               | No     |
|            |   | Share best practice and collaborate to ensure the best outcomes for our populations.<br><br>Maintain and then improve financial position.                   | Response to the Covid-19 pandemic including recovery of elective surgery.  | <ul style="list-style-type: none"> <li>Zero 104-week waiters</li> </ul>  | Finance & Sustainability Committee | Quarterly               | Yes    |
|            |   | New hospital and wellbeing campus in Halton.  | Further enhance and improve the Trust's estate.  | <ul style="list-style-type: none"> <li>Development of ED Plaza.</li> <li>Develop Urology Investigations Unit.</li> <li>Develop Community Diagnostic Centre at Halton Site</li> </ul>   | Finance & Sustainability Committee | Monthly                 | No     |

| QPS Domain | Objectives                        | Required Outcomes   | 22/23 Priorities  | KPIs  | Committee                          | Frequency of Monitoring | In IPR |  |
|------------|-----------------------------------|---|---|---|------------------------------------|-------------------------|--------|--|
|            | patients, staff, and populations. | New hospital in Warrington.   | Continue to develop the Trust's B.I. capability through real time and predictive analytics.   | • By year end 21/22 50% of reports will be available on LiON for self service use by the Trust.   | Finance & Sustainability Committee | Monthly                 | No     |  |
|            |                                   |   | Procurement and implementation of new EPR system for maternity.   | Badgernet implemented March 2022  | Finance & Sustainability Committee | Monthly                 | No     |  |
|            |                                   | Recognised digital exemplar.  | Full roll-out of electronic prescribing, electronic observations and clinical decision support tools.   | Inpatient nursing observations complete - June 21<br>ED nursing observations complete – July 21<br><br>By year end 21/22 the last remaining features of electronic prescribing – Dose range checking and close loop will be live. |                                    |                         |        |  |
|            |                                   |   | Develop automated data capture solutions and automated safety alerts.   | Ward round data capture for complete – Live July 21   |                                    |                         |        |  |
|            |                                   |   | Progress plans for new hospitals for Warrington and Halton.   | • Develop programme plan based on successful receipt of funding and alternative plan if unsuccessful.   | Finance & Sustainability Committee | Quarterly               | No     |  |
|            |                                   | Work with organisations across our localities to ensure that services are delivered in the most effective places, making best use of publicly owned estate. | • Complete review of publicly-owned estate across Warrington including disposals tracker and identification of opportunities to improve utilisation of existing estate.<br><br>•Develop plan for vacation of blocks and release of land on Halton site. | Finance & Sustainability Committee  | Quarterly                          | No                      |        |  |

All objectives, outcomes, priorities and associated KPIs have been updated as part of the Trust's strategy refresh, and will be presented to the Board as part of a separate update on the future governance and monitoring arrangements in June 2023.

As such, this is the final paper reporting against delivery of the above KPIs.

## 2. KEY ELEMENTS

The assessment of the Trust performance against the agreed strategic outcomes for 2022/23 is below.

Where KPIs are reflected in the Trust's Integrated Performance Report, this is noted within the KPI description.

Each is rated on RAG system, over a variable time frame (indicator-dependent), as described below:


| RAG   | Meaning  |
|-------|--|
| Red   | KPI is off track, mitigation in place is not effective or sufficient and requires escalation |
| Amber | KPI is off track and mitigation is in place to achieve                                       |
| Green | KPI is on track and will deliver   |
| White | KPI not currently rated  |

### 3. STRATEGY KPI PERFORMANCE DASHBOARD 2022/23

#### Quality Indicators and Performance:

| QPS Domain   | 22/23 Priorities  | KPIs   | Current Indicator            | Current Position             | Baseline                   | Indicator Description   | Commentary   |
|--|---|--|------------------------------|------------------------------|----------------------------|---|--|
| <b>Quality - We will...always put our patients first delivering safe and effective care and an excellent patient experience.</b> | We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority. | 1. Early recognition of deteriorating patients in ED and Inpatients.<br>2. 90% of patients who meet criteria are screened for sepsis within 1 hour.<br>3. 90% of patients receive IV antibiotics within 1 hour where red flag sepsis is diagnosed. | -14% (ED) / +15% (Inpatient) | → 70% (ED) / 80% (Inpatient) | 87% (ED) / 53% (Inpatient) | Sepsis screening within 1 hour (ED / Inpatient) March 2023 against April 2022 | The Sepsis Improvement Group's inaugural meeting took place in February 2023, with the second meeting taking place in March 2023. Membership of the group includes the Trust's Sepsis Medical Lead, QI Team, Corporate Nursing, Emergency Department, the Trust Medical Lead for Sepsis and Trust stakeholders. Activity in Q4 has included: <ul style="list-style-type: none"> <li>• Commenced a review of the Terms of Reference.</li> <li>• The group has welcomed AQUA Expert by Experience to join the group as a lived experience panel member to support the coproduction of the Trust's improvement plan.</li> <li>• A process map of the ED sepsis pathway has been completed with support from the QI Team.</li> <li>• Evidence reviews to learn lessons from other organisations about approaches to the recognition and management of sepsis supported by the Knowledge and Education Service.</li> </ul> The Group has also commenced monitoring progress against the MIAA audit report (January 2023) which detailed the 2 high risk and 6 medium risk recommendations<br>Examples of processes changed / introduced to support improvements in Q4: <ul style="list-style-type: none"> <li>• An additional lactate machine for the Halton in place, additional machine on Halton site will support staff to meet the target of achieving a full sepsis screen within one hour of diagnosis.</li> <li>• The QI team have identified a designated sepsis facilitator who is reviewing the audit process and how the initial data is collected to improve the patient sample and streamline the process.</li> <li>• Display material has been provided for the wards and departments.</li> <li>• Sepsis management and the importance of prescribing antibiotics in a timely manner is a focus for improvement. This is reinforced through safety huddles in the Emergency Department and ward staff. Training for medical staff is provided by the Patient Safety Improvement Nurses and support from the Trust Medical Director in place to reinforce the standards via Medical Cabinet. The Acute Care Team will support this improvement out of hours for inpatients.</li> <li>• Education sessions continue to be provided in a range of formats to improve accessibility including e-learning is available on ESR. Training compliance 77% end of March 2023</li> </ul> |
|  | Continue to develop models of waiting list management in line   | 1. Continue to undertake clinical triage process.<br>2. Continue to undertake harm review process  | +3.1%                        | ↑                            | 100%                       | 97%   | % of Trust waiting list assigned a priority code March 2023 against April 2022   |

| QPS Domain | 22/23 Priorities  | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description | Commentary  |
|------------|---|--|-------------------|------------------|----------|-----------------------|---|
|            | with national guidance ensuring appropriate clinical prioritisation.  | 3. Continue to report for assurance via Clinical Oversight Group and Quality Assurance Committee.  |                   |                  |          |                       | <p>24/03/2021. Harm reviews are conducted on patients who breach 52 weeks and any patient who has an expired Priority Code. In recent months this as altered to 52 week harm reviews continuing with a random 10% sample of patients who have an expired priority code. This alteration was based upon assurance of the harm profile. This process has been underpinned by the Trust's existing governance processes. This process is also supported by Primary Care colleagues who form part of the review panel. The target to deliver the 104 week wait target by the end of June 2022 was achieved, discounting those patients who were on a P6 code where delay to surgery was at the request of the patient or where the patient was not considered to be fit for surgery.</p> <ul style="list-style-type: none"> <li>• Throughout 2022/2023 bi-weekly presentations have been provided to the Clinical Oversight Group and the Clinical Recovery Oversight Committee with escalation to the Quality Assurance Committee as required.</li> </ul> <p><b>How have we achieved this priority</b></p> <ul style="list-style-type: none"> <li>· A localised RAG rated outpatient's system was developed with the following parameters identified; high/medium/low risk with clinically agreed dates for follow ups.</li> <li>· Electronic systems and processes in place to capture the initial priority code listing.</li> <li>· Panel of appropriate clinicians established amongst Primary and Secondary Care colleagues to capture the patient's full journey when considering potential harm.</li> <li>· Supported by existing governance processes where harm may have been identified.</li> </ul> |
|            | Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework | <p>1. Ensure a patient safety culture continues to be embedded across the organisation in accordance with the requirements of the patient safety strategy and alterations to the investigation process utilising new methodologies.</p> <p>2. Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance.</p> <p>3. Evidenced through implementation of a learning framework.</p> | +0.3%             | ➔                | 1.64%    | 1.33%                 | Incidents graded as moderate to catastrophic harm as a proportion of all incidents Q1&Q2 2022/23 (Current Position) against Aggregate value for 2020/21   |

| QPS Domain | 22/23 Priorities   | KPIs  | Current Indicator   |  | Current Position | Baseline | Indicator Description | Commentary  |
|------------|--|---|---|--|------------------|----------|-----------------------|---|
|            |  |   |   |  |                  |          |                       | <p>final ratification at the Education Governance Group. This will be approved and presented to the Patient Safety &amp; Clinical Effectiveness Meeting (PSCESC) and Quality Assurance Committee. An initial introductory meeting was held with other Trusts (Lancashire and South Cumbria) who had implemented a similar framework to learn from their implementation of PSIRF and staff engagement activities.</p> <p>The focus on this priority remains as per the national requirement and implementation is on track to deliver the agreed milestones.</p>   |
|            | <p>Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.</p> | <ol style="list-style-type: none"> <li>1. Implementation and Audit of LOCSIP safety standards which apply to invasive procedures</li> <li>2. Audit of WHO checklist effectiveness and with evidence of effective operative debriefs delivering effective learning, team culture and improvement.</li> <li>3. Improve patient safety through the delivery and evaluation of human factors training.</li> </ol> |  |  |                  |          | <p>See commentary</p> | <p>Mersey Internal Audit Agency (MIAA) LocSSIP audit was undertaken with recommendations identified and completed. Oversight of LocSSIP interventions has been monitored via the LocSSIP Task and Finish Group, led by the Associate medical Director for Clinical Effectiveness reporting to the Patient Safety and Clinical Effectiveness Sub Committee (PSCESC). LocSSIP documentation audits provided significant assurance with greater than 90% data entry completion.</p> <p>The Deputy Chief Nurse is coordinating audit of Ward areas with infrequent LocSSIPs that were not represented in this years documentation audit.</p> <p>Observation audits: Three LocSSIP observational audits have been undertaken in Clinical areas performing a high volume of procedures, these delivered significant assurance</p> <p>Theatre teams have undertaken a programme of work on the five steps of safe surgery. This has been supported by observation visits at other Trusts to share learning and experience. This has been supported by a revised Standard Operating Procedure and a test of change utilising quality improvement methodologies. Evaluation of the test of change was completed with findings informing the five steps of safer surgery. The changes implemented were derived from reducing human factor questions and not repeating the same questions in the sign in, time out and sign out process. This reduces the repetitive question down from 39 to 16 creating greater efficiency. This was further supported by an improved huddle document and debrief in order to conclude the five steps. The team presented these changes in a national theatre managers conference, and it was well received. A safe surgery dashboard to monitor quality was also formulated and a balanced score card used as an audit tool. This programme of work is being further expanded to eight steps of safer surgery with proposed changes to National Safety Standards for Invasive Procedures documentation, as advised by the Centre for Perioperative Care. The team will be working alongside AQUA in 2023/2024 on the safe surgery programme to further evidence quality improvement.</p> <p>The LocSSIP Awareness e-learning (ESR) has been effectively implemented. Compliance with this training remains high at 87.94%. Human factors training is provided for individuals responsible for developing and updating LocSSIPs. Focused training has also been provided to areas identified as requiring further support. Simulation training is also considered during the design of</p> |

| QPS Domain | 22/23 Priorities  | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description | Commentary  |
|------------|---|--|-------------------|------------------|----------|-----------------------|---|
|            |   |  |                   |                  |          |                       | checklists and incidents with favourable feedback relating to this form of training.  |
|            | 'Get It Right First Time' Clinical Productivity programme to be implemented across all specialities to deliver enhanced quality and productivity. | <p>1. Each speciality to identify and commit to deliver 2 Clinical Productivity priorities as agreed with an Exec led GIRFT Steering Group.</p> <p>2. Improvement to be measured with agreed productivity metrics utilising internal data for assurance.</p> <p>3. To be monitored by GIRFT Steering Group reporting to the Patient Safety and Clinical Effectiveness Sub Committee.</p>     |                   | →                |          | See commentary        | <p>Warrington and Halton Teaching Hospitals NHS Foundation Trust created a dedicated GIRFT team consisting of an Associate Medical Director, Head of Finance, Clinical Lead for Medicine (Unplanned Care), Clinical Lead for Trauma and Orthopaedics (Planned Care) and Clinical Lead for Anaesthetics/Day case (Planned Care). Areas for improvement were agreed with each speciality with the focus to improve efficiency, productivity and quality. Progress is reported bi-weekly through the Care Group Transformation Boards and monthly to the Executive team and to Finance and Sustainability Committee.</p> <p>2023/24 Priorities have been agreed with each Care Group and detailed workplans with timescales and metrics are being finalised.</p> <p>Each Care Group ensured that GIRFT priorities/workstreams were in place for 2022/23 with workstreams including Theatres, Outpatients, and Reduction in Length of Stay</p> <p>These workstreams are aligned to the operational guidance key areas of focus in accordance with GIRFT recommendations.</p> <p>All national GIRFT communications relevant to the Trust are forwarded to the appropriate specialties, including national reports, action plan updates, and webinars.</p> <p>Deep dives have taken place for Trauma and Orthopaedics and within Lung Cancer, actions plans are in place. These form part of the work schedule.</p> <p>Established reporting structure: GIRFT and Transformation work is reported into the bi-weekly Planned/Unplanned/Outpatient Transformation Meeting, this then reports into the GIRFT Steering Group which then reports to the Executive Team, Finance and Sustainability Committee, Patient Safety and the Quality Assurance Committee.</p> |
|            | Discharge processes will be strengthened to improve the quality of discharge to home and community providers.                                     | <p>1. Ensuring early measures are in place to facilitate timely discharge, improving length of stay, with data presented by each ward.</p> <p>2. Patients will be partners in their care through communication and information sharing, measured through survey feedback.</p> <p>3. Plan for discharge from the point of admission with effective management of EDDs identified at Board</p> | 1.24              | ↑                | 5.64     | 4.40                  | Average Length of stay 2022/23 against Average Length of Stay 2017/18   |

| QPS Domain | 22/23 Priorities   | KPIs  | Current Indicator |   | Current Position | Baseline | Indicator Description   | Commentary   |
|------------|--|---|-------------------|---|------------------|----------|---|--|
|            |  | rounds and high quality discharge summaries. <ul style="list-style-type: none"> <li>Increase in incident reporting to show a culture of openness and transparency.</li> </ul>   |                   |   |                  |          |   | <ul style="list-style-type: none"> <li>Semi-automation of D2A forms and Transfer of Care forms to enable timely completion of community provisions.</li> <li>Ongoing work with Criteria Led Discharge. NHSE supporting with plan to implement across all suitable wards.</li> <li>Ongoing work with the digital team reviewing bed management system including weekend discharge lists.</li> <li>Multi-disciplinary Team safari ward rounds implemented for long length of stay patients with a right to reside led by the Medical Director.</li> <li>Virtual wards to support early supported discharge.</li> <li>Therapy teams continue to lead on work around deconditioning to support ongoing improvements with discharge and patient care.</li> <li>Friends and Family survey in place to facilitate feedback. Key trends and themes are reviewed at CBU governance meetings with completion data monitored through the Trust Integrated Performance Dashboard.</li> <li>Social media campaign and re-launch of 'Where Best Next?' and to promote a 'home first' approach, wherever possible. This required full involvement from patients, their loved ones, and carers in discussions about discharge from the earliest opportunity.</li> <li>Discharge letter to be given to patient upon admission outlining what will happen during their stay including prompts to ask questions around their care, again supporting the early discharge process.</li> <li>A review of the discharge pathway terminology and functionality on whiteboards and Lorenzo was undertaken to ensure that processes were effective and efficient.</li> <li>A discharge improvement task and finish group was established to review Board Round Standards. Ongoing project to support wards.</li> <li>'Home for' campaigns throughout the reporting period have been implemented.</li> <li>Work has been undertaken with regard to the quality of discharge summaries which provided significant assurance of appropriate completion.</li> <li>Auto-population of the discharge summary has improved the information provided in support of information required by General Practitioners.</li> </ul> |
|            | By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm. | 1. Implement and monitor the action plan to deliver the outlined recommendations of the 2020 'Independent Review of NHS Hospital Food' report ensuring access to high quality food and choice supported by an independent industry expert.<br>2. To ensure all patients hydration needs are met | 6.7               | ↑ | 6.7              | 5.5      | Trust score CQC Inpatient Survey for food rating 2021 (Current Position) against 2018 | Warrington and Halton Teaching Hospitals NHS Foundation Trust developed a Food and Drink Strategy alongside a workplan to deliver recommendations contained within the 'Independent Review of NHS Hospital Food' (2020). This was approved at the Quality Assurance Committee. The workplan has been monitored during the reporting period at the Nutrition and Hydration Steering Group.<br>Delivered recommendations set out in the NHS Hospital Food Report which have included: <ul style="list-style-type: none"> <li>Catering have received a £1.8 million capital bid for equipment which was approved at Trust Board in May 2022. There is now a full design programme for the project with construction in progress.</li> <li>New crockery for patients living with dementia.</li> <li>Catering questionnaires for patients are carried out on a bimonthly basis with results monitored at the Patient Experience Sub Committee</li> </ul>  |

| QPS Domain | 22/23 Priorities   | KPIs  | Current Indicator |   | Current Position | Baseline | Indicator Description | Commentary  |
|------------|--|---|-------------------|---|------------------|----------|-----------------------|---|
|            |  | <p>and monitored in accordance with their health needs, utilising ward-based quality metrics.</p> <p>3. Refresh and implement the Nutritional Care Strategy in collaboration with patients.</p>   |                   |   |                  |          |                       | <ul style="list-style-type: none"> <li>· Ensuring a wide range of snacks are available for patients.</li> <li>· Hot finger food now in place for patients living with dementia.</li> <li>· Continue to maintain a 5* hygiene rating.</li> <li>· Ensure a wide range of drinks are on offer on wards and departments.</li> <li>· Procure a digital meal ordering system to support patients to have a full understanding of the meals they are choosing to include what the meals will look like, nutritional value, allergy information.</li> </ul> <p>Implementation of the Trust Food and Drink Strategy 2022-2025 with objectives set out that are cognisant of local and national guidance. The strategy sets out to:</p> <ol style="list-style-type: none"> <li>1. Improving the individual nutrition and hydrational needs of our patients.</li> <li>2. Integrating multi-disciplinary working; bringing together all teams to improve nutrition and hydrational outcomes.</li> <li>3. Improving the quality and choice of food offers available to patients.</li> <li>4. Improving the quality and choice of food offers available to our workforce</li> <li>5. Sustainability and procurement of patient, workforce and visitor catering services.</li> </ol> <ul style="list-style-type: none"> <li>· Senior Nurse Workshops held to discuss the Trust Food and Drink Strategy and forward plans.</li> <li>· Performance with specific metrics monitored by the Nutrition and Hydration Steering Group, including assessment that impact nutritional status.</li> <li>· Monitored via observation walk rounds; Board walk rounds, Governor walk rounds, Mock Inspections, Ward Accreditation.</li> <li>· Food tasting events undertaken by Executive team and Governors.</li> <li>· The catering team have and continue to support a number of religious and celebratory events with food and drink for our patients.</li> </ul> |
|            | <p>Ensure the Mental Health and Learning Disability Strategies are implemented Trust wide.</p> | <ol style="list-style-type: none"> <li>1. Audit the use of patient's passports by Care Group via the Learning Disability and Mental Health Steering Groups.</li> <li>2. Evidence effective and robust alert processes for the Trust EPR system.</li> <li>3. Competency based training for Learning Disability, Autism and Mental Health available for all staff groups in the Trust.</li> </ol> |                   | ↑ |                  |          | <p>See commentary</p> | <p>The audit of patient passports has identified that there remains opportunity to work with system partners to ensure that patient passports are provided at the point of admission and updated accordingly. Of the cases reviewed 16% of patients did not attend the Trust with a passport in place. Workstreams are in place to support and improve communication between health providers with regard to vulnerable patient groups. One example of this during the reporting period is Arbury Court with positive progress being made. It is recognised within the Acute Trust and from within the Integrated Care Board that there is further opportunity to enhance care provision with regard to patients with Learning Disabilities and Mental Health complexities for which discussions are underway. This will also be fundamental to the implementation of Liberty Protection Safeguards in the future.</p> <p>Warrington and Halton Teaching Hospitals, NHS Foundation Trust continue to house and work alongside CORE24 based within the Emergency Department to review and support patients with mental health diagnosis. Discussions are underway to determine whether this service provision could be further enhanced recognising the significant increase in patients requiring care at the Trust.</p> <p>Alert systems and processes are in place with the support of the EPR and</p>  |

| QPS Domain | 22/23 Priorities  | KPIs  | Current Indicator |   | Current Position | Baseline | Indicator Description | Commentary   |
|------------|---|---|-------------------|---|------------------|----------|-----------------------|--|
|            |   |   |                   |   |                  |          |                       | <p>Safeguarding Team. This is also supported by the Learning Disability Specialist Nurse. The alert is placed on the patients Lorenzo record.</p> <p>An established training program that is competency based and reflects the Oliver McGowan training program have been in place for almost 2 years. Further work has been supported by a Mental Capacity Act Assessor/ trainer agreed through secondment which has been a very positive measure. Access of Local Authority training provision has also been provided. Work is currently underway to develop a Mental Health Acute Provider training package and has been agreed as a quality priority for 2023/2024.</p> <p>As part of the LD strategy, 20 LD champions are now in place across the Trust and support for staff to ensure that the highest standard of care is delivered has included:</p> <ul style="list-style-type: none"> <li>· Reasonable adjustment care plan and Standard Operating Procedure.</li> <li>· Monday Makaton training sessions 'Makaton Mondays' to support staff in communicating with patients and their relatives.</li> </ul>  |
|            | <p>Through patient centred communication and service development address inequalities for access to health.</p> | <ol style="list-style-type: none"> <li>1. Work with partners to support our population to access preventative and early intervention services specific to the needs of each person through the co-design of digitally enabled services.</li> <li>2. Deploy and audit the accessible information standards policy across WHH.</li> <li>3. Monitor and deliver against the First Impressions project – listening and improving the experience for patients, service users, their families, carers and our workforce.</li> </ol> |                   | ↑ |                  |          | <p>See commentary</p> | <p>During the reporting period the Halton Health Hub was opened. This is situated within Shopping City in Runcorn, providing Optometry, Orthoptics, Audiology and Dietetic Outpatients services. It has been designed to provide an improved patient experience, allowing patients easier access to their appointments, as well as assisting the Trust in furthering our ambitions in improving the health, wealth and prosperity of our boroughs by encouraging use of other facilities within Shopping City and boosting the local economy. To further enhance partnership working and access to preventative and early intervention services, a service level agreement was put in place to enable Halton Borough Council's Public Health team to utilise the Halton Health Hub to provide a drop-in vaccine outreach service for COVID-19 and flu vaccinations. A further service level agreement has been put in place for Halton General Practice Health Connect to utilise the Hub to provide a Primary Care Acute Respiratory hub 3 days a week. This will be expanding to an extended access primary care service from Spring 2023.</p> <p>The Trust has also secured £6m of funding across Warrington and Halton boroughs to develop two out-of-hospital hubs. The Living Well Hub in Warrington town centre will target and address health inequalities in Warrington by providing a range of services focused on prevention and early intervention in a town centre location with close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a flagship project for the local health and care system to work collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project represents an investment of £3.1m, has been co-designed with patients and system partners through extensive engagement and is on track to be operational by Autumn 2023.</p> <p>The Runcorn Health and Education Hub in Runcorn is planned to deliver services focussed on prevention, women and children and long-term conditions, from a central location in Runcorn. Being developed in partnership</p> |

