Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting
Part 1 (held in Public)

Wednesday 2 October 2024
10.00am -12.30pm
Trust Conference Room, Burtonwood Wing, WHH

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 2 October 2024, 10.00am – 12.30pm
Trust Conference Room, Warrington

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/24/10/91	**10:00**	Engagement Story - Till death us do part	***To note***	**Presentation**	Ian Holbrook – Son of Margaret & Jim Holbrook David Merriman, CBU Matron for Urgent and Emergency Care, Claire Grice Interim Head of Patient Experience, Equality, Diversity & Inclusion
BM/24/10/92	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/24/10/93	**10:17**	Minutes and Action Log of the previous meeting held on **7 August 2024**	***For approval***	***Minutes***	Chair
BM/24/10/94	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/24/10/95	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Acting Chief Executive
BM/24/10/96	**10:30**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/24/10/97	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:					
BM/24/10/98 **(a)**	**10:40**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
		Quality Dashboard **Including** Assurance Reports Quality and Assurance Committee 13.08.24, 10.09.24	***For assurance***	***Report & Presentation***	Chief Nurse, Acting Chief Operating Officer & Deputy Chief Executive, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including**	***For assurance***	***Report***	Chief People Officer

		Assurance Reports Strategic People Committee 21.08.24, 18.09.24			Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard Including** Assurance Reports Finance and Sustainability Committee 28.08.24, 23.09.24	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
(d)		**Audit Committee** Assurance Report 22.08.24	***For assurance***	***Report & Presentation***	Mike O'Connor – Senior Independent Director
(e)		**Charitable Funds Committee** Assurance Report 12.09.24	***For assurance***	***Report***	Chair
Strategic aim:					
BM/24/10/99	**11:05**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Acting Chief Operating Officer & Deputy Chief Executive
BM/24/10/100	**11:15**	Compliance Update Q1	***To note for assurance***	**Report**	Chief Nurse
BM/24/10/101	**11:35**	Maternity & Neonatal Update Summary Report to cover: I. Monthly Maternity Quality & Safety review II. Maternity Incentive Scheme Year 5 and 6 including Saving Babies Lives care Bundle v3 update III. Transitional Care Q4 2023/24 IV. WHH Maternity Services – Compliance with Ockenden V. PMRT Q1 2023/24 VI. Q1 Midwifery Summary Safe Staffing Report and annual workforce plan	***To note for assurance***	***Report***	Director of Midwifery
BM/24/10/102	**11:45**	GMC Re-validation Annual Report inc Statement of Compliance	***To approve***	**Report**	Executive Medical Director
Strategic aim:					

BM/24/10/103	**11:50**	Freedom To Speak Up Guardian Bi-Annual Report	***To note for assurance***	**Report**	Chief Finance Officer
Strategic Aim					
BM/24/10/104	**11:55**	Warrington & Halton Teaching Hospitals NHS FT & Bridgewater Community Healthcare NHS FT Integration I. Joint Branding II. Initial Strategic Case for Change	***For approval***	**Report**	Chief Strategy & Partnerships Officer, and Director of Communications & Engagement
BM/24/10/105	**12.05**	Strategy Programme Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer
BM/24/10/106	**12:15**	EPRR Assurance Letter/Statement of Compliance	***To note for assurance***	**Report**	Acting Chief Operating Officer

Governance					
BM/24/10/107	**12:20**	Committee Terms of Reference: • Nomination and Remuneration Committee • Finance and Sustainability Committee	***For approval***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/24/10/108	WHH Charity Committee Chair's Annual Report -	Charitable Funds Committee Date: 12.09.24 Ref: CFC/24/09/13 Outcome: approved	***To note for assurance***	**Report**	Steve McGuirk, Chair
BM/24/10/109	Committee Chair's Annual Report – Audit Committee	Audit Committee Date: 22.08.24 Ref: AC/24/08/47	***To note for assurance***	**Report**	Mike O'Connor, Senior Independent Director
BM/24/10/110	Director of Infection Prevention & Control Q1	Quality Assurance Committee Date: 13/08/24 Ref: QAC/24/08/120 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/10/111	Learning from Experience Summary Report Q1	Quality Assurance Committee Ref: QAC/08/119 Date: 13/08/24 Ref: QAC/ Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/10/112	Learning from Deaths	Quality Assurance Committee	***To note for assurance***	**Report**	Executive Medical Director

		Ref: QAC/24/09/137 Date: 10/09/24 Outcome: Noted			
BM/24/10/113	Guardian of Safe Working Report Q1	Strategic People Committee Date:21/08/24 Ref: SPC/24/08/84 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/24/10/114	Senior Information Risk Owner Report	Finance and Sustainability Committee Date: 23.09.24 Ref: FSC/24/09/129 Outcome: Noted	***To note for assurance***	**Report**	Chief Information Officer
BM/24/10/115	Digital Strategy Group Update	Finance & Sustainability Committee Date: 23.09.24 Ref: FSC/24/09/130 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
Closing					
BM/24/10/116	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/24/10/117		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting – 4 December 2024, Trust Conference Room, WHH					

Warrington and Halton Teaching Hospitals NHS Foundation Trust

‘Till death us do part’

Presenters: Ian Holbrook – Son of Margaret & Jim Holbrook

Attendance: David Merriman, CBU Matron for Urgent and Emergency Care

Authors: Claire Grice – Interim Head of Patient Experience

Margaret & Jim

Jim and Maragret married for 70 years, met at a local fair

Son Ian, grandchildren and 1 great grandchild

Margaret was admitted to a cubicle on the Acute Medical Unit with heart failure, deteriorated quickly requiring end of life care

The family were given unlimited visiting, allowed to personalise the room with family photos, one photo of Jim and Margaret as a young couple, Jim enjoyed sharing with staff regaling stories of them both in their youth.

Support

Just 3 days after his wife's admittance. Jim at 90 years old, also took ill

Suffering episodes of shortness of breath and with the stress of knowing his wife of 70 years only had days/weeks to live

The admitting medical doctor, Dr Dooey was aware of Jims wife being a patient on AMU and her end of life care, recognising the importance of trying to keep Margaret and Jim together and compassionately requested that Jim be admitted onto the same ward as his wife Margaret

Ward team then liaised with the Bed Manager to facilitate this move and on discussion with the family, they set up Margaret's cubicle to allow two beds, so the married couple remain side by side

It was noted that Margaret and Jim held hands and had conversations during their stay together, even in ill health they remained inseparable

Compassionate care

Whilst Margaret and Jim were sleeping, a family member asked the ward staff to check on Margaret. She had sadly passed away in her sleep, holding Jim’s hand

Ward staff woke Jim to break the sad news, he spent time with Margaret to say his final goodbye. Jim then moved on to her bed and hugged her. Staff explained that they would need to move Jim out of the room, so they could privately conduct last offices for Margaret. As his bed was being transferred to a pod, he was still holding Margaret's hand and said ‘don’t worry, I won’t be long Margaret’

Jim asked to go back into the cubicle to continue his care, 2 days later, Jim was also placed on end of life care and passed away joining his wife, Margaret.

Collaboration

Following the deaths of Margaret and Jim :

Staff supported the relatives on AMU, during and after the deaths

Bereavement services even ensured all paperwork was kept together, kept their names together on the notification board as a mark of respect. Ensuring that the family only had to attend one registrar appointment to register their deaths

This is to story is to recognise the importance of collaborative working of staff, how staff take individual circumstances and aim to provide supportive, personal and inclusive care to patients and their families

There is no Trust guidance, it is simply following your heart and instinct to provide this level of support and care

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 5 August 2024 Trust Conference Room/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Ali Kennah (AK)	Chief Nurse
Jane Hurst (JH)	Chief Finance Officer
Dan Moore (DM)	Chief Operating Officer
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Jan O'Driscoll	Partner Non-Executive Director
Norman Holding	Lead Governor
In Attendance	
Lucy Gardner (LG)	Director of Strategy and Partnerships
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Claire Grice (CG)	Head of Patient Experience, Equality, Diversity & Inclusion (*in attendance for Agenda Item BM/24/08/56*
Bernadette Davies-Harwood (BD-H)	Patient (*in attendance for Agenda Item BM/24/08/XX)*
Jo MacGlashan	Matron Women's and Children (*in attendance for Agenda Item BM/24/08/XX)*
Liz Walker	Secretary to Trust Board (minute taking)
Observing	
Nikhil Khashu	Incoming Chief Executive
Sue Fitzpatrick	Governor

Agenda Ref	Agenda Item
BM/24/08/56	**ENGAGEMENT STORY EMERGENCY DEPARTMENT EXPERIENCE** SMcG introduced Bernadette Davies-Harwood, a patient and, Trust member of staff, who had wanted to attend Trust Board to share her personal experience of the communication received from the Trust, following her cancer diagnosis in September 2023.

Bernadette explained the challenges concerning communication following tests, and the impact this had had on herself and her family.

AK expressed her gratitude to Bernadette for sharing her story and acknowledged that the Trust had learnt lessons following the feedback received. Bernadette acknowledged that she felt well supported by the Trust since returning to work.

PF also extended apologies on behalf of the Trust and explained the immediate revision of the professional standards, particularly when delivering bad news to patients, emphasising the importance of face-to-face conversations taking place, rather than phone calls. He confirmed actions would be taken to refine the process.

KH asked if all the support she required had been offered, and Bernadette advised that she had access to a Cancer psychologist at Liverpool Women's Hospital and had also been offered counselling, however felt that access to the psychologist support was sufficient at this time.

BDH explained her choice to share her story with the Board, to emphasise the importance of understanding what had occurred and to receive assurance that lessons would be learnt to prevent from happening again.

The board discussed the ongoing work around culture across the Trust and the importance of staff being empowered to communicate openly, honestly and with compassion to each other and with patients, and being confident to challenge behaviours that they feel are not aligned with Trust Values.

SC suggested that both organisational and individual aspects need to be assessed together, noting that while mistakes occur, the focus should remain on constructive feedback, adding that that the perspectives of affected parties must be considered in future discussions with patients and the importance of the sequence of delivering information must be considered.

CR concluded that the communication failures that had been experienced in this case highlighted some important lesson to be learned, it was suggested that some further assurance been received by the Quality Assurance Committee around mandatory training for staff on delivering news to patients.

The Trust Board;

1. **Discussed and noted the Engagement story.**
2. **Agreed that PF take an action in relation to rewriting professional standards**

	3. **Assurance updates on mandatory training to be presented to the Quality Assurance Committee meeting.**
BM/24/08/57	**WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST** SMcG welcomed the Trust Board, invited presenters and observers to the meeting, apologies were noted as detailed above, there were no declarations of interest made. SMcG welcomed Nikhil Khashu to the meeting, who was attending as an observer prior to commencing his role as Chief Executive of the Trust from the 1 November 2024. **The Trust Board noted the apologies and declarations of interest.**
BM/24/08/58	**MINUTES AND ACTION LOG FROM THE PREVIOUS MEETING HELD ON 5 JUNE 2024** The minutes of the meeting held on 5 June 2024 were agreed as an accurate record, with two minor amendments. The Action Log was reviewed, completed actions were noted, there were no outstanding/ongoing actions. **The Trust Board approved the minutes of the meeting held on 5 June 2024 and noted the Action Log.**
BM/24/08/58	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/24/08/59	**CHIEF EXECUTIVE'S REPORT** SC introduced the paper, which was taken as read and welcomed any questions. JS asked whether, in relation to CMAST, things had progressed with CMAST beyond the scoping stage, particularly regarding efficiencies. SC responded that it remained a challenge in assessing the overarching system responses and the focus was on designated activity and how they were counted. The overarching programme was viewed as facilitating various workstreams and was transitioning from scoping to actionable plans, indicating strong leadership from the central team, along with a robust programme management framework, as well as available resources.

	JH provided an example of the work around energy relating to crown services, noting this was already included in the CIP plans, but the aspects linked to CMAST were not included. JS asked about DNA initiatives as an example and SC clarified that this would sit at operational level and emphasised that CMAST's role was not performance management but rather in a supportive role. LG added that a data pack from the Wirral integration programme had been produced identifying efficiencies between the two organisations and advised something similar would be produced for WHH and Bridgewater Community Health Trust, which would bolster support for the programme. MOC questioned the support measures being implemented in light of the current environment in relation to the incident in Southport. SC responded that although the organisation had not been directly affected, there had been widespread communication to clarify the stance of the Trust and a series of NHSE meetings had taken place, and any further guidance would be put in place accordingly. SMcG stressed the importance of considering the wellbeing of staff who might be indirectly involved based on their community links. DM noted that calls with other trusts were taking place to share their experiences and a report would be presented to the Executive Team Meeting the following week to discuss a further framework around guidance concerning this types of situations. MC added that national guidance was being sought on the issues of racial abuse, and emphasised the implications of workforce conduct, suggesting that attention be given to the vulnerability of staff visiting patients in their homes. It was noted that the situation would continue to be monitored and ensure effective communication and support for staff was provided and the outcomes of the recent NHSE meetings would be shared with further framework development taking place. **The Trust Board noted the Chief Executive's Report**
BM/24/08/60	**CHAIR'S REPORT** SMcG provided a verbal update and noted the integration work that was taking place with Bridgewater Community Healthcare NHS Foundation Trust It was also noted that the Quality Showcase event that had taken place had been successful, however next year it was important that it be publicised more widely in order to increase awareness.

	The Trust Board noted the verbal update from the Chair.
BM/24/08/XX	**BOARD ASSURANCE FRAMEWORK (BAF)** JC introduced the report which provided the Board with an update on each of the strategic risks. The key highlights from the report, were as follows: • No new risks had been added; • The target ratings of four risks had been updated • There had been no changes to the descriptions of any of the risks • No risks had been closed or de-escalated; • There had been changes to the risk appetites of two of the risks JC advised that a Deep Dive in to all the BAF risks had now taken place in the appropriate monitoring Board Committees. The Board discussed how helpful the subsequent discussions in the committees had been, particularly in the use and understanding of risk appetite. **The Trust Board discussed and approved the changes and updates to the Board Assurance Framework**
BM/24/08/XX	**INTEGRATED PERFORMANCE REPORT** SC introduced the agenda item which provided a summary of the Trust performance, the report was taken as read. The Executive team presented a set of summary slides which covered the following areas within the IPR that were both failing and had special cause variation of a concerning nature. These were: **Quality:** • *Healthcare Acquired Infections (CDI) - **New*** • *VTE Assessment* **Access & Performance** • *Ambulance Handovers within 15 minutes - **New*** • *Uncapped Theatre Utilisation* There were 6 categories that had either improved in variation or assurance since last month: • **7.** Healthcare Acquired Infections (Klebsiella) • **22.** Mixed Sex Accommodation Breaches (ITU only) • **25.** Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hr of diagnosis • **34.** RTT – Number of patients waiting 65+ eeks • **39.** Cancer 14 Days

	• **74.** Cost Improvement Programme (recurrent forecast)
	
	Healthcare Acquired Infections
	
	• National and regional increase in CDI cases
	• WHH is a low outlier for cases in comparison to other NW NHS Trusts
	• Outbreak declared on ward B14 (5 linked cases – one CD PCR/toxin negative case) : Outbreak Control Team established
	• Antibiotic Stewardship is good • IPC Brilliant Basics Action Plan launched including a focus on environmental hygiene
	• C. difficile added as a priority for action by the C&M IPC collaborative (led by the ICB Place Team
	
	VTE Assessment
	• VTE assessment performance currently 94.2% (target >95%)
	• Performance recovered above lower centile limit
	• Recovery driven by VTE risk assessment of admitted patients in EAU and Reduction in delays to medical assessment in ED
	• Other actions
	  ○ Speciality level reporting has been shared with Care Groups
	  ○ Engagement with surgical teams RE use 91% of forms rather than notes in EPR
	
	Ambulance Handovers within 15 minutes
	The Trust continues to work with NWAS to support improving this metric and continues to be one of the best performing trusts in C&M.
	
	Uncapped Theatre Utilisation
	• An improvement trajectory for capped and uncapped Theatre utilisation remains one of the Trusts priorities and a sustained improvement has been seen from March 24
	• Key workstreams for improvement identified for July and August. Focusing on delayed starts on the Warrington sit
	
	The Trust Board noted the actions being taken in relation to the 4 identified failing IPR indicators.

QUALITY	
BM/24/08/64	**FRAGILE CLINICAL SERVICES UPDATE** PF introduced the report which provided assurance with regards to the Trust's oversight of Fragile Clinical Services. The following key highlights were taken from the report: The services currently designated as fragile were: • Stroke • Urology • Gynaecological surgery

	• Orthopaedics – Fractured Neck of Femur • ENT However, since the last report Theatres have entered the Fragile Services oversight, this was due to patient flow issues, specifically procedural safety and never events. The focus would be the safety culture within theatres and the need for a cultural shift in reporting and addressing safety concerns. It was acknowledged that safety culture in theatres is complex but crucial for ensuring patient safety and there had been evidence of improved reporting and individual accountability. It was agreed that this would be discussed as a possible Deep Dive at a future Quality Assurance Committee, in three months' time. SMcG emphasised the importance of a robust approach to behavioural issues stemming from cultural challenges, and it was noted that most issues were being addressed through one-to-one conversations and following a formal disciplinary route if required. **1. Urology** The backlog of P2 patients (related to stones and stends) had seen a reduction with initiatives to repatriate percutaneous procedures showing significant improvement, with only one patient being reported outside of the expected pathway. **2. ENT** In relation to ENT, there were still significant workforce challenges, however short to medium term mitigations were in place, including recruitment of additional staff with an ongoing review of staffing requirements. JS queried whether issues experienced in other trusts could be attributed to one specific service, and PF highlighted that ENT was a primary source. SC also noted that gynae was also experiencing its challenges as two cohorts of trusts were adopting new pathways, leading to difficulties across both gynae and ENT services regionally. **The Trust Board noted the current list of Fragile Services and associated high level progress updates**
BM/24/08/65	**MATERNITY & NEONATAL UPDATE** AK introduced the report and noted that an overarching report provided a summary of each paper included as appendices to the paper. It was noted that the reports were discussed in detail at Quality Assurance

	Committee Meetings, the following key areas from the appended reports were highlighted • PPH • Workforce metrics • Service user feedback • Cultural leadership work in maternity • Triage achieved best practice and NICE guidance • Staffing in triage was being reviewed • Induction of labour delays and a task and finish group had been set up • MIS Yr 5 – all actions closed and on track for Yr 6 submission in 2025 • Birth Trauma had seen a Deep Dive presentation at a recent QAC meeting • TC and ATAIN percentages had declined but had now started to improve • Ockenden was on track to achieve in all areas **The Board of Directors noted appended maternity reports as per national recommendations.**
BM/24/08/66	**COMPLIANCE Q4 UPDATE** AK introduced the report and noted the report had been presented to the Quality Assurance Committee on 24 May and the details were summarised as follows; • Maternity Update • Warrington Living Well Hub • Compliance Group & Mock Inspection Programme • Care Quality Commission (CQC) Engagement and Risk Meeting – January 2024 and April 2024 • Single Assessment Framework • Review of ToRs and membership AK advised that a CQC engagement visit had taken place on Tuesday 6 August, with a visit to ED. The agenda had been agreed between the Trust and the CQC, and the CQC had been assured by what had been viewed when visiting ED and that six patients were on the corridor. Discussions had taken place with the staff. The Trust had reiterated its no tolerance to corridor care. From 2024/25 Q1 this report will be extended to provide oversight of wider regulatory compliance and inspections e.g. Health and Safety, Health Technical Memorandums (HTMs). These will be noted within the report whist scrutiny will continue via the relevant sub committees.

	SC provided feedback on the new ways of working for the CQC and it was about stakeholder discussions on a regular basis, and that corridor care in ED had raised concerns with NHSE, but the Trust Board was managing the situation and doing everything possible even though it was not really tolerated. LG added that there had been a report produced in relation to the Living Well Hub and that there was learning around the process and the complexity of the implementation, so further work to be done with the CQC for a future process. **The Trust Board noted the Q4 compliance update**
BM/24/08/67	**MORTUARY UPDATE – RESPONSE TO FULLER REPORT** AK introduced the paper, taking it as read, noting the report had also previously been presented to the Quality Assurance Committee in July and it was a requirement that Trust Board have oversight of the report. The report included the list of recommendations and compliance. It was noted that it had been agreed that the Accountable Officer for this area, AK, would present to Trust Board, but those designated individuals for the service would present to the Quality Assurance Committee. **The Trust Board noted the update**
	PEOPLE
BM/24/08/68	**COMMUNICATONS & ENGAGEMENT DASHBOARD Q1** KH took the report as read and noted the key areas of work for noting during Q1; • Thank you Awards • Website redevelopment • Recruitment of Experts by Experience • Provided engagement support in the areas of PEP user feedback survey, redevelopment of WHH website, dementia and delirium steering group, pathology annual user survey, Children's Ward B11 equipment and Corporate Induction to include compassionate care • New chief executive announcement • Hospital Radio volunteer celebrating 50 years of service The next quarter would focus on the requirement for the Bridgewater integration work and a number of website and intranet projects. **The Trust Board noted the update**
BM/24/08/69	**GUARDIAN OF SAFEWORKING ANNUAL REPORT**

	PF presented the report and noted there had been a reduction in exception reporting, with only 5 reported, 2 of which were of a patient safety concern, so things were progressing in the right direction. **The Trust Board noted the annual report**
BM/24/08/70	**HEALTH INEQUALITIES** LG introduced the paper which provided an overview of the Trust's work on addressing health inequalities, examples of impact and next steps, ensuring that the Trust is continuing the commitment of addressing health inequalities. The paper also set out NHSE guidance for health inequalities which was included in the operational planning guidance and continues to include year on year what is expected of organisations and what they should be doing to address health inequalities. Included in the presentation was "there's always more to do" and next steps. DM explained there was possibly work to do in relation to health inequalities and DNAs, which was now starting to be included in data sets for performance review discussions. CR commented that would take time to understand as an acute trust of where we stand in the system as far as health and inequalities exist It was agreed that a separate session be organised to discuss in more detail. PF added that some of this work was already included as part prioritisation. **The Trust Board noted the update.**
	SUSTAINABILITY
BM/24/08/71	**EPRR REPORT** DM introduced the paper, noting the contents set out the work undertaken during 2023/24 and that changes to core assurances were included. The evidence was due to be submitted by 17 September, and an update on the outcome of the submission would be presented to Trust Board in October. **The Trust Board noted the EPRR report.**
BM/24/08/72	**STRATEGY PROGRAMME HIGHLIGHT REPORT** LG introduced the report which provided a progress update on key strategic projects and initiatives that underpin a number of WHH's strategic (QPS) priorities, these included; • Between mid-March and the end of June, there were 2,500 attendances at the Warrington Living Well Hub.

	• Over 41,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since phase 1 opened in May 2023. • Funding has been secured to implement a new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City). • The Patient Engagement Portal went live on the 12th of June 2024. • Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. Workstreams have been established with representatives from both organisations and delivery plans are being developed. Stakeholder communication is being developed • The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly **The Trust Board noted the programme updates.**
BM/24/08/73	**STRATEGY BI-ANNUAL DELIVERY REPORT** The report provided an update in relation to the strategic priorities within the 2023-25 Trust Strategy and noted that the Trust is on target to meet 37 priorities, 20 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 4 are behind expectations with limited or no mitigations. 1 priority is not yet rated. It had been agreed that progress on delivery of the strategy would be reported twice yearly with the measures of success/KPIs relating specifically to Quality, People and Sustainability aims being reported through the appropriate committees. **The Trust Board noted the report.**
GOVERNANCE	
BM/24/08/74	**TRUST ORGANOGRAMS** JC introduced the updated Trust Organograms for formal approval. There were no issues raised and Trust Board approved the organograms. **The Trust Board approved the updated Trust Organograms**

BM/24/08/75	**FIT AND PROPER PERSONS TEST – ANNUAL REPORT ON BOARD MEMBERS** JC introduced the annual report relating to the Fit and Proper Persons test for Trust Board members. New regulations had been put in place and the report had also been presented to Council of Governors and Audit Committee, with subsequent submission on 30 June after sign off by the Chair. **The Trust Board noted the report**
Supplementary Papers	
BM/24/08/76	Committee Chairs Annual Reports – Strategic People Committee & Finance & Sustainability Committee
BM/24/08/77	Director Infection Prevention &Control Annual Report
BM/24/08/78	Infection Prevention & Control Board Assurance
BM/24/08/79	Safeguarding Annual Report
BM/24/08/80	Safer Nurse Staffing Bi-Annual Report
BM/24/08/81	Quality Strategy Update
BM/24/08/82	Risk Management Strategy & Annual Report
BM/24/08/83	Health & Safety Report
BM/24/08/84	Complaints Annual Report
BM/24/08/85	Learning from Deaths
BM/24/08/86	Medicines Management Annual Report
BM/24/08/87	Controlled Drugs Annual Report
BM/24/08/88	Digital Strategy Group Update
BM/24/08/89	**Review of the Meeting** SMcG reflected on the meeting, noting the meeting had contained good discussion, specifically around the BAF risks at the start of the meeting. **The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items**
BM/24/08/90	**Any Other Business** No further business was raised. **Meeting ended at 12:45pm**
The Date and Time of the next Trust Board Meeting is Wednesday 2 October, Trust Conference Room, WHH	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE	BM/24/10/93ii	SUBJECT:	ACTION LOG	DATE OF MEETING	2 October 2024

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/08/70	7.8.24	Health Inequalities	A separate session to be organised to discuss in more detail	**LG**				

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/08/56	7.8.24	Engagement Story	PF to amend Medical Internal Professional Standards	**PF**	a.s.a.p.	20.08.24	Completed	

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/095**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	2 October 2024			
AUTHOR(S):	Dan Moore, Acting Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/24/10/95

1. BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 7 August 2024, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 5 - August 2024. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

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

2.2 Leadership Changes

Since the last Board meeting in August 2024, the organisation bid Simon Constable a final farewell at the end of the month and wished him luck in his new role as the Chief Executive of the University Hospital of North Midlands NHS Trust.