| QPS Domain | 22/23 Priorities | KPIs | Current Indicator |  | Current Position | Baseline | Indicator Description | Commentary   |
|------------|------------------|------|-------------------|--|------------------|----------|-----------------------|--|
|            |                  |      |                   |  |                  |          |                       | <p>with a range of health and care providers across Runcorn, the scheme includes a flexible education element designed in partnership with Riverside College.</p> <p>The Trust has been successful in bidding for new capital and revenue funding from NHS England to develop a Community Diagnostic Centre (CDC) for Warrington and Halton at the Halton site, which will deliver diagnostic capacity for an additional c140,000 diagnostic tests by the end of 2024, supporting easier access to diagnostic services and earlier diagnosis of disease for patients.</p> <p>First impressions are the lasting impressions, which inspire confidence in the safe care and experience that our patients receive. First impressions are formed within 15 steps of entering the hospital and can influence the way patients, service users, their families and carers perceive their whole experience. The first impressions programme ensures that the Trust advances equality of opportunity between people who share a protected characteristic and those who do not.</p> <p>Achievements to date include:</p> <ul style="list-style-type: none"> <li>· Implementation of a fully staffed welcome desk on the Warrington site providing a range of support including.</li> <li>· Access to interpreters including Basic Sign Language via 'language line' at first point of entry.</li> <li>· Support with wayfinding.</li> <li>· Support with wheelchairs and assistance getting to required departments.</li> <li>· Support with car parking.</li> </ul> <p>Text a task initiative embedded into the Trust supporting staff to take pride in the hospital environment, more notably in communal areas thus ensuring a welcoming, accessible and positive experience for our patients and visitors. This initiative enabled staff to report estate concerns via a text sending a picture and a brief description of the issue instantly. Concerns raised are addressed by the Trust Estates team within 24 hours.</p> <p>Regular 15 steps challenges carried out in the Trust by both Estates and Facilities and Patient Experience and Inclusion Team to mitigate any concerns highlighted in the moment.</p> <p>15 steps challenge utilised for all mock inspections.</p> <p>First and lasting impressions embedded into a plethora of observations and assessments within the Trust including but not limited to:</p> <ul style="list-style-type: none"> <li>· Governors observations.</li> <li>· Ward accreditation.</li> <li>· CQC mock inspections.</li> <li>· Leadership observations.</li> <li>· Patient Led Assessments of the Care Environment (PLACE).</li> </ul> <p>The Head of Patient Experience and Inclusion is a member of a national group who are tasked with the review and refresh the 15 steps challenge toolkit.</p> |

Table 5: Quality KPIs and Commentary

People Indicators and Performance:

| QPS Domain   | 22/23 Priorities   | KPIs  | Current Indicator | Current Position | Baseline | Indicator Description | Commentary  |
|--|--|---|-------------------|------------------|----------|-----------------------|---|
| <b>People</b> - We will...be the best place to work with a diverse and engaged workforce that is fit for now and the future. | All leaders have the skills, competencies, and behaviours to support staff's health and wellbeing  | <ul style="list-style-type: none"> <li>Reduction in sickness absence</li> </ul> | -1.0%             | ↓                | 6.28%    | 7.26%                 | Sickness absence rate (past 12 months) March 2023 (Current Position) against March 2022   |
|  | WHH staff are supported to remain in work and be present through the adoption of best practice as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework |   |                   |                  |          |                       |   |
|  | Bespoke health promotion programmes offered to our workforce to address population health inequalities impacting on their health and wellbeing                                     |   |                   |                  |          |                       |   |
|  | Line managers are equipped to use person centred engagement practices which improve employee experience.   | <ul style="list-style-type: none"> <li>Reduction in time to hire</li> </ul>     | +40.5%            | ↑                | 106.11   | 75.54                 | Time to hire (whole Trust) March 2023 (Current Position) against March 2022   |
| Employee recognition and appreciation schemes accessible which are valued by our staff.                                      |  |   |                   |                  |          |                       | <b>Empower Managers to Enhance Employee Experience</b> <ul style="list-style-type: none"> <li>Year 1 Achievements:                             <ul style="list-style-type: none"> <li>Line manager development programme</li> </ul> </li> </ul> |

| QPS Domain | 22/23 Priorities  | KPIs                                | Current Indicator | Current Position | Baseline | Indicator Description  | Commentary   |  |
|------------|---|-------------------------------------|-------------------|------------------|----------|--|--|--|
|            | Onboarding process consistently applied to the recruitment of our leaders ensuring they have a personal priority to establish a great first impression for our patients and staff.  |                                     |                   |                  |          | Please note increased time to hire related to implementation of new national NHS Jobs system | <p>scoped and ready for implementation as a result of executive review and testing with members of Staff Networks and aligned to most recent staff survey results.</p> <ul style="list-style-type: none"> <li>o Review complete of Mental Health First Aid course with refreshed version a deliverable in Q1 2023-24</li> </ul> <p><b>Promote Employee and Recognition and Appreciation Schemes</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Gratitude and appreciation cards implemented across clinical areas within the organisation, second phase for corporate areas to be delivered in Q1 2023-24</li> <li>o Long Service recognition awards delivered as a joint event with WHH volunteers in December 2021</li> <li>o Long service recognition reviews complete and new approach aligned to best practice to be implemented from 1st April 2023</li> </ul> </li> </ul> <p><b>Onboarding – Create a Great First Impression</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Face to face corporate induction reinstated with added marketplace aligned to WHH Trust Values</li> </ul> </li> </ul> |  |
|            | Annual workforce plans which are reflective of the needs of WHH and the wider health and social care system to meet the changing health needs of our patients and which create new health care roles within clinical and non-clinical teams.                      | • Reduction in Vacancy Rate         | +0.1%             | ➡                | 10.66%   | 10.57%   | Vacancy Rate March 2023 (Current position) against March 2022  | <p><b>Development of Workforce Plans</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Development of a template to support with the monthly submission of the workforce plans to the national team and reporting internally within the Trust</li> </ul> </li> </ul> <p><b>Embed Agile Working Principles</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Following the principles of the NHS Flex for the Future an NHSE/I initiative, supported by Timewise – Talent Through Flexibility, developed an understanding where agile working is working well within WHH.</li> <li>o Using the intelligence discovered, developed a set of WHH Agile Working principles.</li> </ul> </li> </ul> |
|            | System wide process of workforce planning aligned to workforce supply and demand across the wider health and social care system, leading to recruitment and retention campaigns, and informed commissioned, resourced and funded external education and training. | • Reduced Staff Turnover            | -1.6%             | ⬇                | 14.85%   | 16.43%   | Staff Turnover March 2023 (Current Position) against March 2022  |  |
|            | New roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.   | • Improved Retention                | +0.1%             | ➡                | 83.79%   | 83.68%   | Retention Rate March 2023 (Current Position) against March 2022  |  |
|            | Attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.  |                                     |                   |                  |          |  |  |  |
|            | Workforce equipped to shape and deliver effective and changing models of care.  | • Reduction in bank/agency reliance | -2.6%             | ⬇                | 15.60%   | 18.17%   | Bank and agency reliance rate March 2023 (Current Position) against March 2022   | <p><b>Enhance the Digital Capability</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Developed a solution to enable line managers to access their annual leave usage</li> </ul> </li> </ul>   |
|            | Enhanced digital capability, skills and leadership which embraces digitally enabled services.   |                                     |                   |                  |          |  |  |  |

| QPS Domain | 22/23 Priorities   | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description | Commentary   |  |
|------------|--|--|-------------------|------------------|----------|-----------------------|--|--|
|            | Attract and retain a transformed and responsive workforce that can deliver care to patients in new and different ways.   |  |                   |                  |          |                       | percentage.<br><ul style="list-style-type: none"> <li>o Enhanced the use of Microsoft Forms as a way of collecting information on/from the workforce.</li> <li>o Developed the Workforce Information Team with analytical skills to support the development of our Workforce Information</li> </ul> <b>Improve Attraction and Retention</b> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Refreshed approach to Exit Interviews using ESR and monthly reporting of data on the Workforce Information Dashboard (WIDB)</li> <li>o Implementation of Wagestream to allow substantive staff to support enhanced financial wellbeing.</li> <li>o Marketed the Trust as a leading organisation in the region through enhanced recruitment activities and social media presence.</li> </ul> </li> </ul> |  |
|            | Managers and leaders recruited and developed using the WHH Line Management standards within the Line Management Training Framework.  | <ul style="list-style-type: none"> <li>• Improved role-specific training compliance</li> </ul> | +2.5%             | ↑                | 87.46%   | 84.98%                | CSTF Compliance March 2023 (Current Position) against March 2022   | <b>WHH Leadership Development Programme</b> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o OD offers review complete with new leadership programme offer pulled into one document and accessible via Flipping Book</li> <li>o Reciprocal mentoring implemented to support EDI objectives.</li> <li>o Growing As a Leader programme continues to be a success.</li> </ul> </li> </ul> |
|            | Pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans. |  |                   |                  |          |                       |  |  |

| QPS Domain   | 22/23 Priorities   | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description  | Commentary   |
|--|--|--|-------------------|------------------|----------|--|--|
|  | Accessible development programmes, including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.                     |  |                   |                  |          |  | <ul style="list-style-type: none"> <li>o Implementation of Your Future, Your Way nursing programme to support leaders of the future.</li> <li><b>Widen Participation in Development Programmes</b></li> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o WRES and WDES data analysed from 2021 staff survey to develop bespoke development programmes to implement in 2023-24</li> </ul> </li> <li><b>Review Mandatory and Role Specific Training</b></li> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o New approach to review of mandatory and role specific training implemented via a multi-disciplinary panel approach.</li> <li>o Supported SMEs to move to interactive content for mandatory training where possible to enable greater participation and interaction.</li> </ul> </li> </ul>   |
|  | NHS Talent Management and Succession Planning framework - Scope for Growth implemented and line managers clear about their responsibilities for their staff.                                   | <ul style="list-style-type: none"> <li>• Improved mandatory training compliance</li> </ul> | -7.7%             | ↓                | 83.55%   | 91.20%   | Mandatory Training Role-specific Compliance March 2023 (Current Position) against March 2022 <ul style="list-style-type: none"> <li><b>WHH Career Development</b></li> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Career development programme implemented with Staff Networks leading to individual securing promotions internally as a result of support.</li> <li>o Shadow Board approach implemented within WHH with second cohort due to be implemented in 2023-2024</li> <li>o Community of Practice for Shadow Board developed which will continue into 2023-24</li> </ul> </li> <li><b>Team Development</b></li> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Rugby League Cares initiative implemented to support and enhance current OD offer with teams.</li> <li>o Affina journey and approach implemented across four teams within the organisation to support with workforce recovery post-pandemic.</li> <li>o Teams away days supported across the organisation with health and wellbeing initiatives and approaches.</li> </ul> </li> </ul> |
|  | All staff seeking career progression have a range of options available, including professional education, training, shadowing, mentoring, coaching, and secondments.                           |  |                   |                  |          |  |  |
|  | Team leaders equipped to use structured tools and techniques to develop effective team working, within their Care Groups, across Care Groups and with the wider health and social care system. |  |                   |                  |          |  |  |
| Staff able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions. | <ul style="list-style-type: none"> <li>• Improved PDR Compliance</li> </ul>  | +5.1%  | ↑                 | 68.93%           | 63.82%   | PDR Compliance March 2023 (Current Position) against March 2022 <ul style="list-style-type: none"> <li><b>Staff Able to Speak Up and Feel Heard</b></li> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Enabling staff voice through the</li> </ul> </li> </ul> |  |

| QPS Domain  | 22/23 Priorities  | KPIs  | Current Indicator | Current Position | Baseline | Indicator Description   | Commentary   |
|---|---|-------|-------------------|------------------|----------|---|--|
|   | All leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures. |       |                   |                  |          |   | <p>development of the Freedom to Speak Up channel and FTSU Champions across the organisation.</p> <ul style="list-style-type: none"> <li>o Removing barriers to accessing Staff Networks by developing and implementing a Staff Network framework which includes time off for Staff Network duties.</li> <li>o Development of Staff Networks to ensure accessible by all staff across the organisation.</li> </ul> <p><b>Compassionate Leadership</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Self-compassion at work programme implemented in partnership with Dr Amanda Super</li> <li>o Community of Practice for managers and individuals who have participated in Compassionate Leadership programme implemented.</li> <li>o Compassionate leadership scores higher than Acute Trust average score in national staff survey results</li> </ul> </li> </ul> |
|   | Compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination                |       |                   |                  |          |   |  |
|   | Leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.                              |       |                   |                  |          |   |  |
|   | Principles of a restorative and just culture evident in all workforce policies and procedures.  |       |                   |                  |          |   |  |
| Behavioural framework embedded in WHH appraisal process for each Trust Values which promotes civility, kindness, and respect for all staff. | <ul style="list-style-type: none"> <li>• Increased rate of Welcome Back conversations</li> </ul>  | -1.1% | ➔                 | 78.41%           | 79.48%   | <p>Rate of Welcome Back Conversations September 2022 (Current Position) against September 2021</p> <p><b>Access to Co-Created Resources to Assist in the Delivery of Compassionate and Inclusive People Practices</b></p> <ul style="list-style-type: none"> <li>• Year 1 Achievements: <ul style="list-style-type: none"> <li>o Review of Conduct, Capability and MHPS policies to ensure they are supportive of compassionate and inclusive people practices.</li> <li>o Clarity on the roles of all stakeholders within the policies and their contribution to delivering compassionate and inclusive people practices.</li> </ul> </li> </ul> |  |

Table 6: People KPIs and Commentary

Sustainability Indicators and Performance

| QPS Domain   | 22/23 Priorities   | KPIs  | Current Indicator | Current Position | Baseline | Indicator Description  | Commentary  |
|--|--|---|-------------------|------------------|----------|--|---|
| Sustainability - We will...work in partnership with others to achieve social and economic wellbeing in our communities | Further development of out-of-hospital services with partner organisations.  | <ul style="list-style-type: none"> <li>Opening of Health Hub in Runcorn Shopping City and Warrington and Runcorn Town Deal Hubs</li> </ul>  |                   | ↑                |          | Progress of Shopping City and other out-of-hospital hub developments | <p>The Halton Health Hub in Runcorn Shopping City opened to patients in November 2022. This was followed by a formal opening in February 2023. The location went live with services from ophthalmology, audiology and dietetics. The hub has since hosted Halton Borough Council's covid-19 and flu vaccination service and is currently hosting a GP Extended Access service provided by GP Health Connect, the Runcorn GP Federation.</p> <p>Warrington Town Deal Health and Wellbeing Hub due to open late 2023.</p> <p>In December 2022 the Trust received notification that the business case submitted for the Health and Education Hub as part of the Runcorn Town Deal Health bid had been accepted. The £2.85 million project is due to open in 2025. Architects are currently leading a design process and a change of use planning application is due to be submitted to Halton Borough Council in July 2023.</p>  |
|  | Play a key role in the development of Cheshire & Merseyside Integrated Care System as an enabler to the development of local place-based integrated care models. | <ul style="list-style-type: none"> <li>ICS Partnership Board created with WHH having representation alongside representation at C&amp;M Acute and Specialist Provider Collaborative.</li> <li>Trust strategic priorities reflected in ICP strategies and implementation plans.</li> </ul> |                   | ↑                |          | See commentary   | <p>Integrated Care Systems were formally constituted on 1st July 22 with the Cheshire &amp; Merseyside Integrated Care Board formally commencing its duties from this date.</p> <p>Place Based Boards – One Halton and Warrington Together Partnership Boards were also constituted on 1st July 2022. The Trust has senior representation at both Boards.</p> <p>The Trust is now formally part of The Cheshire and Merseyside Acute and Specialist Trust (CMAST) provider collaborative. Simon Constable is the lead for the Clinical pathways programme of work.</p> <p>The Trust's strategic objectives and priorities have been shared with CMAST and PLACE partners to be incorporated into local plans and into the ICB joint forward plan.</p> <p>Lucy Gardner has been appointed SRO for One Halton's Wider Determinants workstream. High level priorities have been developed to improve outcomes in Halton, and an initial workshop is being planned with stakeholders in June.</p> |
|  | Full roll-out of new Continuity of Carer model across maternity services and integration of Halton community midwifery services.                                 | <ul style="list-style-type: none"> <li>75% of BAME community will be in receipt of CoC by 2024.</li> <li>51% of women in receipt of CoC</li> </ul>  | +88.2%            | ↑                | 88.20%   | 0%   | All Women in receipt of CoC (February 2023) Against Baseline  |

| QPS Domain | 22/23 Priorities   | KPIs  | Current Indicator | Current Position | Baseline | Indicator Description | Commentary     |   |
|------------|--|---|-------------------|------------------|----------|-----------------------|----------------|---|
|            | Develop partnerships with other local anchor institutions  | <ul style="list-style-type: none"> <li>Develop partnership with St Rocco's Hospice and formulate agreed workplan to address partnership opportunities.</li> <li>Develop partnership with University of Chester and formulate agreed workplan to address partnership opportunities.</li> <li>Develop partnership with Warrington and Vale Royal College               <ul style="list-style-type: none"> <li>Submit application for Institute of Technology</li> <li>Completion of business case for Health &amp; Social Care Academy</li> <li>Ensure syllabus for H&amp;SC Academy reflects Trust priorities</li> </ul> </li> </ul> |                   | ↑                |          |                       | See commentary | <ul style="list-style-type: none"> <li>Linked St Rocco's COO with WHH senior HR team to explore potential for WHH to provide occupational health support to the Hospice.</li> <li>Site visit to Halton Haven and meeting with Hospice CEO set up to open discussions around opportunities for improved partnership</li> <li>The Health and Social Care Academy has begun delivering it's curriculum from the new facility.</li> </ul> <p>A site visit was conducted to share learning of the Town Deal projects and the Health and Social Care Academy and to develop an understanding of the continued development of the curriculum.</p> <p>As a result of this project, closer links have now been developed with WVRC which are resulting in ongoing mutually beneficial opportunities.</p> <p>A list of opportunities for partnership working have been identified and an initial programme of work subsequently compiled between the Trust and the University of Chester. The specific outcome required from each individual project has been agreed and a named individual from both WHH and University of Chester have been identified to take each individual project forward.</p> |
|            | Exploit future opportunities to access central government funding for town regeneration and schemes to address health inequalities via national "levelling up" scheme. | <ul style="list-style-type: none"> <li>Secure initial funding commitment from MHCLG for Runcorn Town Deal programme.</li> <li>Submit bids for any future levelling up funding for both Halton &amp; Warrington.</li> </ul>  |                   | ↑                |          |                       | See commentary | <p>Funding secured from Government for the Runcorn Town Deal Programme, including the health and education hub. The hub is expected to open to the public in 2025.</p> <p>Halton Borough Council's £12.3million bid to the national Levelling Up Fund was unsuccessful. The council are awaiting an opportunity to bid for a third tranche of funding, expected late 2023. The bid contained two submissions from the Trust totalling £3.1 million. These bids are to expand the outpatient clinic within Halton Health Hub at Runcorn Shopping City, and to develop plans around the blocks at Halton General Hospital, as previously described in the Halton Hospital Masterplan.</p> <p>In Warrington we are working closely with Warrington Borough Council on the allocation of the UK Shared Prosperity funding received, to ensure that health is considered.</p>  |

| QPS Domain | 22/23 Priorities   | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description | Commentary   |
|------------|--|--|-------------------|------------------|----------|-----------------------|--|
|            | Lead the implementation of a Health & Wellbeing Hub in Warrington Town Centre and a Health & Education Hub in Runcorn Town Centre under the national Town Deal initiative.     | <ul style="list-style-type: none"> <li>Secure funding for Warrington Town Deal Health &amp; Wellbeing Hub via business case to MHCLG.</li> <li>Establish governance and delivery infrastructure for Runcorn Town Deal project following confirmation of commitment to funding.</li> </ul>                    |                   | ↑                |          | See commentary        | <p>Initial funding commitment totalling £3.12mil confirmed by Ministry of Housing, Communities and Levelling Up for Warrington Town Deal Health and Wellbeing Hub. A Grant Funding Agreement between Warrington Borough Council and the Trust was approved, and a procurement exercise completed in January 2023 to leading to the appointment of contractors. Building works are expected to complete in October 2023.</p> <p>Governance structures established and in place following notification of successful bid for RTD Health and Education Hub. The Project Team continues to work with internal (WHH) and external partners to fully realise the service provision and offering. A planning application is expected to be submitted for a change of use in July 2023 - Hub is expected to open in 2025.</p>  |
|            | Embedding the principles of supporting the prevention agenda and enhancing social value across the organisation.   | <ul style="list-style-type: none"> <li>Complete baseline assessment of local health inequalities and opportunities to add social value, identify gaps and establish workplan to address gaps.</li> <li>Establish Strategy &amp; Sustainability sub-committee as primary mechanism for governance.</li> </ul> |                   | ↑                |          | See commentary        | <p>Progression of the Trust's journey as an anchor institution has been embedded in the Trust strategy for 23-25 and is reflected in the Trust's objectives. The Prevention Pledge Action Tracker for 2023/24 has been updated to reflect new and existing work and submitted to C&amp;M ICB. The update was well received and noted as exemplary for introduction of SMART principles to the tracker.</p> <p>Connections have been made between the Trust's Active Hospitals work and the Cheshire and Merseyside Physical Activity Sub-Group, with a meeting scheduled to identify greater collaboration opportunities.</p> <p>Work is underway with therapy colleagues to embed strengths-based approaches to support patients to live well. This is connected to Place initiatives.</p> <p>Lucy Gardner has been appointed SRO for One Halton's Wider Determinants workstream. High level priorities have been developed to improve outcomes in Halton, and an initial workshop is being planned with stakeholders in June. Strategy and Sustainability sub-committee established as primary governance route.</p> |
|            | Work collaboratively with acute and specialist providers through the Provider Collaboration to ensure delivery of sustainable services which meet the needs of our population. | <ul style="list-style-type: none"> <li>Development and implement of optimal pathways for Cardiology patients with LHCH.</li> <li>Development of out-of-hospital pathways for management of follow up appointments in community settings</li> </ul>   |                   | ↑                |          |                       | <p>The Trust is now formally part of The Cheshire and Merseyside Acute and Specialist Trust (CMASST) provider collaborative. Simon Constable is the lead for the Clinical Pathways programme of work. The initial focus is on ENT, T&amp;O and dermatology to ensure consistency in access and outcomes across C&amp;M. To date the Clinical Pathways Programme has begun implementing improvement models and focus in dermatology and ENT, and adopting the priorities identified through the Orthopaedics Alliance.</p> <p>Executive level discussions with St Helens and Knowsley have recommenced with a view to prioritising our collaboration to ensure sustainability of services. Collaboration at pace with STHK is being undertaken within ENT and Pathology. This includes the establishment of joint positions within ENT.</p> <p>The Trust's strategic objectives and priorities have been shared with CMASST and PLACE partners to be incorporated into local plans and into the ICB joint forward plan.</p>   |

| QPS Domain | 22/23 Priorities  | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description | Commentary  |   |
|------------|---|--|-------------------|------------------|----------|-----------------------|---|---|
|            | Collaboration with St Helens and Knowsley and across Cheshire and Merseyside to deliver sustainable Pathology services on a regional footprint. | <ul style="list-style-type: none"> <li>Develop agreed operational plan for regional Pathology service</li> </ul>   |                   | →                |          |                       | See commentary  | <p>Work on the collaboration has been paused and the TU has been engaged for 6 months to conduct a review. The direction of travel is not yet known.</p> <p>The WHH position in regards to service fragility has improved significantly, through collaboration with STHK on Cellular Pathology and work undertaken internally.</p>  |
|            | Response to the Covid-19 pandemic including recovery of elective surgery.   | <ul style="list-style-type: none"> <li>Zero 104-week waiters</li> </ul>  | -20               | ↓                | 1        | 21                    | Number of patients waiting more than 104 weeks March 2023 (current position) against September 2021 | <p>The Trust continues to undertake a recovery elective programme with:</p> <ul style="list-style-type: none"> <li>Urgent cancer and elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients.</li> <li>Prioritisation of P2 patients and &gt; 52-week breeches for scheduling into capacity with a commitment to clear the &gt;65 weeks by the end of March 2024</li> <li>Planning submission in line with National guidance for reduction of waiting lists has been completed for 23/24</li> <li>Harm assurance piece being undertaken on all 52-week breeches to identify any risk of harm for patients who have waited a long time during the pandemic.</li> <li>The surgical bed base has been reconfigured to create a surgical floor which incorporates green capacity, and this became operational in February 2021 and is being fully utilised.</li> <li>A recovery dashboard is being utilised to monitor progress against agreed trajectories. This is being updated and new trajectories agreed to recover performance in 2022 / 23 and 23/24</li> <li>The post anaesthetic care unit (PACU) is now working at full capacity.</li> </ul> |
|            | Further enhance and improve the Trust's estate.   | <ul style="list-style-type: none"> <li>Development of ED Plaza.</li> <li>Develop Urology Investigations Unit.</li> <li>Develop Community Diagnostic Centre at Halton Site</li> </ul> |                   | ↑                |          |                       | See commentary  | <p>ED Plaza, Urology Investigation Unit and Children's Outpatient schemes have all been delivered.</p> <p>The Breast Care reconfiguration completed in May 2023.</p> <p>The Trust has been allocated £12million to create a Community Diagnostic Centre at Halton. This programme was designed in three phases:<br/>Phase 1 - delivery of a range of diagnostic services within the Nightingale Building at Halton<br/>Phase 2 - delivery of diagnostic services at Runcorn Shopping City<br/>Phase 3 - a new build extension to CSTM to accommodate MRI and CT services.</p> <p>Phase 1 is expected to complete in June 2023.</p> <p>Costings for Phase 2 have been received at 53% over budget. Mitigating actions are being explored.</p> <p>The Trust has also received funding to improve and increase our elective surgery facilities, via TIF. Plans include delivery of additional theatre and endoscopy space.</p>   |

| QPS Domain | 22/23 Priorities   | KPIs  | Current Indicator | Current Position | Baseline | Indicator Description | Commentary  |
|------------|--|---|-------------------|------------------|----------|-----------------------|---|
|            | Continue to develop the Trust's B.I. capability through real time and predictive analytics.                      | • By year end 21/22 50% of reports will be available on LiON for self service use by the Trust.   |                   | ↑                |          | KPI Achieved          | >50% of reports are available on LiON for self service.   |
|            | Procurement and implementation of new EPR system for maternity.  | Badgernet implemented March 2022  |                   | ↑                |          | KPI Achieved          | Badgernet went live in maternity in May 2022. A neonatal extension to Badgernet has been deferred to 2024/25 unless alternative capital is identified.  |
|            | eRostering Tactical - Implementation of RotaMap to support medical and consultant-led Teams - Attainment Level 1 | By year end 21/22 at least 90% of medical and consultant employees will be registered on an e-roster.   |                   | ↑                |          | KPI Achieved          | At least 90% of medical and consultant employees are registered on an e-roster.   |
|            | Full roll-out of electronic prescribing, electronic observations and clinical decision support tools.            | Inpatient nursing observations complete - June 21<br>ED nursing observations complete – July 21<br><br>By year end 21/22 the last remaining features of electronic prescribing – Dose range checking and close loop will be live. |                   | ↑                |          | See commentary        | Inpatient and ED nursing observations live in Lorenzo.<br><br>Pharmacy - ePMA Part 3 (key HiMSS L5 deliverable) – Dose Range Checking within Lorenzo. Dose range checking safety concerns raised unable to deploy functionality required for HiMSS level 5. Meeting to be scheduled with Pharmacy colleagues to review next steps.<br><br>Ward round data capture live in Lorenzo.  |
|            | Develop automated data capture solutions and automated safety alerts.  | Ward round data capture for complete – Live July 21   |                   |                  |          |                       |   |
|            | Progress plans for new hospitals for Warrington and Halton.  | • Develop programme plan based on successful receipt of funding and alternative plan if unsuccessful.   |                   | ↓                |          |                       | The Trust received notification May 2023 that it was unsuccessful in its bid to receive national funding for the creation of new hospital estate. Next steps will now be developed through the New Hospitals Oversight Group. This will include the exploration of alternative funding routes which may provide opportunities to take forward enabling plans on a service by service basis, aligned to the overall vision of the programme.<br><br>Opportunities to support the delivery of new hospitals have been progressed, including community hubs and the community diagnostic centre.<br><br>A refresh is underway of the Trust's Estates Strategy, which will incorporate options to deliver the new hospitals vision. |

| QPS Domain | 22/23 Priorities  | KPIs   | Current Indicator | Current Position | Baseline | Indicator Description | Commentary  |
|------------|---|--|-------------------|------------------|----------|-----------------------|---|
|            | Work with organisations across our localities to ensure that services are delivered in the most effective places, making best use of publicly owned estate. | <ul style="list-style-type: none"> <li>• Complete review of publicly-owned estate across Warrington including disposals tracker and identification of opportunities to improve utilisation of existing estate.</li> <li>• Develop plan for vacation of blocks and release of land on Halton site.</li> </ul> |                   | ➔                |          |                       | <p>The Warrington Wider Estates Review concluded Phase 1 of the Project in June 2022. A Data Asset Map has been produced that details all public sector estate across Warrington, as well as some Third Sector organisations who also participated in the project. Systematic utilisation of the asset map is being embedded into the emerging place estates plan for Warrington and will be monitored via the place Transforming Estates Enabling Group to ensure opportunities are maximised.</p> <p>Halton Borough Council's £12.3million bid to the national Levelling Up Fund was unsuccessful. The council are awaiting an opportunity to bid for a third tranche of funding, expected late 2023. The bid contained two submissions from the Trust totalling £3.1 million. These bids are to expand the outpatient clinic within Halton Health Hub at Runcorn Shopping City, and to support delivery of the plans around the blocks at Halton General Hospital, as previously described in the Halton Hospital Masterplan. A plan for the vacation of the blocks and release of land has been developed, with support from One Public Estate.</p> |

Table 7: Sustainability KPIs and Commentary

#### **4. ACTIONS REQUIRED/RESPONSIBLE OFFICER**

The board is asked to note the progress against delivery of the strategic objectives and the governance arrangements in place. As noted, these governance arrangements have been updated following the recent refresh of the Trust's strategy, as documented in a separate paper.

#### **5. IMPACT ON QPS?**

Delivery of our strategy enables the Trust to deliver our aims under Q, P and S, and it is essential that this is monitored for assurance and escalated where necessary.

#### **6. MEASUREMENTS/EVALUATIONS**

The strategy delivery summary is provided to Trust board every six months by the Director of Strategy and Partnerships. Key strategic developments are discussed at each Trust board as appropriate.

#### **7. TRAJECTORIES/OBJECTIVES AGREED**

The KPIs support the delivery of the Trust Strategy to 2023. It is to be noted that the Trust Strategy has been refreshed in 2023 and as such this is the final report against the 2018 strategy.

#### **8. MONITORING/REPORTING ROUTES**

The governance for each strategic objective is outlined in section 2.

#### **9. ASSURANCE COMMITTEE**

Each KPI is assured at a number of committees/sub-committees as indicated above.

#### **10. RECOMMENDATIONS**

The Board is asked to note the progress against delivery of the strategic objectives and the governance arrangements in place.

**REPORT TO BOARD OF DIRECTORS**

|   |  |          |                     |          |
|---|--|----------|---------------------|----------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/60</b>   |          |                     |          |
| <b>SUBJECT:</b>   | <b>Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence</b>   |          |                     |          |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023  |          |                     |          |
| <b>AUTHOR(S):</b>   | John Culshaw, Trust Secretary  |          |                     |          |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Simon Constable, Chief Executive   |          |                     |          |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.   |          |                     | x        |
|   | SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.  |          |                     | x        |
|   | SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.  |          |                     | x        |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | All  |          |                     |          |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | 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. |          |                     |          |
| <b>PURPOSE: (please select as appropriate)</b>  | Information  | Approval | <b>To note</b><br>✓ | Decision |
| <b>RECOMMENDATION:</b>  | The Chair and Chief Executive approved the self-certification on behalf of the Board and the Self-Certification for the items is attached. The Board is asked to note compliance with NHS Conditions G6 and CoS7   |          |                     |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>  | <b>Committee</b>   | N/A      |                     |          |
|   | <b>Agenda Ref.</b>   |          |                     |          |
|   | <b>Date of meeting</b>   |          |                     |          |
|   | <b>Summary of Outcome</b>  |          |                     |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full   |          |                     |          |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>   | None   |          |                     |          |

**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 £5.4m which is slightly better than the £6.1m deficit plan. This adjusted surplus is the value which NHSE/I monitors the Trust against and was achieved.  
 The annual capital programme was £25.6m and the actual spend for the year was £25.5m, delivering an underspend of £0.1m.  
 The cash balance at the end of the year was £34.9m which will be utilised to fund the remaining annual leave accrual, new EPCMS (Electronic Patient Care Management System) and 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 Capital Planning Group and Finance and Sustainability Committee, with particular focus on schemes over £0.5m.  
 Over the last 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   
 Name Steve McGuirk  
 Capacity Chair  
 Date 26th May 2023

Signature   
 Name Simon Constable  
 Capacity Chief Executive  
 Date 26th May 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

[Empty box for explanatory information]

**REPORT TO BOARD OF DIRECTORS**

|   |   |               |                     |
|---|---|---------------|---------------------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/61</b>  |               |                     |
| <b>SUBJECT:</b>   | <b>Revised Provider Licence</b>   |               |                     |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |               |                     |
| <b>AUTHOR(S):</b>   | John Culshaw, Company Secretary   |               |                     |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Simon Constable, Chief Executive  |               |                     |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.  | ✓             |                     |
|   | SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.   | ✓             |                     |
|   | SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.   | ✓             |                     |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | All   |               |                     |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>The NHS Provider Licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded health care services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.</p> <p>Changes from the previous iteration of the Licence largely relate to system working and references to Monitor updated to NHS England.</p> <p>All changes were made following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS provider licence and the NHS controlled provider licence.</p> <p>Work will be undertaken in 2023/24 to confirm on-going compliance from the previous iteration.</p> <p>The signed provider licence certificate is included in the paper for reference, the revised licence in full can be found on the Trusts Website:<br/><a href="http://www.whh.nhs.uk">Statutory information :: Warrington and Halton Hospitals NHS Trust (whh.nhs.uk)</a></p> |               |                     |
| <b>PURPOSE: (please select as appropriate)</b>  | Information   | Approval<br>✓ | To note<br>Decision |
| <b>RECOMMENDATION:</b>  | The Trust Board is asked to note and approve  |               |                     |
| <b>PREVIOUSLY CONSIDERED BY:</b>  | <b>Committee</b>  |               |                     |
|   | <b>Agenda Ref.</b>  |               |                     |
|   | <b>Date of meeting</b>  |               |                     |



|   |                           |  |
|---|---------------------------|--|
|   | <b>Summary of Outcome</b> |  |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full  |  |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b> | None                      |  |

Warrington and Halton Teaching Hospitals NHS  
Foundation Trust

Warrington Hospital  
Warrington  
WA5 1QG

**Licence number: 130139**

**Date of issue**  
1 April 2023

**Version number**  
3



Miranda Carter  
Director of Provider Development, NHS England

## Version History

| Version number | Date          | Comments                             |
|----------------|---------------|--------------------------------------|
| 1.0            | 26 March 2013 | Created                              |
| 2.0            | 04 April 2013 | Formatting changes                   |
| 3.0            | 31 March 2023 | Modified licence standard conditions |

**REPORT TO TRUST BOARD**

|   |  |               |                     |
|---|--|---------------|---------------------|
| <b>AGENDA REFERENCE:</b>  | BM/23/06/62  |               |                     |
| <b>SUBJECT:</b>   | <b>Chairs Annual Reports 2022-23</b><br><b>Finance and Sustainability Committee (i)</b><br><b>Strategic Peoples Committee (ii)</b>   |               |                     |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023  |               |                     |
| <b>AUTHOR(S):</b>   | John Somers, Non-Executive Director & Chair of F&SC & Julie Jarman Non-Executive Director & Chair of SPC   |               |                     |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | 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.   |               | ✓                   |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | <b>Finance and Sustainability Committee</b><br><b>#134</b> 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<br><b>#1114</b> 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.<br><b>#1372</b> 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<br><br><b>Strategic Peoples Committee</b><br><b>#1134</b> 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<br><b>#1757</b> 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 |               |                     |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | This report seeks to deliver assurance to the Trust Board that the: <ul style="list-style-type: none"> <li>• Finance and Sustainability Committee</li> <li>• Strategic People Committee</li> </ul> Have met their Terms of Reference and have gained assurance throughout the reporting period of the Trust’s performance.   |               |                     |
| <b>PURPOSE: (please select as appropriate)</b>  | Information  | Approval<br>✓ | To note<br>Decision |

|   |  |  |
|---|--|--|
| <b>RECOMMENDATION:</b>                        | The Trust Board is asked to review the document and ensure it meets its purpose. |  |
| <b>PREVIOUSLY CONSIDERED BY:</b>              | <b>Committee</b>   | Finance & Sustainability Committee<br>Strategic People Committee   |
|   | <b>Agenda Ref.</b>   | FSC/22/05/92<br>SPC/23/05/62                                       |
|   | <b>Date of meeting</b>   | FSC – 23 <sup>rd</sup> April 2023<br>SPC 17 <sup>th</sup> May 2023 |
|   | <b>Summary of Outcome</b>  | Approved   |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full   |  |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b> | None   |  |



## TRUST BOARD

|                |   |                    |                        |
|----------------|---|--------------------|------------------------|
| <b>SUBJECT</b> | <b>Chair's Committee Annual Report – Finance &amp; Sustainability Committee</b> | <b>AGENDA REF:</b> | <b>BM/23/06/62 (i)</b> |
|----------------|---|--------------------|------------------------|

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Finance and Sustainability Committee (F&SC) Annual Report which covers the reporting period 1 April 2022 to 31 March 2023.

The Committee is responsible on behalf of the Board for reviewing financial and operational planning, digital, performance and strategic and business development.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has primarily been composed of two Non-Executive Directors with a quorum of two (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence. I have been the Chair of the Committee since October 2023. Prior to me, the Committee had been chaired by Terry Atherton since 2015.

The Finance and Sustainability Committee attendance record is attached in Appendix 1.

Regular attendees at the Committee meetings are the Chief Finance Officer & Deputy Chief Executive, Executive Medical Director, Chief Nurse & Deputy Chief Executive, Chief People Officer, Chief Operating Officer, Director of Strategy & Partnerships, Deputy Director of Finance & Commercial Development, Chief Information Officer and the Company Secretary & Associate Director of Corporate Governance. Furthermore, a Trust Governor observes each meeting and provides feedback to the Council of Governors on how the meeting was chaired, the extent of challenge and degree of assurance received.

### **Terms of Reference**

The Committee's Terms of Reference were reviewed and approved by the Trust Board in September 2022 to ensure they continued to remain fit for purpose with amendments approved to:

#### **Amendment to section 4 – Duties & Responsibilities:**

- Updated reference to Committee Assurance Report and amended NHSI to NHSE following NHS Improvement becoming part of NHS England in July 2022

#### **Section 9: Reporting Groups**

- Addition of GIRFT/Clinical productivity Group
- Amend title of Digital Board to Digital Management Group

#### **Frequency of Meetings and Summary of Activity**



In light of the ongoing COVID-19 pandemic, the meetings were held virtually via MS Teams until July 2022. Face to face meetings, with the option of attendance via MS Teams, were re-introduced from August 2022.

Due to ongoing extreme weather conditions and subsequent significant operational pressures, the Finance & Sustainability Committee scheduled to take place on Wednesday 21<sup>st</sup> July 2022, was cancelled. All agenda items were reviewed or approved as appropriate by Terry Atherton as Chair of the Committee any questions raised and subsequent answer provided were shared with the Committee/ Trust Board. The Committee were asked by the Chair to virtually review and indicate support (or not) for the following items:

- Capital requests from CPG
- The increase to the capital contingency for the VAT rebate
- Lease arrangements in respect of the Warrington Town Deal
- Emergency Preparedness, Resilience & Response Annual Report
- Updates to the BAF and Corporate Risk Registers

The Committee met either face to face or virtually 11 times during the year. A summary of the activity covered at these meetings follows:

### **Reporting**

In terms of reporting to the Finance and Sustainability Committee, the following key reports were submitted in 2022-23.

### **Pay Assurance**

The Pay Assurance reports set out an overview of workforce FTE position across the Trust on a monthly basis throughout 2022/2023 and provided information to the Finance and Sustainability Committee information on compliance with processes in place to control pay spend including:

- Establishment Control Process
- Estimated Cost of Absence
- Medical Bank Rate Card Compliance
- Agency Rate Card Compliance
- Temporary Staffing Booking Lead Times

This paper also provided information to the Committee on agency use across all staff groups.

The data in the report was taken from the Trust Workforce Information Dashboard, Patchwork Insights Database and the IPR Report Data. This ensured consistency in the use of data across the Trust by using these single sources across multiple reports within the Trust.

### **Risks**

The Committee received updates on the key risks on the Strategic and Corporate Risk Registers affecting the Trust's Financial and Sustainability position at each meeting. The Committee monitors updates to existing risks, reviews and discusses proposals to add new risks, de-escalate risks and amend risk ratings or descriptions.

Examples of the risks and gaps in controls that were considered during the year include:

- Financial Sustainability
- Electronic Patient Record solution
- Cyber Security
- Capital planning
- CIP
- ERF

**Strategic Risk Register** – During the year, no new risks were added, the rating of two risks were amended, and one risk was closed/de-escalated.

**Corporate Risk Register** – During the year, three new risks were added and two risks were closed/ de-escalated.

## Finance

The Trust recorded an adjusted deficit of £7.9m which is worse than the £6.1m deficit plan (revised £5.4m deficit). This adjusted surplus is the value which NHSE/I monitors the Trust against and the movement from plan was approved by the ICS and the national team.

The annual capital programme was £25.6m and the actual spend for the year was £25.5m, delivering an underspend of £0.16m.

The cash balance at the end of the year was £34.9m which will be utilised to fund the remaining annual leave accrual, new EPCMS (Electronic Patient Care Management System) and 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 Capital Planning Group and Finance and Sustainability Committee, with particular focus on schemes over £0.5m.

Over the last 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.

During the year the Committee received and reviewed the following:

- Dashboard setting out key finance and procurement metrics and performance
- Monthly, year to date and forecast financial performance
- Monthly, year to date and forecast capital expenditure.
- Monthly, year to date and forecast cash balances including short term cash flow.
- Draft Trust Strategy (Finance Sections)
- Cost Improvement Programme & GIRFT updates
- Monthly, year to date and forecast of COVID-19 expenditure and income
- Review of aged debt and aged creditors.
- Updates on the Electronic Patient Care Management System (EPCMS)
- Cheshire & Merseyside Financial Position
- Risks and mitigating actions to financial position.
- Updates on, Service Line Reporting and Reference Costs.
- Updates on benefits realisation



- Local system financial performance information.
- NHSI Updates.
- Digital assurance reports
- Medical Staffing Review
- Operational Plan & Budget

### **Approvals – delegated authority from Trust Board**

Following approval by the Trust Board in January, it was agreed that capital spend up to £5m could be delegated to the Finance & Sustainability Committee.