As previously reported by Simon, Nikhil Khashu has been appointed as his successor and he commences in post on 1 November 2024, on a two-year secondment from NHS England's Northwest regional team, where he has been Director of Finance since April 2022 and from NHS England where he has also held the role of Deputy Chief Finance Officer.

As agreed by the Nomination & Remuneration Committee following its meeting on 7 August 2024, interim arrangements have been put in place. I am now acting as the Chief as Executive until Nikhil commences on the 1 November.

Similarly, Zoe Harris, is the Acting Chief Operating Officer and Sharon Kilkenny is the Acting Director of Operations and Deputy Chief Operating Officer backfilling Zoe's role. The Associate Director of Unplanned Care role that Sharon substantively holds is being covered by different members of the Clinical Business Unit (CBU) team in Unplanned Care.

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

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

2.4 Integration planning with Bridgewater

Plans for closer integration with Bridgewater continue to be progressed. The executive teams meet face to face once a fortnight, alternating between the Warrington Hospital and the Bridgewater site at Spencer House in Birchwood. Both executive teams are overseeing the

delivery of the agreed 6, 12 and 18 month priorities across a number of work streams and identifying opportunities for efficiency savings in line with the operational plan.

Furthermore, earlier this month, both the Boards of each respective Trust met together for the first time.

The next steering group meeting with the ICB and key system stakeholders was rescheduled at the request of the ICB from the 18 September to the 9 October. An update on progress to date and a discussion on further opportunities and resourcing implications will be discussed.

2.5 Endoscopy Hub

Our new Endoscopy Hub officially started operating this week, welcoming our first patient on Monday the 9th of September. It will be a staged opening over 2 months and will become fully operational by the 1st of November.

The £5m facility, which has been developed as part of the wider Cheshire and Merseyside Endoscopy Transformation Programme, aims to increase the number of patients from across Cheshire and Merseyside that can be seen by providing a central hub for endoscopy services.

The hub, which has four new rooms, state of the art equipment and a five-bed recovery area, will provide additional capacity to enable quicker access to vital diagnostic, surveillance and screening procedures and improve patient experience.

The hub demonstrates our commitment to working as one system that delivers an endoscopy service without borders to reduce inequalities of access to services and make the best use of our resources, not only as a Trust but as a region. We know that collaborative working is key to improving health outcomes and ultimately providing the best patient care.

This project has been a truly multidisciplinary effort across our estates and facilities, Endoscopy, IT and the Cheshire and Merseyside Endoscopy Network and a number of external contractors.

The team received a lovely email from Karen Lloyd, Diagnostics Programme Manager, following the event.

"*You should be immensely proud of the work that has gone into this and the amazing teamwork and commitment that has been demonstrated by colleagues at Warrington and Halton. Your ambition and hard work is going to make a significant difference to thousands of families across Cheshire and Merseyside. We are enormously proud to be working with you as a partner of the Cheshire and Merseyside Endoscopy Network*."

2.6 Commencement of the building of a new Operating Theatre in the Nightingale Building at Halton.

Plans and contract for a new "Theatre 3" in the Nightingale Building at Halton have commenced. Theatre teams have vacated the space and Trust estates colleagues have worked on completing the preliminary works throughout the department in order to hand over to Kier, our construction partner, to commence construction.

This means the remaining theatres at the Halton site will be closed until the end of March 2025 when the work is set to complete. The impacted theatre sessions have all been accommodated during this time.

This new theatre is the final phase of a 2 year construction programme of work to increase the amount of elective operating facilities at the hospital to support restoration and recovery of waiting lists after the pandemic. This new facility will provide much needed capacity to reduce waiting times for our patients and potential opportunities for income growth through new activity and improving productivity and efficiency.

2.7 August Bank Holiday Preparedness, including the Cream field Festival

In the lead-up to the August bank holiday weekend we ran our Multi Agency Discharge Event (MaDE) to deliver a focused period of activity to reduce length of stay for our patients and improve patient safety and experience through increased morning discharges. MaDE for the August Bank Holiday ran from Monday 19 August through to Tuesday 27 August.

This helped the prepare for the long weekend operationally by unblocking delays in the system and ultimately freeing up beds and de-escalating wards in our hospitals with the intention of achieving the best position going into the bank holiday weekend, which also supported the Trust's preparedness for the Creamfields music festival held that weekend, that was pleasingly, for the most part, unimpactful on the hospital this year.

2.8 Supported Internship Programme for a second year.

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

I'm pleased to write that we have launched the second year of this programme in early September. This programme serves as a transition from education to employment by enabling the students to develop employability skills.

2.9 New Trust Website

Last week our new public-facing Trust website went live, following the launch of the new internal staff intranet (to replace the extranet) in mid-August.

This marks the completion of two large scale digital projects that our Communications and Engagement Team have been focusing efforts on over the last six months. As a digital first Trust this is another big step in enhancing people's experience and supporting the delivery of digital enabled personalised and efficient care.

The new website has been streamlined so it is easier for our patients and visitors to find the information they need in a timely manner, with an improved site navigation and search functionality. The website is now split into six clear sections for people to navigate.

The site has been developed in partnership with our Experts by Experience and tested by patients, governors, partners and staff, who have already shared some positive feedback.

"*The new site is easy to follow and sub-headings made it easy to find the information I need*" - Kathy McMullin, Community Outreach Lead, Healthwatch Halton

"*The menu is easy to follow, the headings are understandable and navigation through is simple*" - Norman Holding, Lead Governor, Warrington and Halton Hospitals

"*The new site looks to be a really positive piece of co-produced work*" - Amanda Hunt, Education and Disability Manager, Warrington Wolves Foundation

The new website also features a refreshed searchable service directory to support people when they are referred to or attending one of our hospital services and/or wards, which links to information on locations where services are provided.

The transformation work doesn't stop there though and there will be some further additions to the website over the coming months.

2.10 Special Days/Weeks for professional groups

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

- World Sepsis Day: 13 September
- Falls Prevention Week: 16 – 20 September
- International Week of Deaf People: 23 - 27 September
- National Inclusion Week: 23 - 27 September

2.11 Local political leadership engagement

Since starting in the role of Acting Chief Executive I've taken the opportunity to engage with local political leaders to maintain established relationships and make a professional connection. I have continued regular communication and updates with our local political and system leaders and have met the chief executive of Warrington Borough Council and have plans to meet the Chief Executive of Halton Borough Council. I have also been in communication with local Westminster MPs when they have raised issues on behalf of their constituents. All of our senior stakeholders are active participants and members of our New Hospitals Strategic Oversight Group, which I attended for the first time in my Acting role in September.

2.13 Employee Recognition

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

You Made A Difference Award (August 2024): Dr Natalie Ohlson-Turner and Mr Stephen Porter, Oral and Maxillo-Facial Surgery.

Simon recognised two members of staff. Drs Natalie Ohlson-Turner and Stephen Turner, and I would like to take this opportunity to bring to your attention their excellent work and also an example in my opinion of going 'above and beyond' what is generally expected of them in their roles.

They both deserve praise for teamwork and going the extra yard in the daily work, in particular Dr Natalie and her team and their great work and heartfelt gratitude for making an elderly proud lady pain free and happy again when she was in a dark place.

You Made A Difference Award (September 2024): Felicity Lewis

I was keen to recognise Felicity Lewis, a physiotherapist in our Rapid Response team, who went above and beyond in her role, showing overwhelming compassion and thoughtfulness for a patient on one of the wards whose funeral was taking place in Zimbabwe. The support, compassion and thoughtfulness that Felicity has given the patient and her family is a wonderful example of going above and beyond, demonstrating a number of our organisational values including working together, kindness and excellence.

Simon, before leaving, handed out a Chief Executive's Awards as follows:

Chief Executive's Award (August 2024): Community Respiratory, Rapid Response Team

Simon recognised the work that the community respiratory and rapid response team have been doing around Fuel Poverty and how it fits in nationally with health inequalities work. When the ICB funded the 4 ARI nurses, the team were asked if they would do some work around Fuel Poverty. All the practices in Warrington, using the CIPHA dashboard found their top patients in the highest area of deprivation and with COPD. They were all contacted and screened to have a conversation about financial planning.

These patients, obviously with their permission were referred to the Energy Agency who did the most amazing things. They got grants, fuel vouchers worth £49 each, some had the offer to be rehoused. They got slow cookers and blankets.

The team presented this work at a big learn and lunch meeting and the feedback was fabulous. It was chaired by the Medical Director of ICB, who was very kind in his praise.

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

Simon specifically and personally recognised the contribution of the following colleagues before he left:

- Yasmin Habib and team, Urgent and Emergency Care
- Julie Lyon, Surgical Specialties
- Kieran Beach, Estates and Facilities
- Nicola Loynd, Clinical Support Services
- Samantha Mercer, Clinical Operations
- Felicia Swift, Corporate Nursing
- Christine Trimble, Clinical Support Services
- Michelle Lucas & Dental nursing teams, Surgical Specialties
- Corinne Roe and Leonie Hardman, Women and Children's Health

I have, or intend to, specifically and personally recognise the contributions of the following colleagues:

- Amy Campbell, AMU
- Kayleigh Logston, AMU
- Tracy Delamere, Recruitment Officer - People Directorate
- Rachel Hanson, Recruitment Manager - People Directorate
- Amy Moreton, Living Well Hub Team
- Emma Whaley, Living Well Hub Team
- Kelly Adams, Living Well Hub Team

- Yvette Amibang, Ward K25/A10

2.14 Signed under Seal

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

3 MEETINGS ATTENDED

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

- 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)
- Steven Broomhead, Chief Executive, Warrington Borough Council
- Carl Marsh, ICB Place Director (Warrington)
- Anthony Leo, ICB Place Director (Halton)
- Warrington & Halton System Executive Oversight Group (Weekly)

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 5 (August 2024)
Appendix 2: CMAST Board Update (September 2024)

Appendix 1 - CEO Dashboard Month 5 – August 2024

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	80.35%	F
RTT 18 Weeks	92.00%	57.84%	F
RTT 65+ Weeks	0	1728	F
A&E % patients seen within 4 hours	> 75.00%	64.83%	F
A&E % waiting longer than 12 hours	< 2.00%	18.48%	F
Cancer 28 Day Faster Diagnostic Standard	75.00%	61.90%	?
Cancer 62 Day Wait	85.00%	77.70%	No SPC
Ambulance Handovers within 60 mins	100%	92.13%	F
Discharge Summaries 24 hours	95.00%	91.42%	F
Cancelled Operations – 28 days	0	0	?
Super Stranded Patients	Trajectory	120	No SPC
Uncapped Theatre Utilisation	85.00%	79.10%	F
Capped Theatre Utilisation	85.00%	74.40%	F

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	43	?
Sepsis Screening Emergency	90.00%	70.00%	F
Sepsis Screening Inpatients	90.00%	60.00%	F
Sepsis Antibiotics Emergency	90.00%	90.00%	F
Sepsis Antibiotics Inpatient	90.00%	88.00%	F
Inpatient Falls	20.00% reduction	35	?
VTE	95.49%	94.09%	?
Pressure Ulcers	10.00% reduction	18	?
Medication Reconciliation (24 hrs)	80.00%	40.00%	F
Complaints over 6 months	0	1	P
Healthcare Infections - MRSA	0	1YTD	P
Healthcare Infections - MSSA	N/A	16 YTD	No SPC
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	49 YTD	F
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	32 YTD	?
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	14 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	3 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	2.55%	F
MUST nutritional assessment completion	85%	68.63%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (£m)	-£2.80	-£2.79	No SPC
Capital Spend (£m)	£5.14	£3.96	?
Cash Balance (£m)	£2.26	£4.92	No SPC
Better Practice Payment Code (£m)	95%	84%	F
CIP In Year Delivered (£m)	£4.54	£4.54	?
CIP Forecast (Recurrent) (£m)	£4.54	£3.77	F
Agency Ceiling	Less than 3.7%	120%	P

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.65%	F
Retention	85.00%	87.12%	P
Core/Mandatory Training	85.00%	89.90%	P
PDR Compliance	85.00%	76.88%	F

Strategy

Living Well Hub: The Living Well Hub in Warrington has seen over 4,500 visitors attend since the doors opened in mid-March 2024. Around 60% of these attendances have been people "dropping in" to the hub to access a service, and the remainder have been for pre-booked appointments.

Community Diagnostics Hub: Almost 53,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023.

A new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is due to be implemented this autumn. Clinical posts are currently being advertised and the project team are engaging with primary and secondary care colleagues to develop the clinical pathway.

Integration: Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. Workstream teams are developing work plans to take forward all aspects of the programme and stakeholder communication is ongoing

Improvement: The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly.

CMAST Leadership Board
Update to Boards September

CMAST Leadership Board met on 6th September, including Trust Chairs, and discussed four substantive items as follows:

Ann Marr presented a summary of CMAST's Annual Plan, as she had presented to the ICB in July and which included highlights of a number of the main achievements for 23/24. Thereafter CMAST Programme Directors provided an outline of programme plans for 24/25, as well as updates on delivery progress year to date.

Claire Wilson, ICB Chief Finance Officer, provided an update on the system financial position, NHSE and partner scrutiny and the current areas of focus. Correspondence outlining initial recommendations from Simon Worthington, the NHSE partner placed with the ICB, had been circulated to CEOs recommending a number of measures to increase grip and control across organisations, highlighting the need for a rapid adjustment in trajectory and approach.

Tony Mayer, Director MHLDC Provider Collaborative updated on Virtual Wards, the variance in performance against planned occupancy rates was noted, as well as the increased challenge for Trusts with multiple community/Place partners.

A review of the CMAST Joint Working Agreement and committees in common terms of reference was presented to the Board with a request for review and support in commending this documentation to Trust Boards for adoption. The changes were summarised as mainly relating to updates to circumstantial commentary. The updated documentation will now be recommended to Trust Boards following CMAST Leadership Board support.

The above referred to documentation is supplied as part of this update.

Updates were also received on the following areas:

- System financial report
- System performance update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/97**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	2 October 2024			
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at the relevant Board Committees. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. **Since the last meeting:** • No new risks have been added. • There is a proposed change to the description of two risks; risk 1757 relating to Industrial Action and risk 224 regarding capacity constraints in ED.			

	• It is proposed that the scoring rating of risk 1757 is reduced to 9 from 20. No other risk scores have changed • It is proposed that risk 1757 is deescalated, no other risks have been deescalated. Key updates to existing risk; controls, assurances and gaps are detailed within section 2.6 of the report. Detailed individual BAF risks reports are included as **Appendix 1.**		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to discuss the updates to the Board Assurance Framework and approve: • the reduced rating, amended risk description and de-escalation of risk 1757 • the updated description of risk 224		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee	
	Agenda Ref.	Multiple	
	Date of meeting	Multiple	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/24/10/97

1. BACKGROUND/CONTEXT

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

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

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New Risks

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

2.2 Amendment to Risk Ratings

Since the last meeting, the Executive Team have reviewed the rating of Risk 1757 due to the improved position in relation to industrial action. Several pay disputes have been resolved nationally including the resolution of the junior doctors dispute. This significantly reduces the risk.

Risk #1757

As a result of the resolution of the pay disputes it is proposed to reduce the current risk rating from **20** (Likelihood 5 x Consequence 4) to **9** (Likelihood 3 x Consequence 3) to reflect the improved position. As at 16/09/24 the Trust does not have any operational and live strike mandates for any staff groups within the Trust or across the NHS (except for the GP collective action).

2.3 Amendments to descriptions

Further to the proposal referenced in section 2.2 and the ongoing risk around GP collective action. It is proposed that the description of risk 1757 is amended:

From:

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

To:

If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.

The second amendment being proposed is to risk 224 to include the result should the risk continue.

From:

If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival.

To:

If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.

2.4 De-escalation of Risks

Further to the proposed updates in sections 2.2 and 2.3 and taking into account that the remaining risk relates to the operational impact of the GP collective action, which is the only remaining assurance gap; it is its proposed that risk 1757 is deescalated to the Corporate Risk Register for monitoring and ownership is moved from the Executive Medical Director and Chief People Officer to the Executive Medical Director only, with operational ownership from the Trusts Emergency Preparedness, Resilience and Response lead.

ID	Updated Risk Description	Previous rating	Revised rating	Executive Lead
1757	If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.	20 (5Lx4C)	9 (3Lx3C)	Executive Medical Director

2.5 Risk Appetite

Since the last meeting no risk appetites have been amended.

2.6 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	**Current:** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely,	**Controls** • Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational 7 days per week. • Relaunch of the deflection policy for minor injury patients overnight, where appropriate. Historical controls and assurances have been removed	**20 (L5xC4)**	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival. **Proposed:** *If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.*			
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.	**Controls:** • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reservice programme of work. • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • Ongoing validation of the trust waiting lists to improve data quality **Assurances** • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • CDC phase 3 including CT & MRI due to open in spring 2025 • The Trust Board supported £4.6m for third party providers to treat all 78 & 65 waiters by the end of September 2024 & significantly reduce 52 week waiters. Monthly reporting to the Finance and Sustainability Committee. **Controls & Assurance Gaps** Workforce capacity challenges in the medical workforce	**20 (L5xC4)**	none ⟷
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;	**Controls** • CEO led improvement meeting (inc finance & improvement) now take place three times per month • NHSE have approved (March 2024) Cash support Q4 2023/24 c£7m and Q1 £3m, Q2 £10.4m 2024/25 requested, Q3 15m requested – Enhanced controls	**20 (L5x4C)**	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	and impact the ability to provide local services for the residents of Warrington & Halton	regarding pay and non-pay expenditure must be adhered to and are part of the controls outlined above. • Daily huddle at 4pm to manage any financial issues • Daily review of Nurse variable pay • Weekly review of medic variable pay • PWC action tracker in place – monitored through Execs **Assurances** • The 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Unqualified audit opinion (2023/24) submitted on time • Submitted revised risk adjusted forecast with £4.7m variance from the control total, following development of mitigation plans throughout August 2024 **Control Assurance Gaps:** Bank expenditure 12.5% of total pay bill YTD		
1757	**Current:** *If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services* **Proposed:** If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.	**Controls** • Band 2-3 re-banding resolution framework update as at 31/07/24: - Formal agreement at JNCC on 11 July 2024 for end date for claims to be 30 September 2024. - Audits and targeted support to be given in areas where less claims have been received. - Joint Management and Staff Side Communications drafted and awaiting approval to communicate claims end date. • CPO leading a regional Workforce Collaborative Delivery Group which has been developed to support greater collaboration across C&M Trusts related to national, regional, system and place-based workforce challenges, in order to mitigate risks associated with local responses to system / national issues and affect a C&M response. **Assurance** • The Government has offered junior doctors in England a 22.3% pay rise to end strike action. The British Medical Association's (BMA) Junior Doctors Committee has agreed to put the offer to its members dates to be confirmed as at 12/08/24. The pay rise offer will take place over two years: ○ It constitutes a pay rise of between 8.1% and 10.3%, as well as a backdated 4.05% increase for 2023-24. ○ That is on top of a 6% pay rise for 2024-2025, topped up by a £1,000 payment - an equivalent to a pay rise of between 7% and 9%. • Band 2-3 re-banding resolution framework update as at 31/07/24: ○ Panel update: ▪ 526 Back-Pay Claims Received ▪ 351 Approved ▪ 162 claims pushed back due to insufficient evidence ▪ 5 on-hold –3 due to small queries and 2 pending AFC Panel ▪ 1 claim rejected following AFC Panel ▪ 7 outstanding awaiting for next approval panel ○ Financial Update: ▪ 301 Individual Processed Claims ▪ 26 Individuals in negative arrears ▪ 51 received payment in June ▪ Payments range from £12.29 - £11559.16 ▪ Total Cost for July £153,497.55	From **20 (5Lx4C)**	Propose to Reduce rating, To **9 (3Lx3C)** Updated description and De-escalation of risk

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		▪ Total Cost so far (March-July) £1,091,927.49* (*These figures do not include employer national insurance (13.8%) and employer pension contributions (14.38%) • 2024 Pay Awards - AfC and Medical and Dental including 'Resident Doctor' Offer - NHS Employers 2024 pay award detail • Junior doctor referendum on pay offer closes 15/09/24 • Junior doctor referendum pay offer accepted by the junior doctors on 16/09/24. **Gaps** • GP Collective Action From 1st August 2024 ○ 8,500 GPs in England took part in the ballot and 98.3% voted in favour of taking part in one or more examples of collective action. ○ This means from 1st August, the Association will encourage practices to choose from a list of ten actions, and practices can choose to implement as few or as many as they think appropriate. (link here for full list of 10 actions) ○ Actions may include refusing to share patient data unless it's in the best interests of a patient, referring patients directly to specialist care rather than following longer and more complex NHS processes, and switching off NHS software which tries to cut prescribing costs. ○ GPC England is not recommending which action(s) practices take. It is for each practice to pick and choose as they see fit. Trust EPRR lead linking in with ICB to provide any information requests.		
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.	**Controls** • NHSP Request Review Meetings chaired by Chief Nurse or Deputy Chief Nurse 3 times a week • Monthly Cost Pressure Clinics in place reviewing sickness management/recruitment/skill mix/supernumerary status/maternity leave cover plans **Assurance** • Increase in registered nursing establishment in the Emergency Department, January 2024 – reducing band 5 vacancy rate to 36.8 WTE from 46.84 WTE in May 2024 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.88 % in July 2024 • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.35% in July 2024 • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. 35 students recruited in Summer 2024 who will commence in post in Q3 • Cost avoidance of £1.9369,084 m from agency managed service contract started August 2022 • Golden key initiative has reduced agency spend by £547,524 since April 2024 • The number of wards achieving 90% fill rate increased to 21 wards in July 2024 **Gaps** • 9% increase in the number of Red Flags reported in July compared to June 2024- 130 red flags were linked to difficulties in providing enhanced care Between June – July 2024 over 1200 patients were admitted to WHH with a mental health condition	**16 (L4xC4)**	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	**Controls** • [DSPT Standard(s): 8.1.4 & 8.4.2] MUSE migrated to new server **Gaps in Assurances** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24). • 24/25 DSPT has been aligned to the new Cyber Assurance Framework. No Trust is expected to be compliant until 2030.	**16 (L4xC4)**	none ⟷
1898	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	**Controls** • WHH not included in Phase 3. Programme now termed New Hospital Programme (NHOP) under review by new government. **Assurances:** Endoscopy Hub – opened September 2024	**16 (L4xC4)**	none ⟷
125	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	**Assurance** • Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension and the roof has now been replaced. • Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been supported and phase 2 is due for completion October 2024 • Funding identified in the 2024/25 Capital Plan to Support refurbishment of another patient lift on the Warrington Site to improve operational efficiency to commence in november 2024. **Gaps** Delays in approvals of PO resulting in risk to compliance and delivery of standards	**15 (L3xC5)**	none ⟷

5 RECOMMENDATIONS

The Trust Board is asked to discuss the updates to the Board Assurance Framework and approve:

- the reduced rating, amended risk description and de-escalation of risk 1757
- the updated description of risk 224

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival.	1	20 (L5xC4)	8 (L2xC4)	Open	Quality Assurance Committee
1215	COO	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (L4xC5)	6 (L3xC2)	Open	Quality Assurance Committee
134	CFO	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (L5xC4)	12 (L4xC3)	Open	Finance & Sustainability Committee
1757	CFO and EMD	If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.	1	20 (L5xC4)	8 (L4xC2)	Cautious	Strategic People Committee
2001	EMD	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (L4xC4)	8 (L2xC4)	Minimal	Quality Assurance Committee
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (L4xC4)	5 (1x5)	Minimal	Finance & Sustainability Committee
1372	EMD	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	3	16 (L4xC4)	8 (L2xC4)	Cautious	Finance & Sustainability Committee

		return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety					
1898	CSPO	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	3	16 (L4xC4)	9 (3x3)	Seek	Finance & Sustainability Committee
125	COO	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	1	15 (L3xC5)	10 (L2xC5)	Open	Executive Management Team
145	CSPO	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (L3xC4)	8 (L4xC2)	Open	Executive Management Team
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Open	Strategic People Committee

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

Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Finance Officer (CFO), Chief People Officer (CPO), Executive Medical Director (EMD), Chief Nurse (CN), Chief Strategy and Partnerships Officer (CSPO)

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

People

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

Financial and Operational Sustainability

We aim to be a highly productive organisation that consistently delivers on all our constitutional performance standards whilst demonstrating public value for money with integrity and probity. We aim to continuously

improve and innovate in the best interests of our patients, staff and communities. We are therefore open to seek out risk through innovative approaches, subject to appropriate procedures and controls.

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

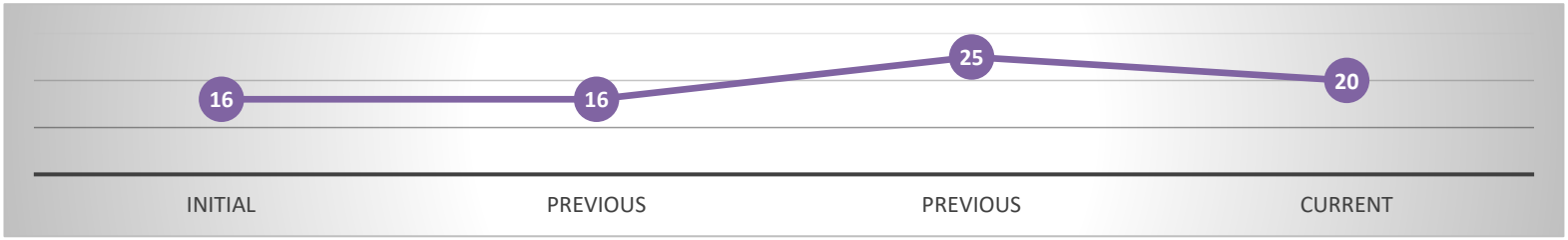
Risk appetite definitions for levels of risk appetite are set out in table 1, below.