- **January 2023** – Approval of £1.4m from external capital for replacement MRI Scanner.
- **February 2022** – Support of £0.5m funding to allow the build of additional Ultrasound rooms.
- **March 2022** – Approval of the purchase of the current onsite external mortuary unit at a purchase price of **£168,513 ex VAT**

### **Financial Resources Group**

The Financial Resources Group (FRG) is responsible for monitoring and managing financial performance of all CBUs and Corporate divisions to ensure the provision of high-quality healthcare within the resources available. An example agenda will review:

- Financial Performance
- Productivity and Efficiency
- Patient Level Costing
- Service Line Reporting

### **Capital Planning Group**

The Capital planning Group (CPG) monthly minutes are shared with the Committee. The group is responsible for monitoring and managing capital spend.

### **Digital**

The Committee continued to receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

Key areas of focus contained in the reports in the previous year have been:

- Updates on the Digital Programme
- Information & Business intelligence
- IT Services
- Digital Compliance & Risk
- Digital Diagnostics
- eRostering
- Badgnernet Maternity Electronic Patient Record System
- Anti-Virus Protection
- Updates on the Electronic Patient Care Management System (EPCMS)

### **Other issues considered / Reviewed during the year**



- April 2022 onwards – The Committee received and considered the Mersey Internal Audit Agency (MIAA) review of the WLI process.
- May 2022 – The Committee received and considered a report on the indicative financial cost of harm.
- June 2022 – Received and supported the Business Case for Runcorn Town Deal Health & Education Hub
- November 2022 - Received and supported the Business Case for phase 2 of the Community Diagnostic Centre

A review and refresh of the Performance Assurance Framework (PAF) and Integrated Performance Report (IPR) was approved.

### **Issues Carried Forward/Escalated**

Each Finance and Sustainability Committee considers whether any business matters discussed should be escalated to the Board. The following were raised by the Finance and Sustainability Committee to the Board:

- Winter Planning
- Capital Position
- Annual Planning
- EPCMS
- Risks to CDC Programme
- Protocol for changing the forecast
- CIP Performance

The Committee will continue its work to ensure the overall financial governance system of internal controls and the assurance processes remain robust.

The Committee continued to receive and consider Sub Committee minutes, namely:

- Finance Resource Group
- Capital Planning Group
- Digital Services Board

### **Summary**

The Committee encourages frank, open dialogue between regular attendees to the meetings. I would like to thank all attendees and members of the Committee for their responses, support and contributions during the year.

**John Somers**  
**Chair of Finance and Sustainability Committee**  
**May 2023**

## Finance and Sustainability Committee Attendance Record 2022-23

| Name   | 2022 |     |     |                      |     |     |     |     |     |     | 2023 |     |   |
|--|------|-----|-----|----------------------|-----|-----|-----|-----|-----|-----|------|-----|---|
|  | Apr  | May | Jun | Jul                  | Aug | Sep | Oct | Nov | Dec | Jan | Feb  | Mar |   |
| <b>CORE MEMBERSHIP</b>   |      |     |     |                      |     |     |     |     |     |     |      |     |   |
| Terry Atherton, Chair - Non-Executive Director (left 30.09.22) | √    | √   | √   |                      | √   | √   |     |     |     |     |      |     |   |
| John Somers, Chair - Non-Executive Director (from 1.10.22)     |      |     |     |                      |     |     | √   | √   | √   | √   | √    | √   |   |
| Julie Jarman, Non-Executive Director                           | √    | √   | √   |                      | √   | √   | √   | √   | √   | √   | √    | √   |   |
| <b>IN ATTENDANCE</b>   |      |     |     |                      |     |     |     |     |     |     |      |     |   |
| Michel Cloney, Chief People Officer                            | A/D  | √   | √   | Meeting<br>Cancelled | A/D | √   | √   | √   | √   | √   | √    | √   |   |
| John Culshaw, Trust Secretary                                  | √    | √   | √   |                      | √   | √   | √   | √   | √   | √   | √    | √   | √ |
| Paul Fitzsimmons, Executive Medical Director                   | A/D  | √   | √   |                      | A/D | √   | √   | √   | √   | √   | √    | A/D | √ |
| Jane Hurst, Deputy CFO   | √    | √   | √   |                      | X   | √   | √   | √   | √   | √   | √    | A/D | √ |
| Andrea McGee, Chief Finance Office & Deputy CEO                | √    | √   | √   |                      | √   | √   | √   | √   | √   | √   | √    | √   | √ |
| Dan Moore, Chief Operating Officer                             | √    | √   | √   |                      | √   | √   | √   | √   | √   | √   | √    | A/D | √ |
| Nigel Richardson, Public Governor Observer                     | √    | √   | √   |                      | √   | √   | √   | √   | √   | √   | √    | A/D | √ |
| Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO            | √    | √   | A/D |                      | A/D | √   | √   | √   | √   | √   | √    | √   | √ |
| Lucy Gardner, Director of Strategy & Partnerships              | A    | √   | √   |                      | √   | √   | √   | √   | √   | A   | √    | A/D | √ |
| Nigel Richardson, Public Governor Observer                     | √    | √   | √   | √                    | √   | √   | √   | √   | √   | √   | A/D  | √   |   |
| Tom Poulter, CIO   | √    | √   | √   | √                    | √   | √   | √   | √   | √   | √   | √    | √   |   |
| <b>NED/EXECUTIVE/DEPUTY IN ATTENDANCE</b>                      |      |     |     |                      |     |     |     |     |     |     |      |     |   |

**KEY:**

A = Apologies

A/D = Apologies/Deputy in Attendance

R = Left Trust

**TRUST BOARD**

|                |  |                    |                         |
|----------------|--|--------------------|-------------------------|
| <b>SUBJECT</b> | <b>Chair’s Committee Annual Report – Strategic Peoples Committee</b> | <b>AGENDA REF:</b> | <b>BM/23/06/62 (ii)</b> |
|----------------|--|--------------------|-------------------------|

**1. Introduction**

- 1.1 The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Strategic People Committee Annual Report which covers the reporting period 1 April 2022-31 March 2023.
- 1.2 The Strategic People Committee (the Committee) is accountable to the Board of Directors (the Board) 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.
- 1.3 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.
- 1.4 The Committee provides oversight and assurance on organisational strategic workforce risks and ensures that these are managed appropriately.
- 1.5 This report details the membership and role of the Committee and the work that it has undertaken during the reporting period.
- 1.6 During the reporting period, the Committee has been composed of two Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence.

**2. Terms of Reference**

- 2.1 The Committee’s Terms of Reference and the Cycle of Business were reviewed during Quarter 4 of 2022-23. This included a review of the membership of the Committee, frequency of the meeting, and a revised Cycle of Business. It should be noted that the Committee delegated the approval of Workforce Policies and Procedure ratification to the Operational People Committee, effective 1 April 2023.
- 2.2 Frequency of meetings was reviewed with the Committee moving from a bi-monthly to monthly meetings in line with other assurance committees, commencing in January 2023.

2.3 Duration of monthly meetings reduced from 3 hours to 2 hours.

2.4 The Terms of Reference are attached in **Appendix 2** and the Cycle of Business in **Appendix 3**. The Committee continues to focus on assurance monitoring, with its reporting sub committees meeting to deliver the agenda.

2.4.1 Key changes / adaptations to the Cycle of Business:

|   |
|---|
| <p>To include a Deep Dive presentation / discussion</p> <ul style="list-style-type: none"> <li>○ Rationale: <ul style="list-style-type: none"> <li>➤ Requires an in-depth review of the topic to be reviewed</li> <li>➤ Background to topic and why the ‘deep dive’ is being considered</li> <li>➤ Data, variance and narrative with contributory factors identified and mitigations, risk and action plan</li> <li>➤ Recommendations that form an action plan with assurance of reporting mechanisms</li> </ul> </li> <li>○ Deep Dive Topics selected from: <ul style="list-style-type: none"> <li>➤ Items SPC request further assurance on from agenda items</li> <li>➤ Items escalated from Operational People Committee or other committee /meeting</li> <li>➤ Items noted from wider triangulation – Just and Restorative Culture, Improving People Practices, Workforce Race Equality Scheme (WRES), Workforce Disability Equality Scheme (WDES), Staff Opinion Survey, Workforce Plans (multi-professional), PLACE based collaboration plans etc</li> <li>➤ Items flagging from Care Quality Commission Insight Report</li> <li>➤ Items flagging from Trust IPR – People Key Performance Indicators (KPI) and Board Assurance Framework (BAF)s</li> <li>➤ Items flagging from People Strategy / WEDI Strategy / HWB Framework</li> </ul> </li> </ul> |
| <p>To include a Hot Topic presentation / discussion</p> <ul style="list-style-type: none"> <li>○ Rationale: <ul style="list-style-type: none"> <li>➤ High level information that share a ‘story’ or journey</li> <li>➤ Areas of current focus: national, local, partner, internal</li> <li>➤ New services (Workforce Impact / Planning)– e.g. Clinical Diagnostic Centre</li> <li>➤ Accreditation (Navajo, Disability Confidence, Stonewall, People Directorate)</li> <li>➤ Items linked to the workforce Board Assurance Framework risks</li> </ul> </li> <li>○ Hot Topic Items may also be escalated from Operational People Committee, Workforce Equality, Diversity and Inclusion Committee (WEDISC) or other committee /meeting <ul style="list-style-type: none"> <li>➤ Areas of current workforce focus, i.e. COVID pandemic, industrial action prep</li> <li>➤ Current and emerging workforce issues that have arisen in month which require oversight and assurance by the Committee</li> <li>➤ Supporting Attendance / COVID absence management</li> <li>➤ HWB</li> <li>➤ Place Based / System Collaboration</li> <li>➤ Summary points and actions including where are actions tracked.</li> </ul> </li> </ul>  |
| <p>To include a Workforce Brief on National, Regional, Integrated Care Board / System or Local Workforce Issues.</p>  |

2.5 Chairs Logs from Sub-Committees are provided to the Committee from the Sub Committees for assurance purposes.

### 3. Frequency of Meetings

- 3.1 Meetings continued to take place bi-monthly throughout 2022 and following the Committee Effectiveness review in November 2022, the decision was taken to increase the frequency of meeting to monthly commencing in January 2023.
- 3.2 During the reporting period, there were 8 meetings. In 2022 the Committee met 5 times during the year and in 2023, a total of 3 times (31 April 2022 to 31 March 2023).
- In 2022 the Committee meetings were held via MS Teams during the reported year.
  - In 2023 the Committee re-instated physical face to face meetings with opportunity for those unable to attend in person to join virtually via MS Teams
  - 18 January 2023 - The meeting scheduled in January 2023 was reviewed to ensure Quoracy of membership but with an agenda focused on items of assurance or those seeking approval due to significant operational pressures.
- 3.3 The Committee attendance record is attached in **Appendix 1**.

### 4. Summary of Activity

#### 4.1 Strategy Development

- 4.1.1 The Committee has had regular updates in relation to the Strategic Workforce Priorities for the Trust. The People Strategy and Workforce Equality, Diversity and Inclusion Strategy were approved for implementation in April 2022. A dashboard has been developed for the People strategy covering 3 years with bi-annual updates provided on progress, implementation, issues, concerns as appropriate to provide the Committee assurance.
- 4.1.2 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. Details of a FTSU Awareness Raising month in 2022 was provide. The Chair of the Committee is the FTSU Non-Executive Lead.
- 4.1.3 The Committee receives a bi-annual Health and Wellbeing (HWB) Guardian Report. This report provides details benchmarking against national toolkits and HWN frameworks; 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 through refer to third parties or to the Mental Health Counsellors. The report is presented to the Committee by the HWB Guardian.

#### 4.2 Risk Management (Workforce)

- 4.2.1 The Committee oversees the Trust's Workforce Strategic Risks. The Committee has liaised closely 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.
- 4.2.2 Risks are presented in line with the Business Cycle at the following Committees:
- Risk Review Group

- Finance and Sustainability Committee – to include, Workforce Costs, Cost of Temporary Staff Utilisation, Compliance with NHSE Rate Card, Reduction of Agency Spend (in line with C&M ICB target)
- Strategic People Committee – to include, Workforce Supply, Recruitment, Retention, Turnover, Vacancies, Attendance Management, Health & Wellbeing, Flexible Working
- Quality Assurance Committee

4.2.3 21 September 2023 – Full review of all Board Assurance (BAF) and Corporate Risks related to Workforce was undertaken. Actions, mitigation and scoring discussed and amended as appropriate. All changes escalated to BAF Trust Board. In March 2023 it was agreed that the frequency of presentation of risks to the Committee would be amended in line with recommendations from the Good Governance Institute.

4.2.4 The Risk Review Group and Joint Negotiating and Consultation Committee (JNCC) continued to meet to ensure that there was scrutiny of the Corporate Risk Register with appropriate escalation processes in place.

### 4.3 Workforce Integrated Performance Report Dashboard

4.3.1 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.

4.3.2 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.

4.3.3 The Committee review clarified that Performance Indicators for Trust Board and implemented a new Strategic People Committee Workforce Indicator Report.

| KPI                                     | Change                                | Rationale  |
|---|---------------------------------------|--|
| Monthly sickness absence                | Replace with rolling 12-month average | To benchmark nationally / across the ICS<br><br>Provide overview over 12 months rather than in month which can skew performance data |
| Short and long-term sickness absence    | Remove from Trust IPR                 | Report and monitor via SPC   |
| Monthly sickness absence by staff group | Remove from Trust IPR                 | Report and monitor via SPC   |
| Monthly return to work                  | Remove from Trust IPR                 | Report and monitor via SPC   |
| Recruitment time to hire                | Remove from Trust IPR                 | Report and monitor via SPC   |
| Vacancy rate                            | Remove From Trust IPR                 | Report and monitor via SPC   |
| Turnover                                | No change                             | No change  |
| Retention                               | No change                             | No change  |

| KPI  | Change   | Rationale   |
|--|--|---|
| Pay spend vs budget                                    | Remove from Trust IPR  | Report and monitor via FSC  |
| Agency Spend   | Remove from Workforce section of Trust IPR and transfer to Finance section |   |
| Bank spend and agency reliance                         | No change  | Agency spend to be reported via Finance IPR to Trust Board<br>Bank spend to be reported and monitored via FSC |
| Core/Mandatory Training                                | No change  | No change   |
| Safeguarding Training compliance                       | No change  | No change   |
| Role Specific training compliance                      | Remove   | Report and monitor via SPC  |
| Use of the Apprenticeship Levy                         | Remove   | Report and monitor via SPC  |
| Workforce Carrying out an Apprenticeship qualification | Remove   | Report and monitor via SPC  |
| PDR compliance   | No change  | No change   |

The above proposed changes will result in the total number of indicators on the Trust IPR reducing for the Workforce from 16 to 7 indicators.

#### 4.4 Assurance

4.4.1 The Cycle of Business for the Committee has been reviewed, with focus on assurance monitoring. Reporting Sub-Committees are constantly under review, ensuring ongoing scrutiny.

4.4.2 Key areas which have been monitored in year in order to provide the Committee with assurance are:

- Impact of COVID-19 absences on the workforce
- Reliance on Bank and Agency temporary workers, rationale and impact on substantive workforce
- National Pay Dispute Industrial Action and Emergency Planning Readiness
- Appraisal Compliance and Pay Affected Incremental Reviews
- Civility and Respect Campaign
- Staff Networks – Annual Priorities
- Allied Health Professional Workforce Recruitment and Retention plan
- Areas of Concern - Recruitment Plans for Emergency Department, Maternity and Pharmacy

#### 4.4.3 Investigations and Lessons Learned – Improving People Practices and Just and Restorative Practise

- The Committee receive regular updates, to assure itself on the handling of Employee Relations Case work.
- In March 2023 the Committee received a presentation from the Head of Human Resources, Head of Workforce equality, Diversity and Inclusion and the FTSU Guardian, on the recent Employment Tribunal findings related to the case Michelle Cox vs NHS England (North West) to provide assurance that the initial findings and recommendations were in place within the Trust and to confirm that as further recommendations were developed this would be included in future Cycle of Business reporting.

## 5. Regulatory and Statutory monitoring

- 5.1 The Committee continued to monitor the statutory and regulatory requirements relating to workforce, equality and diversity governance throughout the year.

## 6. Trust Workforce Accreditations

- Navejo Charter Mark for LGBTQA+ services for patients and workforce
- Disability Confident Leader Level 3
- NHS Employers Partners Programme
- Stonewall Diversity Champion
- Defence Employee Recognition Scheme Accreditation

## 7. Issues Carried Forward

There are a number of issues which the Committee will carry forward into 2023-24.

- Implementation of the People Priorities and Workforce Equality, Diversity and Inclusion for the year.
- Oversight of Industrial Relations climate and maintain good relationships with workforce and staff side colleagues
- Implementation of the Workforce IPR Dashboard – with emerging new indicators including Equality, Diversity and Inclusion.
- Monitoring of the requirements of all regulatory reporting
- To ensure that the staff voice is heard, on a bi-monthly basis, meeting commences with a staff story.
- Shadow Board attendance

## Summary

I, as Chair of the Strategic People Committee encourage honest and open discussion, so that areas of success can be celebrated, and areas of improvement escalated and actioned.

This has been a challenging year and the Committee has had to adapt and adopt a flexible approach in order to maintain the necessary level of oversight needed during the continuing pandemic and recovery period, along with Industrial Action nationally impacting on services. Committee members have responded to this challenge and provided the assurance required as well as managing the demands resulting from the pandemic and recovery.

I would like to thank all members of the Committee, along with Directors and staff for their responses, support and contributions during the year.

**Julie Jarman**  
**Chair of Strategic People Committee**

## REPORT TO TRUST BOARD

|   |   |                                    |                     |
|---|---|------------------------------------|---------------------|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/63</b>  |                                    |                     |
| <b>SUBJECT:</b>   | <b>Finance &amp; Sustainability Committee – Terms of Reference and Cycle of Business</b>  |                                    |                     |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |                                    |                     |
| <b>AUTHOR(S):</b>   | Andrea McGee Chief Finance Officer & John Culshaw, Company Secretary  |                                    |                     |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Simon Constable, Chief Executive  |                                    |                     |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | 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.  |                                    |                     |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | <p><b>#134</b> 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 &amp; Halton</p> <p><b>#1114</b> 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.</p> <p><b>#1372</b> 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</p> |                                    |                     |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>  | <p>In accordance with the Foundation Trust’s Constitution ‘Board of Directors – Standing Orders’ the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis.</p> <p>The proposed amended Terms of Reference and Cycle of Business for the Finance &amp; Sustainability Committee are attached for consideration and approval. Key updates include amendments to:</p> <ul style="list-style-type: none"> <li>• Section 4: Duties &amp; Responsibilities</li> <li>• Section 6: Core Attendees</li> <li>• Section 9: Reporting Groups</li> </ul>  |                                    |                     |
| <b>PURPOSE: (please select as appropriate)</b>  | Information   | Approval<br>✓                      | To note<br>Decision |
| <b>RECOMMENDATION:</b>  | The Trust Board is asked to review and approve the Strategic People Committee Terms of Reference and Cycle of Business  |                                    |                     |
| <b>PREVIOUSLY CONSIDERED BY:</b>  | <b>Committee</b>  | Finance + Sustainability Committee |                     |
|   | <b>Agenda Ref.</b>  | FSC/23/04/15                       |                     |



|   |                           |            |
|---|---------------------------|------------|
|   | <b>Date of meeting</b>    | 26.04.2023 |
|   | <b>Summary of Outcome</b> | Approved   |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>  | Release Document in Full  |            |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b> | None                      |            |



## FINANCE & SUSTAINABILITY COMMITTEE TERMS OF REFERENCE

### 1. PURPOSE

The Finance and Sustainability Committee (“the Committee”) is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

### 2. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

### 3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust’s Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

### 4. DUTIES & RESPONSIBILITIES

The Committee’s responsibilities fall broadly into the following two areas:

#### Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the [Monitor-NHS Provider License \(under the auspices of NHS Improvement\)](#).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust’s financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust’s performance against its annual financial plan and budgets.
- [Review the service line reports for the Trust and seek assurance that service improvements are being implemented.](#)
- [To review the Trust’s operational performance against its annual plan and to monitor any necessary corrective planning and action.](#)
- [Overseeing the development and subsequent monitoring of an operational plan including activity, workforce, finance, annual budget, annual capital programme and cashflow for approval by the Trust board.](#)

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- ~~To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).~~
- ~~To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored appropriately.~~
- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- ~~To review the performance indicators relevant to the remit of the Committee.~~
- Consider any relevant risks within the Board Assurance Framework and Corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Committee Assurance Report.
- To monitor compliance with NHSE requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- Benchmark financial and operational performance within the Integrated Care System, regionally and nationally
- Approve capital expenditure up to £5m on behalf of the Trust Board
- ~~To monitor all elements of the Board Assurance Framework that relate to the work of this Committee~~

Commented [CJ(AHTHNF1): Suggest remove as performance is reference elsewhere in section

#### Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £5m00k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

#### 5. MEMBERSHIP

The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the member's Trust email account.

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## 6. CORE ATTENDEES

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- [Chief Executive](#)
- Chief Finance Officer & Deputy CEO
- Chief Nurse & Deputy CEO
- Chief Operating Officer
- Executive Medical Director
- Chief People Officer
- Deputy Chief Finance Officer
- Director of Strategy & Partnerships
- [Trust Company Secretary & Associate Director of Corporate Governance](#)
- [Associate Director of Estates and Facilities Management](#)

Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

## 7. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non-Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

## 8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

## 9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting;
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have;
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- ~~Finance and~~ [Financial Resources Group](#)
- ~~Digital~~ [Management Strategy](#) Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group

## 10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

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**11. REVIEW / EFFECTIVENESS**

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed at least annually by the Committee.