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

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	224	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival			**Initial**	16(L4xC4)
				Current	20(L5xC4)
				Target	8 (L2 xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					

Assurance Details

Controls

- Regular Trust Wide Capacity meetings led by the Tactical Manager for the day
- Discharge Lounge/Patient Flow Team/Silver Command
- ED Escalation processes/intentional rounding with ED Consultant and Nurse in charge.
- Private Ambulance Transport to complement patient providers in and out of hours
- Frailty Assessment Unit FAU/ operational 5 days per week.
- Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational 7 days per week.
- Relaunch of the deflection policy for minor injury patients overnight, where appropriate.
- Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance.
- Co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Became operational April 24.
- Increase IMC provided by the system such as the opening of the additional bedded capacity
- Increase IMC at home
- Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.
- Same Day Emergency Care Centre (SDEC) completed July 2022.
- Co-located and upgraded Minor Injuries nit.
- Meetings with senior leaders from the ICB and Local Authority to review and discharge taking place weekly.
- Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings
- Additional Senior Manager on call support a weekends
- Senior Dr at Triage Function
- CT scanner co-located in the main body of the ED department in 2023.
- Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.
- Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter
- Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E
- Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board
- On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy.
- Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience
- Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2024/25 to support flow and urgent care

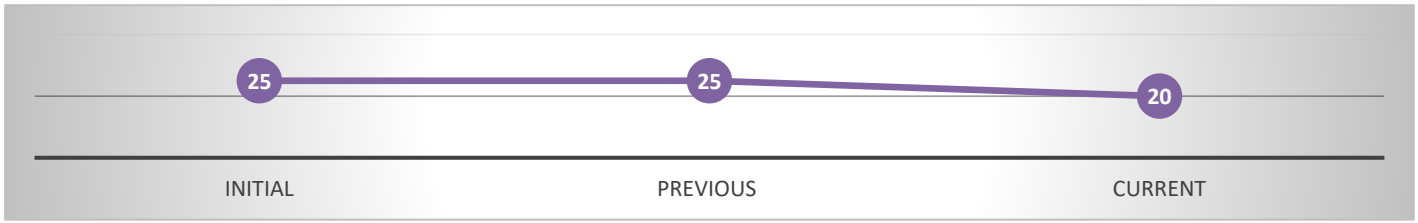
	• The Performance Improvement & Oversight Group has been established in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group • The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee **Assurances** • System actions agreed supporting the Winter Plan • Redeveloped ED 'at a glance' dashboard • Trust implemented NHS 111 allowing for directly bookable ED appointments • Integrated discharge Team in place • Respiratory Ambulatory Care Facility agreed. • Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved • Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 • Same Day Emergency Care Centre (SDEC) opened July 2022 • Plans to reduce length of stay for criteria to reside patients using SAFER methodology. • Following closure of the Lilycross facility at the end of May 2023, additional capacity has opened in Statham Manor, Grapenhall Manor and Oak Meadow. This replacement capacity is open and operational. • As a result of national urgent care tiering (Warrington placed in Tier 1), the Trust continue working with ECIST to support a service improvement programme. • Continuous flow commenced on 8th October 2023. • Triage and streaming test of change commenced in November 2023 to improve productivity and utilisation of assessment areas to support lowering ED occupancy. • Transition to type 5 SDEC reporting went live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. • Reconfiguration of the ED footprint took place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12 hour time in department as referenced in the Tier 1 urgent care metrics. • As part of being in tier 1 urgent care, the Trust and wider system were supported by Newton to undertake a place diagnostic on capacity and demand. The outcome has instigated a project to help improve flow, reduce attendances and thus lower bed occupancy. • Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds in to the ICB Urgent Care programme of work. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. • Updated nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor
Assurance Gaps	**Gaps in Controls** • Ongoing industrial action across a number of staffing groups including junior medical staff. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Tactical Command and SMOC (out of hours) and Executive on Call.	Bowman, Karen	31/03/2025 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG and monthly Unplanned Care Performance Meetings.	Bowman, Karen	31/03/2025 (ongoing)	

Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

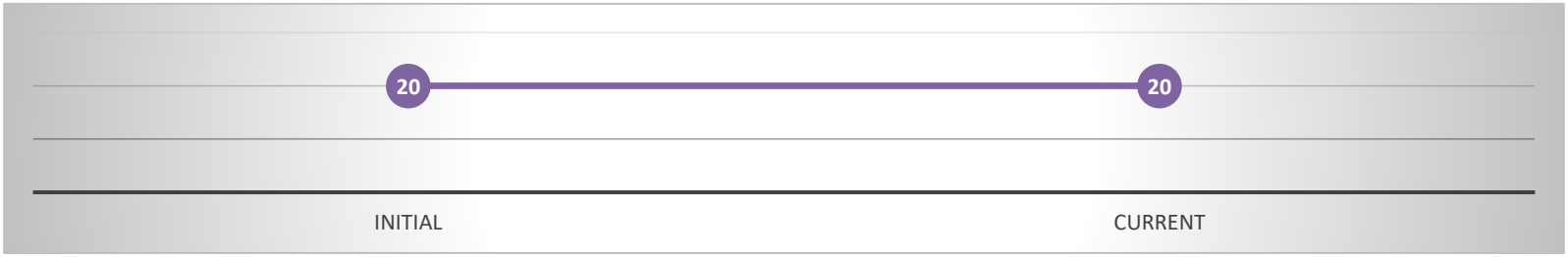
Risk ID	1215	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial**	25 (L5xC5)
				Current	20 (L4xC5)
				Target	6 (L3xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls**. • 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. • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reservice programme of work. • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers • . • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside Productive Partners • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 65weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends. • Continued use of Insourcing and outsourcing providers(NHS approved contractors) in 2024/2025 to support 78-week target. Following approval by Execs. • Ongoing validation of the trust waiting lists to improve data quality **Assurances** • All elective patients have been clinically reviewed and categorised in line with national guidance. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021				

	• New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems.. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • The Trust has been confirmed as the regional diagnostic hub to support the reduction of local and system waiting lists. • New CT and MR scanner replacement to be undertaken in 2023/24 • CDC phase 1 gone live in July 2023. CDC phase 3 including CT & MRI due to open in spring 2025 • Trust Board support for additional use of independent sector to treat all outpatients in 65 week wait cohort. The Trust Board supported £4.6m for third party providers to treat all 78 & 65 waiters by the end of September 2024 & significantly reduce 52 week waiters. Monthly reporting to the Finance and Sustainability Committee. • Regional funding secured to support reduction in the echocardiogram waiting list. This is with third party providers and commenced on 1st November 2023.
Controls & Assurance Gaps	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint on the Warrington site. • Workforce capacity challenges in the medical workforce

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	134	**Executive Lead:**	Chief Finance Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			**Initial:**	20 (L5xC4)
				Current:	20 (L5xC4)
				Target:	12 (L4xC3)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** •Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning • CEO led improvement meeting (inc finance & improvement) now take place three times per month • Procurement/tender waiver training in place • TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years) • Latest guidance from MIAA Counter Fraud Team circulated • Counter Fraud campaign took place for national anti-fraud week in November 2023 • Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced. • Appointed GIRFT Finance Lead and 5 PAs allocated. • Appointed Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5 year plan presented to the Finance & Sustainability Committee in April 2024 • CDC phase 1 & 2 complete. Phase 3 to be completed by 31st March 2025 • Capital Plans for 2024/25 approved by the Trust Board in March 2024. • Revenue plans 2024/25 approved by the Trust Board in June 2024 • Introduced system of escalation where there are risks to CIP delivery • 2023/24 position was in line with original plans and with the reported likely forecast throughout the year • New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified. • In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee • Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023 • Tightening controls of non-pay expenditure with executive review of catalogue spend and implemented cease option to purchase some items				

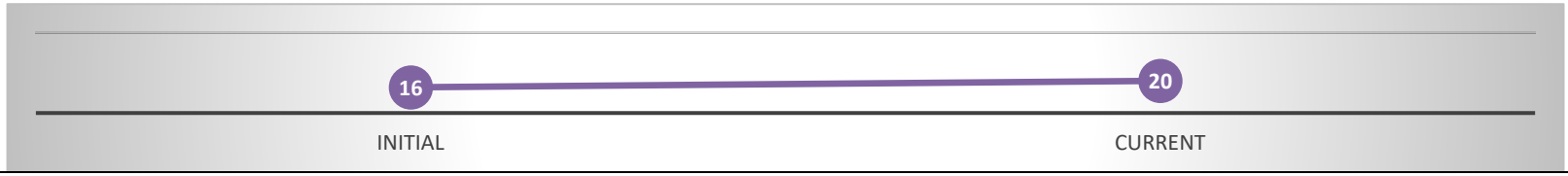
	• NHSE have approved (March 2024) Cash support Q4 2023/24 c£7m and Q1 £3m, Q2 £10.4m 2024/25 requested, Q3 15m requested – Enhanced controls regarding pay and non-pay expenditure must be adhered to and are part of the controls outlined above. • Enhanced ECF meetings in place with Chief Executive sign off, with ICS attendance. Bridgewater Community Healthcare NHS FT invited to attend. • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible • Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 & 52 Week recovery. • Daily huddle at 4pm to manage any financial issues • Daily review of Nurse variable pay • Weekly review of medic variable pay • PWC action tracker in place – monitored through Execs **Assurances** • Achieved ICS control total in 2022/23 • The 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 Capital Plan • Unqualified audit opinion (2023/24) submitted on time • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge is to keep agency to below the 3.2% ceiling and reduce bank. Month 4 agency is 1.4% • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We have allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • Final 2024/25 Operational Plan has been submitted in June 2024 • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements • Submitted revised risk adjusted forecast with £4.7m variance from the control total, following development of mitigation plans throughout August 2024
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high risk schemes, presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Additional capacity remained open in quarter 1 closed in June 2024. • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Industrial action uses management capacity to plan for safety which places CIP/GIRFT improvement programme at high risk as capacity/focus is diverted

	• Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP • Bank expenditure 12.5% of total pay bill YTD

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	1757	**Executive Lead**	Chief People Officer and Executive Medical Director	**Rating**	
Strategic Objective	**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, engaged workforce that is fit for the future.				
Risk Description	If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.			**Initial**	16 (L4 xC4)
				Current	20 (L5 xC4)
				Target	8 (L4 xC2)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					

Control & Assurance Details:	**Controls**
	• Trust policies updated in relation to industrial action
	• Trust approach to industrial action established following implementation of IA Task and Finish group.
	• Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible.
	• Executive led IA Operational Task and Finish group in place for each period of IA with an Executive led check and challenge session to ensure strike rosters support safe staffing.
	• IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH.
	• Participation in ICB IA Clinical Cell calls where applicable.
	• Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA.
	• IA Task and Finish group completed organisational preparedness for industrial action policies and procedures ratified and FAQ documents created and published and updated regularly.
	• Executive Medical Director led check and challenge meetings for periods of industrial action to prepare and mitigate risk.
	• Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.
	• Following national guidance available for Consultant IA
	• Recruiting Junior Doctors to WHH bank following legal challenge meaning collaborative bank cannot be utilised during IA.
	• Trust proposal for split pot LCEA's with eligibility criteria to go to Board 07/02/24 which is the reflective approach of the proposed pay deal.
	• Regular briefing sessions held in person and virtually for senior leaders and staff r.e. outcome of Band 2 HCA Acas collective conciliation agreement and subsequent process required to implement the agreement.
	• Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.
	• Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, Practice Educator Facilitator and a member of the HR Business Partnering team.
	• Band 2-3 re-banding resolution framework update as at 31/07/24:
	  ○ Formal agreement at JNCC on 11 July 2024 for end date for claims to be 30 September 2024.
	  ○ Audits and targeted support to be given in areas where less claims have been received.
	  ○ Joint Management and Staff Side Communications drafted and awaiting approval to communicate claims end date.
	• CPO leading a regional Workforce Collaborative Delivery Group which has been developed to support greater collaboration across C&M Trusts related to national, regional, system and place-based workforce challenges, in order to mitigate risks associated with local responses to system / national issues and affect a C&M response.				

	Assurance
	• Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
	• BMA have published letter 13/07/23 r.e. the process for requesting derogations. No derogations been required thus far.
	• Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of industrial action
	• Long term NHS Workforce plan published 30/06/23 to address gaps in workforce.
	• NHS England letter 03/10/23 to BMA welcoming pause to any further industrial action dates reiterating concerns formally re Christmas Day cover and patient safety concerns.
	• B2 HCA IA stood down following successful Acas collective conciliation agreement.
	• BMA SAS doctors mandate for industrial action on hold whilst a ballot is underway on a government pay offer dates of the ballot to be confirmed by the BMA.
	• On 5th April 2024 following weeks of voting the consultants committee accepted the latest Government offer on pay for consultants in England. 83% of eligible BMA consultant members voted 83% with a (62% turnout). The effective date for the new pay structure will be 1 March 2024.
	• Mandate met for Junior Doctors Industrial Action
	• The Government has offered junior doctors in England a 22.3% pay rise to end strike action. The British Medical Association's (BMA) Junior Doctors Committee has agreed to put the offer to its members dates to be confirmed as at 12/08/24. The pay rise offer will take place over two years:
	  ○ It constitutes a pay rise of between 8.1% and 10.3%, as well as a backdated 4.05% increase for 2023-24.
	  ○ That is on top of a 6% payrise for 2024-2025, topped up by a £1,000 payment - an equivalent to a pay rise of between 7% and 9%.
	• Band 2-3 re-banding resolution framework update as at 31/07/24:
	  ○ Panel update:
	  ▪ 526 Back-Pay Claims Received
	  ▪ 351 Approved
	  ▪ 162 claims pushed back due to insufficient evidence
	  ▪ 5 on-hold –3 due to small queries and 2 pending AFC Panel
	  ▪ 1 claim rejected following AFC Panel
	  ▪ 7 outstanding awaiting for next approval panel
	  ○ Financial Update:
	  ▪ 301 Individual Processed Claims
	  ▪ 26 Individuals in negative arrears
	  ▪ 51 received payment in June
	  ▪ Payments range from £12.29 - £11559.16
	  ▪ Total Cost for July £153,497.55
	  ▪ Total Cost so far (March-July) £1,091,927.49*
	  (*These figures do not include employer national insurance (13.8%) and employer pension contributions (14.38%)
	• 2024 Pay Awards - AfC and Medical and Dental including 'Resident Doctor' Offer - NHS Employers 2024 pay award detail
	• Junior doctor referendum on pay offer closes 15/09/24
	• Junior doctor referendum pay offer accepted by the junior doctors on 16/09/24.

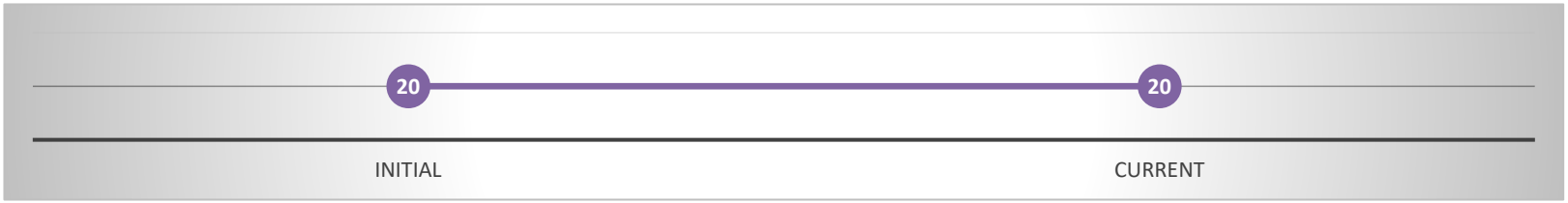
Assurance Gaps:	• Medical IA is based on nationally negotiated Terms and Conditions which are outside of the influence and control of the Trust. • Lack of clarity from the ICB regarding mutual aid • Lack of MOU from ICB • Lack of clarity from BMA process for requesting derogations • No further updates on national position regarding talks with Trade Unions, specifically the BMA for Junior Doctors • BMA derogations process means unlikely to get derogations signed off for critical services. • High court ruling on 13/07/23 that employers can no longer use agency staff to fill in for striking workers for industrial action from 10/08/23. Also, Collaborative banks cannot be utilised. • Previous increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extra contractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. This is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics • GP Collective Action From 1st August 2024

	○ 8,500 GPs in England took part in the ballot and 98.3% voted in favour of taking part in one or more examples of collective action. ○ This means from 1st August, the Association will encourage practices to choose from a list of ten actions, and practices can choose to implement as few or as many as they think appropriate. (link here for full list of 10 actions) ○ Actions may include refusing to share patient data unless it's in the best interests of a patient, referring patients directly to specialist care rather than following longer and more complex NHS processes, and switching off NHS software which tries to cut prescribing costs. ○ GPC England is not recommending which action(s) practices take. It is for each practice to pick and choose as they see fit. Trust EPRR lead linking in with ICB to provide any information requests.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Check and challenge meetings to commence for Junior Doctor Industrial Action	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Fitzsimmons, Paul	Ongoing New Jr Dr IA Dates; 7am 27th June to 7am on 2nd July 2024	02/07/24
Participate in regional ICB Workforce Industrial Action preparedness group	Participate in regional ICB Workforce Industrial Action preparedness group	Attending and participating in regional ICB Workforce Industrial Action preparedness group	Hilton, Laura	Ongoing whilst national disputes continue	02/07/24
Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Laura Hilton	30/09/24	17/09/24
Consistency panel meetings established to review and consider Band 2 HCA banding review claims.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Ali Kennah	31/10/24	17/09/24
Weekly Industrial Action Update to Execs	Execs to receive weekly updates re IA to ensure senior oversight and support organisational risk management	Execs to receive weekly updates re IA	Laura Hilton	03/03/25	17/09/24
Trust EPRR lead linking in with ICB to provide any information requests.	Trust EPRR lead linking in with ICB to provide any information requests.	Trust EPRR lead linking in with ICB to provide any information requests.	Rachel Clint	27/02/2025	
Band 2-3 re-banding resolution framework updates to OPC.	Update to re Band 2-3 re-banding resolution framework progress to be presented at committee.	Update on Band 2-3 re-banding resolution framework to be provided and presented at the committee meeting.	Laura Hilton	31/12/24	17/09/24
Band 2-3 re-banding resolution framework updates to JNCC.	Update to re Band 2-3 re-banding resolution framework progress to be presented at committee.	Update on Band 2-3 re-banding resolution framework to be provided and presented at the committee meeting.	Laura Hilton	31/12/24	17/09/24
Band 2-3 re-banding resolution framework updates to OPC	Update to re Band 2-3 re-banding resolution framework progress to be presented at committee.	Update on Band 2-3 re-banding resolution framework to be provided and presented at the committee meeting.	Laura Hilton	31/12/24	17/09/24
Participation in regional Workforce Collaborative Delivery Group	CPO to lead the regional Workforce Collaborative Delivery Group	CPO to lead the regional Workforce Collaborative Delivery Group	Michelle Cloney	31/06/25	17/09/24

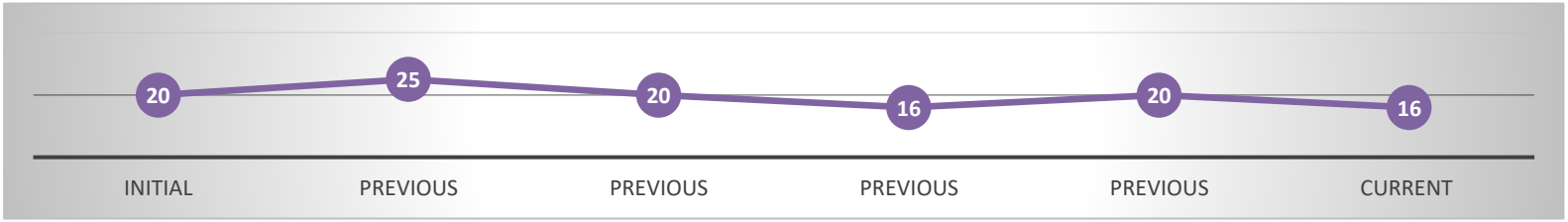
Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID	115	**Executive Lead**	Chief Nurse	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial**	20 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					

Assurance Details:

Controls

- 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG)
- Weekly E-Rostering KPI sign off meetings in place.
- NHSP Request Review Meetings chaired by Chief Nurse or Deputy Chief Nurse 3 times a week
- Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity.
- Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels.
- Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service
- Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making.
- Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust.
- Agency reduction plan in place
- Local workforce plans in place for Emergency Department and Maternity with additional support from Executive Team
- Local recruitment in place targeting ED and Endoscopy who have had recent investment / establishment increases.
- Open advert for RN / HCSW recruitment
- Quarterly recruitment events in place
- Sickness absence being manged in line with Trust policy.
- Monthly Cost Pressure Clinics in place reviewing sickness management/recruitment/skill mix/supernumery status/maternity leave cover plans

Assurances

- Increase in registered nursing establishment in the Emergency Department, January 2024 – reducing band 5 vacancy rate to 36.8 WTE from 46.84 WTE in May 2024
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.88 % in July 2024
- Overall CHPPD sustained improvement at national standard of 8.1 in Q1
- Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.35% in July 2024
- Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy,
- Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. 35 students recruited in Summer 2024 who will commence in post in Q3
- Cost avoidance of £1.9369,084 m from agency managed service contract started August 2022

Board Assurance Framework

	• Golden key initiative has reduced agency spend by £547,524 since April 2024 • International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus. When was final cohort • Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead • Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly. • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends • Rolling recruitment for RN and HCA posts, weekly interviews • Leaver data is closely monitored, and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner. • Internal Transfer process in place for staff to support retention • A7, A8 and A9 uplift in healthcare support workers for night shifts approved to support provision of enhanced care. • Nurse Staffing and Clinical Outcomes Group provides a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk. • Increased cohort of Care Support worker Development Programme (CSWDs) for 2024 • The number of wards achieving 90% fill rate increased to 21 wards in July 2024 from 17 in December 2023.
Assurance Gaps	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – Beds were opened in escalation areas 74 times in July 2024 • Increased request to provide enhanced care. • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients. • Continued escalation during winter of ward A10 and intermittent escalation of Cardiac Catheter Lab • Partially funded revenue requests • Time to post when recruiting new staff. • 9% increase in the number of Red Flags reported in July compared to June 2024- 130 red flags were linked to difficulties in providing enhanced care • Between June – July 2024 over 1200 patients were admitted to WHH with a mental health condition

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

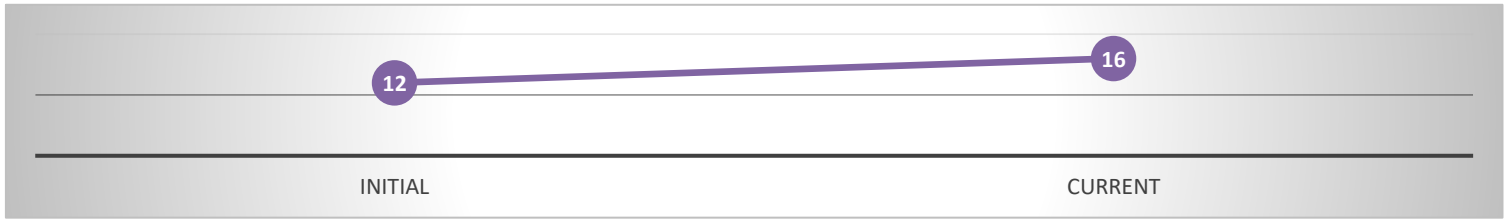
Risk ID	1114	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			**Initial**	20 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	**Assurance:** • [DSPT Standard(s): 1.3.5] & 1.3.6] Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • [DSPT Standard(s): 1.3.5] & 1.3.6] Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • [DSPT Standard(s): 9.4.5] Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • [DSPT Standard(s): 7.1.4] Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) • Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness. **Controls:** • [DSPT Standard(s): 1.3.5, 7.1.2. 7.1.3, 7.2.1, 7.2.2 & 7.3.2] **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • [DSPT Standard(s): 9.5.1] **Digital Change Management** regime including including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • External NHS England approved Cyber Training for the Trust Exec Board • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • [DSPT Standard(s): 7.3.4] Secondary secure backup at Halton Data Centre				

	• [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy • New Phishing exercise by NHS England has been arranged for 24/25 • [DSPT Standard(s): 8.4.1, 9.6.6] Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • [DSPT Standard(s): 4.5.3] MFA active on new starters for NHSMail • [DSPT Standard(s): 8.1.4 & 8.4.2] MUSE migrated to new server
Assurance Gaps	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24). • 24/25 DSPT has been aligned to the new Cyber Assurance Framework. No Trust is expected to be compliant until 2030. **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • [DSPT Standard(s): 4.2.3 & 4.4.1] No dedicated logging tool to pull all key logs together and provide useable alerts. • [DSPT Standard(s): 8.3.6] Lack of process to check antivirus/MDE alerts in console. MIAA to review processes and tools • [DSPT Standard(s): 4.4.2] Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • [DSPT Standard(s): 8.1.4 & 8.4.2] Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • [DSPT Standard(s): 8.1.2] Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • [DSPT Standard(s): 4.5.3] MFA on limited number of systems • [DSPT Standard(s): 8.3.4] Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • [DSPT Standard(s): 8.1.4] Version 7 of Clinisys Ice is end of life • [DSPT Standard(s): 9.3.8] Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • [DSPT Standard(s): 4.1.2] No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • [DSPT Standard(s): 7.3.4 & 7.3.5] Backup storage being end of life and out of support • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported	Migrate all 2003 and 2008 servers to 2016.	Clinical Audit Manager has confirmed the full migration of their clinical documents. Head of Employment Services has asked for an extension regarding some HR elements of the ECF process needs migration. It was agreed at Digital SLT to extend the shutdown of the Hub servers until the end of July 24. *** The SIRO has agreed to extend the switch off of the 2008 servers due to continuing work of migrating data.	Deacon, Stephen	31/10/24	

Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).		Draft communications are ready to be sent out announcing the shutdown to the HUB. This will be sent out by the Senior Information Risk Officer (SIRO)			
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommission Server 2012 servers	Update to the 2012 EOL project: Endoscopy Server Not on schedule due to the need to merging of patient records is required to migrate the last of the records. CBU speaking to HD Clinical, as if anything goes wrong merging the patient records would cause a clinical risk. Digital Analytics and CBU to migrate the remaining patient records from the old server to the new, before HD Clinical complete the migration.	Waterfield, Tracie	31/10/24	
Multifactor authorisation (MFA) review of Trust critical systems	Multifactor authorisation (MFA) review of Trust critical systems as data has shown that majority of cyber attacks can be prevented within 20 minutes of the initial attack starting with MFA compared to organisations who don't use MFA.	Create a document that details the Trust's critical systems and contact the vendors to inquire whether they have Multi-Factor Authentication (MFA) and, if not, where it is on their roadmap.	Deacon, Stephen	31/03/2025	
Review Digital BCP Documentation	Review Digital BCP Documentation	Review Digital BCP Documentation, after the recent unplanned downtime of clinical systems. MIAA to audit the new documentation in November 24	Deacon, Stephen	30/11/2024	
Attend the C&M Cyber Desktop Exercise	Attend the C&M Cyber Desktop Exercise	Attend the C&M Cyber Desktop Exercise with NHS England in September 24 (Has been delayed until the end of November 24)	Deacon, Stephen	30/11/2024	
Perform Cyber Assurance Service (CAS) with NHS England	Perform Cyber Assurance Service (CAS) with NHS England	Engage with NHS England and their 3rd part for onboarding to be cyber assed by the Cyber Assurance Service (CAS). Current status: Accepted and completing the onboarding documentation.	Deacon, Stephen	31/12/2024	

Board Assurance Framework

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

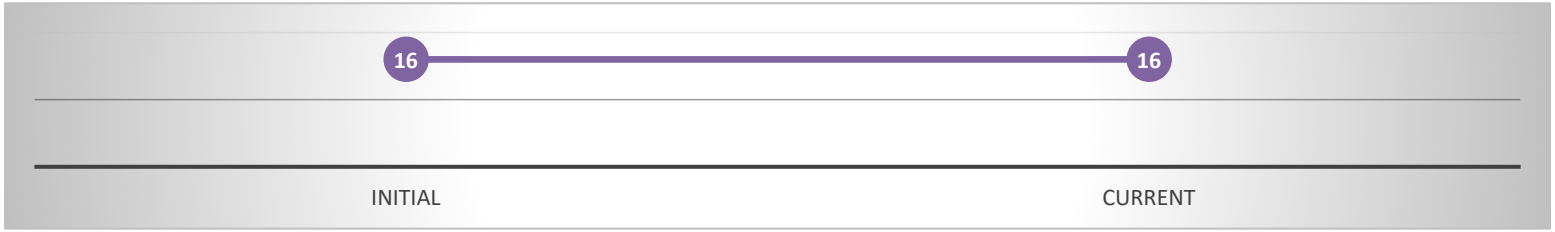
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**

Board Assurance Framework

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1898	**Executive Lead:**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communit				
Risk Description:	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.			**Initial**	16 (L4xC4)
				Current	16 (L4xC4)
				Target	9 (L3 xC3)
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).				
Risk Movement					

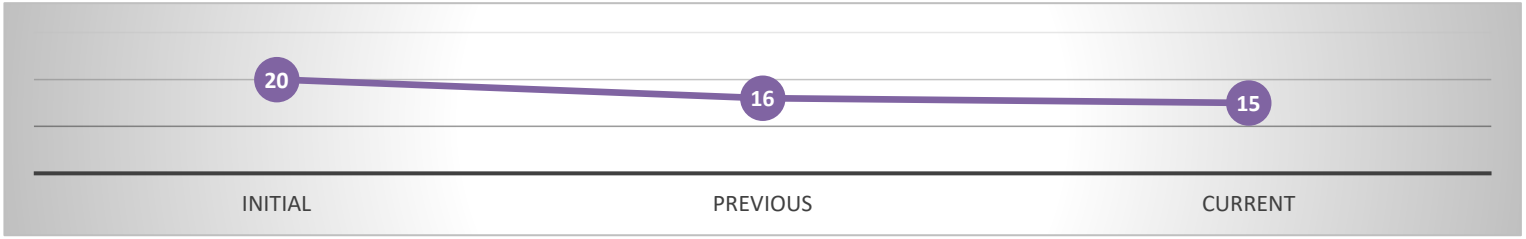
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have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

Assurance Gaps	• Confirmation received that the Trust was unsuccessful in securing funding via HIP phase 3. • Requirement to secure funding to complete the development of the phased new hospital plan				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work	Lucy Gardner	31.10.2024	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Lucy Gardner	31.03.2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

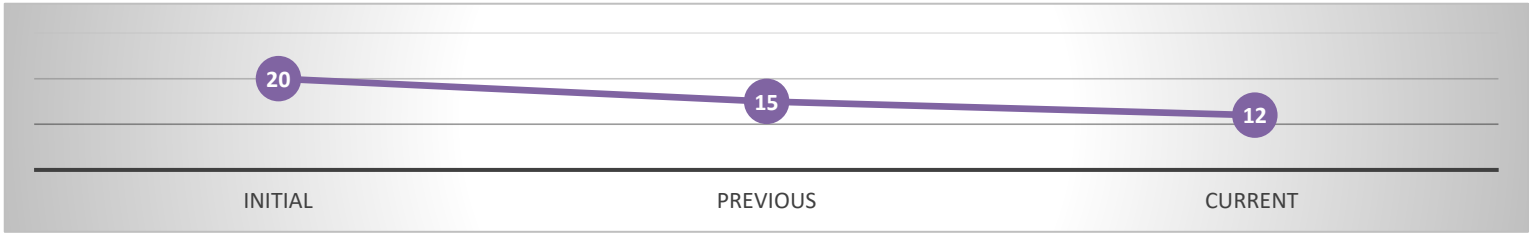
Risk ID	125	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns			**Initial**	20 (L5xC4)
				Current	15 (L3xC5)
				Target	10 (L2xC5)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** • Annual capital funding is allocated to mandated and statutory estates projects • The estates team operate a Planned Maintenance Program (PPM) • The estates team operate a reactive maintenance process via the Computer aided facilities mananagement software (CAFMS) • Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance • Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out • Capital Planning Group and associated capital funding allocation process • Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding **Assurance** • Health and safety sub committee acts as an esclation point for issues • Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers • Non funded capital schemes are risk rated and monitoired through the above group • Fire Safety Group – monitors fire safety issues across the trust • PLACE assessment with subsequent action plan • Capital Planning Group – determine how the trust capital is spent • Cleanliness monitoring identifies estates issues that are addressed through the CAFMS system • Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations • Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk • Completed a formal Reinforce autoclave aerated concrete (RAAC) survey across whole estate. Small extension building identified as having RAAC present. • Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension and the roof has now been replaced. • Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been supported and phase 2 is due for completion October 2024 • Establishment of the Tactical Estates Group (TEG), reporting to the Capital Planning Group, to help support efficient decision making relating to estate allocation. • Associate Director of Estates & Facilities and Director of Strategy & Partnerships represents the Trust on ICB Estates meetings from an operational and strategic perspective				

	• Funding identified in the 2024/25 Capital Plan to Support refurbishment of another patient lift on the Warrington Site to improve operational efficiency to commence in november 2024. • Plan are in deveopment to undertake roof repairs to pathology as part of the backlog maintenance plan for 2024/25.
Assurance Gaps	Limited capital funding to address entire backlog Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more, with less and the estates maintenance team is currently under resourced and further impacted by non clinical CIP target. Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market. Delays in approvals of PO resulting in risk to compliance and delivery of standards

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities Phase 1 completed Phase 2 due for completion in October 2024	Lee Bushell	31/10/2024	
Upgrade Warrington lifts	Conditional report completed Undertake refurbishment or replacement of all lifts	Lift 1 to commence in November 2024 Lift 4 completed early 2024 Lift 5 plan in development Croft and Burtonwood lifts next for refurbishment	Kieran Beech	01/04/2027	
To replace the roof on the pathology department	Following a roof survey and persistent leaks a new roof is required	Business case required for funding	Kieran Beech	01/04/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

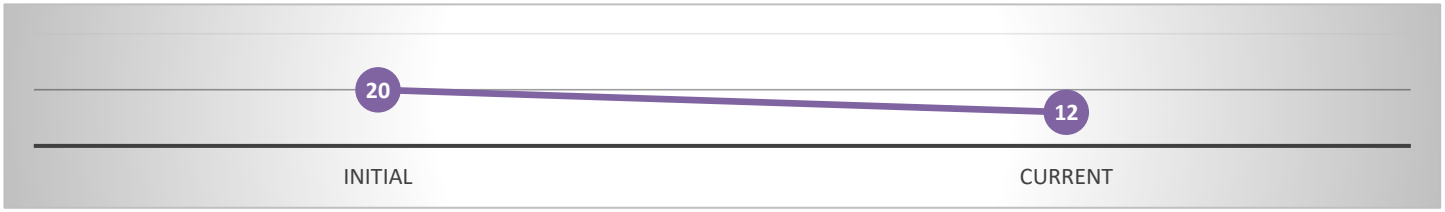
Risk ID	145	**Executive Lead**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			**Initial**	20 (L5xC4)
				Current	12 (L3xC4)
				Target	8 (L4xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • Council and Place Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level are refreshed annunallly • Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Refreshed programme for pathology collaboration shared by the Cheshire & Mersey Pathology Network. The first phase is to develop an outline business case for the hub model expected by the end of October 2024. • CSPO invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. • Health & Wellbeing Hub (Living Well Hub) opened in March 2024 • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. • Consistent Trust representation within Cheshire & Merseyside ICS.				

	• Trust representation on place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • Funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • CSPO co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Trust Estates priorities now also reflected in the ICB infrastructure plan • Adaptive Reserve Fund created with Warrington Place partners • Discussions with neighbouring Trust to accelerate collaboration taking place • Joint Executive team meetings & programme of collaboration established with Bridgewater Community Healthcare NHS FT **Assurances** • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. • Pace of pathology collaboration no longer poses a such significant risk to service delivery for WHH as challenges within histopathology are being addressed via mutual aid and recruitment. • National funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case approved by the Trust Board in June 2024. • Detailed work commenced, supported by external consultants, to help address no criteria to reside & enable admission avoidance. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside. Endoscopy Hub – opened September 2024 • CDC phase 2 including ultrasound, spirometry, sleep studies, audiology & phlebotomy opened in Halton Health Hub in December 2023 • CDC phase 3 including CT & MRI due to open in spring 2025
Assurance Gaps	• Self assessments of both Warrington & Halton place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy. • Trust's capacity to deliver significant number of capital projects

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at Place & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Lucy Gardner	30/04/2025	
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Interim arrangements to support delivery given lack of available funding	Lucy Gardner & Dan Moore	30/04/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	1134	**Executive Lead**	Chief People Officer	**Rating**	
Strategic Objective	**Strategic Objective 2:** We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial**	20 (L4xC5)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Control & Assurance Details	**Sickness Absence** The rolling 12-month sickness absence rate is 5.69% as at July 2024 and is showing minimal variation. This is a slight month on month increase since the lowest sickness absence rate reported in December 2023 (5.56%) since April 2020. Target remains 4.2%. **Controls** • Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. • Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers. • Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. • Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management. • Focused welcome back conversation recording and internal audit • Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. • Sickness absence, turnover and attraction workstreams have been reviewed in line with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been considered. **Assurance** • The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub. • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.81% % in May 2024. • Pilot took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE • Pro-active health interventions offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate. Well attended by staff. • As a result of the sickness absence data analysis undertaken by the People Health and Wellbeing Group, OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within the last 12 months who have experienced an absence of depression/stress/anxiety, and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required.				

Turnover and Attraction
Turnover in July 2024 was below target at 11.81% and is showing an improving variation. Turnover of permanent staff in July 2024 was 11.06% which was below Trust target. Target is 13%.

Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving.

The Trust's July 2024 vacancy rate is 9.26%, and is showing minimal variation, target is 9%.

Controls
- Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review.
- Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.
- Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work
- Grief and Menopause cafes implemented to support individuals
- Social media accounts have been created to support recruitment attraction across a number of social media platforms
- Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream
- A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working. Pilots commence January 2024
- HR are working with pilot areas to review their approach to rostering and the impact on agile/flexible working to support a reduction in turnover.

To support with attraction, the Trust has adopted a coordinated approach to recruitment which has included:
- International recruitment
- Enhanced HCA recruitment events
- Investment in TRAC (Recruitment system)
- Enhanced Student Nurse recruitment
- Enhanced wellbeing benefits package (financial and mental)
- Improvements in agile/flexible working
- Enhanced retirement support/offers

Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention.

Assurances
- The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.
- As a result of analysis of exit interviews, a theme identified was working hours and flexible working. Pharmacy are working towards changes to working hours, which have been raised as a factor by leavers and potential joiners as a barrier.
- The responses to Exit Interviews are positive, only 7.21% (July 2024) of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions.
- As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. July 2024 staff in post is 4,193 FTE, which is reducing in line with th additional scrutiny exerted to the recruitment process.
- Staff completing apprenticeships is above target at 3.9%, target is 2.3%

Temporary Staffing and Agency spend

Bank and Agency reliance in July 2024 was 14.5% . Target is 9%. Bank reliance continues to increase and is 12.9% and agency reliance continues to decrease to 2.6%.

Controls

	• The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. • The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies approval • The Resourcing Task and Finish group worked with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this has enabled the organisation to develop plans to improve the effectiveness of workforce deployment. The Trust is engaging with the ICB relating to next steps. **Assurances** • Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee • To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings has been introduced. • Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives and an options appraisal put forward.
Assurance Gaps	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Lack of assurance regarding industrial action ending which impacts bank and agency utilisation. • Exit interview completion rates are low, currently reviewing process to improve completion rates.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff	Laura Hilton	31.03.2025	
Embed an agile and flexible working culture within all WHH Teams – linked to WHH Culture Plan	As part of the WHH Culture Plan, through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2025	

Review of Exit Interview Process to Support Improvement of Completion Rates	As part of the Delve OD programme within the People Directorate there is a further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	31.12.2024	
Develop an approach to exert greater pay and discretionary spend controls.	In line with the work with PWC and the Trust Vacancy Control processes (ECF), develop similar approaches to ensure appropriate controls are in place relating to all pay spend, including: • Overtime • WLIs • Bank • Agency Substantive roles	• Complete a gap analysis to understand the current levels of pay control across all staff groups. • Using the gap analysis and working with the Staff Group leads, develop systems/processes to ensure appropriate pay controls are in place. • Where required, make recommendations for process/system improvements. • Establish a long-term approach to monitoring pay controls at a staff group and/or CBU level.	Gemma Leach	31/11/2024	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/10/98**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

<table>
<tr><td rowspan="6">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✔</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✔</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="4">EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✔</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td colspan="4">The Trust has 76 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance.

There is 1 new KPI, “76. 4-hour performance <u>including Walton Walk-in Centre (WWIC)”</u>, following approval at August 2024 Trust Board.

Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>3 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality:
• 5.Healthcare Acquired Infections (CDI)
Access and Performance:
• 61. Uncapped Theatre Utilisation
Finance and Sustainability:
• 72. Better Payment Practice Code (NEW)

In Month 3 there were 4 failing and declining indicators, however 2 of these indicators now have normal variation or are no longer consistently failing, so have been removed from the top category since the Month 3 2024/25 IPR. These indicators are included below:
• 10. VTE Assessment
• 41. Ambulance Handovers within 15 minutes

At Month 5 the plan was a £16.4m deficit. The actual deficit was £17.4m with the overspend being due to the impact of Industrial Action with cost and loss of income totalling £1m.</td></tr>
</table>

PURPOSE: ***(please select as appropriate)***	Approval ✓	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support of up to £14.954m from NHSE for Q3 noting that the Trust may not need to draw it down. 2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 3. Note the 2023/24 NCC was completed and submitted in line with national guidance. 4. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/24/08/101 FSC/24/09/128 FSC/24/09/127	
	Date of meeting	28/08/2024 23/09/2024	
	Summary of Outcome	Cash support application supported for approval at Trust Board. Changes to the capital contingency supported and approved. The 2023/24 NCC was completed and submitted in line with national guidance and supported for Trust Board assurance.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/24/10/98

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 76 Integrated Performance Dashboard (IPR) indicators have been placed into one of several “Assurance” categories and one of several “Variation” categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

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

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

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

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

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

Table 1: KPIs by Assurance and Variation Categories

	 Special Variation of a Concerning Nature	 Common Cause Variation	 Special Variation of an Improving Nature	 No SPC/Not Enough Datapoints/NA
 **Consistently Fails the Target (based on the last 7 months)**	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) **(29 YTD - *36 target*)** **A&P** 61. Uncapped Theatre Utilisation **(73.4% - *80% target*)** **Finance & Sustainability** 72. Better Payment Practice Code ⬇	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 13. Medication Safety - Reconciliation within 24 hours 21. Friends and Family (ED and UCC) ⬇ 22. Mixed Sex Accommodation Breaches (ITU Only) ⬆ 23. Sepsis - % screening for all emergency patients 24. Sepsis - % screening for all inpatients 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ⬇ 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage ⬇ 31. MUST nutritional assessment completion **A&P** 35. A&E Wait Times - % patients waiting under 4 hours 36. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 41. Ambulance Handovers within 15 minutes ⬆ 42. Ambulance Handovers within 30 minutes 43. Ambulance Handovers within 60 minutes 44. Discharge Summaries - % sent within 24hrs 62. Capped Theatre Utilisation	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **A&P** 32. Diagnostic Waiting Times 6 Weeks 33. Referral to treatment Open Pathways ⬆ 34. RTT - Number of patients waiting 52+ weeks ⬆ 76. A&E 4 hour wait (including WWIC) (**NEW KPI**) **Workforce** 63. Supporting Attendance 66. Bank and Agency Reliance 68. PDR **Finance** 74. Cost Improvement Programme (recurrent forecast) – In year performance to date ⬆	**CONSISTENTLY FAILING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **A&P** 1.Incidents 38. 28 Day Faster Cancer Diagnosis Standard	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 10. VTE Assessment ⬆ 11. Inpatient Falls & harm levels ⬇ 12. Pressure Ulcers 15. Staffing Care Hours per patient day (CHPPD) ⬇ **A&P**	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 6. Healthcare Acquired Infections (Ecoli) ⬆ **A&P** 45. Discharge Summaries - Number NOT sent in 7 days 53. Elective Outpatient Activity **Finance** 71. Capital Programme	**INCONSISTENTLY PASSING TARGET & NO SPC**

		47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation **Finance** 73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)		
Consistently Passes the Target (based on the last 7 months)	**CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
		Quality 2. Duty of Candour (serious incidents) 3. Healthcare Acquired Infections (MRSA) 19. Complaints 20. Friends and Family (Inpatients & Day cases) 28. Acute Kidney Injury ⬆ **A&P** 46. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 48. Urgent Operations Cancelled for 2nd Time	**Quality** 14. Staffing - Average Fill Rate 18. NICE Compliance **A&P** 55. Patients seen in the Fracture Clinic within 72 hours **Workforce** 64. Retention 65. Turnover 67. Core/Mandatory Training **Finance** 75. Agency Ceiling	
No SPC/Not Enough Datapoints/Not Applicable	**NO ASSURANCE SPC & DECLINING PERFORMANCE**	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**
		Quality 4. Healthcare Acquired Infections (MSSA) ⬆ 30. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 37. Average time in department ED 49. Super Stranded Patients 50. No Criteria to Reside (NCTR) 57. Type 5 attendances 59. % Patients discharged to their usual place of residence	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 16. Mortality ratio – HSMR 17. Mortality ratio - SHMI **A&P** 58. Reduction in Outpatient Follow Ups 60. Virtual Appointments	**A&P** 39. Cancer 31 Days First Treatment 40. Cancer 62 Days First Treatment 51. Elective Recovery Activity (Grouped SPCs) 52. Elective Recovery Diagnostic Activity 56. % patients referred to long COVID service not assessed within 15 weeks **Finance** 69. Trust Financial Position (£m) 70. Cash Balance (£m)

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

Areas exceeding the target and continuously maintaining/improving performance

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

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

2.2 IPR Update

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

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

2.3 Financial Update

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

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

- CIP delivery.
- Cost pressures – there was an overspend of £2.3m year to date at month 5 with a year to date forecast overspend of £4.7m. The cost pressures in the year to date position have been mitigated, if the future cost pressures are not mitigated in the same way, then the Trust will have an overspend of £2.4m. An enhanced monitoring process is in place to mitigate these cost pressures where possible.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), activity delivered is under plan resulting in loss of income.
- Utilisation of additional capacity due to the levels of no criteria to reside patients.
- Ongoing industrial action – the Trust has assumed that the industrial action to date will be funded but if this is not the case it will worsen the forecast position.
- Funding for the pay award – the Trust is awaiting confirmation of the funding associated with the pay award and whether that will leave a shortfall compared to the cost estimate. If funding is less than the cost of the pay award this will worsen the forecast position.

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

Cash

The cash balance at the end of August is £4.9m, of which, £3.7m is related to capital creditors. Given the current cash position and the planned deficit for 2024/25 the Trust is in receipt of cash support. Due to the level of cash at the end of July, cash

support was not required for August. A cash support request for September was submitted to NHSE for £5.228m, however only £4m has been approved.

The Trust has been allocated a share (£16.458m) of the £150m deficit support provided to the Cheshire and Merseyside ICS. £9.601m of this is expected to be received in October and then £1.372m each month between November and March. Funding is also expected for the impact of the Agenda for Change and Medical pay awards. The timing of the receipt of the funding compared to when the pay award is paid to employees may lead to the requirement for temporary cash support which is being facilitated by the ICS.

The Finance and Sustainability Committee discussed and supported the Q3 application for cash support from NHSE. The Trust Board is asked to approve up to £14.954m cash support for Q3 which includes cash support funding for the agenda for change and medical pay awards (£9.475m). Given the additional cash receipts for the deficit support and the temporary cash support for the pay award, it is unlikely that the Trust will need to draw down any of the Q3 cash support allocation. There is no commitment to draw down, however, once the value has been requested an increase is not possible, therefore it is recommended that the application is approved by Trust Board noting that the Trust may not need to draw it down.

CIP

At 31 August 2024, the Trust has delivered a CIP of £4.5m against a target of £4.5m, therefore on plan. It should be noted that the delivery year to date has been mainly achieved from central items and reduction in non-clinical posts. The full year CIP target is £19.4m which has been fully identified however there is £3m of high-risk schemes included in the plans. The current level of identified recurrent CIP is £18m.

Capital Programme

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

The Trust year to date capital spend at month 5 is £3.96m which is £0.85m below the Trust plan of £4.81m.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 5		**202**
Proposed changes in month		
VAT Recovered		**155**
Requests supported at CPG - 13 Sept 2024		
EPCMS Accomodation addendum (will be returned to contingency if and when Frontline Digitalisation has confirmed funding available following the abandoned procurement process)	- 30	
Laerdal Megacode kid mannequins	- 24	
Aseptic Unit addendum - **£290k** to be prioritised for 2025/26 Capital plan	N/A	
Intra Oral Scanner **£19k** - funded from League of Friends Charity	N/A	
Theatre Wellbeing Room **£16k** - funded from WHH Trust Charitable Funds	N/A	
Sub Total		**- 54**
Contingency as at end of month 5		**303**

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

2023/24 National Cost Collection

The Trust submitted the 2023/24 National Cost Collection (NCC) in July 2024.