**Date:** ~~September 2021-April 2023~~

### TERMS OF REFERENCE REVISION TRACKER

|                             |  |
|-----------------------------|--|
| <b>Name of Committee:</b>   | Finance and Sustainability Committee   |
| <b>Version:</b>             | <b>V8 DRAFT</b>  |
| <b>Implementation Date:</b> | September 2022 <del>4</del>  |
| <b>Review Date:</b>         | <del>September 2022</del> April 2023   |
| <b>Approved by:</b>         | Finance & Sustainability Committee   |
| <b>Approval Date:</b>       | <del>FSC 22 September 2021, Trust Board 24 November 2021</del> FSC Spril 2023, Trust Board June 2023 |

| REVISIONS                   |   |   |          |
|-----------------------------|---|---|----------|
| Date                        | Section   | Reason on Change  | Approved |
| 22 March 2017               | 3 – Reporting arrangements                              | - There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.  |          |
| 22 <sup>nd</sup> March 2017 | 4. Duties and Responsibilities                          | - To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement  |          |
| 22 March 2017               | 6 - Attendance  | - Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy.<br>- Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance |          |
| 22 March 2017               | 9. Reporting Groups                                     | Two groups removed:<br>- The Business Planning sub Committee (strategic).<br>- Strategic & Annual Planning Steering Group.<br>One Group added:<br>- Pay Spend and Review Committee minutes to reporting groups.   |          |
| 22 March 2017               | 10 Administrative Arrangements                          | - Due to change in administrative support to the Committee<br>- Agreement with the Chair and Director of Finance to amend the timescale for circulating papers  |          |
| 18 October 2017             | 4. Duties and responsibilities<br><br>6. Core attendees | - Delete items relating to Estates and IM&T<br><br>- Delete Director of IM&T  |          |

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|                                       |   |   |   |
|---------------------------------------|---|---|---|
|                                       | <b>9. Reporting Groups</b>                      | Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records  |   |
| <b>22 November 2017</b>               | <b>Section 4 Duties and Responsibilities</b>    | <ul style="list-style-type: none"> <li>- To monitor compliance with NHSI requirements relating to pay policies</li> <li>- To review and monitor the Trust's overall pay bill</li> <li>- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee</li> </ul> |   |
|                                       | <b>Section 9 Reporting Groups</b>               | To include: reports on premium pay spend  |   |
| <b>21 March 2018</b>                  | <b>Core Attendees</b>                           | Addition of Medical Director  | Trust Board<br>29.5.2019                    |
| <b>19 September 2018</b>              | <b>Core Attendees</b>                           | Remove Director of Transformation   | Trust Board<br>29.5.2019                    |
| <b>20 March 2019</b>                  | <b>Section 6: Core Attendees</b>                | Remove Medical Director<br>Add Head of Corporate Affairs  | Trust Board<br>29.5.2019                    |
| <b>20 March 2019</b>                  | <b>Section 9: Reporting</b>                     | Add Financial Resources Group<br>Remove Out Patient Turnaround<br>Remove ICIC   | Trust Board<br>29.5.2019                    |
| <b>18 March 2020</b>                  | <b>Section 6: Core Attendees</b>                | ADD Medical Director<br>Amend Title of Head of Corporate Affairs to read Trust Secretary<br>Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development<br>ADD Director of Strategy (when required)  | FSC 18.03.2020<br>Trust Board<br>25.03.2020 |
| <b>18 March 2020</b>                  | <b>Section 9: Reporting</b>                     | Remove Urgent & Emergency Care Improvement Committee  | FSC 18.03.2020<br>Trust Board<br>25.03.2020 |
| <b>23 September 2020</b>              | <b>Section 4 Duties and Responsibilities</b>    | Addition of reports from Digital Services   | FSC 23.09.2020<br>Trust Board<br>25.11.2020 |
| <b>23 September 2020</b>              | <b>Section 6: Core Attendees</b>                | Amend the titles of three Directors<br>Add Chief Information Officer  | FSC 23.09.2020<br>Trust Board<br>25.11.2020 |
| <b>23 September 2020</b>              | <b>Section 9: Reporting</b>                     | Add Digital Board   | FSC 23.09.2020<br>Trust Board<br>25.11.2020 |
| <b>22 September 2021</b>              | <b>Section 6: Core Attendees</b>                | Amend title of Deputy Director of Finance & Commercial Development and<br>Delete post of Chief Information Officer  | FSC 22.09.2020<br>Trust Board<br>24.11.2020 |
|                                       | <b>Section 9: Reporting</b>                     | <b>Add Medical Staffing Review Group and Strategy &amp; Sustainability Review Group</b>   |   |
| <b>21<sup>st</sup> September 2022</b> | <b>Section 4: Duties &amp; Responsibilities</b> | Updated reference to Committee Assurance Report and amended NHSI to NHSE following NHS Improvement becoming part  |   |

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|  |  |  |  |
|--|--|--|--|
| 21 <sup>st</sup> September 2022            | Section 9: Reporting Groups                              | of NHS England in July 2022<br>Addition of GIRFT/Clinical productivity Group<br>Amend title of Digital Board to Digital Management Group   |  |
| <a href="#">26<sup>th</sup> April 2023</a> | <a href="#">Section 4: Duties &amp; Responsibilities</a> | <ul style="list-style-type: none"> <li>• <a href="#">Updated reference to new Provider Licence</a></li> <li>• <a href="#">Re-instated review of performance following dis-establishment of Clinical Recovery Oversight Committee</a></li> <li>• <a href="#">Addition of oversight of annual operational plan</a></li> <li>• <a href="#">Removal of duplicate responsibility</a></li> <li>• <a href="#">Updated Committee Capital Spend limit</a></li> <li>• <a href="#">Remove reference to MTFM and LTFM</a></li> </ul> |  |
| <a href="#">26<sup>th</sup> April 2023</a> | <a href="#">Section 6: Core Attendees</a>                | <ul style="list-style-type: none"> <li>• <a href="#">Addition of Chief Executive and Associate Director of Estates &amp; Facilities Management</a></li> </ul>  |  |
| <a href="#">26<sup>th</sup> April 2023</a> | <a href="#">Section 9: Reporting Groups</a>              | <ul style="list-style-type: none"> <li>• <a href="#">Update of Report Group titles</a></li> </ul>  |  |

| TERMS OF REFERENCE OBSOLETE                    |  |                                |
|--|--|--------------------------------|
| Date   | Reason                                   | Approved by:                   |
| 20 March 2020                                  | V5 to be replaced by V6                  | FSC 18.03.2020                 |
| 23 September 2020                              | V6 to be replaced by V7                  | FSC 23.09.2020                 |
| 22 September 2020                              | V7 to be replaced by V8                  | FSC 22.09.202 <del>2</del> 4   |
| <a href="#">21<sup>st</sup> September 2022</a> | <a href="#">V8 to be replaced by V9</a>  | <a href="#">FSC 21.09.2022</a> |
| <a href="#">26<sup>th</sup> April 2023</a>     | <a href="#">V9 to be replaced by V10</a> |                                |

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FINANCE & SUSTAINABILITY COMMITTEE CYCLE OF BUSINESS 2023/24

| AGENDA ITEM   | EXEC LEAD      | 2023    |         |           |          |          |          |          |          |          |          |          |          | 2024     |          |          |
|---|----------------|---------|---------|-----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
|   |                | 18.1.23 | 22.2.23 | 22.3.23   | 25.04.23 | 24.05.23 | 28.06.23 | 26.07.23 | 23.08.23 | 27.09.23 | 25.10.23 | 29.11.23 | 20.12.23 | 24.01.24 | 28.02.24 | 27.03.24 |
| <b>INTRODUCTION &amp; ADMINISTRATION</b>  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Apologies for Absence   | Chair          | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Declarations of Interest  | Chair          | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Minutes of the Last Meeting & Action Log  | Chair          | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Rolling attendance log + cycle of business  | Chair          | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Matters Arising   | Chair          | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| <b>GOVERNANCE &amp; COMPLIANCE</b>  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Hot Topic   | Chair/CFO&DCEO |         |         |           |          |          | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Deep Dive   | Chair/CFO&DCEO |         |         |           |          |          | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Committee Terms of Reference  | Trust Sec      |         |         |           | X        |          |          |          |          |          |          |          |          |          |          |          |
| Committee Cycle of Business   | Trust Sec      |         |         |           | X        |          |          |          |          |          |          |          |          |          |          | X        |
| Committee Chair's Annual Report to Board  | Chair          |         |         |           |          | X        |          |          |          |          |          |          |          |          |          |          |
| Pay Assurance Report  | CPO            | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Risk Register   | Trust Sec      | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Deep Dive in relation to Risk Register (annual)   | Trust Sec      |         |         |           |          | X        |          |          |          |          |          |          |          |          |          |          |
| PAF Review and Refresh of Trust KPIs  | CFO&DCEO       |         | X       |           |          |          |          |          |          |          |          |          |          |          | X        |          |
| Committee Effectiveness Review – 6 month  | Chair/T Sec    |         |         |           |          |          |          |          |          | XrepOct  | X        |          |          |          |          |          |
| Committee Effectiveness Review – annual   | Chair/T Sec    |         |         | X rep Apr | X        |          |          |          |          |          |          |          |          |          |          |          |
| Trust Strategy: Measures of Success - biannual Report   | DS&P           |         |         |           |          |          | X        |          |          |          |          | X        |          |          |          |          |
| Emergency Preparedness Annual Report (EPRR) & Annual Assurance Letter Statement of Compliance | COO            |         |         |           |          |          |          | X        |          |          |          |          |          |          |          |          |
| <b>PERFORMANCE</b>  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Corporate Performance Report  | CFO&DCEO       | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Digital Services HLB & Digital Board minutes  | CIO&SIRO       | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| SIRO (Senior Information Risk Owner) Report   | CIO&SIRO       |         |         |           |          | X        |          |          |          |          |          |          |          |          |          |          |
| <b>FINANCIAL ASSURANCE</b>  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Monthly Finance report, +   | CFO&DCEO       | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| - Capital Planning Group Minutes  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| - Finance + Resources Group Minutes and escalation log  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| - CPG detailed projection of each scheme  |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Cost Pressures  | CFO&DCEO       |         |         |           |          |          | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Capital Planning Group planning cycle annual review (wef June 2021)                           | CFO&DCEO       |         |         |           |          |          | X        |          |          |          |          |          |          |          |          |          |
| Monthly CIP Report (including GIRFT & Theatre Productivity)                                   | CFO&DCEO       | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Indicative Financial cost of harm annual report   | CFO&DCEO       |         |         |           |          | X        |          |          |          |          |          |          |          |          |          |          |
| Capital Expenditure Approvals (schemes above £500k) wef May 2021 (as required)                | Exec Lead      | X       | X       | X         | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Benefits Realisation Quarterly Report (wef 10/21)   | CFO&DCEO       |         | Q3      |           |          | Q4       |          |          | Q1       |          |          | Q2       |          |          | Q3       |          |
| Medical Staffing Review Quarterly Update (wef May 22)   | EMD            |         | X       |           |          | X        |          |          | X        |          |          | X        |          |          | X        |          |
| B5 Staffing - Progress Report/Review  | COO            |         |         |           |          |          |          |          |          |          |          |          | X        |          |          |          |
| Use of Resources Annual Report  | CFO            |         |         |           |          |          |          |          |          |          | X        |          |          |          |          |          |
| <b>INVESTMENT</b>   |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Annual Capital Programme  | CFO&DCEO       |         | X       |           |          |          |          |          |          |          |          |          |          |          | X        |          |
| <b>PLANNING</b>   |                |         |         |           |          |          |          |          |          |          |          |          |          |          |          |          |
| Operational Plan & Budgets  | CFO&DCEO       |         |         | X Draft   | X Draft  | X Final  |          |          |          |          |          |          |          |          | X draft  | X final  |

## REPORT TO TRUST BOARD

|   |   |   |
|---|---|---|
| <b>AGENDA REFERENCE:</b>  | <b>BM/23/06/64</b>  |   |
| <b>SUBJECT:</b>   | <b>Trust Strategy: measures of success and governance arrangements</b>  |   |
| <b>DATE OF MEETING:</b>   | 7 <sup>th</sup> June 2023   |   |
| <b>AUTHOR(S):</b>   | Kelly Jones, Head of Strategy & Partnerships  |   |
| <b>EXECUTIVE DIRECTOR SPONSOR:</b>  | Lucy Gardner, Director of Strategy & Partnerships   |   |
| <b>LINK TO STRATEGIC OBJECTIVE:</b><br><i>(Please select as appropriate)</i>                          | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.   | X |
|   | SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future   | X |
|   | SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.  | X |
| <b>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</b><br><i>(Please DELETE as appropriate)</i> | <p><b>#1215</b> 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.</p> <p><b>#224</b> 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.</p> <p><b>#115</b> 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.</p> <p><b>#134</b> 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 &amp; Halton</p> <p><b>#1134</b> 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</p> <p><b>#1114</b> 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.</p> <p><b>#1372</b> 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</p> <p><b>#125</b> 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</p> |   |

|  |   |   |         |          |
|--|---|---|---------|----------|
|  | <b>#145</b> 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. |   |         |          |
| <b>EXECUTIVE SUMMARY (KEY ISSUES):</b>         | <p>In March 2023, Trust Board approved a refresh of the Trust Strategy, which included a set of 12 strategic objectives underpinned by high level priorities.</p> <p>This paper sets out the proposed measures of success/KPIs for each objective and the underpinning priorities, alongside updated governance arrangements to ensure appropriate oversight of the strategy's delivery.</p>  |   |         |          |
| <b>PURPOSE: (please select as appropriate)</b> | Information   | Approval<br>x   | To note | Decision |
| <b>RECOMMENDATION:</b>                         | <p>It is recommended that the Trust Board:-</p> <ul style="list-style-type: none"> <li>• approve the recommended measures of success/ KPIs for each of the strategic objectives and priorities.</li> <li>• approve the governance arrangements for the reporting of delivery of the strategy.</li> </ul>  |   |         |          |
| <b>PREVIOUSLY CONSIDERED BY:</b>               | <b>Committee</b>  | Finance + Sustainability Committee                    |         |          |
|  | <b>Agenda Ref.</b>  |   |         |          |
|  | <b>Date of meeting</b>  | 24th May 2023   |         |          |
|  | <b>Summary of Outcome</b>   | Sustainability KPIs and proposed governance supported |         |          |
| <b>FREEDOM OF INFORMATION STATUS (FOIA):</b>   | Release Document in Full  |   |         |          |
| <b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>  | None  |   |         |          |

REPORT TO BOARD OF DIRECTORS

|                |  |                    |                    |
|----------------|--|--------------------|--------------------|
| <b>SUBJECT</b> | <b>Trust Strategy: measures of success and governance arrangements</b> | <b>AGENDA REF:</b> | <b>BM/23/06/64</b> |
|----------------|--|--------------------|--------------------|

**1. BACKGROUND/CONTEXT**

In March 2023, Trust Board approved a refresh of the Trust Strategy, which includes four strategic objectives for each of the Trust’s Quality, People and Sustainability aims. These are summarised below.



Figure 1 – Summary of Trust Strategy 2023-25

Since April, the strategy has been designed and branded as a corporate document. Proposed measures of success/KPIs for each of the Trust’s strategic objectives and priorities have been developed, and a review undertaken of existing governance arrangements to ensure appropriate oversight of the strategy’s delivery.

This paper describes the measures of success/KPIs for each objective and the priority within, and outlines recommendations and implications of all strategic objectives being monitored through a committee of the Board.

The fully designed strategy document is included in appendix 1.

**2. KEY ELEMENTS**

**2.1 Measuring the impact of the strategy**

The tables below summarise the Trust’s twelve strategic objectives and the proposed measures of success/KPIs for each identified priority. Where a baseline and target have been applied this is

specified, while grey boxes indicate a qualitative measure. A number of these priorities are already regularly reported within the Trust's Integrated Performance Report, as indicated in the table. These indicators are replicated here to demonstrate how they support delivery of the Trust Strategy.

**Table 1 – Trust objectives and proposed measures of success/KPIs**

**Quality Aim: We will always put our patients first delivering safe and effective care and an excellent patient experience.**

| Strategic Objectives   | Strategic Priorities  | Measures of Success / KPIs   | Baseline (Apr-23)               | Current Position | Target                       | In IPR                   | RAG |  |
|--|---|--|---------------------------------|------------------|------------------------------|--------------------------|-----|--|
| <b>1. Patient Safety:</b> We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility. | 1.1 We will reduce avoidable harm and patient deterioration with a focus on Covid-19 elective recovery.   | Delivery of 110% of pre-pandemic activity by the end of 2022/23.   | 85.07%                          |                  | 110%                         | Yes                      |     |  |
|  |   | Potential Harm review panel will continue to undertake reviews where harm is suspected following a delay to treatment – feeding into wider governance processes                              |                                 |                  |                              | No                       |     |  |
|  | 1.2 We will implement actions to deliver new standards required as a result of national reviews in Maternity care/provision, ensuring learning is acted upon. | Progress against action plans  |                                 |                  |                              |                          | No  |  |
|  |   | - Ockenden 1b:   | 94.91%                          |                  |                              | 100% compliant by Dec 23 |     |  |
|  |   | - Ockenden 2:  | 68.53%                          |                  |                              | 100% compliant by Nov 23 |     |  |
|  | 1.3 We will enhance timely patient recovery through therapy led initiatives, including work around deconditioning and rehabilitation.                         | Change in practice as a result of learning being acted upon, evidenced through monthly tracking of improvements and impact of actions with triumvirate.                                      |                                 |                  |                              |                          | No  |  |
|  |   | Reduction in the number of patients who develop pressure ulcers.   | 10                              |                  |                              | 0                        | Yes |  |
|  |   | Patients participating in active movement and cognitive stimulation on the wards.  |                                 |                  |                              |                          | No  |  |
|  | 1.4 We will improve recognition and response to deteriorating patients.   | Annual reduction in the number of inpatient falls & harm levels. Based on 590 falls in 2021/22   | 46                              |                  |                              | 20% annual reduction     | Yes |  |
|  |   | Clinical deterioration is recognised and escalated in accordance with NEWS2 parameters, evidenced by recording of and response to NEWS2 score for unplanned critical care admissions (CQUIN) | In development for Q1 reporting |                  |                              | Min 10%<br>Max 30%       | No  |  |
|  | 20% improvement in response to patients who trigger a clinical review on NEWS2.   | 63%  |                                 |                  | 75.6% correct escalation for | No                       |     |  |

|  |  |  |  |  |          |  |      |
|--|--|--|--|--|----------|--|------|
|  |  |  |  |  | NEWS 5-6 |  |      |
|  |  | Time to medical review and coordination of treatment   | 19%  |  |          | 33% of patients seen within 60 minutes |      |
|  |  | Sepsis - % screening for all emergency within 1 hour   | 86%  |  |          | 90%                                    | Yes  |
|  |  | Sepsis - % screening for all inpatients within 1 hour  | 88%  |  |          | 90%                                    | Yes  |
|  |  | Sepsis - % patients within an emergency setting receive antibiotics administered within 1hour of diagnosis   | 78%  |  |          | 90%                                    | Yes  |
|  |  | Sepsis - % patients within an inpatient setting receive antibiotics administered within 1hour of diagnosis   | 80%  |  |          | 90%                                    | Yes  |
|  | 1.5 We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)             | Reduction in the number of patients who develop pressure ulcers.   | 10   |  |          | 0                                      | Yes  |
|  | 1.6 We will continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.   | Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance.   |  |  |          |  | No   |
|  |  | Evidenced through richer learning via new investigation methods including cluster reviews.   |  |  |          |  | No   |
| <b>2. Clinical effectiveness:</b><br>We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients. | 2.1 We will continue to utilise and evidence best clinical practice through the evidencing of compliance with guidance, such as the National Institute for Clinical Effectiveness. | NICE compliance  | 91.65%   |  |          | 90%                                    | Yes  |
|  | 2.2 We will continue to embed a positive risk management culture from ward to board.   | Flexibility in risk appetite is recognised, this will be informed by the management of risk registers at service level, corporately and through the Board Assurance Framework. |  |  |          |  | No   |
|  | 2.3 We will recover core services and improve productivity in line with targets set in the NHS Long-term plan.   | % of plans on track to deliver annual operational improvement trajectories   | 0  |  |          |  | 100% |
|  | 2.4 We will improve a culture of quality, safety and learning through the consistent application of LOCSIPs, achieving   | Implementation and audit of LOCSIP safety standards, with focus on non theatre areas. 90% compliance to be achieved  | N/A - areas currently measured as high, medium or low instead of a |  |          |  | 90%  |

|   |   |  |  |     |     |    |  |
|---|---|--|--|-----|-----|----|--|
|   | >90% compliance in documentation and observational audits.  | in the following areas for 23/24 <ul style="list-style-type: none"> <li>• Endoscopy</li> <li>• Cardiac Catheter Lab</li> <li>• Ophthalmology</li> <li>• Paediatric</li> <li>• Gynaecology</li> <li>• Neonatal</li> <li>• Breast Screening</li> <li>• Interventional radiology</li> <li>• ITU</li> <li>• B18</li> </ul> | percentage baseline.   |     |     |    |  |
|   |   | Audit of WHO checklist effectiveness with evidence of effective operative and a focus upon theatre culture.  |  |     |     | No |  |
|   |   | Systemisation of safety improvement, evidenced through robust system controls and incident response processes.   |  |     |     | No |  |
| 2.5 We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.  | Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95%.                     | 78.46%   |  | 95% | Yes |    |  |
|   | Improved access to Elective Care through reduced waiting times - eliminating 65+ week waits by March 2024   | 478  |  | 0   |     |    |  |
|   | Improved access to Elective Care through improved theatre productivity to 85%.  | 75.72%   |  | 85% | No  |    |  |
|   | Improve ED waiting times so that no less than 76% of patients are seen within 4 hours   | 65.13%   |  | 76% | Yes |    |  |
| 2.6 We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework). | Increase QI capability and capacity to 10% (400) for QI Foundation and 2.5% (100) for QI Practitioner programmes.                                       | Foundation 6.3% (252)<br>Practitioner 0.6% (23)  | Foundation 6.4% (258)<br>Practitioner 0.8% (34)  | 10% | No  |    |  |
|   | Achieve 80% Quality Improvement assessment score in line with CQC requirements.   | In development for Q1 reporting.   |  | 80% | No  |    |  |
|   | Evidence learning and improvement through Quality Improvement Projects and assurance of actions   |  |  |     | No  |    |  |
| <b>3. Patient experience:</b><br>We will place the quality of patient experience at the heart of  | 3.1 We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care. | A reduction in both PALS and complaints in relation to communication as a key theme.   | 9.4% (Complaints with a primary theme of communication)<br><br>22.75% (PALS with a primary theme of communication) |     |     | No |  |

|  |  |  |   |  |                                   |     |    |  |
|--|--|--|---|--|-----------------------------------|-----|----|--|
| all we do, where 'seeing the person in the patient' is our norm. | 3.2 We will ensure an inclusive communications method for each patient, taking into account their personal circumstances, using clear and easy to understand language. | Evidenced through improved use of interpreters for both people of whom English is not their first language and British sign language users   |   |  |                                   | No  |    |  |
|  | 3.3 We will create first and lasting impressions which contribute towards a positive experience of care.   | Monitored by:<br>- Ward accreditation<br>- Leadership observations<br>- Patient experience walk round<br>- Governors walk rounds.<br>- Feedback received at Patient experience sub committee |   |  |                                   | No  |    |  |
|  | 3.4 We will improve patient experience for those with mental health attendance.  | Training package to be developed specific to the care of mental health patients in an acute trust with evidence of evaluation.   |   |  |                                   | No  |    |  |
|  |  | All staff in the Emergency Department to be compliant with the training package and trajectories in place for compliance across all wards.   | 0   | Training needs analysis currently underway and training being developed. | 100 %                             | No  |    |  |
|  |  | Ensure consistency in the assessment of patients with mental health needs, evidenced through the 1-hour time to review standard where clinically appropriate.                                | KPIs of Core 24 service being reviewed.         | Mental Health service provided by Core 24, hosted by Merseycare          | 100% where clinically appropriate | No  |    |  |
|  | 3.5 We will reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.  | Patients with a learning disability are referred and reviewed by the Specialist Nurse/team to ensure that communication needs are met >90%.  | In development via audit ready for Q1 reporting |  | 90% of patients reviewed          | No  |    |  |
|  |  | Embed an alert system for patients, where English is not the first language including British Sign Language.   |   |  |                                   |     |    |  |
|  |  | Audit of patients requiring interpretation services as identified through the alert system and actions taken   | In development via audit ready for Q1 reporting |  | 90%                               | No  |    |  |
|  | 3.6 We will improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours.  | Evidence of Improved patient/ family experience through patient feedback.  |   |  |                                   | No  |    |  |
|  |  | Feedback from staff to support focused learning and improvement.   |   |  |                                   | No  |    |  |
|  |  | Results from evaluation to support Trust wide implementation.  |   |  |                                   | No  |    |  |
|  | <b>4. Research, Development</b>  | 4.1 We will continue to create   | Increase Pathway to Research participants       | 8  |                                   | 250 | No |  |

|  |  |  |     |   |                                  |    |  |
|--|--|--|-----|---|----------------------------------|----|--|
| <p><b>and innovation:</b><br/>We will work in partnership on high quality clinical research for the benefit of patients, public and staff.</p> | opportunities for members of the public to gain access to clinical research trials contributing to the health of our population.         | Increased awareness of research across the Trust, evidenced through annual research survey   |     |   |                                  | No |  |
|  |  | Continue to operate as part of a wider research Board, embracing commercial, non-commercial and academic opportunities.  |     |   |                                  | No |  |
|  | 4.2 We will further develop and grow our research capability through the application and selection for clinical trials.                  | Commercial studies will achieve minimum income target (approx. £600k) to sustain Halton Clinical Research Unit infrastructure with additional funding to invest in capacity and capability building initiatives. | £0k |   | £600k                            | No |  |
|  |  | Working in partnership with providers and across sectors.  |     |   |                                  | No |  |
|  | 4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.     | Annual increase in 20% of Principal Investigators.   | 27  |   | 20% (+4 Principal Investigators) | No |  |
|  | 4.4 We will grow the academic research portfolio supporting staff recruitment and retention.   | Formal arrangement established with Higher Education Institutes eg Chester Medical School, Edge Hill Faculty of Health   |     |   |                                  | No |  |
|  |  | Submission of relevant research grant applications.  |     |   |                                  | No |  |
|  |  | Growth in workforce involvement in academic research.  |     |   |                                  | No |  |
|  | 4.5 We will seek to expand our research offer seeking opportunities for further collaboration through the Halton Clinical Research Unit. | Established formal agreements with Clinical Research Organisations and commercial sponsors to identify relevant studies secure preferred site arrangements.  |     |   |                                  | No |  |
|  |  | Increase opportunity for further expansion in collaboration with other research partners.  |     |   |                                  | No |  |
| Increased number of Participant Identification Centre agreements signed between Primary Care and Halton Clinical Research Unit                 |  | 1  |     | 3 | No                               |    |  |