An NCC update is required to be reported to Trust Board, both pre and post submission. Confirmation that the 2023/24 NCC was completed in line with national guidance was reported to and supported by the Finance and Sustainability Committee.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve cash support of up to £14.954m from NHSE for Q3 noting that the Trust may not need to draw it down.
2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
3. Note the 2023/24 NCC was completed and submitted in line with national guidance.
4. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	QUALITY	Plan/Target	Actual	Period	Variation	Actual	Period	
1	Incidents	0	43	Aug-24	H	38	Jul-24	?
2	Duty of Candour (serious incidents)	100.00%	100.00%	Aug-24		100.00%	Jul-24	P
3	Healthcare Acquired Infections (MRSA)	0	0	Aug-24		0	Jul-24	P
4	Healthcare Acquired Infections (MSSA)	No threshold set	4	Aug-24		1	Jul-24	No SPC
5	Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	10	Aug-24	H	10	Jul-24	F
6	Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	0	Aug-24	L	6	Jul-24	?
7	Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	2	Aug-24		1	Jul-24	?
8	Healthcare Acquired Infections (PA)	Less than 2 - annual	2	Aug-24		1	Jul-24	?
9	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Aug-24	L	0	Jul-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target*

Inconsistently passes and fail the target*

Consistently fails the target*

*based on the last 6 datapoints/months

10	VTE Assessment	95.00% (quarterly position)	94.09%	Aug-24		95.31%	Jul-24	
11	Inpatient Falls & harm levels	20% or more decrease from previous year	35	Aug-24		41	Jul-24	
12	Pressure Ulcers	10% reduction	18	Aug-24		11	Jul-24	
13	Medication Safety Reconciliation within 24 hours	80.00%	40.00%	Aug-24		33.00%	Jul-24	
14	Staffing - Average Fill Rate	90.00%	97.77%	Aug-24		90.43%	Jul-24	
15	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.8	Aug-24		7.6	Jul-24	
16	Mortality ratio - HSMR	No target set	88.86	Aug-24		88.86	Jul-24	No SPC
17	Mortality ratio - SHMI	No target set	94.70	Aug-24		93.20	Jul-24	No SPC
18	NICE Compliance	90.00%	93.42%	Aug-24		93.53%	Jul-24	
19	Complaints	Zero complaints open over 6 months old/in the backlog	1	Aug-24		0	Jul-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

20	Friends and Family (Inpatients & Day cases)	95.00%	97.00%	Aug-24		97.00%	Jul-24	P
21	Friends and Family (ED and UCC)	87.00%	77.00%	Aug-24		76.00%	Jul-24	F
22	Mixed Sex Accommodation Breaches (ITU Only)	0	12	Aug-24		8	Jul-24	F
23	Sepsis - % screening for all emergency patients.	90.00%	70.00%	Aug-24		72.00%	Jul-24	F
24	Sepsis - % screening for all inpatients	90.00%	60.00%	Aug-24		75.00%	Jul-24	F
25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	90.00%	Aug-24		80.00%	Jul-24	F
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	88.00%	Aug-24		94.00%	Jul-24	F
27	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	8	Aug-24		17	Jul-24	F
28	Acute Kidney Injury	Less than previous month	153	Aug-24		148	Jul-24	P
29	Maternity Postpartum Haemorrhage	3.70%	2.55%	Aug-24		7.70%	Jul-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	23%	Aug-24		39%	Jul-24	No SPC
31	MUST nutritional assessment completion	above > 85%	68.63%	Aug-24		68%	Jul-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	Plan/Target	Actual	Period	Variation	Actual	Period	
32	Diagnostic Waiting Times 6 Weeks	95.00%	80.35%	Aug-24	H	81.65%	Jul-24	F
33	Referral to treatment Open Pathways	92.00%	57.84%	Aug-24	H	59.28%	Jul-24	F
34	RTT - Number of patients waiting 52+ weeks	0	1728	Aug-24	L	1847	Jul-24	F
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WWIC).	75%	64.83%	Aug-24		66%	Jul-24	F
76	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WWIC).	75%	69.62%	Aug-24	H	70%	Jul-24	F
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	18.48%	Aug-24		19.2%	Jul-24	F
37	Average time in department ED	No Target	356	Aug-24		359	Jul-24	No SPC
38	28 Day Faster Cancer Diagnosis Standard	75%	61.90%	Jul-24	L	58.50%	Jun-24	?
39	Cancer 31 Day Wait	96%	96.90%	Jul-24	No SPC	98.50%	Jun-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

40	Cancer 62 Day Wait	85%	77.70%	Jul-24	No SPC	79.30%	Jun-24	No SPC
41	Ambulance Handovers within 15 minutes	65%	35.60%	Aug-24		40.85%	Jul-24	F
42	Ambulance Handovers within 30 minutes	95%	74.66%	Aug-24		78.25%	Jul-24	F
43	Ambulance Handovers within 60 minutes	100%	92.13%	Aug-24		92.54%	Jul-24	F
44	Discharge Summaries - % sent within 24hrs	95%	91.42%	Aug-24		90.70%	Jul-24	F
45	Discharge Summaries - Number NOT sent within 7 days	0	0	Aug-24	L	0	Jul-24	?
46	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.00%	Aug-24		0.00%	Jul-24	P
47	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	0	Aug-24		0	Jul-24	?
48	Urgent Operations Cancelled for 2nd Time	0	0	Aug-24		0	Jul-24	P
49	Super Stranded Patients	Trajectory	120	Aug-24		111	Jul-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

50	No Criteria to Reside (NCTR)	No Target set	165	Aug-24		184	Jul-24	No SPC
51	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
52	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
53	Elective Outpatient Activity	104%	97%	Aug-24	H	95%	Jul-24	?
55	Patients seen in the Fracture Clinic within 72 hours	95%	95.70%	Jun-24	H	100%	May-24	P
56	% patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Aug-24	No SPC	0	Jul-24	No SPC
57	Type 5 attendances	No Target set	1257	Aug-24		1199	Jul-24	No SPC
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	97%	Aug-24	H	95%	Jul-24	No SPC
59	% Patients discharged to their usual place of residence	No Current Threshold	97%	Aug-24		95%	Jul-24	No SPC
60	Virtual Appointments	No Target set	20%	Aug-24	H	21%	Jul-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

61	Uncapped Theatre Utilisation	85%	79.10%	Aug-24	L	79%	Jul-24	F
62	Capped Theatre Utilisation	85%	74.40%	Aug-24		72%	Jul-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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- Consistently fails the target*

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
63	Supporting Attendance	4.20%	5.65%	Aug-24	L	5.70%	Jul-24	F
64	Retention	85.00%	87.12%	Aug-24	H	87.23%	Jul-24	P
65	Turnover	Below 13%	12%	Aug-24	L	12%	Jul-24	P
66	Bank and Agency Reliance	9% or Below	14.64%	Aug-24	L	14.93%	Jul-24	F
67	Core/Mandatory Training	85.00%	89.90%	Aug-24	H	90.09%	Jul-24	P
68	PDR	85.00%	76.88%	Aug-24	H	77.69%	Jul-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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- Consistently fails the target*

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
69	Trust Financial Position (£m)	-£2.80	-£2.79	Aug-24	No SPC	-2.49	Jul-24	No SPC
70	Cash Balance (£m)	£2.26	£4.92	Aug-24	No SPC	10.54	Jul-24	No SPC
71	Capital Programme (£m)	£5.14	£3.96	Aug-24	H	£3.25	Jul-24	?
72	Better Payment Practice Code	95%	84%	Aug-24	L	77%	Jul-24	F
73	Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£4.54	£4.54	Aug-24		3.24	Jul-24	?
74	Cost Improvement Programme (recurrent) – In year performance to date (£m)	£4.54	£3.77	Aug-24	H	3.24	Jul-24	F
75	Agency Ceiling	Less than 3.2%	1.2%	Aug-24	L	1%	Jul-24	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	Open Incidents - 40 Days; Total Incidents Reported by month; Total PSIIs recorded in month; Serious Incidents / PSII Actions Breached; Never Events; Qty of 'prevention of future death orders'	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause variation of a concerning nature.**	**Incident reporting is showing a special cause variation. Increases seen are due to a change in the management pathway to strengthen governance structures and oversight at Care Group level, ensuring appropriate investigations and actions are taking place** **There are 43 overdue 40-day incidents at the time of reporting.** **There were no PSIIs reported in July 2024 and no Never Events.** **There were 9 breached patient safety incident investigation actions at the time of reporting. This was due to timeframes being initially being set that had very short timescales.**	**A detailed overview of incidents and PSIIs and associated actions is overseen by the Executive Team weekly at the Safety Oversight Meeting. A weekly Governance Dashboard is also reviewed at the Executive Management Team Meetings where incidents, complaints, claims and inquests can be triangulated.** **An evaluation of incident reporting will be included as part of the local priority review, which will take place in Quarter 3.** **Incidents overdue 40 days- Daily dashboards are being produced to Care Group Triumvirate leads to action outstanding incidents. This work is being prioritised with weekly oversight from the Executive Team at the Safety Oversight Meeting.** **Datix system also alerts at an additional lower threshold (30 days) to enable further support to be provided and this will be monitored closely.** **PSII's** **Weekly monitoring continues by the Director of Governance and the Executive Team via the Safety Oversight Meeting. Outstanding actions are escalated to the Care Group Leads to address.**
There were 43 incidents over 40 days old.				
2. Duty of Candour (serious incidents) **Target: 100%**	Duty of Candour (DoC) - Moderate Incidents; Duty of Candour (DoC) - Serious Incidents	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**There is no variance in Duty of Candour, the Trust remains 100% compliant.**	**Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained. This is overseen by the Director of Governance and the Executive Team at the weekly Safety Oversight Meeting.**
The Trust achieved 100% for Duty of Candour in month.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Quality Improvement - Trust Position

Appendix 2

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

3. Healthcare Acquired Infections (MRSA)
Target: ZERO

4. Healthcare Acquired Infections (MSSA)
Annual threshold: NA

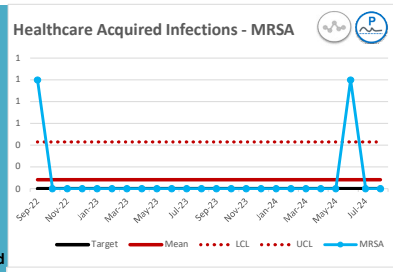
5. Healthcare Acquired Infections (CDI)
Annual threshold: 61

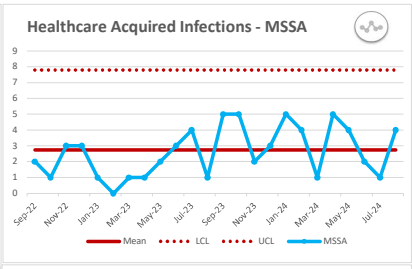
6. Healthcare Acquired Infections (Ecoli)
Annual threshold: 80

7. Healthcare Acquired Infections (Klebsiella)
Annual threshold: 29

8. Healthcare Acquired Infections (PA)
Annual threshold: 11

9. Healthcare Acquired Infections
COVID-19 Hospital Onset & Outbreaks (No Target)



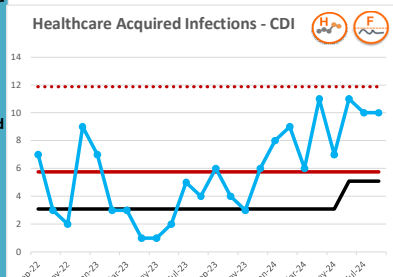


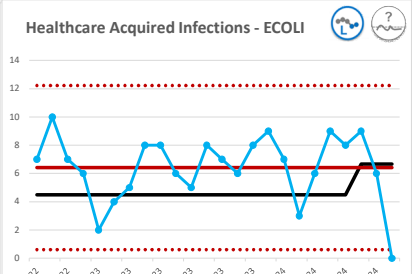
MRSA cases YTD - annual threshold exceeded by 1

MSSA 16 cases YTD - no threshold set

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

Variation: Variation: Common Cause (Normal) variation.





CDI 49 cases YTD - annual threshold exceeded by 0

E. coli 32 cases YTD - annual threshold exceeded by 0

(CDI) Assurance: The Trust consistently fails the target.

(CDI) Variation: Special cause variation of a concerning nature.

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

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

HCAI Thresholds published

Trust apportioned cases for Aug 2024

MRSA: 0 cases

MSSA: 4 cases

CDI: 10 cases

ECOLI: 6 cases

Klebsiella: 2 cases

Pseudomonas aeruginosa 2 case

HCAI reporting guidance now includes decision to admit (instead of admission date) which is resulting in additional cases being apportioned to acute Trusts

MRSA: MSSA: Driving compliance with ANTT training and competency assessments, clear audit schedule in place to provide assurance on compliance with care of invasive devices.

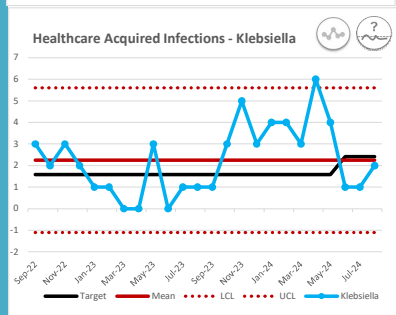
CDI: CDI prevention action plan in place. Brilliant Basics Action Plan and Project Implementation and Education Plan all remain on target.

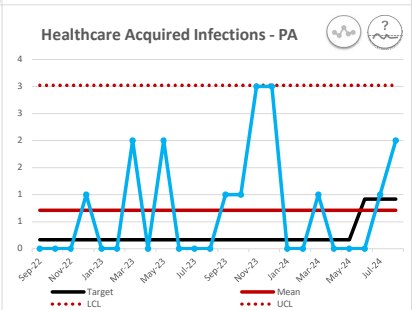
Deep dive of 2023/24 cases and thematic analysis to identify any additional learning in progress.

Senior Nursing Leadership Team undertaking IPC visits and spot checks.

MDT review and Swarm Huddles ongoing for all hospital onset healthcare associated cases.

ECOLI: Klebsiella: Pseudomonas aeruginosa: UTI audit completed, and findings have been disseminated at UEC Governance meeting, Nursing and Midwifery Forum and plan to present at the ICB system collaborative for IPC. Review of National Action Plan on tackling Antimicrobial Stewardship in progress.



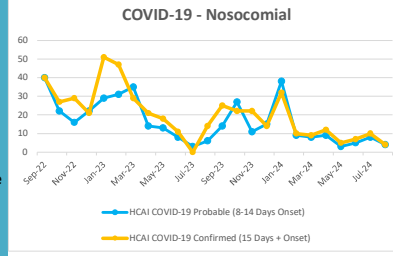


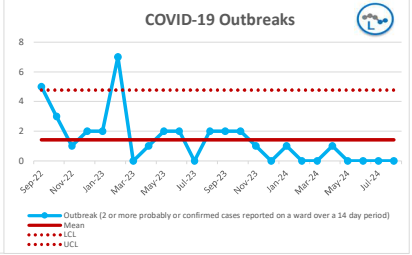
(K) Assurance: The Trust consistently fails the target

(K) Variation: Special cause variation of a concerning nature.

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

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





0 in month COVID-19 outbreak.

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

Assurance: N/A - No target.

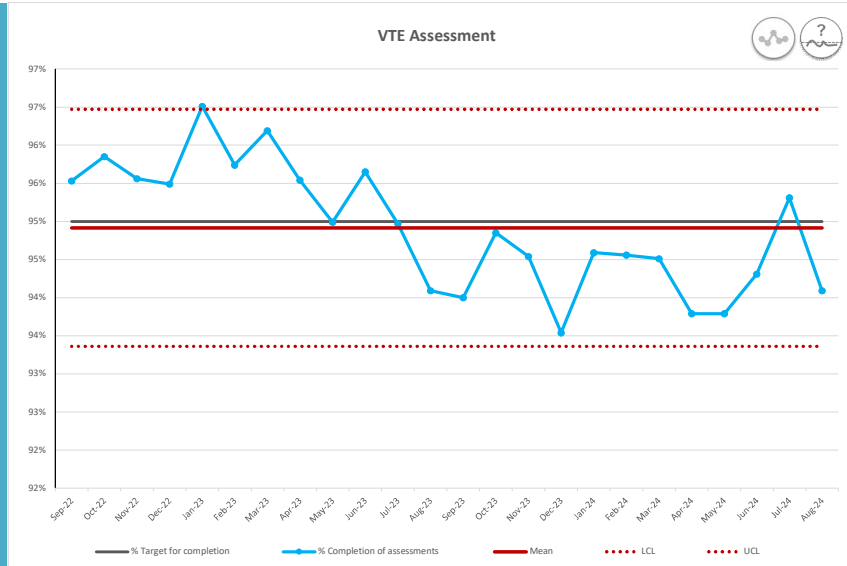
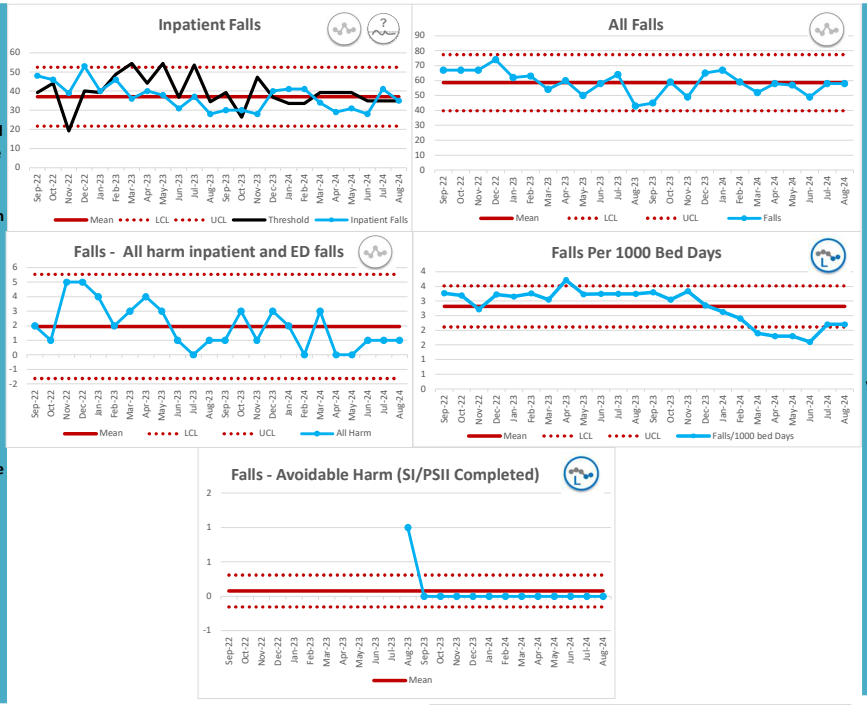
Variation: Special cause variation of an improving nature

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment **Target: 95% (quarterly position)**	**The Trust did not achieve the required target at 94.09% for VTE assessments in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause Variation.**	**Performance target in August 2024 was below the mandatory threshold at 94.09 %.** **August is the first month of new junior doctors intake at the Trust contributing to this variance.**	**Actions taken to improve VTE RA compliance:** **Non-completion of VTE risk assessment data on GIRFT In-patient Ward productivity dashboard projected on E- whiteboard to encourage the completion of risk assessments in real time.** **Data on this dashboard can be drilled down at the ward level daily for identification of patients and for the ownership of this VTE RA data by clinicians to improve overall compliance.** **Induction for VTE for new intake of junior doctors was delivered with distribution of a Lorenzo guide to all new junior doctors' trust wide which includes VTE risk assessments and prescribing information.** **VTE risk assessments dashboard is also live on LION this is shared with CBUs to monitor the data in monthly CBU Meetings.** **The non-completion numbers of VTE RA can be filtered to Care Group, CBU and to individual ward level with close monitoring of top ward 5 wards to improve their performance data.** **The Thrombosis Group monitors the data trend and receive the feedback from CBUs on progress against their improvement plans.**
11. Inpatient Falls & harm levels **Target: decrease from 23/24 (418 Inpatient Falls in 2023/24)**	**58 total falls were reported in month. 35 of these were inpatient falls.** **There was 1 fall(s) in month with harm.** **There were 671 total falls in 2023/24. There have been 280 total falls YTD in 2024/25.** **We are expecting a 0% increase in falls from last year.** **There were 418 inpatient falls in 2023/24. There have been 164 inpatient falls YTD in 2024/25.** **We are expecting a 6% increase in falls from last year.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**During August 2024 there were a total of 35 inpatients falls which is within expected variation. This is a decrease from 41 in July 2024. There was 1 fall causing moderate harm resulting in a subdural haematoma.**	**Ward based training is continuing throughout the Trust. Patient Safety Improvement Nurses (PSIN) are undertaking an audit to include risk assessments, ensure correct documentation is in place and the that the correct and relevant interventions and equipment are in use. This will audit conclude end September. The PSINs are also providing leadership and advice on the wards regarding enhanced care, reviewing whether enhanced care and 1-1 staffing is appropriate.** **Ward Managers are invited to present falls from their area to share any learning and gain advice and support from the PSIN. An Enhanced Care Audit took place during July 2024. The Clinical Audit Team are currently compiling the results which will be shared in Q3 along with lessons learned and an action plan, when available. National falls week took place in September, a drop learning event was scheduled where a variety of education, information, specialist expertise and advice was available for staff to access.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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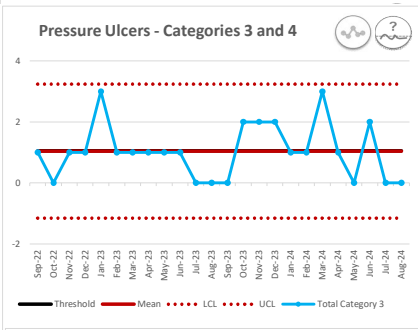
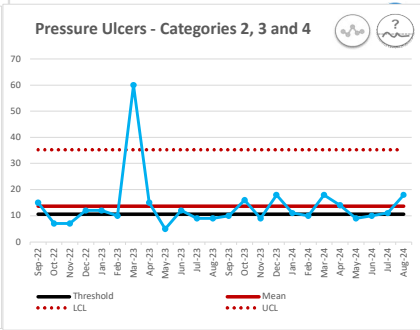
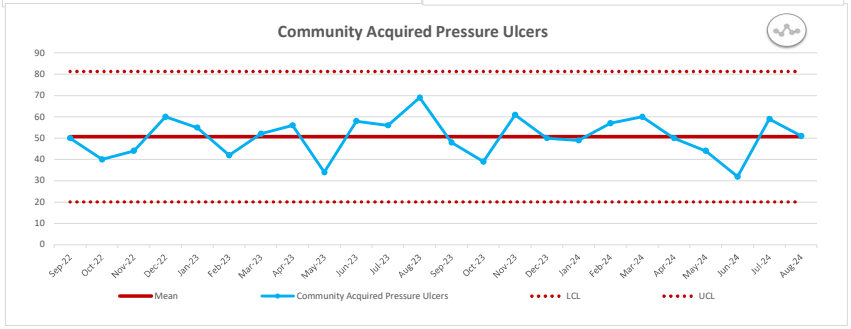
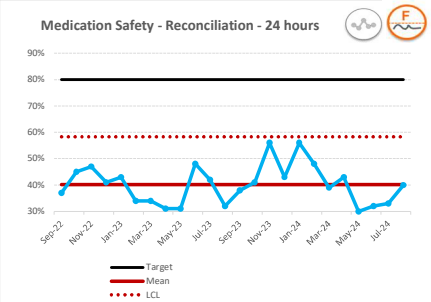
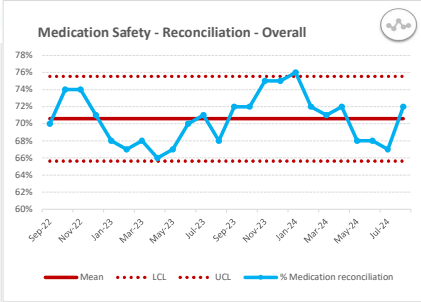
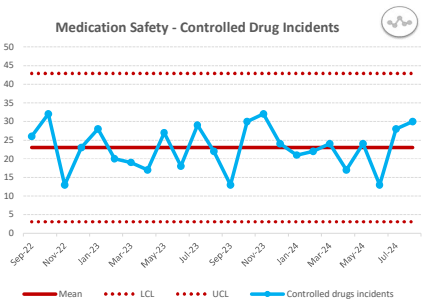
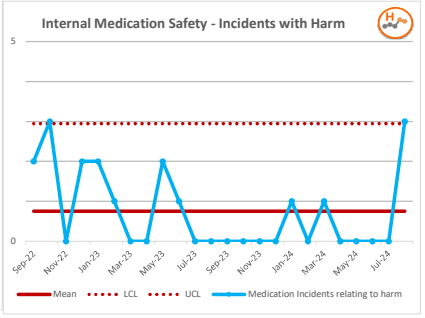
Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Pressure Ulcers (Category 2 and above) **Target: 10% reduction based on 2023/24**				
There were 18 hospital acquired category 2 pressure ulcers, 0 Category 3 pressure ulcers and 0 Category 4 ulcers in month. There were 51 community aquired pressure ulcers in month.	  	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	In August 2024, there were 18 category 2 pressure ulcers, this is an increase on previous months. There were six device related pressure ulcers in August 2024. There were no category 3 or 4 pressure ulcers in August 2024.	Actions to improve the position include: 1 Ward Managers now have to present their After-Action Reviews to the Deputy Chief Nurse and lessons are shared with ward teams and via Operational Patient Safety Group and Chief Nurse Check in. 2. Minimum Category 3 and above will have an MDT review completed. 3. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses. 4. Compliance meetings reviewing pressure ulcer prevention care plan completions has commenced with the Deputy Chief Nurse. Weekly review meetings will be re-established from September. 5. A Task and Finish Group continues with an associated action plan . All actions remain on track.
13. Medication Safety **Reconciliation within 24 hours Target: 80%**				
Medicines reconciliation was completed within 24 hours of admission for 40% of patients. 72% of patients had MR completed during inpatient stay. There were 30 controlled drug incidents. There was 3 medication harm incident reported in month.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Medicines Reconciliation: difficulty in achieving target is linked to vacancy rate in pharmacy establishment. Controlled drug incidents: there is no target for this metric. 30 controlled drug incidents were reported in August 2024. The most common type of incident related to balance discrepancies , prescribing and administration . No themes have been identified. Incidents causing harm: there is no target for this metric. There were 3 medication incidents causing harm reported in August 2024, this is higher than previous months. These have been managed through the incident management process.	Actions to improve performance against the medicines reconciliation (MR) target: Ongoing recruitment to vacancies - 11 pharmacists due to start between July and November 2024. Medicines reconciliation improvement action plan in place, overseen at Pharmacy Specialty Governance Meeting. Actions include: 1 reviewing pharmacy ED Team prioritisation and deployment 2 piloting remote MR for elective surgical admissions 3 work with midwifery to embed midwife-led MR for low risk patients 4 Deployment of BI dashboard to support prioritisation of pharmacy staff, 5 data analysis to review themes and trends to identify process efficiencies. Medication/controlled drug incidents: all incidents are reviewed by a multiprofessional group and lessons learned are disseminated. Themes are identified and action plans developed through the medicines governance structure.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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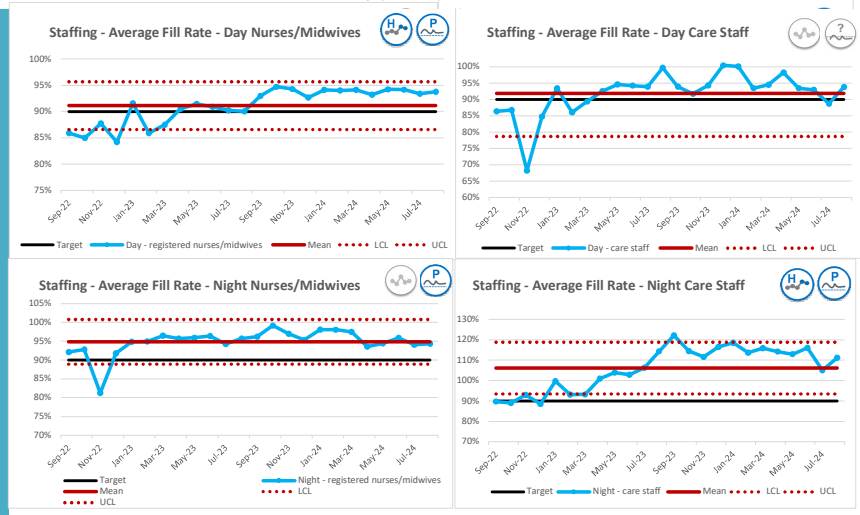
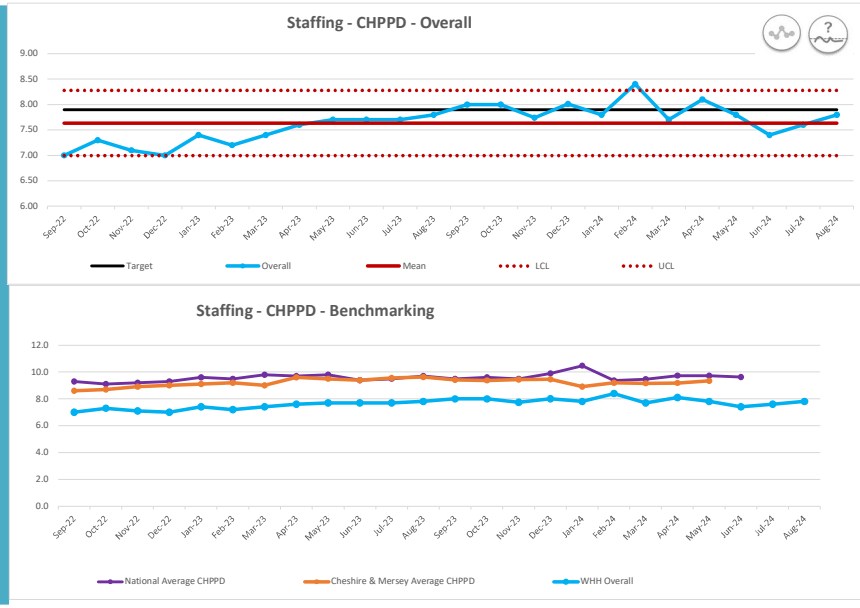
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate **Target: 90%**	**In month, the average staffing fill rates were:** **Day (Nurses/Midwife) 93.76%** **Day (Care Staff) 93.75%** **Night (Nurses/Midwife) 94.39%** **Night (Care Staff) 111.2%** RR115 RR1108		**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**This remains within normal variance** **Pressures continue due additional beds being open due to increased demand and high acuity.**	**Staffing is reviewed twice daily by the Senior Nursing Team and robust escalation processes are in place.** **The current percentage vacancy for August 2024 for registered staff is 11.41% against a Trust target of 9%. This is mainly due to AED increased establishment of 49.36 WTE.** **Specialist recruitment and corporate recruitment is taking place. The Trust has 26 newly qualified nurses commencing in Q3. The next Trust recruitment event is 16 October 2024.** **The current percentage vacancy for August 2024 for unregistered staff is 10.49% against a Trust target of 9%. The advert is currently live for unregistered staff with Interviews planned for the 4 October.**
15. Staffing - Care Hours Per Patient Day (CHPPD) **Target: 7.9 CHPPD**	**In month, the average CHPPD were:** **Nurse/Midwife: 4.3 hours** **Care Staff: 3.5 hours** **Overall: 7.8 hours**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**The CHPPD for August 2024 increased to 7.8 from 7.6 in July 2024 which remains below the national target of 7.9. This is linked to vacancy and sickness.**	**Standard Operating Procedures regarding NHSP cancellations have been strengthened. Daily monitoring by NHSP commenced with actions to restrict staff where appropriate. Cohort 41 of NHSP CSWD staff x 12 commenced their ward placement at the beginning of September with a further cohort commencing in November 2024. The Trust has 26 newly qualified nurses commencing in Q3.**

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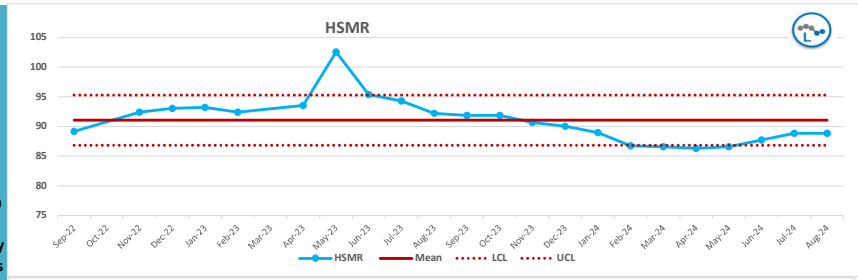
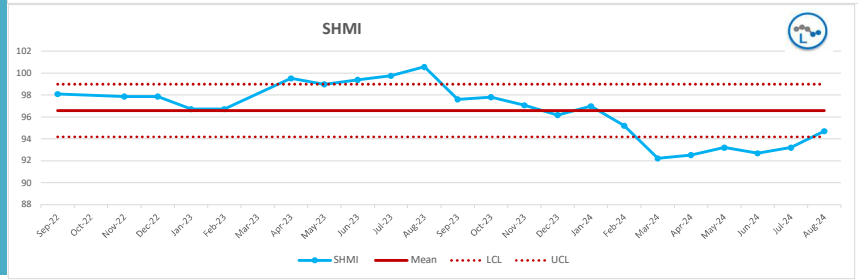
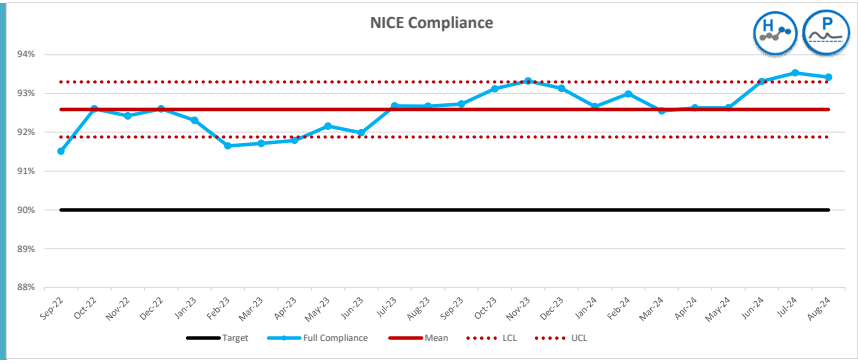
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 88.86. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 94.7.	 	(HSMR) Assurance: NA - no target Variation: Special Cause Variation of an improving nature. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of an improving nature.	NHS Digital have changed the definition of SHMI as from May 2024. a) reintroduction of COVID activity from September 2021 onwards b) removal of activity from sites with 'hospice' in their title for Trust level SHMI figures c) SHMI figures no longer to be published for certain sites (no change for Warrington) d) methodology for identifying primary and secondary diagnoses for spells with multiple episodes expanding to review all episodes, not just the first two e) activity with an invalid primary diagnosis moved to a separate diagnosis group.	Going forward, the mortality diagnosis method for grouping will change. Instead of just reviewing the first 2 episodes in a spell, they are looking at all episodes in a spell, and selecting the first 'non – R' primary diagnosis, if there is one, or the primary diagnosis of the first episode if there isn't. The Charlson score will come from the first 'non – R code' primary diagnosis episode, not the first, going forward. It is noted that Warrington is an early adopter for 'SDEC' (Same Day Emergency Care). As from 2nd November 2023, this low risk activity will be reported as ECDS activity. This activity will therefore no longer be included in mortality calculations. This means that the remaining patient population will, on average, have a higher mortality risk, which is likely to make mortality ratios for Warrington increase, until all Trusts follow suit. The deadline for reporting SDEC as ECDS activity is July 2024. This month's HED report is based on what is known as 'Month 13' data. This is data which goes up to the end of the financial year
18. NICE Compliance Target: 90%	The Trust achieved 93.42% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Performance against the target of 90% continues to be sustained.	We currently have 629 pieces of NICE guidance where a total of 536 are fully compliant, 36 are agreed partially compliant, of the 36 that are partially compliant 21 are for information only. Current compliance is 93.42%. The Clinical Business Units' (CBU) are asked to review all partial compliance guidance and when relevant actions have been completed the guidance is re-reviewed to determine compliance against the relevant guidance.

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19. Complaints

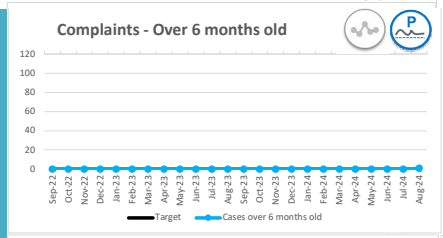
Target: Zero complaints open over 6 months old/in the backlog

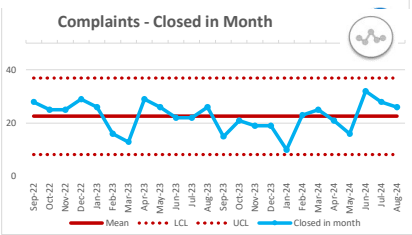
Trust Performance

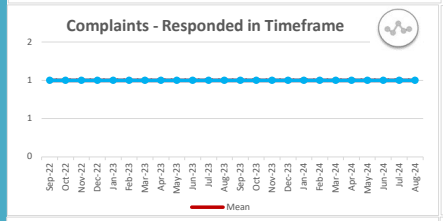
In month, 27 new complaints were received to the Trust which was a decrease of 2 from the previous month. There were 6 dissatisfied complaints received in month, which is an increase from the previous month.

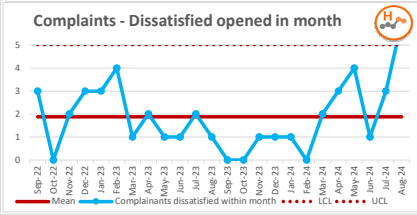
4 PHSO cases were opened in January, these were not linked to a specific area or theme.

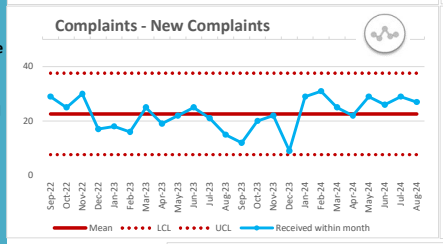
Trend

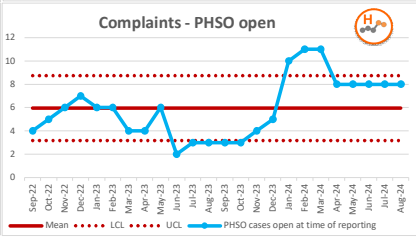


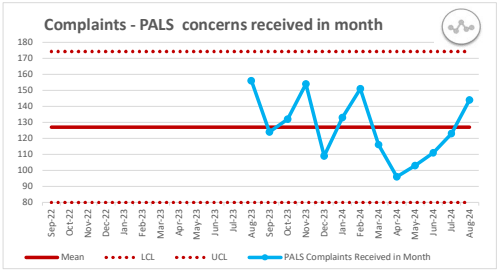












Statistical Narrative

Assurance: The Trust consistently passes the target.

Variation: Common Cause (Normal) variation.

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

The Trust continues to sustain performance in the timely completion of complaints with 100% completed within time.
There was an increase in the number dissatisfied complaints in month no key themes have been identified.

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

Complaints position of 75 open complaints at the time of reporting. 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, as well as follow up meetings upon receipt of the initial response letter.
All CBUs have a designated complaints case handler to ensure consistency. The Team continues to consistently work to improve response times and often are able to provide letters of response prior to the due date.

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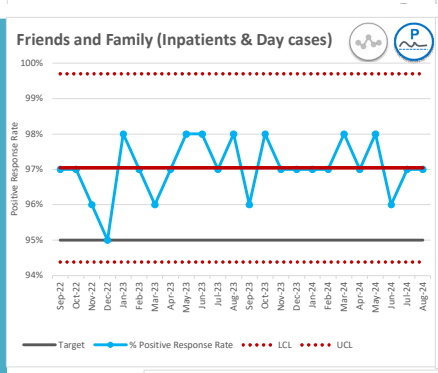
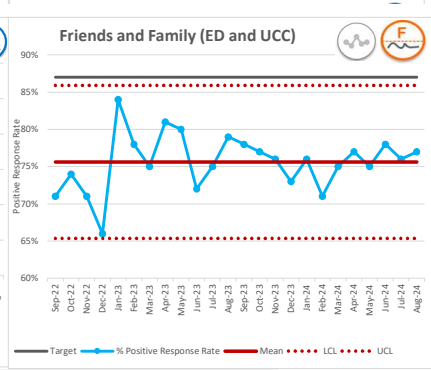
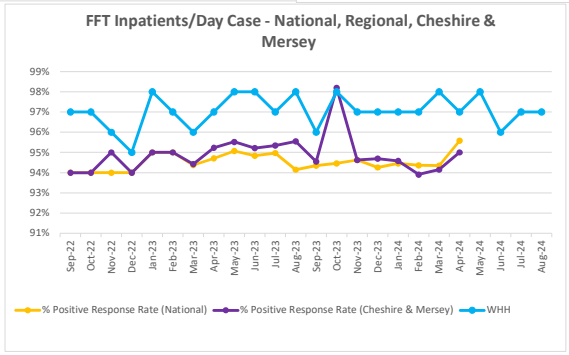
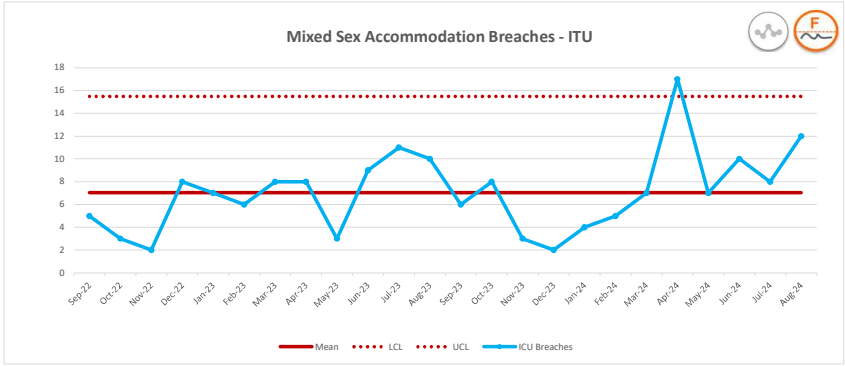
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) Target: 95% 21. Friends and Family (ED and UCC) Target: 87%	The Trust achieved 97% in month for Inpatient & Day case FFT and 77% for ED/UCC FFT.	  	(IP/DC) Assurance: The Trust consistently passes the target. (IP/DC) Variation: Common Cause (Normal) variation. (ED/UCC) Assurance: The Trust consistently fails the target. (ED/UCC) Variation: Special Cause variation of an improving nature.	Inpatient/Day Case - The Trust achieved a 97% positive recommendation rate in August 2024. ED/UCC - The Trust achieved a 77% positive feedback in Friends and Family Test results in August 2024.	Across all areas there is a monitoring of themes, identifying areas for improvement, best practice is shared at Patient Experience Sub-Committee and Patient Equality, Diversity and Inclusion Sub-Committee. Trust Board, Governors, PLACE and Patient Experience Team observations are fed back to wards/department and action plans are initiated and monitored through the governance structure. For ED/UCC Key themes for improvement include communication, waiting times, pain management and the environment. Monitoring of care and comfort rounds Visual communications to be more prominent in waiting areas. A charity bid will be progressed in October 2024. Mapping patient journeys to understand the support required at each touch point Reviewing opportunities to involve volunteers in FFT completion within the department Volunteers are assisting with drinks rounds The UEC Improvement Plan has commenced for 2024-2025, this work will address overcrowding, length of stay and discharge challenges.
22. Mixed Sex Accommodation Breaches (ITU Only) Target: Zero	There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There was 12 MSA incident(s) within the ITU.		Assurance: The Trust consistently fails the target. Variation: Variation: Special Cause variation of a concerning nature.	There were 12 mixed sex accommodation breaches reported in August 2024 in the Intensive Care Unit, an increase of 11 from July 2024. This is due to delayed discharges of Level 1 patients There were 0 breaches within any other ward area	All delayed discharges are escalated to the Patient Flow Team and Tactical Manager of the day, and discussed at each bed meeting. 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 is the high number of super-stranded patients within the Trust bed base. The Trust's policy relating to Mixed Sex Accommodation breaches is currently being updated.

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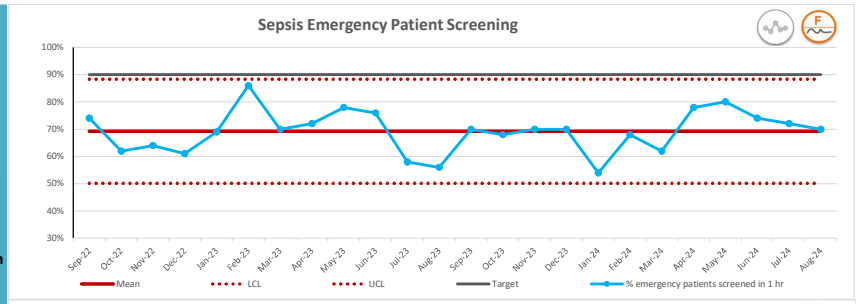
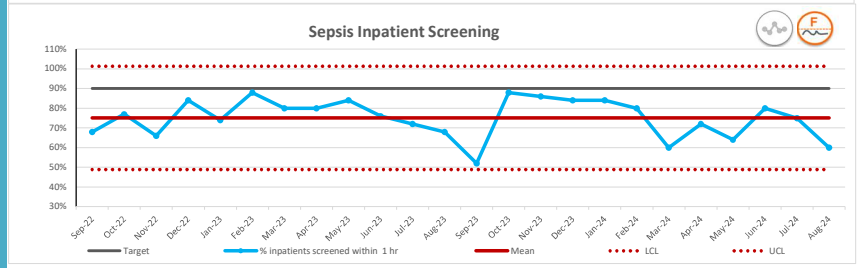
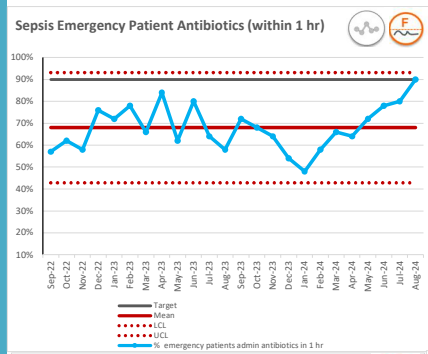
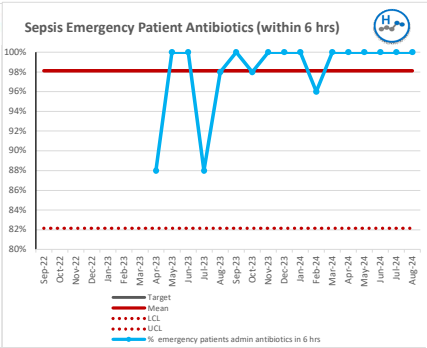
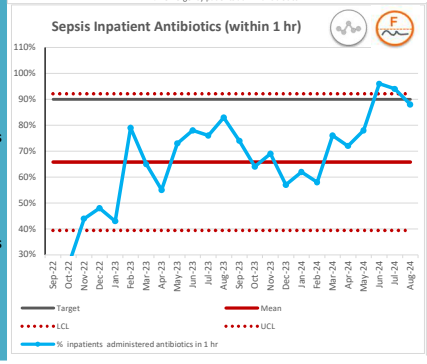
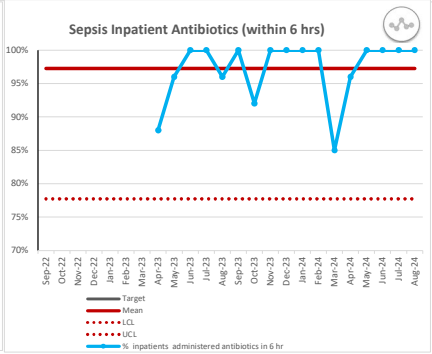
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%** **The Trust achieved:** **• 70% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** **• 60% screening for all inpatients with suspected sepsis within 1 hour.**	 	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**ED: 10 patients had a partial screen August 2024 .** **Inpatients: there were 4 patients who had a partial screen** **Over crowding and corridor care has remained consistent during August 2024, with full capacity protocol being in place for the majority of the month impacting this metric.** **When reviewing the reduction in this metric the inability to obtain blood cultures has been noted as a theme.**	**Sepsis management remains a focus on Safety Huddles and during the Trust Wide Safety Brief. The new NG 51 sepsis guidance was launched on the 13/09/24 in line with World Sepsis Day where the previous tool has been replaced with a new assessment criteria. Teaching sessions on using the tool have now commenced. A new e learning package has been completed and is due to be uploaded onto ESR by learning and development in Q3.** **ED continue where possible to 'ring fence' beds for patients with suspected sepsis, so they are not needing to be cared for on the corridor.**
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%** **The Trust achieved:** **• 90% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 100% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.**	 	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) cause variation.**	**In ED there has been a 10% increase in patients receiving their antibiotics with the 1 hour timeframe. This is the highest compliance to date.**	**Please see NG51 sepsis update above regarding the implementation of the new tool and the associated education plans.**
26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis **Target: 90%** **The Trust achieved:** **• 88% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.** **• 100% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	 	**(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**All inpatients and ED patients included in the audit received their antibiotics within 6 hours.**	

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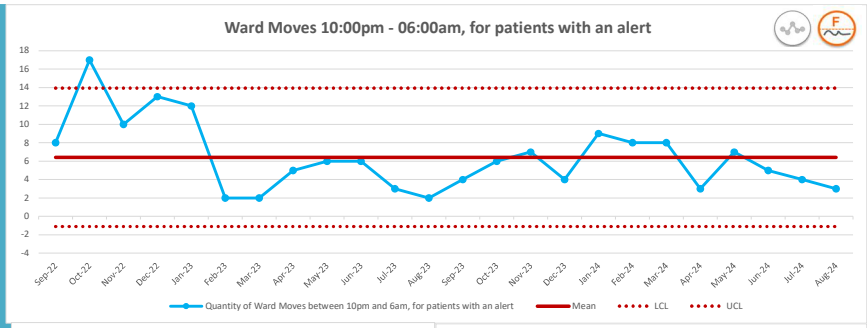
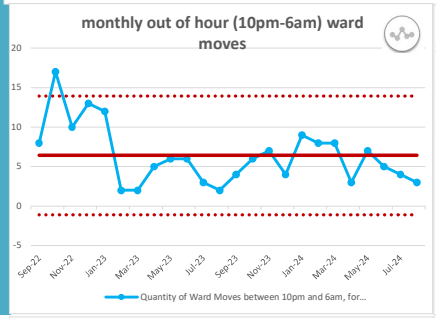
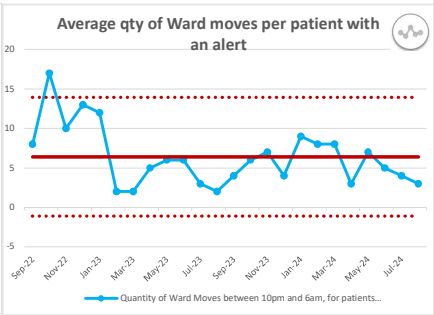
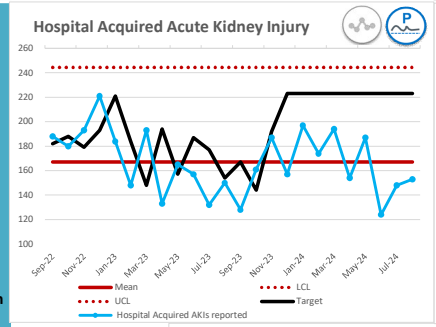
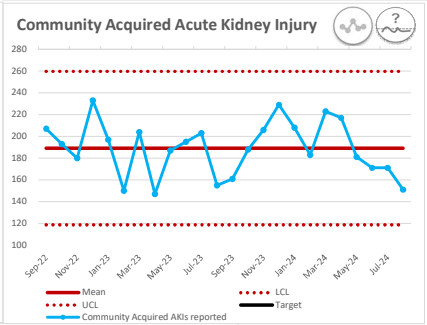
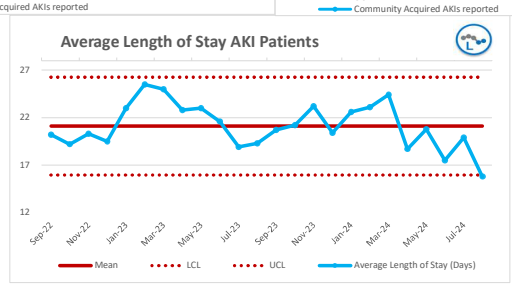
27. Ward Moves between 10:00pm and 06:00am with a dementia, LD and/or Mental Health alert **No Target**	**There were a total of 3 ward moves in month between 10pm-6am for patients with an alert, compared to 2 in June 2023.**	  	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**The reason for the reduction on ward moves after 10 pm for this reporting period compared to last year is as a result of the out of hours patient flow and Tactical Manager on call minimising non essential clinical patient moves.**	**The Tactical Manager on call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who undertake a welfare check.**
28. Acute Kidney Injury **Target: Less than month in previous year**	**There were 153 acute kidney injuries reported in month compared to 148 last month.**	  	**Assurance: The Trust Consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**All targets have been achieved. Community AKI has continued to reduce since March 2024.**	**Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient. Trust wide actions have been agreed following a Trust wide fluid balance audit to include** **1 amendment to the AKI E-learning package to strengthen fluid balance guidance,** **2 changes to fluid balance guideline to more clearly define roles and responsibilities,** **3 increasing simulation opportunities related to fluid balance recording in HCA induction.** **4 Ward based further AKI education as part of the AKI role.** **5 Drive to increase the AKI bundle to improve practice and utilise the AKI clinics each week to reduce the 30-day readmission rate.**

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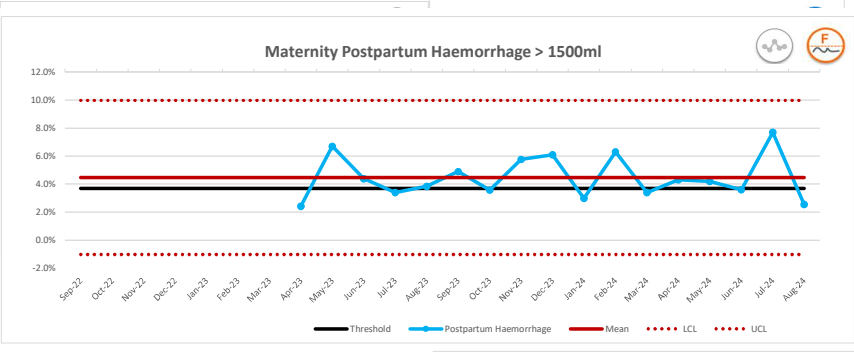
29. Maternity Postpartum Haemorrhage >1500ml Threshold: < 3.7%	There were 2.55% Postpartum Haemorrhages >1500ml in month.		N/A - Not enough datapoints.	Rates for August have seen a significant decrease. QI work is ongoing but rates continue to fluctuate. The benchmark is based on historical regional data. The service is waiting for recent data to more accurately compare the service with other providers.	PPH >1500mls will continue to be reviewed on an individual basis via governance processes but will also be subject to additional review through the Intrapartum Incident Review Group which meets regularly to review patterns and themes from incidents of PPH >1500ml. In addition a PPH QI Group has been established. This QI Group is leading on the improvements identified as part of the previous audit. The PPH action plan is reported monthly to QAC alongside an SPC chart from June 2024. No trend identified to date.