**People Aim: We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.**

| Trust Objectives                | Strategic Priorities  | Measures of Success / KPIs    | Baseline (Apr 23) | Current Position | Target                     | In IPR | RAG |
|---------------------------------|---|-------------------------------|-------------------|------------------|----------------------------|--------|-----|
| 5. Looking after our people: We | 5.1 We will ensure leaders have the skills, competencies, and | Reduction in sickness absence | 5.60%             |                  | 4.2% supporting attendance | Yes    |     |

|  |   |                                       |        |  |               |     |  |
|--|---|---------------------------------------|--------|--|---------------|-----|--|
| will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.   | behaviours to support staff health and wellbeing.   | Improved Retention                    | 83.36% |  | 86% retention |     |  |
|  | 5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.        | Reduction in bank and agency reliance | 17%    |  | 9% reliance   |     |  |
|  | 5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.                                   | Reduced turnover                      | 15.98% |  | 13%           |     |  |
|  | 5.4 We will equip line managers to use person centred engagement practices which improve employee experience.   | Reduction in vacancy rate             | 11.53% |  | 9%            |     |  |
|  | 5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.  |                                       |        |  |               |     |  |
|  | 5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff. |                                       |        |  |               |     |  |
| <b>6. Innovating the way we work:</b> We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients. | 6.1 We will develop strategic workforce plans which are reflective of current and future needs.   | Reduction in Vacancy Rate             | 11.53% |  | 9%            | Yes |  |
|  | 6.2 We will participate in system wide workforce planning.  | Reduced Staff Turnover                | 15.98% |  | 13%           |     |  |
|  | 6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.           | Improved Retention                    | 83.36% |  | 86% retention |     |  |
|  | 6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.  | Reduction in bank/agency reliance     | 17%    |  | 9% reliance   |     |  |
|  | 6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.   |                                       |        |  |               |     |  |
|  | 6.6 We will enhance digital capability, skills  |                                       |        |  |               |     |  |

|  |  |  |        |  |   |     |  |
|--|--|--|--------|--|---|-----|--|
|  | and leadership which embrace digitally enabled services.   |  |        |  |   |     |  |
| <p><b>7. Growing our workforce for the future:</b><br/>We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.</p> | 7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.  | Improved mandatory training compliance     | 86.11% |  | 85% compliance for mandatory              | Yes |  |
|  | 7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans. | Improved role-specific training compliance | 84.21% |  | 85% compliance for role specific training |     |  |
|  |  | Reduction in Vacancy Rate                  | 11.53% |  | 9%  |     |  |
|  |  | Reduced Staff Turnover                     | 15.98% |  | 13%                                       |     |  |
|  |  | Improved Retention                         | 83.36% |  | 86%                                       |     |  |
|  |  | Reduction in bank/agency reliance          | 17%    |  | 9%  |     |  |
|  |  | Improved appraisal compliance              | 64.24% |  | 79%                                       |     |  |
|  | 7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.   |  |        |  |   |     |  |
| 7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.                     |  |  |        |  |   |     |  |
| 7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.                          |  |  |        |  |   |     |  |
| 7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system. |  |  |        |  |   |     |  |

|  |   |  |               |  |             |            |  |
|--|---|--|---------------|--|-------------|------------|--|
| <p><b>8. Belonging in WHH:</b> We will enable staff to have a voice through the development of a just and learning culture.</p>  | <p>8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.</p>                    | <p>Reduction in Vacancy Rate</p>         | <p>11.53%</p> |  | <p>9%</p>   | <p>Yes</p> |  |
|  |   | <p>Reduced Staff Turnover</p>            | <p>15.98%</p> |  | <p>13%</p>  |            |  |
|  |   | <p>Improved Retention</p>                | <p>83.36%</p> |  | <p>86%</p>  |            |  |
|  |   | <p>Reduction in bank/agency reliance</p> | <p>17%</p>    |  | <p>9%</p>   |            |  |
|  | <p>8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.</p> | <p>Reduction in sickness absence</p>     | <p>5.60%</p>  |  | <p>4.2%</p> |            |  |
|  | <p>8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.</p>              |  |               |  |             |            |  |
| <p>8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.</p> |   |  |               |  |             |            |  |
| <p>8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.</p>   |   |  |               |  |             |            |  |
| <p>8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.</p>             |   |  |               |  |             |            |  |

**Sustainability Aim: We will work in partnership with others to achieve social and economic wellbeing in our communities.**

| Trust  | Strategic Priorities   | Measures of Success / KPIs  | Baseline (Apr 23) | Current Position | Target   | In IPR    | RAG       |
|--|--|---|-------------------|------------------|----------|-----------|-----------|
| <p><b>9. Working in partnership:</b> We will collaboratively work to provide sustainable, high quality acute services and to support prevention and integrated care in the community</p> | <p>9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.</p> | <p>RTT – Number of patients patient waiting 65+ weeks will be 0 by March 2024</p>   | <p>478</p>        |                  | <p>0</p> | <p>No</p> |           |
|  |  | <p>Volume and Impact of collaborative projects being delivered with partners to reduce care backlogs to reduce unwarranted variation in care access and service delivery, address health inequalities and deliver</p> |                   |                  |          |           | <p>No</p> |

|   |  |  |  |  |                         |    |    |  |
|---|--|--|--|--|-------------------------|----|----|--|
|   |  | more efficient, sustainable services.  |  |  |                         |    |    |  |
|   | 9.2 We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector to support the provision of integrated care in the community and prevention of ill health. It is proposed that this includes relocation of appropriate secondary care into the community, following the principle of right service, delivered in the right place to deliver excellent patient care and experience and to improve access and address health inequalities. | Increased number of clinical appointments in off-site locations  | 87,582<br>(Total number of appointments, including DNAs & cancellations) |  | 5% increase             | No |    |  |
|   |  | Deliver Living Well Hub in 2023/24.  |  |  |                         | No |    |  |
|   |  | Deliver Runcorn Town Hub by end of 2025/26.  |  |  |                         | No |    |  |
|   |  | Deliver phase 1 and 2 of new Community Diagnostic Centre in 2023/24.   |  |  |                         | No |    |  |
|   |  | Deliver phase 3 of new Community Diagnostic Centre in 2024/25.   |  |  |                         | No |    |  |
|   |  | Deliver breast screening reconfiguration at Bath Street by 2023/24.  |  |  |                         | No |    |  |
|   |  | Actively contribute to delivery of projects at place and regional level which seek to improve access and address health inequalities   |  |  |                         | No |    |  |
|   |  | 9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts. This would be approached on a service by service basis to ensure the best outcomes for patients and our regional healthcare system. | Proactively review repatriation opportunities at service level.          |  |                         |    | No |  |
| <b>10. Working responsibly: We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.</b> | 10.1 We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.  | Support both Warrington and Halton to develop place maturity.  |  |  |                         | No |    |  |
|   |  | Deliver our Core20PLUS5 objectives.  |  |  |                         | No |    |  |
|   |  | Deliver community spirometry services on behalf of Warrington and Halton.  |  |  |                         | No |    |  |
|   | 10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.   | Heat decarbonisation plan in place by end of 2023/24 for Halton and Warrington sites.  |  |  |                         |    | No |  |
|   |  | Annual reduction in CO2 emissions  | 14,200tCO2e  |  | 5-10% reduction by 2025 | No |    |  |
|   |  | Number of procedures/care pathways with carbon footprints calculated.  | 0  |  | 5                       | No |    |  |
|   | 10.3 We will drive improved social value for our local population increasing the social and  | Maintain the number of local people employed by the Trust  | 77.05%<br>(staff with a Warrington or Halton postcode)                   |  | 77.05%                  | No |    |  |
| Prioritise spend with local suppliers In  |  |  |  |  | No                      |    |    |  |

|  |  |  |   |  |    |     |    |  |
|--|--|--|---|--|----|-----|----|--|
|  | economic wellbeing in the communities we serve.  | Cheshire and Merseyside.   |   |  |    |     |    |  |
|  |  | Jobs created as a result of projects.  |   |  |    | No  |    |  |
|  |  | Increased Town centre footfall as a result of enhancing service provision within community locations, with 70% of clients attending Halton Health hub, the Living Well Hub and the Runcorn Health and Education Hub reporting that the presence of the Hub has encouraged them to come to the Town Centre. | In development via patient survey ready for Q1 reporting. |  |    | 70% | No |  |
|  |  | Learning opportunities created and supported to support people into education and jobs   |   |  |    | No  |    |  |
|  | 10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045 | Staff-led initiatives/Quality Improvement projects incorporating sustainability.   |   |  |    | No  |    |  |
|  |  | Green ambitions included within corporate paperwork (job descriptions, Trust induction etc)  |   |  |    | No  |    |  |
|  |  | Assessment criteria for environmental impact included in capital project proposals   |   |  |    | No  |    |  |
| 10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care. | Delivery of prevention pledge action plan.   |  |   |  | No |     |    |  |
| <b>11. Sustainable Estate and digitally enabled service models: We will provide our services in an estate that is fit for purpose, supported by the realisation of digital opportunities and aligned to the needs of</b>         | 11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.   | Submit bids at all available opportunities.  |   |  |    | No  |    |  |
|  |  | Delivery of case of need communications plan.  |   |  |    | No  |    |  |
|  |  | Explore alternative funding options to deliver new hospitals and estates enablers.   |   |  |    | No  |    |  |
|  | 11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and   | Deliver TIF<br>Deliver CDC<br>Deliver Living Well Hub<br>Deliver Runcorn Health & Education Hub.<br>Deliver Trust Capital Programme  |   |  |    | No  |    |  |

|   |  |  |                                       |       |                |       |     |
|---|--|--|---------------------------------------|-------|----------------|-------|-----|
| our patients, staff and populations   | effective use of clinical space, whilst we work towards our realisation of our new hospitals.  | Refresh Trust Estates Strategy and develop opportunities. Work with partners at place and in C&M to maximise public sector estate utilisation. |                                       |       |                |       |     |
|   | 11.3 We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.   | HIMSS Level 5 by 2023.   | 2                                     |       | 5              | No    |     |
|   |  | A chosen new Electronic Patient Record system by 2025.   |                                       |       |                | No    |     |
|   |  | 100% Compliance with all national cyber security requirements by 2025.   | 78%                                   |       | 100%           | No    |     |
|   |  | 100% Compliance with all Data Protection and Security Toolkit (DSPT) requirements by 2025.   | 80%                                   |       | 100%           | No    |     |
|   |  | 100% Of Business Continuity Plans (BCP) in place and tested against pre-determined schedules by 2023.  | 90%                                   |       | 100%           | No    |     |
|   |  | Digital dimension within all Trust Professional Development Reviews (PDRs) by 2024.  |                                       |       |                | No    |     |
|   | 11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised through Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare. | 70% Of patient follow-ups to be delivered virtually by 2024.   | 40%                                   |       | 70%            | No    |     |
|   |  | Digital User satisfaction score of 80%   | In development ready for Q1 reporting |       | 80%            | No    |     |
|   |  | A chosen 'Patient Portal' Registration of 80% of patients by 2023 (NHS App or otherwise)   | 54%                                   |       | 80%            | No    |     |
|   |  | Patients to receive digital home monitoring by 2024.   |                                       |       |                | No    |     |
| 30 extra Digital Champions within the Trust by 2023   |  | 10   |                                       | 40    | No             |       |     |
| 12. Finance sustainability: We will act according to our duty to collaborate, by working with partners on shared financial objectives to achieve sustainability of the Trust and the wider Cheshire and |  | 12.1 We will deliver the Trust's agreed financial plan.  | Achievement of CIP programme          | 17.9m |                | 17.9m | Yes |
|   | Achievement of agreed financial plan   |  | £15.7m deficit                        |       | £15.7m deficit | Yes   |     |
|   | 12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.   | Actively participate and contribute to the delivery of the ICS Procurement 34 Point Action Plan.   |                                       |       |                | No    |     |
|   |  | Actively participate and contribute to the development of procurement within the ICS.  |                                       |       |                | No    |     |

|                    |   |  |       |  |                       |     |  |
|--------------------|---|--|-------|--|-----------------------|-----|--|
| Merseyside system. |   | Successful in leading on the introduction of a single Contract Management platform across the ICS.   |       |  |                       | No  |  |
|                    | 12.3 We will deliver value for money by ensuring efficient use of resources | Amber or Green rating achieved in the Value for Money assessment undertaken by the Trust's external auditors and reported in the Auditor's Annual Report | Amber |  | Amber or Green rating | Yes |  |

## 2.2 Governance of the Trust Strategy

The proposed monitoring and reporting route for the Trust Strategy is described in the diagram below:

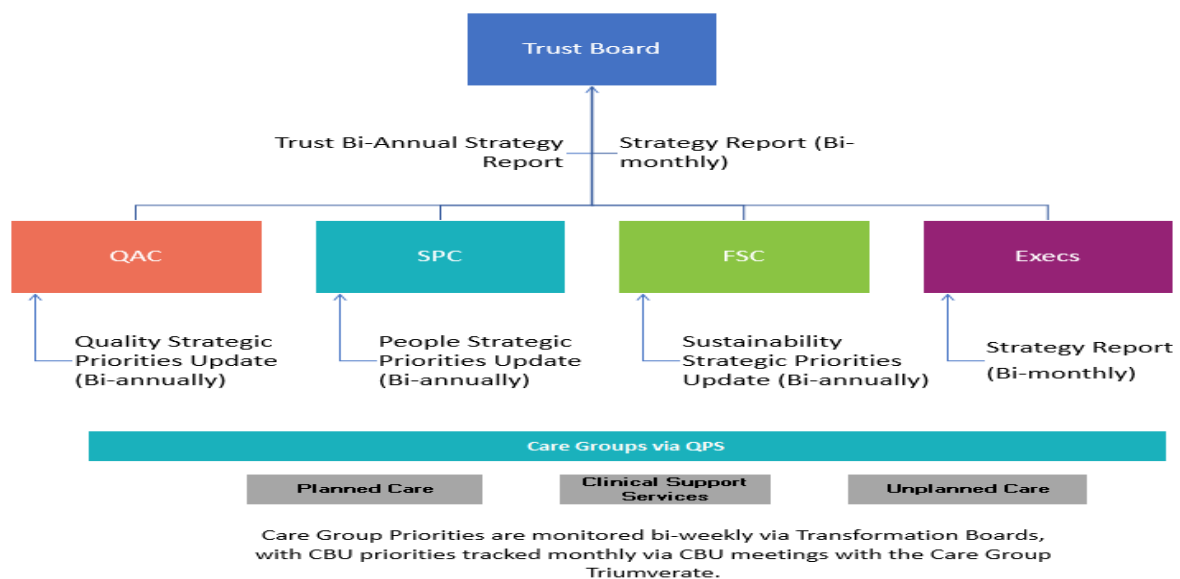


Figure 2 – Proposed monitoring and reporting arrangements for Trust Strategy 2023-25

Governance arrangements are already in place for the Quality objectives to be monitored via Quality Assurance Committee annually and the People objectives to be monitored via Strategic People Committee bi-annually. It is proposed that reporting to Quality Assurance Committee is bi-annual. Routine committee level oversight is not fully established for the Sustainability objectives. Currently, Finance and Sustainability Committee receives exception reporting only from Strategy and a Greener WHH Sub-Committee, alongside a bi-monthly update report containing a high-level summary of progress against strategic projects.

It is proposed this arrangement is replaced by formal bi-annual reporting of the sustainability objectives and priorities through Finance and Sustainability Committee, using the details contained in table 1.

The strategy spans a two-year timeframe from 2023-25. The proposed measures of success/KPIs will cover the duration of the strategy with bi-annual monitoring of delivery through each committee of the Board in September and March each year. The KPIs will be reviewed and refreshed as appropriate.

## 2.3 Communication of the Trust Strategy

Staff and key stakeholders have been involved and engaged in the development of the refreshed strategy. The strategy has also been used to inform Place plans and the Cheshire and Merseyside 5 year Joint Forward Plan.

The Trust strategy was launched to senior leaders across the Trust as part of the Start of the Year Conference held in May 2023. A simplified strategy on a page is in development and will be used as a key aid to communicate the strategy to all staff throughout June 2023 and with wider stakeholders.

## 3. RISKS

Delivery of this strategy enables the Trust to deliver our aims under Q, P and S, and it is essential that this is monitored for assurance and escalated where necessary to mitigate risks to delivery.

## 4. TIMELINES

The strategy spans a two-year timeframe from 2023-25. The proposed measures of success/KPIs and governance will cover the duration of the strategy with bi-annual monitoring of delivery through each committee of the Board in September and March. The KPIs will be reviewed and refreshed as appropriate.

## 5. RECOMMENDATIONS

Trust Board is asked to: -

- approve the recommended measures of success/ KPIs for each of the strategic objectives and priorities.
- approve the governance arrangements for the strategy.

## 6. APPENDIX 1 – TRUST STRATEGY 2023- 2025



WHH\_Strategy\_2023  
-2025\_AW\_web.apprc

# Our Strategy

## 2023-2025

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





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Working Together



Excellence



Inclusive



Kind



Embracing Change

# Foreword

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

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

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

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

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

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

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



**Steve McGuirk**  
Chair



**Simon Constable**  
Chief Executive

# Who we are... What we do



Serve a population of **330,000** across both Halton and Warrington boroughs.



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



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



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



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



Operate **680 beds** – assessment beds and trolleys – across both sites.



Provide **122,000 episodes of emergency care** – 91,695 episodes at the Emergency Department and 30,654 at the Runcorn Urgent Treatment Centre Department.



Deliver **58,045** procedures and stays each year.



Deliver **3,000 babies** in hospital and in the community each year.



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



Have a team of **343 registered volunteers** with a variety of roles available.

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

**Warrington:** 97.8%  
**Halton:** 97.5%

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

**High Risk Areas**  
Wards, Accident & Emergency, Public areas, Pharmacy, Ward Kitchens, Main Outpatients and X-Ray.



# Who we are... Where we do it

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

## Warrington Hospital

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

### Services provided at Warrington Hospital include:

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

### Support services include:

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

## Halton Hospital

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

### Services provided at Halton Hospital include:

#### Nightingale Building:

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

#### Captain Sir Tom Moore Building:

Orthopaedic surgery, urology and gynaecology surgeries, cancer surgeries, post-anaesthetic care unit.

#### Support services include:

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

#### The Runcorn Urgent Treatment Centre:

Provides care and treatment for illnesses and injuries that are not life or limb-threatening but require urgent attention. The centre is open from 8am to 9pm seven days a week.



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



### Halton Health Hub

The Halton Health Hub, a standalone outpatient unit situated within Shopping City in Runcorn, provides a range of services including optometry, orthoptics, audiology and dietetics. The Hub also provides space for partners to deliver preventative and early intervention services, such as the Stop Smoking Service and other public health services provided by Halton Borough Council and primary care services.



### Mobile Screening Services

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



### Halton Clinical Research Unit

Provides opportunities for members of the public to access clinical research and trials.



### Bath Street Health and Wellbeing Centre

From this health centre, the Trust provides maternity and breast screening services.