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CQC Care Quality Commission
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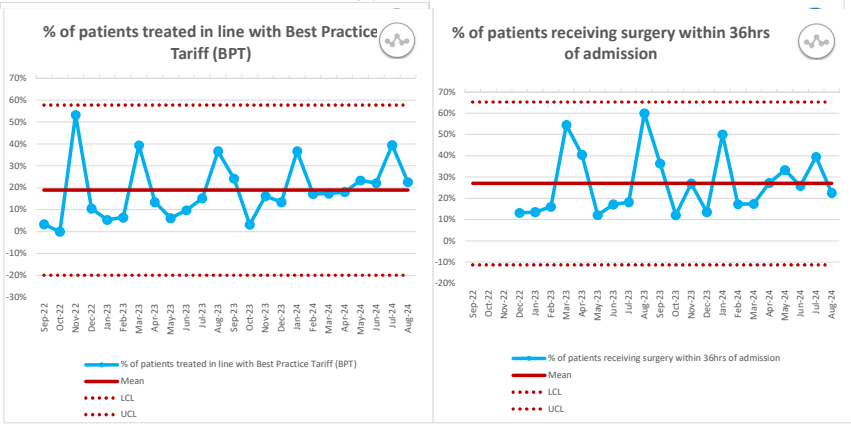
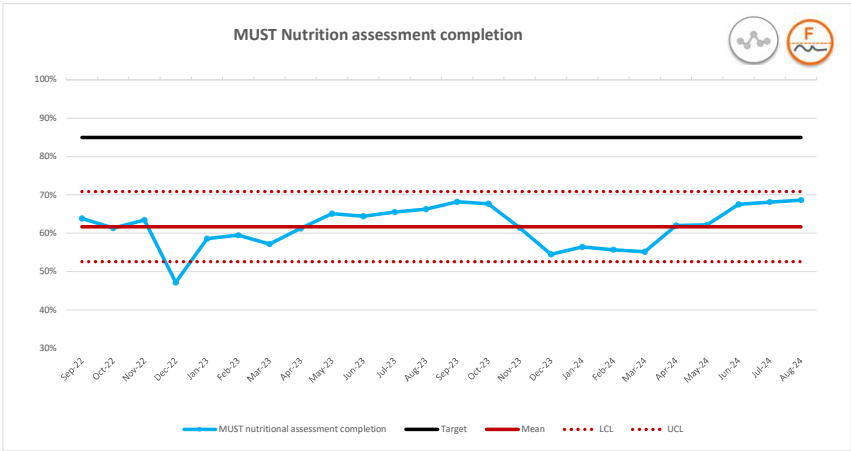
Quality Improvement - Trust Position

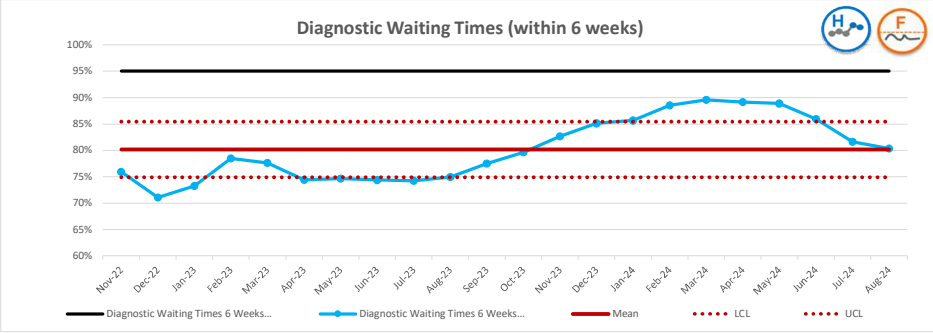
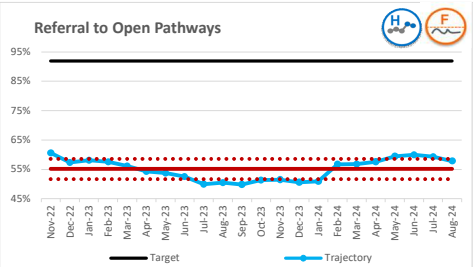
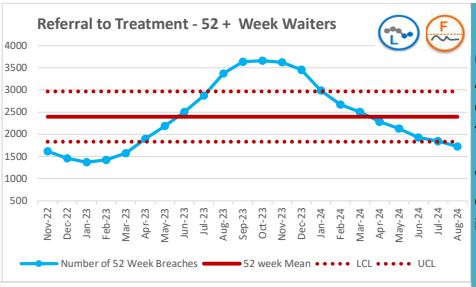
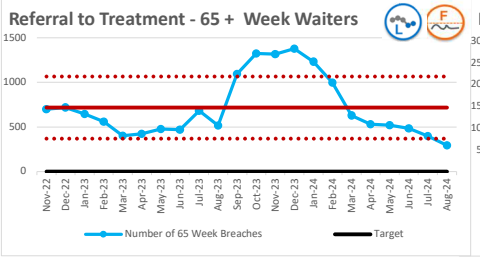
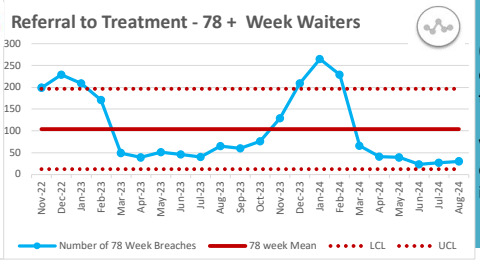
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
30. Fractured Neck of Femur **Target: Best Practice Tariff**	**39.47% of patients were treated in line with Best Practice Tariff (BPT) in Jul-24.**	 	**Variation: Common Cause (Normal) variation.**	**Overall average time to theatre increased in the cohort of patients who were discharged in August. This was due to the volume of trauma patients There was a total of 34 operated cases from this cohort, of which 31 were NOF fractures and 3 were peri-prosthetic in nature.**	**Continue theatre improvement work to increase efficient performance of trauma lists. Escalation Standard Operating Procedure in place Executive oversight through Patient Safety and Clinical Effectiveness Meeting. Further work with clinical leads for T&O and BPT, senior nursing and operational leads to identify further opportunities to sustain and build upon improvement.**
31. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 68.63% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**MUST compliance remains below Trust target on the LION Dashboard. Improvement continues in comparison to 23/24. Aug 2024 compliance is 42.96% for assessment within 6 hrs, 68.67% for assessment within 24hrs of admission, 41.74% for reassessment at 7 days from admission. These results have noted a continued improvement since May.**	**MUST weekly data is sent out to all Ward Managers and Matrons to ensure clinical oversight to improve compliance. Nutrition Champions have been reinstated with meeting held, meetings scheduled for the year. Review of weighing pat-slide scales currently in the Trust Compliance Meetings are ongoing with the Deputy Chief Nurse for areas struggling with compliance. All areas have access to the LION dashboard data and are asked to provide an action plan to improve MUST compliance**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 85.94% in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.	A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although radiological modalities remain fully recovered, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies and Endoscopy, the opening of the Endoscopy hub will support recovery, plans are in place for all modalities.
33. Referral to treatment Open Pathways Target: 92% 34. RTT - Number of patients waiting 52+ weeks Target: 0	The Trust achieved 59.91% in month. There were 1930, 52 week breaches, 23, 78 week breaches and 484, 65 week breaches.	   	(Open Pathways) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature. (52+) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	RTT performance - both 52 weeks and 65 weeks are off trajectory, with Gynae, T&O and Max Fac being major contributing specialties, 78 weeks numbers continue to reduce no capacity breaches were declared in July or August, mitigation plans through use of insourcing and mutual aid are supporting recovery plans.	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Restoration and recovery plans for 2024/25 have been drawn up in line with current Operational Planning Guidance. • Commencement of the TIF elective project has necessitated the closure of theatres 1 and 2 at Nightingale, Halton, sessions have been redistributed across both sites, once works have completed this will give an additional theatre at Halton Nightingale

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Access & Performance - Trust Position

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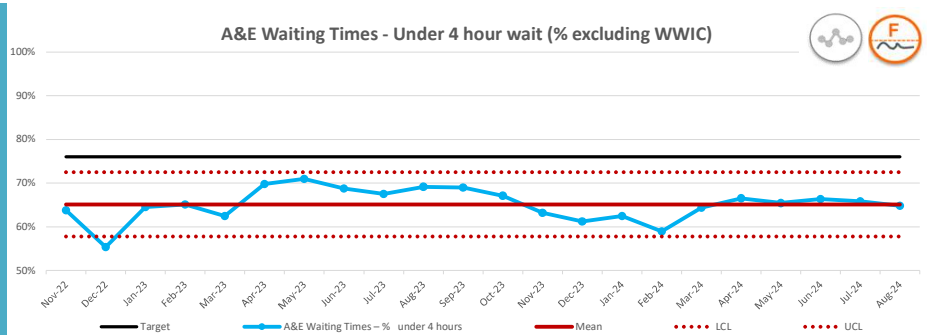
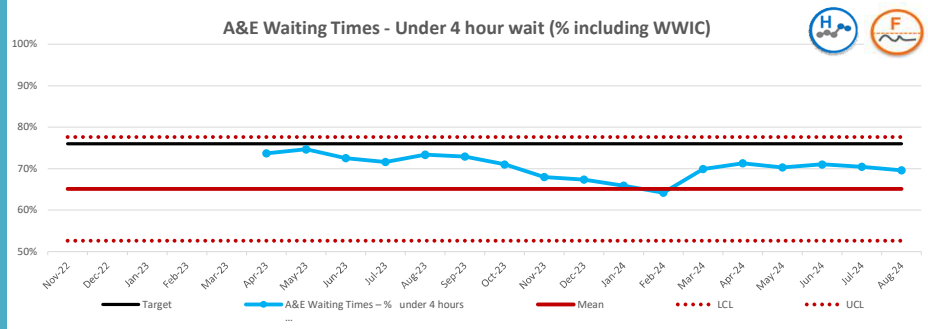
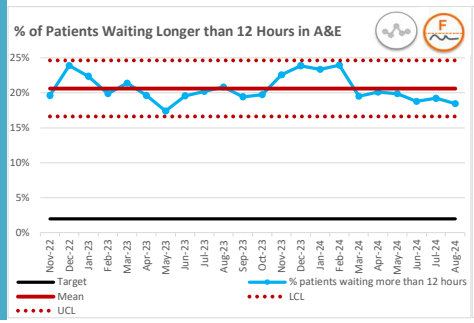
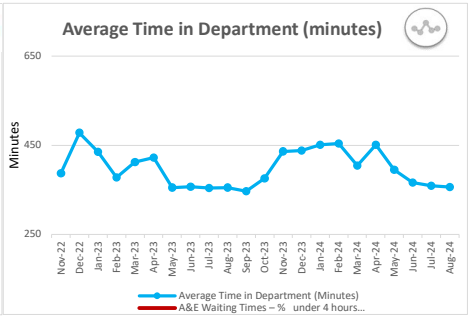
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
35.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WWIC) Target: 75%	CQC **The Trust achieved 66.36% excluding Widnes walk ins in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy.**	**• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** **• System resource investment in order to support Pathway 1 discharges.** **• A10 escalation beds closed on 7th June taking out 14 beds which negatively impacts on ED performance.**
76.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	RR224				
76.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WWIC) Target: 75%	**The Trust achieved 0% excluding Widnes walk ins in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**		
36. Average time in department ED No Target	**18.8% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 366 minutes.**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) variation.**	**12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in ED.**	**The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 24/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 24/25 is set up to support improvement.**

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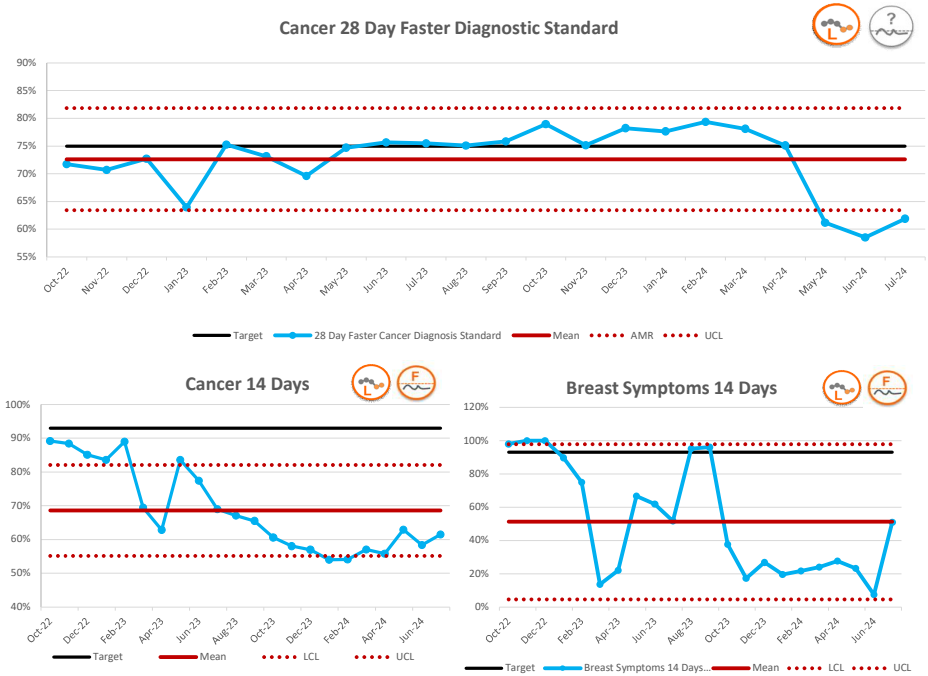
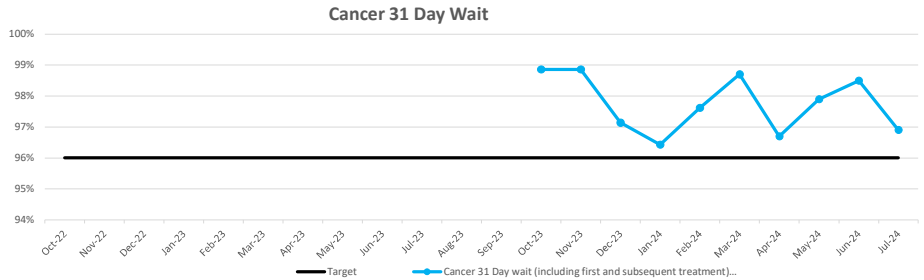
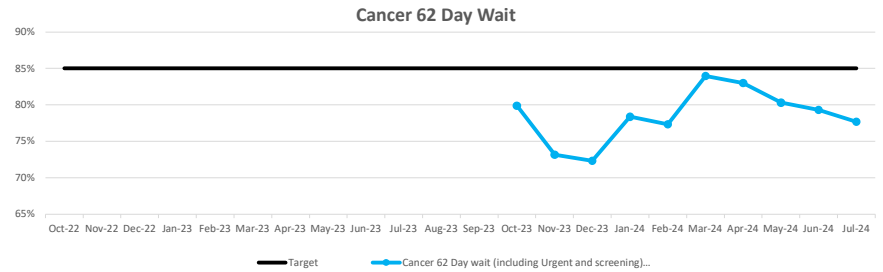
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
SOF The Trust achieved 61.2% in month.		Assurance: Target failed for the past 3 months due to breast first appointment capacity. Capacity recovered in July. FDS recovering for Aug/Sept Variation: Common Cause (Normal) variation.	The Trust is currently meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology and Breast that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG).
SOF CQC The Trust achieved 97.8% in month for Cancer 31 Day Wait.		Assurance: Target met consistently Variation: NA - not enough data	The Trust achieved the 31 day target.	
SOF CQC The Trust achieved 79.4% in month for Cancer 62 Day Wait.		Assurance: NA - Commitment to achieveing 70% by March 25 required nationally. This is currently being met Variation: NA - not enough data	The 62-day referral to treatment target remains challenging but is seeing some improvement due to the combined standards. From the 1st October 2023 this standard will be combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 70% by March 2025. The Trust is currently achieving this.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

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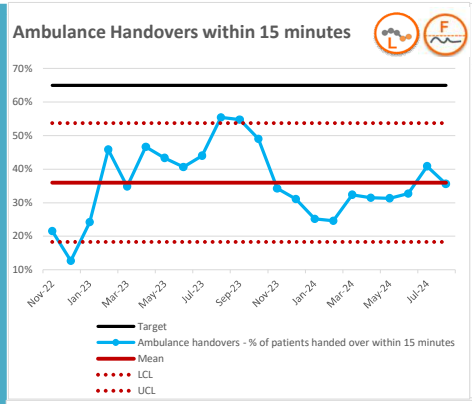
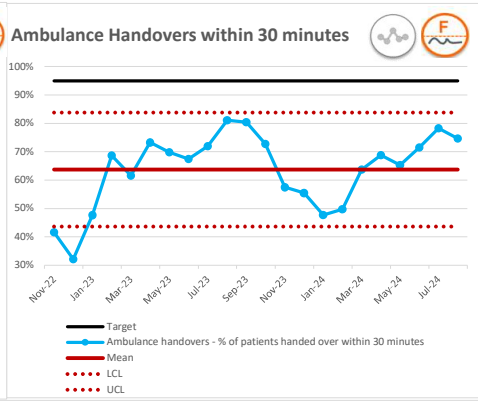
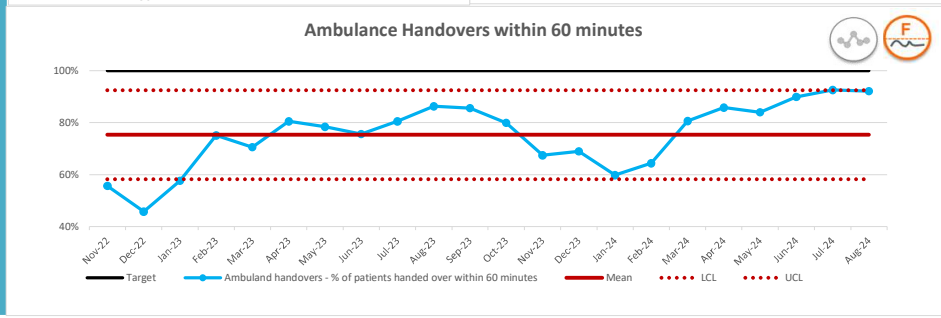
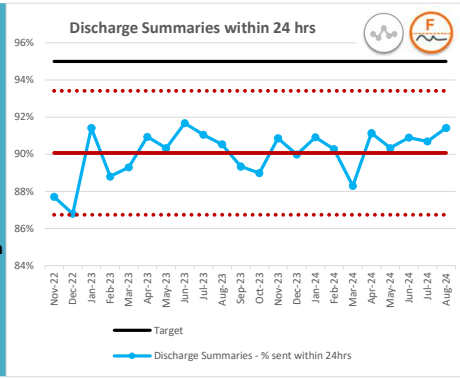
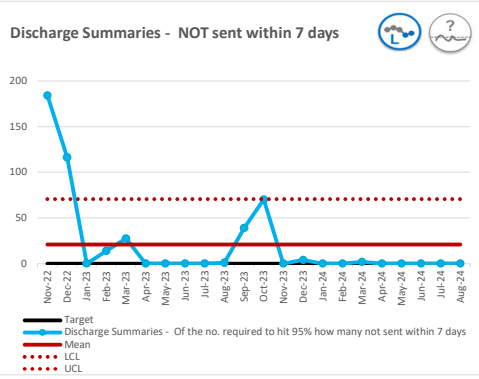
Access & Performance - Trust Position

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)?
In month 32.7% of patients were handed over within 15 minutes, 71.53% were handed over within 30 minutes and 89.9% were handed over within 60 minutes.	  	(15) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature. (29) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (60) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Handover performance continues to be a priority, it has been challenged due to surges in demand and workforce constraints	The Trust will continue to work in partnership with NWAS to identify and implement improvements.
The Trust achieved 90.79% in month for discharge summaries sent within 23 days, against the target of 95%. There were 1 discharge summaries in month not sent within 7 days, against the target of 0.	 	(24 hrs) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (7 Days) Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.	The Performance Review Group (PRG) continues to monitor this standard to support improvements.

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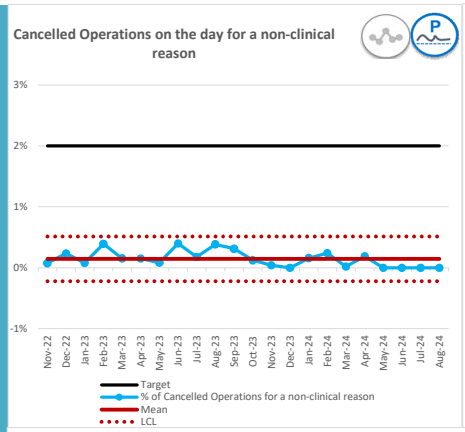
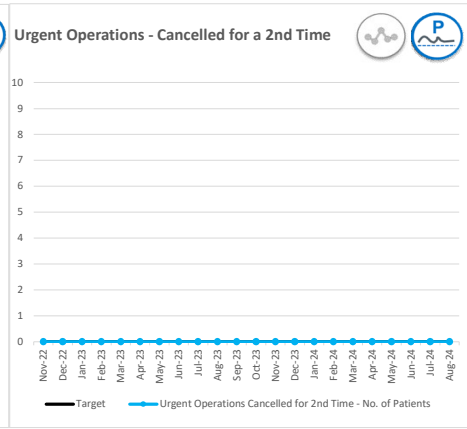
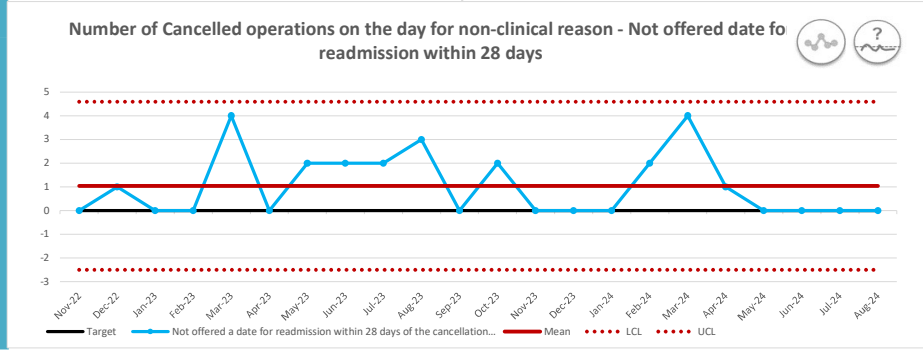
Access & Performance - Trust Position

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)?
CQC Cancelled operations for a non-clinical reason was 0% in month. 2 cancelled operations were not offered a date for readmission within 28 days.	  	(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation. (Not offered 28 days) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation. (Urgent Ops cancelled 2nd time) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	The position is currently being reviewed by the Care Groups.	Recovery of elective activity continues to be monitored via Performance review group. A discrepancy in reporting has been identified by analytics this will mean an increase in reporting, it is anticipated that this will keep us in line with peers, there will be an increase in the number reported from next month.