### Virtual Wards

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

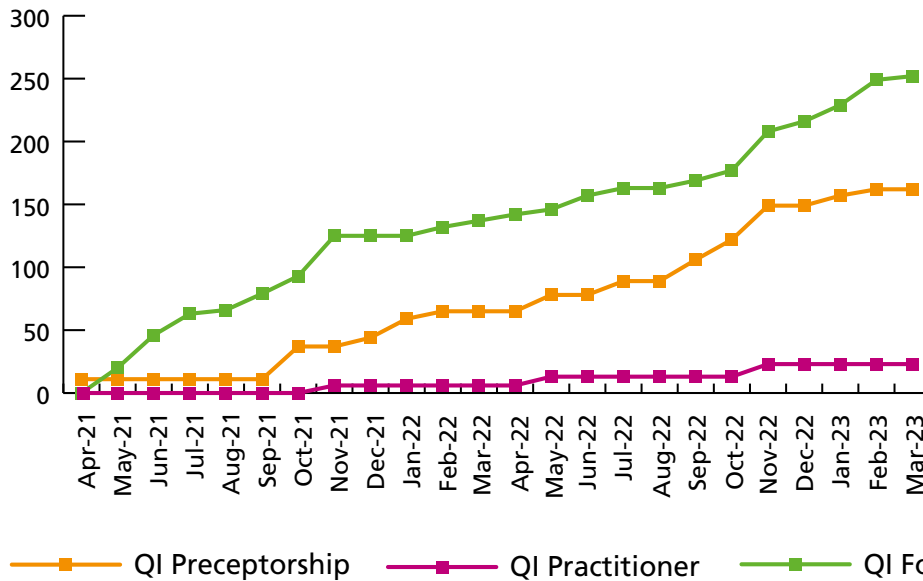
### Virtual Consultations

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

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

# Who we are... How we do it

## Cumulative staff trained in QI



We develop our quality improvement (QI) capabilities to continue to improve for our patients and each other

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

### We seek to reduce inequalities in health

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

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

### We use and learn from data

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

### We listen and learn from patients

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

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

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



“

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

Michelle Cloney,  
Chief People Officer

”

# Building on our quality successes

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

## Our quality successes

**Active Hospitals** – A stay in hospital can make patients feel weaker and everyday tasks can feel challenging and tiring. We are committed to helping people stay as active as possible whilst recovering from an illness in hospital and recognise that doing so helps with recovery.

### How do our patients stay active in hospital?

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



### Service accreditation

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

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

### JAG accreditation feedback:

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

### Enhancing patient experience with a warm welcome

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

### Introduced new research and development capability and capacity

This has resulted in:

- 51 active studies
- 791 recruits
- 31 active investigators
- 18 specialities



### Key Achievements

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



## Building on our people successes



In 2022, the Trust achieved the Disability Confident Level 3 Leader Status, part of a Government scheme

which recognises our commitment to supporting people living with a disability or long-term health condition to thrive in work.

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

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

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



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

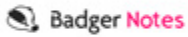
The Trust engaged in a Reciprocal Mentoring programme with executive directors and senior leaders of the organisations' Staff Networks over a period of 12 months. This aim of the programme was focused on increasing the strategic influence of under-represented groups across the Trust, whilst reducing and removing barriers in accessing opportunities and career progression.

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

A leadership development programme 'Growing as a Leader' has been developed, with successful participants achieving their CMI Principles of Management and Leadership qualification as a result of successfully completing the course. All participants identify a work based service development project and a number of participants have progressed in their career utilising the skills they have developed on the course.

# Building on our sustainability successes

## Digitally improved care that reduces inequalities and enhances patient experience



In 2021, BadgerNet, an electronic system aimed at giving mothers more control of their pregnancy records and care notes, was introduced to replace our old paper notes. The online portal and app allows expectant mothers to access their maternity records over the internet through a PC, tablet device or mobile phone in real-time and to interact with their midwife or other health professionals involved in their care by a message board.

## Working in partnership to achieve social and economic wellbeing in our communities

Through strong partnership working with Warrington Borough Council and Halton Borough Council, investment has been secured from The Department for Levelling Up, Housing and Communities (DLUHC) for major investment in both Towns, known as the 'Town Deals'. Focused on economic growth, regeneration, improved transport infrastructure, better digital connectivity, skills and culture, the investment includes funding for the Living Well Hub in Warrington and the Runcorn Health and Education Hub.

## Adapting how we deliver services to respond to changes in the way patients want to access care and enabling this by maximising technologies

We have introduced patient initiated follow ups across a range of services, which enables patients

to initiate an appointment request when they need one, based on their symptoms and individual circumstances, rather than services setting routine appointments which may not be as impactful.

## New Hospitals Programme

In September 2021, the Trust submitted an expression of interest (EOI) to be considered for one of the 8 remaining spaces on the Government's New Hospitals Programme, which was supported by commissioners, local government, educators including the University of Chester, social care, third sector partners and MPs. The EOI set out a compelling and cost efficient case for the investment required to build a new hospital in Warrington and redevelop the Halton hospital site (through an extension to the newest estate, Captain Sir Tom Moore Building). The vision for future-proofed, adaptable and appropriate healthcare facilities has been well embedded since the previous strategy and has strong support. While the outcome of the EOI is awaited, the Trust continues to maximise opportunities to progress plans within the current footprint and to work towards our new hospitals vision of modern, compliant estate, by changing and adapting how and where we deliver care, to set the foundations for the future.

We are doing this by investing wisely in existing estate to support long-term plans and making the most appropriate and effective use of the clinical space we have. Successes include funding secured with partners to open community hubs, refurbishment of clinical areas and replacement of ageing equipment.



Opened Oct 2022

New Halton Health Hub



Opened Sept 2022

Refurbished Paediatric Outpatients



Opened July 2022

New Same Day Emergency Care (SDEC) unit



Opened Oct 2021

Breast Care Centre at the Captain Sir Tom Moore (CSTM) Building

# Our communities

**One of the biggest challenges facing Warrington and Halton is the inequalities caused by socio-economic deprivation and the impact this has on the health and wellbeing of individuals and communities. Addressing the impact on the most vulnerable communities is a key challenge.**

Inequalities in health are most starkly demonstrated by the gap in life expectancy between the most and least deprived areas of each borough, a difference of 10 years in both boroughs. Marked inequalities are evident in Warrington across a range of other areas such as educational attainment, income, employment, the experience and fear of crime, poor lifestyle, general health and mental wellbeing.

Meanwhile, the poorest people in Halton are dying at a younger age than others living in wealthier areas – long-term health conditions caused by poor lifestyle conditions are too often the cause.

In older years, quality of life is often compromised because of increased frailty and poor health that can result in a loss of independence and a reliance on health and care services. Young children are not always getting the best start to their lives. There are high rates of smoking during pregnancy, low breastfeeding rates and higher than average levels of childhood obesity. As well as this too many under-18s are admitted to hospital because of alcohol.

The impact of these inequalities puts significant pressure on services right across the system and demands a different focus and approach to the way we deliver healthcare, as well as how we work with our partners across Warrington and Halton.

## If Warrington was a village of just 100 people...

**31**

Children are overweight or obese by year 6

**14**

Adults suffer from depression

**65**

Adults are overweight or obese

**12**

Will die from heart disease

**18**

People take less than 30 mins exercise a week

**9**

5-16 year-olds have a mental health disorder

**4**

Adults under 40 have Type 2 diabetes

**16**

Are smokers

**79**

Is the average age that men will live to

**28**

Will die from cancer

**54**

People are living with a long term condition

**82**

Is the average age that women will live to

**8**

People are over 75 years of age

## If Halton was a village of just 100 people...

**38**

Children are overweight or obese by year 6

**19**

Adults suffer from depression

**71**

Adults are overweight or obese

**13**

Will die from heart disease

**24**

People take less than 30 mins exercise a week

**10**

5-16 year-olds have a mental health disorder

**4**

Adults under 40 have Type 2 diabetes

**18**

Are smokers

**77**

Is the average age that men will live to

**30**

Will die from cancer

**59**

People are living with a long term condition

**81**

Is the average age that women will live to

**7**

People are over 75 years of age

# The changing landscape

**The current challenges facing the Trust and the NHS as a whole are multi-layered, sizeable and real. Recovery from a global pandemic, growing demand for services from an ageing population, constrained finances and national and local workforce availability and recruitment challenges, have coincided with political instability and influenced an unprecedented and ever-changing operating environment.**

At the same time the structural landscape of how health and care is planned and delivered across England has changed. The Health and Care Act (2022), introduced on July 1 2022, created 42 Integrated Care Systems (ICS) nationwide, replacing over 100 Clinical Commissioning Groups. Warrington and Halton operate as 'Places' and form part of the Cheshire and Merseyside ICS that connects each Place through a structure which aims to bring together a wide range of partners to develop a plan to address the broader health, public health, and social care needs of the population.

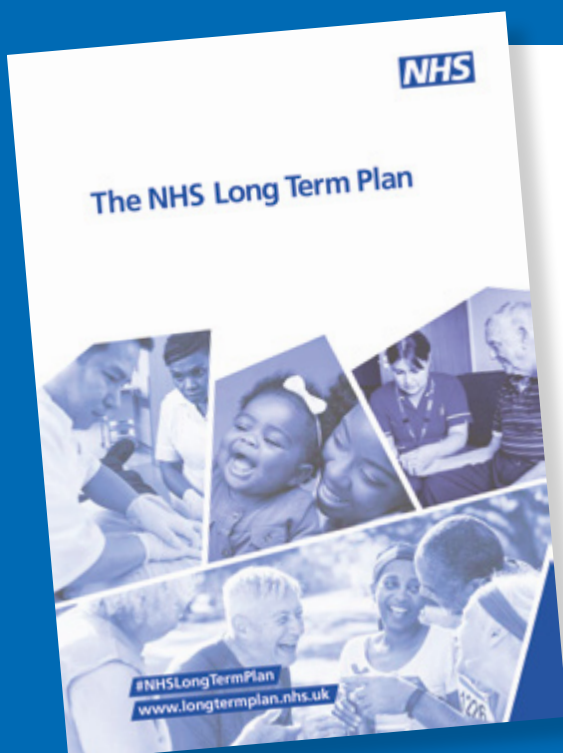
As the local context we work in continues to evolve and mature, it is important to reflect on local health and wellbeing outcomes which are below the national average.



In developing our strategy we have taken a holistic view of the health and public service landscape to ensure that our ambitions align with those of:

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

This approach provides assurance that we are making the best contribution towards delivering high quality, sustainable services to the communities we serve, responding effectively to the challenges facing health and social care and maximising opportunities to do this at scale with partners.



## Impact of key national and local priorities

**Our strategy acknowledges the important role we play in each of the following strategies.**

The **NHS Long Term Plan** places a focus on moving to a new model in which patients get more joined-up care, closer to home. The plan emphasises the need to strengthen the NHS contribution to prevention and reduce health inequalities, improve mental health services, reduce pressure on the emergency treatment system, personalise care, and make the most of digital opportunities, innovation and research to truly transform care, for example in outpatients. It is essential we are aligned with the delivery of these ambitions.

**Levelling up** sets out aims to make life more equitable across the UK by recognising and tackling the wider determinants of health. We are and will continue to use population health data to determine what the needs of our communities are.

**Health as the new wealth** highlights the NHS's role in economic and social recovery and outlines the role health services should play in the wider recovery and rebuilding of communities and economies. We recognise this will be crucial to addressing inequalities and will actively take opportunities to make the economy more socially just by leveraging support towards local economic and environmental goals.

The **NHS People Plan** sets out the workforce strategy to deliver the Long Term Plan. It has four core features which must inform our priorities:

1. **looking after our people** – with quality health and wellbeing support for everyone
2. **belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face

3. **new ways of working and delivering care** – making effective use of the full range of our people's skills and experience
4. **growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.

The **NHS Patient Safety Strategy** seeks to maximise the things that go right and minimise the things that go wrong, an ambition we share and actively support.

**Cheshire and Merseyside Health and Care Partnership** – of which we are a part – was established to confront the health and care challenges in Cheshire and Merseyside of population health, the quality of care, access to care and increasing financial pressures. As a partner, our strategy also considers ways in which we can contribute to the aspiration of transforming health and social care for the residents of Cheshire and Merseyside, while supporting broader social and economic developments.

**Warrington Together Partnership** and **One Halton Partnership** aim to deliver integrated health and social care through effective stakeholder collaboration. This approach is called 'place based care'. Our strategy seeks to support the individual 'place' priorities of both Warrington and Halton, which share many commonalities.

### Warrington Together priorities

- **Improve population health and support vulnerable communities and individuals.** Develop a place-wide 'Living Well' framework that supports people to start, live and age well, be active, and live healthy, fulfilling lives.
- **Deal with rising demand** and respond to the changing needs and expectations of the local population.
- **Improve and maintain quality services** and manage more complex needs locally.
- **Sustain and grow our workforce**, volunteers and community led services.
- **Ensure good access to early help** that will prevent crisis and needs from escalating.
- **Maintain an effective and financially sustainable health and care system**, with budgets under pressure.

### One Halton priorities

- **Improve the employment opportunities for people** in particular where it affects children and families.
- **Starting Well:** Enabling children and families to live healthy, independent lives.
- **Living Well:** Providing a supportive environment where systems work efficiently and support everyone to live their best life.
- **Ageing Well:** Enabling older adults to live healthy, independent lives.



Our Trust delivers CQC rated good care; however we recognise there is more to do to improve and to respond effectively to the challenges facing health and social care and there are opportunities to do this at scale with partners.

The Trust's previous strategy was built upon three key strategic aims of Quality, People and Sustainability, which remain relevant today and have been refined to reflect the changing landscape in which the NHS operates and key national and local priorities/policies.

Our refreshed strategy for 2023/24 and 2024/25 is summarised on the following pages.

# Our mission, vision, aims and values

## Our Mission

We will be outstanding for our patients, our communities and each other

## Our Vision

We will be a great place to receive healthcare, work and learn

## Our Aims



### QUALITY

We will...  
**Always put our patients first** delivering safe and effective care and an excellent patient experience.



### PEOPLE

We will...  
**Be the best place to work** with a diverse and engaged workforce that is fit for now and the future.



### SUSTAINABILITY

We will...  
**Work in partnership** with others to achieve social and economic wellbeing in our communities.

## Our Values



**Working Together**



**Excellence**



**Inclusive**



**Kind**



**Embracing Change**

# Our objectives 2023-2025

We have three strategic aims framed around Quality, People and Sustainability. These aims are interdependent; they are woven into each of our strategic objectives, and throughout all of our plans, programmes and projects.



## QUALITY

We will...**Always put our patients first** delivering safe and effective care and an excellent patient experience.

1

### Patient safety

We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.

2

### Clinical effectiveness

We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.

3

### Patient experience

We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.

4

### Research, development and innovation

We will work in partnership on high quality clinical research for the benefit of patients, public and staff.



## PEOPLE

We will...**Be the best place to work** with a diverse and engaged workforce that is fit for now and the future.

5

### Looking after our people

We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.

6

### Innovating the way we work

We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.

7

### Growing our workforce for the future

We will support personal and professional development, ensuring equal access to opportunities, and nurturing, growing and developing diverse teams.

8

### Belonging in WHH

We will enable staff to have a voice through the development of a just and learning culture.



## SUSTAINABILITY

We will...**Work in partnership** with others to achieve social and economic wellbeing in our communities.

9

### Working in partnership

We will work collaboratively to provide sustainable, high quality acute services and to support prevention and integrated care in the community.

10

### Working responsibly

We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.

11

### Sustainable estate and digitally enabled

We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.

12

### Financial sustainability

We will develop and delivering financial sustainability plans with our staff, system partners and stakeholders.

# Our objectives 2023-2025

We have twelve strategic objectives to progress over the next two years, which support our three strategic aims of Quality, People and Sustainability. Each strategic objective will be realised through a set of associated priorities and plans. The following section describes in more detail the key work that will be delivered to achieve these strategic objectives.



## QUALITY

Our Quality strategy aim is: **“We will always put our patients first, delivering safe and effective care, and an excellent patient experience.”** Our four strategic objectives for quality and associated priorities are summarised below to demonstrate how we plan to deliver on our strategic aim.

### 1. Patient safety:

We will develop and enhance our patients' safety and a learning culture where quality and safety is everyone's top priority.

#### How will we achieve this objective:

Overarching priorities covering the duration of the strategy

- |     |   |
|-----|---|
| 1.1 | We will reduce avoidable harm and patient deterioration with a focus on COVID-19 elective recovery.   |
| 1.2 | We will implement actions to deliver new standards required as a result of national reviews in maternity care/provision, ensuring learning is acted upon. |
| 1.3 | We will enhance timely patient recovery through therapy led initiatives, including work around deconditioning and rehabilitation.                         |

#### 2023/24 Annual quality priorities

- |     |   |
|-----|---|
| 1.4 | We will improve recognition and response to deteriorating patients.   |
| 1.5 | We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN). |
| 1.6 | We will continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.  |

### What this means in practice

Our maternity services recently provided care to a very complex patient who, under the provisions of Section 3 of the Mental Health Act 1983, had been detained in segregation at a mental health facility due to significant violence. To ensure the best care for the patient, the team reached out for support and expertise internally, regionally and nationally. The conclusion was that this was such a rare situation no-one had any experience of this in the country. As a result, the whole team was required to carefully risk assess and plan care with partners to deliver effective and compassionate care.

They recognised the value of building memories for women who have to give their baby up for safeguarding reasons and this was critical.

#### The result was:

- ✓ The de-escalation of the patient's behaviour since the birth of her baby
- ✓ Full medication review achieved
- ✓ Patient no longer needs care to be provided in segregation and can now be cared for with 1:1 support rather than 6 carers
- ✓ Demonstrable difference in the patient's mental health

## 2. Clinical effectiveness:

We will ensure practice is based on evidence so that we do the right things, the right way, to achieve the right outcomes for our patients.

### How will we achieve this objective:

Overarching priorities covering the duration of the strategy

- |     |  |
|-----|--|
| 2.1 | We will continue to utilise and evidence best clinical practice through the evidencing of compliance with guidance, such as the National Institute for Clinical Effectiveness. |
| 2.2 | We will continue to embed a positive risk management culture from ward to Board.   |
| 2.3 | We will recover core services and improve productivity in line with targets set in the NHS Long Term Plan.   |

### 2023/24 Annual quality priorities

- |     |   |
|-----|---|
| 2.4 | We will improve a culture of quality, safety and learning through the consistent application of LOCSIPs, achieving >90% compliance in documentation and observational audits. |
| 2.5 | We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.  |
| 2.6 | We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).                               |

## Example of the work we will build on

### Managing risk effectively

Clinical risk management is integral to the co-ordination and delivery of effective and safe care. Acknowledging that risk cannot always be completely eliminated; indeed some risks are difficult or even impossible to predict, we have developed a systematic approach to clinical risk management. This is underpinned by effective communication, record keeping and governance to maximise the chances of managing risk.

We recognise that risk management also involves consideration of positive risk taking to promote independence and choice, once the potential benefits and harm to the individual and others have been thoroughly assessed.

As such, we have developed an open and transparent culture, where clinical risks are appropriately discussed and escalated to reduce potential harm occurring.



Utilising learning from the national Getting It Right First Time programme, we have developed plans to improve the treatment and care of patients based on benchmarking of best practice and data-driven evidence to support effective change. As these improvements are implemented they will improve care and patient outcomes.

Paul Fitzsimmons, Executive Medical Director



### 3. Patient experience:

We will place the quality of patient experience at the heart of all we do, where “seeing the person in the patient” is our norm.

#### How will we achieve this objective:

Overarching priorities covering the duration of the strategy

|     |  |
|-----|--|
| 3.1 | We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care.                |
| 3.2 | We will ensure an inclusive communications method for each patient, taking into account their personal circumstances, using clear and easy to understand language. |
| 3.3 | We will create first and lasting impressions which contribute towards a positive experience of care.   |

#### 2023/24 Annual quality priorities

|     |   |
|-----|---|
| 3.4 | We will improve patient experience for those with mental health attendance.   |
| 3.5 | We will reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods. |
| 3.6 | We will improve patient experience with the pilot of a patient/family ‘access line’ primarily for out of hours.           |

### Example of the work we will build on

“Hello my name is Vicky and in my life I have frequently used my local hospital in many services.

“As a member of the deaf community I have found it difficult to communicate with your staff due to lack of awareness of the deaf community and lack of understanding for the requirement for me to have an interpreter present.

“Most people assume that I can lip read very well but different backgrounds, lighting and facial hair make this really difficult for me and some deaf people can’t lip read at all but it’s always assumed. Other times I’ve been asked to write

stuff down but I don’t speak or write in English, I communicate in British Sign Language – this is why an interpreter is important. They help to translate English into a way that I can understand and also share with you my symptoms so you can properly diagnose and treat me.

“During the pandemic communication has been harder for me and other members of the deaf community due to face masks that staff have had to wear. Sometimes clear face masks are used but with the steam and reflections this isn’t always helpful.”

### Our response

Engagement is vital to learning and sharing lived experience

New Diversity, Inclusion and Belonging Strategy will heavily feature engagement with the deaf community

Vicky signed up to be an Expert by Experience working with the Patient Experience and Inclusion Team

Commissioning deaf awareness training for all staff

Including brilliant basics associated with interpretation and translation as part of the Staff Guide in all areas

Launch of the Accessible Information Standard policy and project plan to ensure communication needs are recorded, shared and acted on

Vicky’s story will be used in Equality, Diversity and Inclusion training



## 4. Research, development and innovation:

We will continue to work in partnership with others to undertake and facilitate high quality clinical research, for the benefit of patients, public and staff.

### How will we achieve this objective:

Overarching priorities covering the duration of the strategy

|     |   |
|-----|---|
| 4.1 | We will continue to create opportunities for members of the public to gain access to clinical research trials contributing to the health of our population. |
| 4.2 | We will further develop and grow our research capability through the application and selection for clinical trials.   |
| 4.3 | We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.                            |
| 4.4 | We will grow the academic research portfolio supporting staff recruitment and retention.  |
| 4.5 | We will seek to expand our research offer seeking opportunities for further collaboration through the Halton Clinical Research Unit.                        |

## Example of the work we will build on

Health research plays an integral part in how the NHS develops services and continues to provide high quality healthcare for our population. It is vital in providing the evidence we need to transform services, enabling earlier diagnosis, more effective treatments, prevention of ill health, better outcomes and faster returns to everyday life. Meanwhile, research is also beneficial to healthcare professionals who are able to develop imaginative solutions for real challenges facing the NHS, improving care and increasing job satisfaction.

Through our research alliance with Liverpool University Hospitals NHS Foundation Trust and the National Institute for Health Research (NIHR) Clinical Research Network, North West Coast,

we are able to enhance our clinical research capability and give access to clinical trials for local people, while ensuring we benefit from the expertise of our research partners.

“

**The new research facility represents a major opportunity for the people of Halton and Warrington to take part in research and improve the health of our communities.**

Dr Chris Smith, Chief Operating Officer, Clinical Research Network: North West Coast

”



## PEOPLE

Our People strategic aim is: **“We will always be the best place to work, with a diverse and engaged workforce that is fit for now and the future.”** Our four strategic objectives for people and associated priorities are summarised below to demonstrate how we plan to deliver on our strategic aim.

### 5. Looking after our people:

We will prioritise the safety, health and wellbeing of our people to ensure work has a positive impact.

#### How will we achieve this objective:

|     |   |
|-----|---|
| 5.1 | We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.   |
| 5.2 | We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.            |
| 5.3 | We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.                                       |
| 5.4 | We will equip line managers to use person centred engagement practices which improve employee experience.   |
| 5.5 | We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.  |
| 5.6 | We will consistently apply the onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff. |

### What this means in practice

In July 2022, absence for staff working in Estates and Facilities was higher than the Trust’s overall sickness absence. The Leadership team conducted a review to identify the common reasons for absence and any particular staff groups that were affected. As part of this review, it was identified that 84% of our domestic staff are over the age of 40, an age which 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 there is an impact on the overall health and wellbeing of this staff group.

To support staff, a health and wellbeing event was delivered with partners, with advice and interventions framed around the needs of the staff group. This resulted in:

- 36 health checks being performed, including blood pressure checks and health fitness checks
- 18 referrals to various services including GPs, counselling and reflexology
- Tailored advice offered on topics such as smoking cessation, weight management and menopause
- Information handouts provided on financial wellbeing
- Free day gym passes

The impact of the support will be monitored. Feedback on the day was very positive from staff.

## 6. Innovating the way we work:

We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.

### How will we achieve this objective:

|     |   |
|-----|---|
| 6.1 | We will develop strategic workforce plans which are reflective of current and future needs.   |
| 6.2 | We will participate in system wide workforce planning.  |
| 6.3 | We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams. |
| 6.4 | We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.  |
| 6.5 | We will equip our workforce with the skills to shape and deliver effective and changing models of care.   |
| 6.6 | We will enhance digital capability, skills and leadership which embrace digitally enabled services.   |



Physician Associates are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Although the Physician Associate profession is still considered relatively 'new' in the UK, the role of Physician Assistant first developed in the US in the 1960s, and equivalent or similar roles exist in many healthcare systems around the world.

At WHH, there are currently 18 Physician Associates working in the Emergency Department, Paediatrics, Surgery and Care of the Elderly. We also host Physician Associate students from the University of Chester who gain experience in various departments such as Trauma & Orthopaedics, Endocrinology, Cardiology, Respiratory, Stroke, Obstetrics & Gynaecology, Paediatrics and the Emergency Department.

Physician Associates bring new talent to healthcare and can provide vital support to patients and the multidisciplinary team. Physician Associates are intentionally trained as 'generalists' so that they can switch into different types of work either for their own growth and satisfaction, or for the benefit of the community or hospital they work in. The profession has gone from strength to strength in the UK, with the adoption of the managed voluntary register for Physician Associates in 2011, and the launch of the Faculty of Physician Associates through collaboration with UKAPA and the RCP in 2015.



## 7. Growing our workforce for the future:

We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.

### How will we achieve this objective:

|     |  |
|-----|--|
| 7.1 | We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.  |
| 7.2 | We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans. |
| 7.3 | We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.   |
| 7.4 | We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.   |
| 7.5 | We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.  |
| 7.6 | We will equip team leaders to use structured tools and techniques to develop effective team working within their care groups, across care groups and with the wider health and social care system.   |

### Example of how the priorities will be progressed

The Trust is undertaking a number of programmes of work to develop a pipeline for our workforce across various roles and professional groups, including the Supported Internship Scheme and Health Education England's Health Ambassadors scheme. We are working with partners to support the growth of our future workforce through grass-roots investment in academies. The Health and Social Care Academy, developed by Warrington and Vale Royal College in partnership with a number of local organisations including the Trust and Warrington Borough Council, is a great example of our commitment to growing our future workforce.

By working collectively, local health and social care organisations can support identification of the areas of greatest need in terms of the health and social care workforce for future, and input into the student curriculum to ensure students leave with the skills required in the workplace.

## 8. Belonging in WHH:

We will enable staff to have a voice, through the development of a just and learning culture.

### How will we achieve this objective:

|     |  |
|-----|--|
| 8.1 | We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.                    |
| 8.2 | We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures. |
| 8.3 | We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.              |
| 8.4 | We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.                              |
| 8.5 | We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.  |
| 8.6 | We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.  |

## Commitment to equality, diversity and inclusion

In 2022, WHH achieved the Navajo Cheshire and Merseyside LGBTQ+ Charter Mark. The accreditation recognises the commitment WHH continues to make to improve the experience and health outcomes of the LGBTQ+ community – both for our patients and our workforce.

The Trust also became a Stonewall Diversity Champion to continue to improve our policies, procedures and workstreams for the future.



## Commitment to our Armed Forces Community

The Armed Forces Covenant is a pledge to acknowledge and understand the needs of the Armed Forces community and aims to build a more open and honest relationship between employers, the Ministry of Defence and reservists.

As an **accredited Armed Forces Friendly Hospital and Silver accredited with the Employer Recognition Scheme**, we identify and record our patients and staff within the military community to ensure they receive support needed.





# SUSTAINABILITY

Our Sustainability strategic aim is: **“We will work in partnership with others to achieve social and economic wellbeing in our communities.”** Our four strategic objectives for Sustainability and associated priorities are summarised below to demonstrate how we plan to deliver on our strategic aim.

## 9. Working in partnership:

We will work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable. We will also work with primary care, community care, social care and all community partners, including the voluntary sector, to support the provision of integrated care in the community and prevention.

### How will we achieve this objective:

|     |   |
|-----|---|
| 9.1 | We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.   |
| 9.2 | We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector, to support the provision of integrated care in the community and prevention of ill health. It is proposed that this includes relocation of appropriate secondary care into the community, following the principle of the right service, delivered in the right place to deliver excellent patient care and experience and to improve access and address health inequalities. |
| 9.3 | We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts. This will be approached on a service by service basis to ensure the best outcomes for patients and our regional healthcare system.   |

“  
**We’re delighted to have the NHS Trust and Halton Health Hub here in the heart of the community at Runcorn Shopping City. It forms a synergy between the continued development of the shopping centre and improves convenience and access for patients. We believe it will serve as a blueprint for other locations around the country.**  
 Dave Pearman, Centre Manager, Runcorn Shopping City  
 ”

## Example of how the priorities will be progressed

The Runcorn Health and Education Hub will open in late 2024, in partnership with Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare, Halton Borough Council, voluntary and third sector partners and Riverside College. We will deliver services focused on prevention, women and children and long term conditions in the heart of the Runcorn community. In addition, flexible education facilities will support the growth of our future workforce, helping local people into local jobs.



## 10. Working responsibly:

We will continue to address inequalities, creating social value for our communities, and progressing our Green Plan ambitions.

### How will we achieve this objective:

|      |  |
|------|--|
| 10.1 | We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the <a href="#">Core20PLUS5 approach</a> .  |
| 10.2 | We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO <sup>2</sup> emissions.  |
| 10.3 | We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.   |
| 10.4 | We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045. |
| 10.5 | We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.  |

## Example of how the priorities will be progressed

**The Living Well Hub:** The Hub will target and address health inequalities in Warrington by providing a range of services focused on prevention and early intervention in a town centre location with close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a key project for the local health and care system to work collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project represents an investment of £3.1m, has been co-designed with patients and system partners through extensive engagement and is on-track to be operational by Autumn 2023.

At Warrington and Halton Hospitals NHS Foundation Trust we recognise the scale of the issue that climate change presents in our community.



As a healthcare provider we acknowledge our responsibility to minimise our contribution to climate change and integrate sustainability into our organisation to reduce the potential risks for our local population. Our Green Plan outlines our commitment to embedding sustainability throughout our organisation and delivering net zero by 2045.



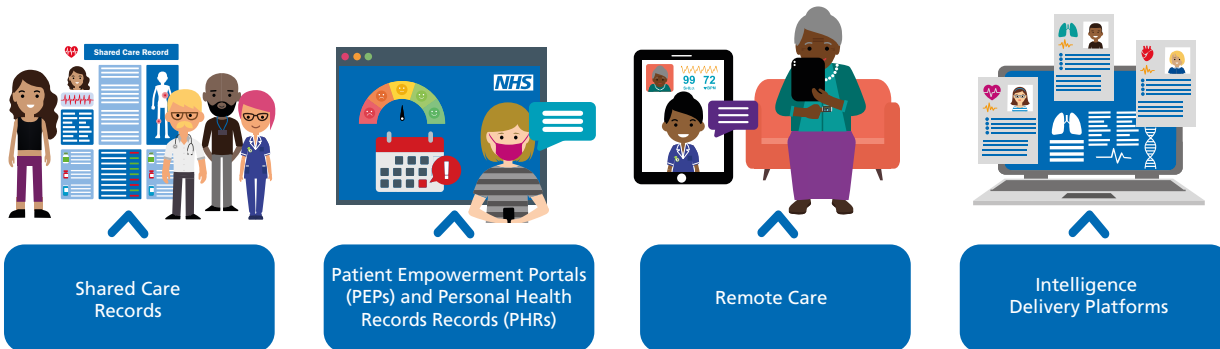
## 11. Sustainable estate and digitally enabled:

We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.

### How will we achieve this objective:

|      |   |
|------|---|
| 11.1 | We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.   |
| 11.2 | We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and effective use of clinical space, whilst we work towards our realisation of our new hospitals.   |
| 11.3 | We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.   |
| 11.4 | We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised through Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare. |

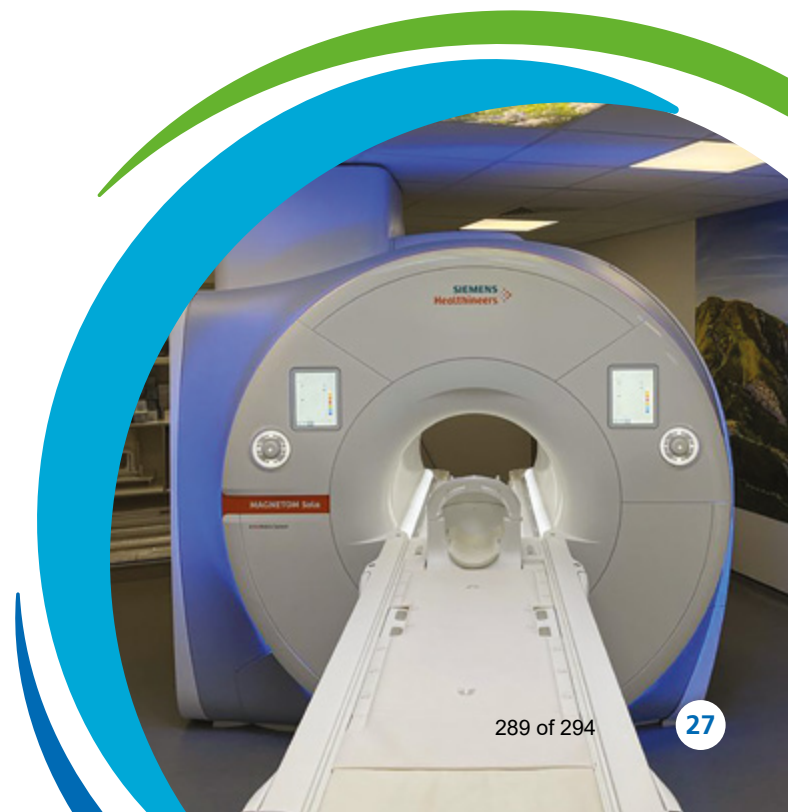
## Digital solutions for the future will focus on at scale solutions as highlighted below



## Creating a Community Diagnostic Centre

The Trust has been successful in bidding for funding from NHS England to develop a Community Diagnostic Centre, which will be located at the Halton site and at the Halton Health Hub in Runcorn Shopping City. This funding will deliver new diagnostic capacity, including ultrasound, phlebotomy with point of care testing, CT and MRI facilities, alongside additional audiology and sleep study services, to support easier access to diagnostic services and earlier diagnosis of disease for patients. It will also free up capacity at the Warrington site as the choice of locations for diagnostic services increases.

These plans are a step towards delivering care in future-proofed, compliant estate and support delivery of care in line with future new hospital plans.



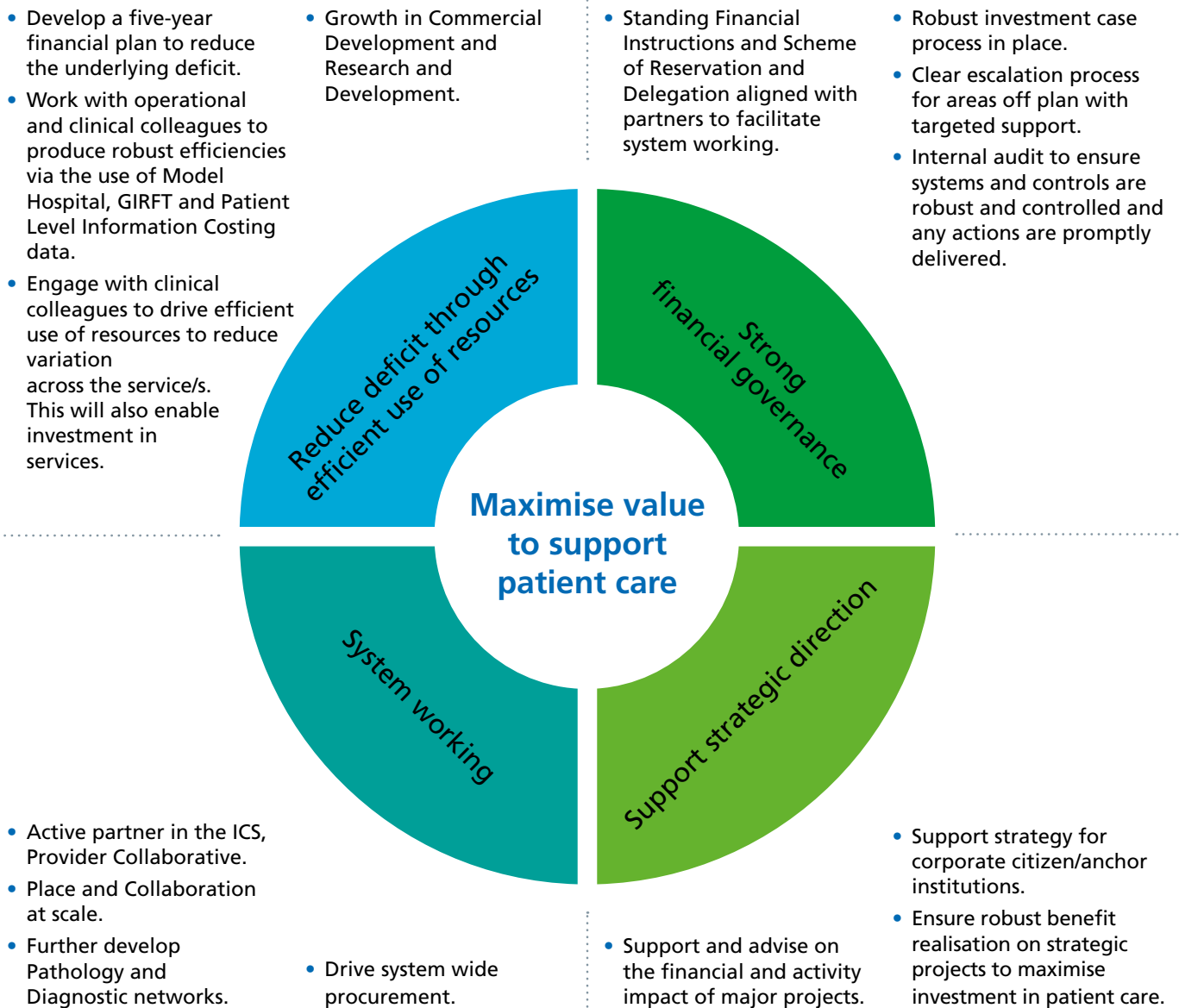
## 12. Finance sustainability:

We will develop and deliver financial sustainability plans with our staff, system partners and stakeholders.

### How will we achieve this objective:

|      |  |
|------|--|
| 12.1 | We will deliver the Trust's agreed financial plan.   |
| 12.2 | We will participate, lead and contribute to system wide programmes to drive increased efficiencies and benefits. |
| 12.3 | We deliver value for money by ensuring efficient use of resources.   |

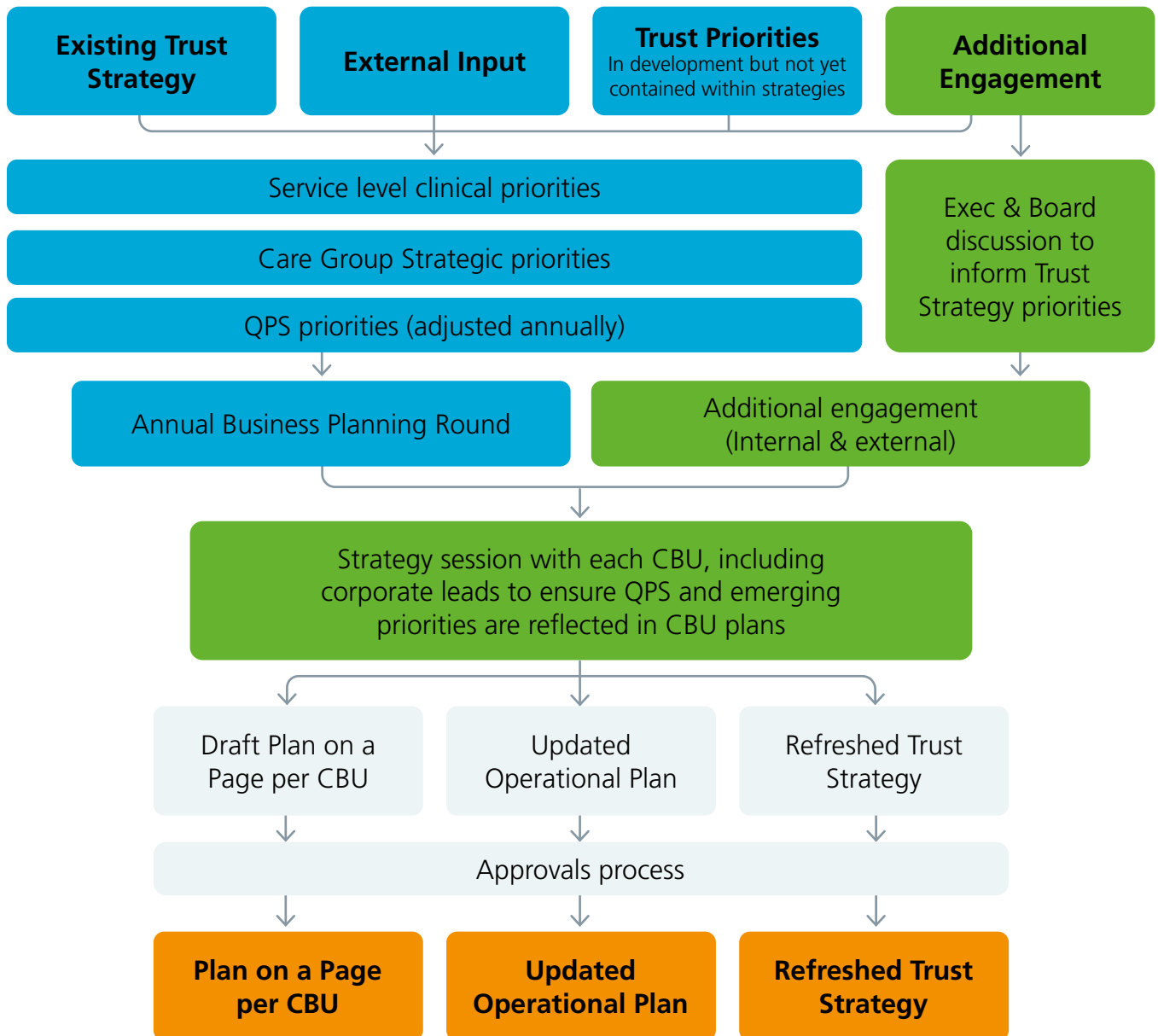
## We will utilise the four principles below to help us embed our priorities



# How we got here... engagement to date

Successful delivery of our future vision for the Trust is dependent upon the full engagement of our patients, staff and local system partners, who are the people who have informed and will bring this strategy to life.

The development of the strategy has been shaped through systematic communication and engagement with our stakeholders, using the process below, and we will continue to engage with all partners as delivery progresses.



## Specific engagement activities and events have included:

- Market stall events, both at our hospital sites and in the community, to gather input from staff, patients and the public.
- Engagement with Healthwatch.
- Discussion with Council of Governors.
- Engagement with place partners, via Place Boards.
- Review of existing sources of patient insight and experience data.



# Thank you



**Lucy Gardner**

Director of Strategy  
and Partnerships

**We would like to take this opportunity to thank our patients, carers, public, staff, governors, members, partners and all stakeholders for your support in developing and delivering our strategy.**

Never has working together been so important and the strength of our partnerships is evident in many of our shared successes since our previous strategy was developed in 2018. Halton Health Hub delivered in 2022 and the development of both the Living Well Hub in Warrington and Health and Education hub in Runcorn are just a few examples of significant investment and innovative integrated

service delivery, tailored to the needs of our communities, which would not be possible without working together with our local residents, councils, health and wellbeing and education partners and the commercial sector.

These important projects, alongside the delivery of all of our objectives outlined within our strategy, will support us to together reduce health inequalities within our boroughs, narrowing the 10 year gap in life expectancy between the most and least deprived.

We look forward to continuing to work together to be outstanding for our patients, our communities and each other. Together we can help support our communities to thrive, leading happy and healthy lives.

For more information on our strategy and to download copies of this and/or any of our supporting strategies, please visit our website [whh.nhs.uk/strategy](http://whh.nhs.uk/strategy)

**Contacting us:**

We would love to hear your comments and ideas about our future plans and what we'd like to achieve.

Strategy Office, Kendrick Wing  
Warrington Hospital, Lovely Lane  
Warrington WA5 1QG

[whh.communications@nhs.net](mailto:whh.communications@nhs.net)

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**Urdu:** یہ اشاعت درخواست پر متبادل زبانوں یا وضعوں میں دستیاب ہے

**Bengali:** এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে উপলব্ধ

**Gujurati:** આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા ફોર્મટમાં ઉપલબ્ધ છે

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