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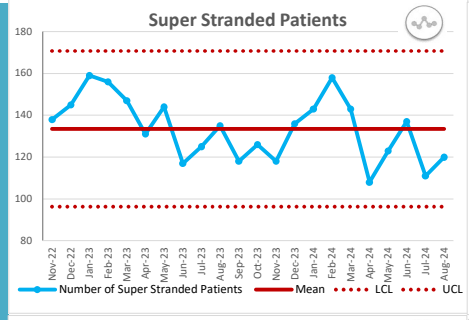
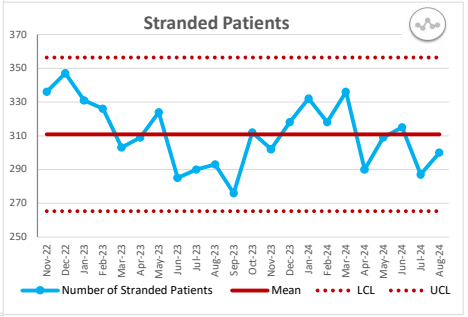
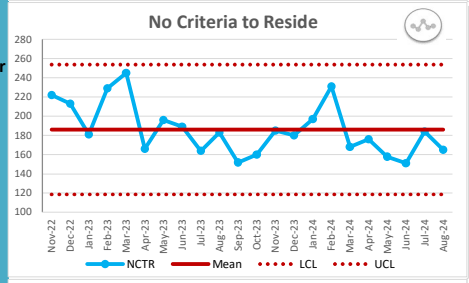
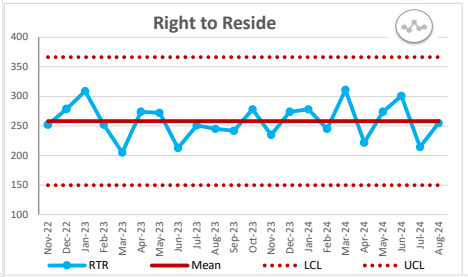
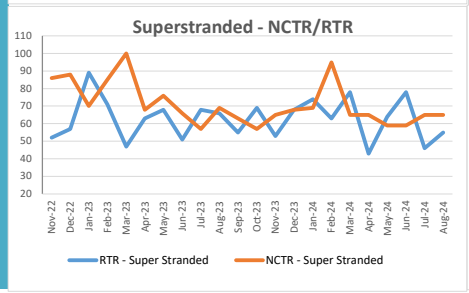
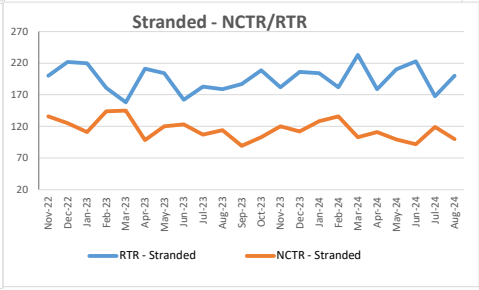
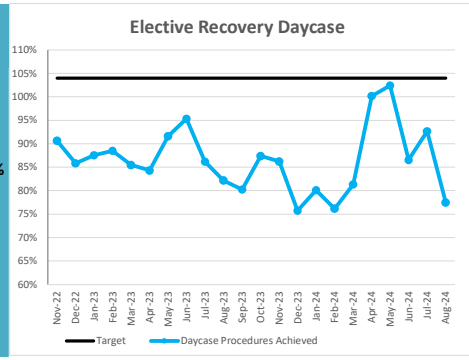
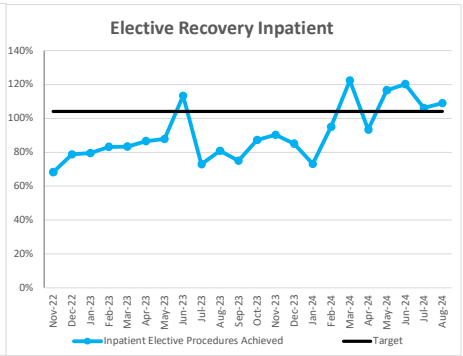
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
There were 315 stranded and 137 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	     	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The number of Super Stranded patients has increased in month showing a similar pattern to last year, this is being driven by NCTR patients, work is on-going with system partners to support a reduction	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included 88% of Daycase Procedures and 120.24% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient electives had a strong performing month a decrease in day cases was seen as a result of the focus on clearing the complex long waiters	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.

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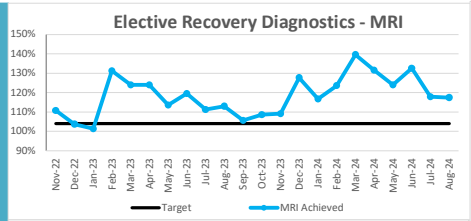
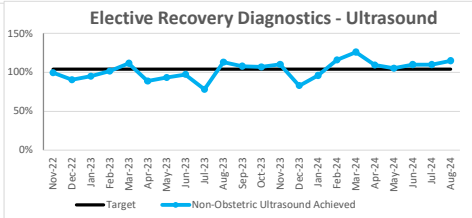
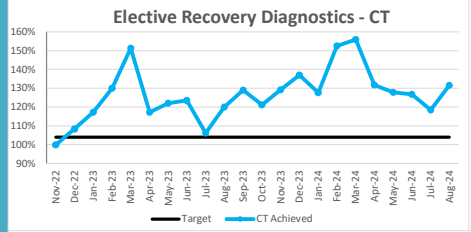
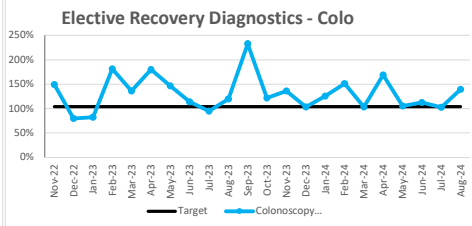
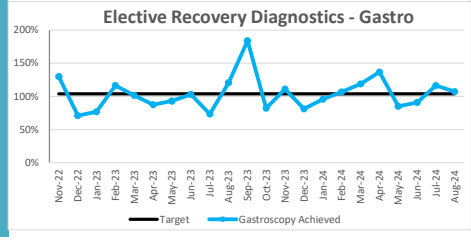
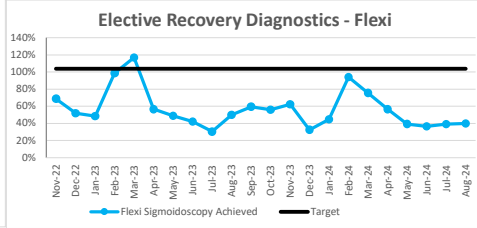
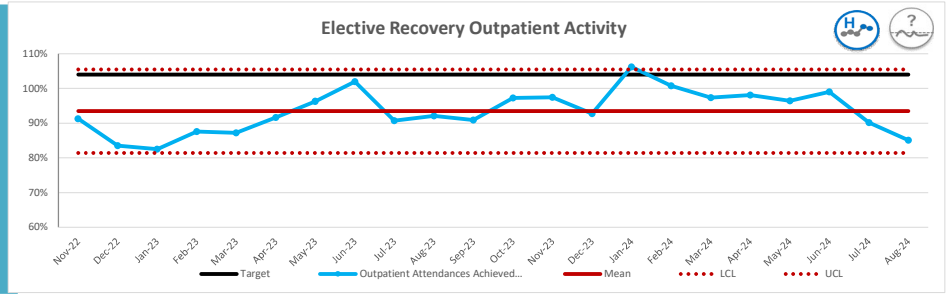
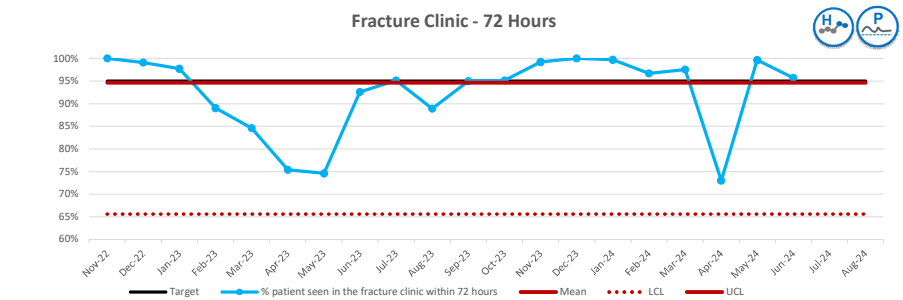
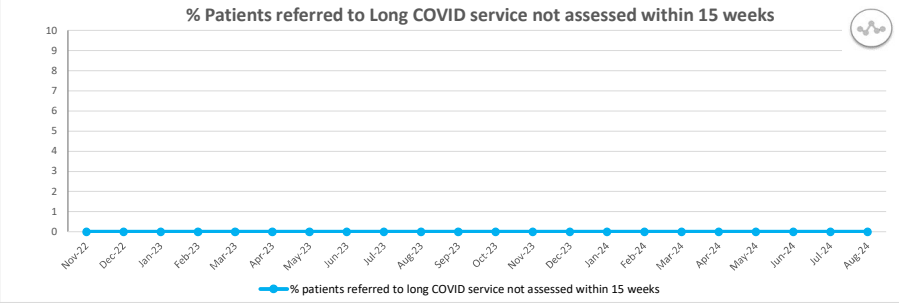
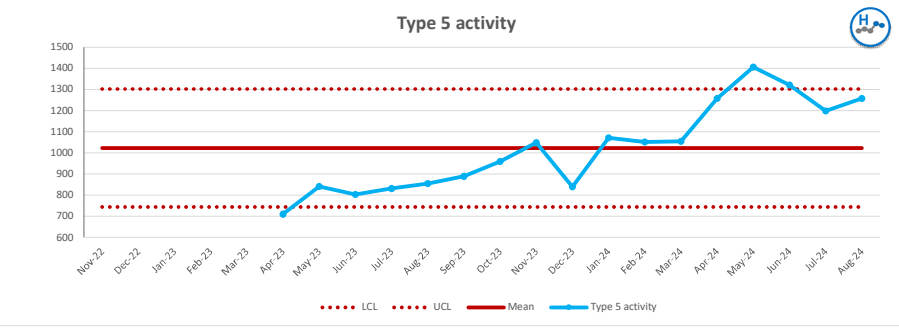
Access & Performance - Trust Position

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)?
SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included: 132.55% of MRI 126.77% of CT 109.85% of Non-Obstetric Ultrasound 36.63% of Flexi Sigmoidoscopy 112.32% of Colonoscopy 90.84% of Gastroscopy RR1125	     	N/A - Grouped indicator.	Radiology modalities remain fully recovered, Challenges in Endoscopy due to the delay in the hub being operational and on-going pressure within cardiorespiratory remain Challenges remain in Cardiorespiratory services.	The Trust continues to restore clinical services in line with the national operating guidance. Additional insourcing support for Echo is being progressed to help reduce waiting times. Underperformance modalities are monitored at PRG with recovery trajectories in place for each service
SOF RR1125 In month, the Trust achieved 97.34% of Outpatient activity against 2019.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The Trust continues to deliver Outpatient activity inline with operational planning guidance	The Trust continues to restore clinical services in line with the national operating guidance. The August position will improve following completion of coding of OPD procedures

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
In monthly, the fracture clinic saw 95.7% of patients within 72 hours.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Good performance position is being sustained.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.		
Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 96300 Type 5 Attendances.		Assurance: N/A Trajectory Not Agreed. Variation: Special Cause variation of an improving nature.	As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.	

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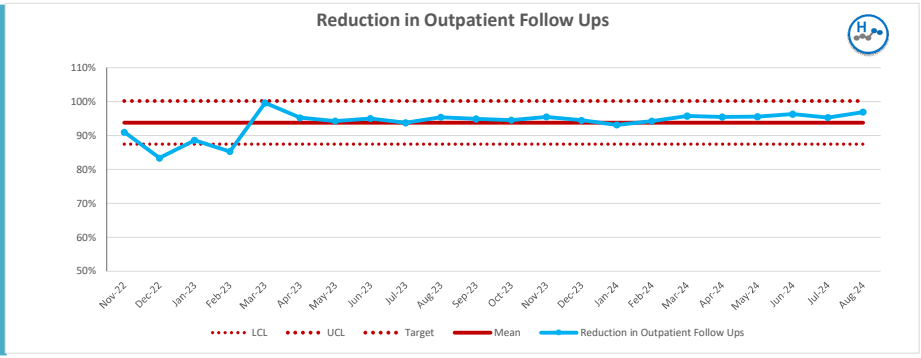
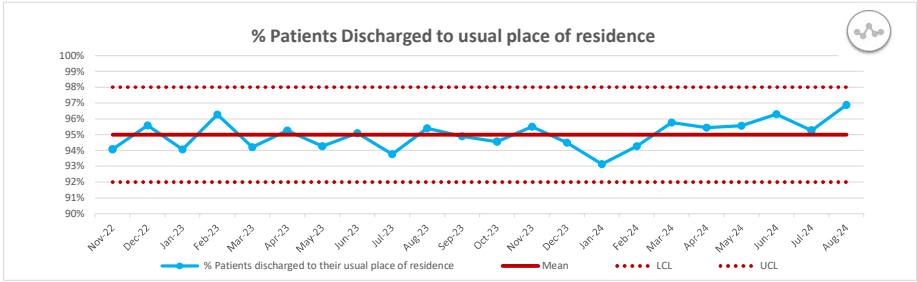
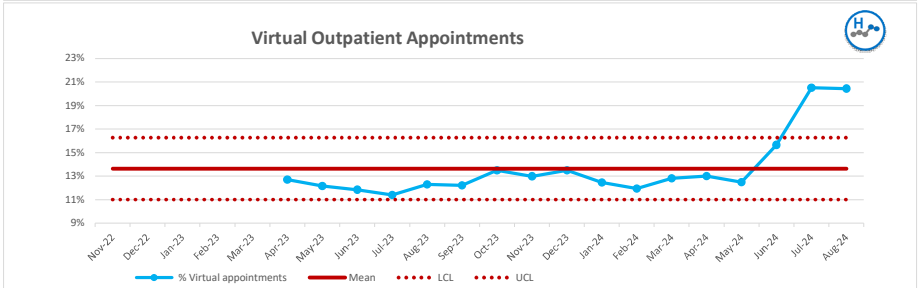
Access & Performance - Trust Position

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)?
Outpatient follow ups have reduced to 96.3% of 19/20 activity in month.		Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature.	Outpatient follow ups is in line with the agreed trajectory as part of annual planning.	
96.29% patients in month were discharged to their usual place of residence.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.		
15.63% Virtual Outpatient appointments in month.		Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature.	Use of the Virtual clinics for both Frailty and Respiratory is monitored via the bed meetings on a daily basis	Capacity in Frailty Virtual clinic has increased in line with the service maturing, case finders for both Respiratory and Frailty support utilisation

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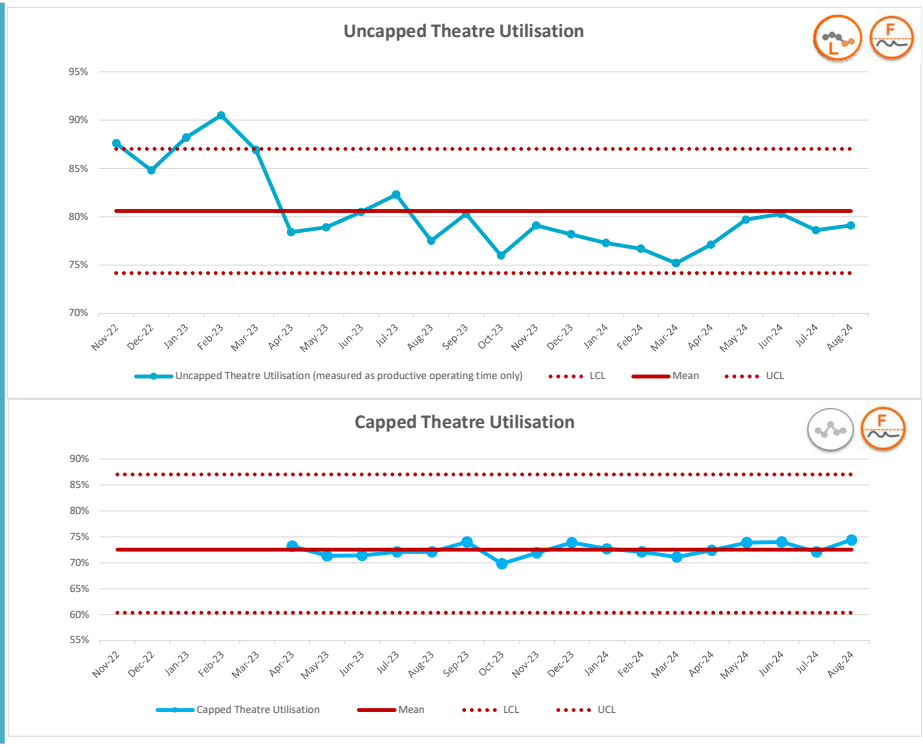
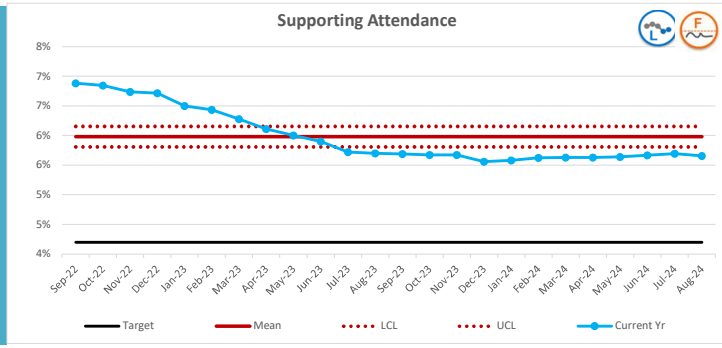
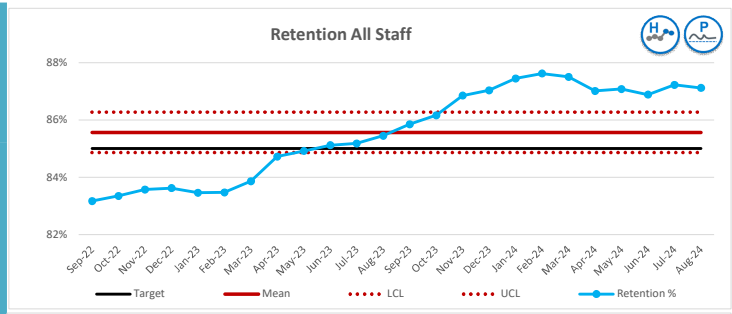
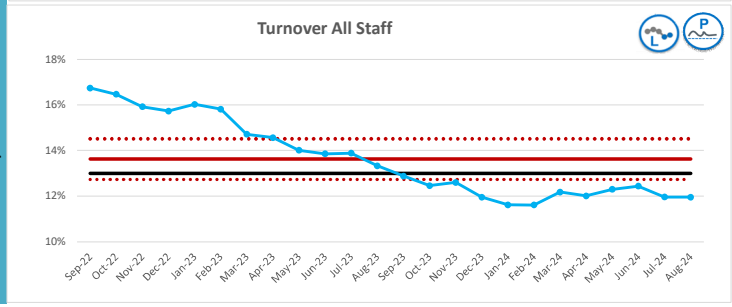
Access & Performance - Trust Position

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)?
80.3% Uncapped Theatre utilisation in month (measured as productive operating time only). 74% Capped Theatre utilisation in month (measured as productive operating time only).		Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of a concerning nature. Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Theatre Utilisation remains a challenged area, a focus on late starts and improving productivity are key priorities for 24/25. *Please note, data in the IPR has been revised to reflect utilisation - previously a combined utilisation and productivity figure. As a result, figures are different from those previously reported in the IPR.	The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data. Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors. The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates. Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
63. Supporting Attendance Target: Below	UoR SOF S The Trust's annualised sickness rate was 5.65%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence is showing an Improving Variation. The annualised sickness absence percentage in August 2024 was 5.65%, which is very similar to the previous 6 months. Reasons for the reduction in sickness absence from 2022 can be attributed to the reduction in long term sickness following implementation of the new Attendance Management policy and the People Health and Wellbeing Group being established which focuses on specific reasons for absence and interventions to reduce.	Sickness absence levels remain above target but are below 2022/23 absence rates. Stress, anxiety and depression continue to be the highest reason for sickness absence. A pilot is currently underway with Rugby League Cares (RLC) to support those off long term sick back to work. RLC will also be implementing targeted interventions to support those areas deemed as 'supported' in the 'We are WHH' culture plan to support people staying well in the workplace. The Mental Health Wellbeing Hub have implemented a new triage system and group therapy approach to support staff experiencing any mental health related episode or illness.
64. Retention Target: 85%	UoR RR1108 RR1134 The Trust's annualised retention of all staff was 87.12%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Annualised retention is showing an Improving Variation. Retention of all staff in August 2024 was above Trust target at 87.12%, a slight increase from 86.89% in June 2024. Retention for permanent staff in August 2024 remains above Trust target at 89.65%.	Work/life balance, relocation, retirement and promotion are the main reasons people leave WHH. Improving flexible working continues to be a priority and is embedded into the We Are WHH Culture Plan. It is a key area of delivery for the Trust's nationally funded People Promise programme of work. The People Promise Manager is working with areas identified for piloting flexible working including team rostering. Improvements in turnover and retention are reflected in the overall increase in substantive workforce numbers, thus leading to a reduction in temporary staffing.
65. Turnover Target: Below 13%	S CQC SOF UoR The Trust's annualised turnover of all staff was 11.95%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in August 2024 was 11.95%, a decrease from June 2024 at 12.44% Turnover of permanent staff in August 2024 remains above Trust target at 11.10%.	

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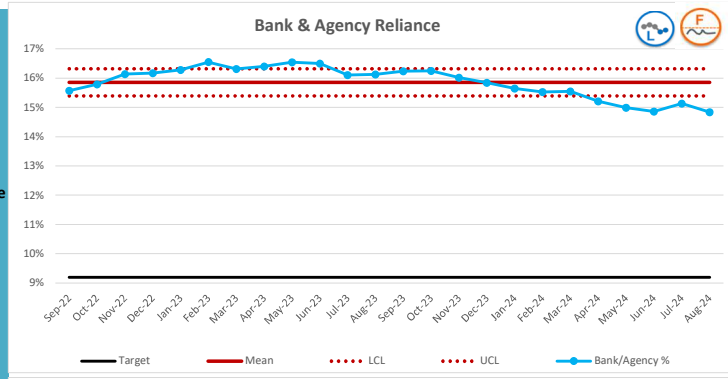
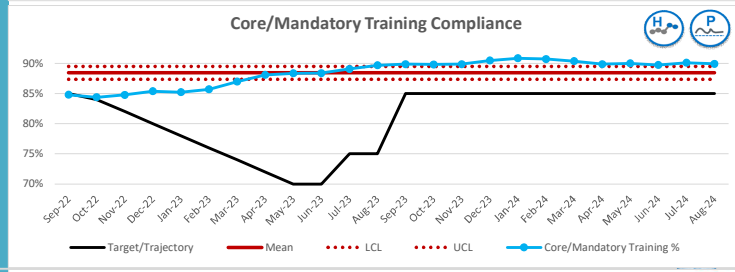
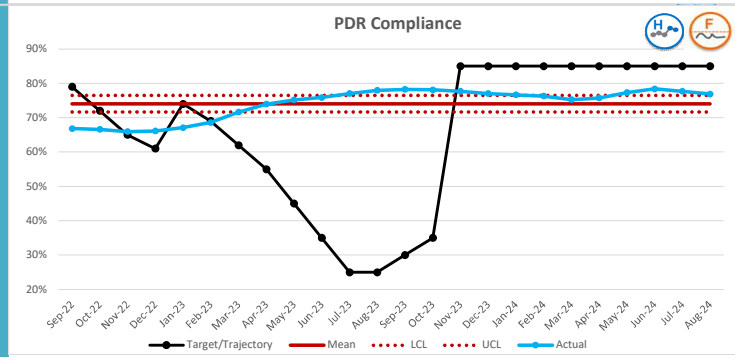
66. Bank and Agency Reliance Target: 9% or Below	UoR Annualised Bank and Agency Reliance was 14.64%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Bank and Agency reliance is showing an Improving Variation. Bank and Agency reliance in August 2024 was 14.64%, a slight improvement from June 2024 at 14.66%. Bank reliance in August 2024 is 12.9%, a slight increase from 12.4% in June 2024. Agency reliance continues to decrease and was 2.4% in August 2024 against a target of 3.2%.	The Resourcing Task and Finish group has shared with Staff Group leads findings relating to approaches to improve how effectively the Trust deploys it's workforce. The Trust is working with regional colleagues to review it's roster systems/capability and job planning system/process to ensure staff are effectively deployed. There are also workstreams within Nursing and Medical to convert agency to bank and bank to substantive which is reflected in the reducing reliance on agency workers.
67. Core/ Mandatory Training Target: 85%	UoR CQC Core/Mandatory training compliance was 89.9% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training is showing an Improving Variation. In August 2024, CSTF Mandatory Training compliance was 89.9%.	Care Groups report compliance at Operational People Committee with actions required to ensure targets are met. Further to the national CSTF review, there were only a few areas identified as a variation at WHH to the proposed national approach. These areas are being discussed with the national team to ensure the correct approach within legislative frameworks is applied.
68. PDR Target: 85%	S CQC Annualised PDR compliance was 76.88%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In August 2024, Appraisal compliance was 76.88%, a slight decrease from 78.4% in June 2024. Currently Appraisal rates are below the trajectories but higher than 2022.	Care Groups and Corporate areas report their PDR compliance at Operational People Committee (OPC) and have set trajectories to achieve 85% compliance by July 24. OPC continues to support Care Groups to achieve the target by sharing best practice across Care Groups and amending processes and ways of working to support achievement of the Trust target.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
SOF System Oversight Framework
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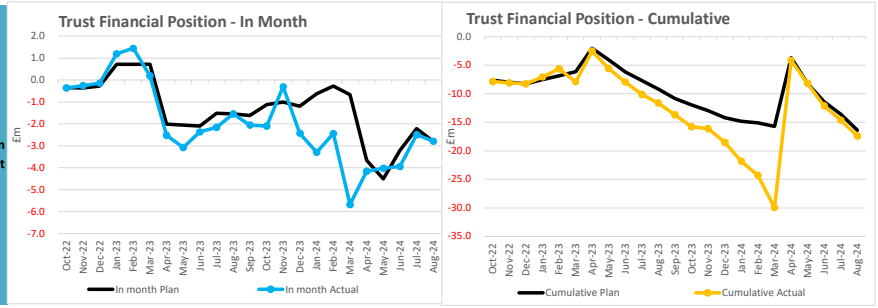
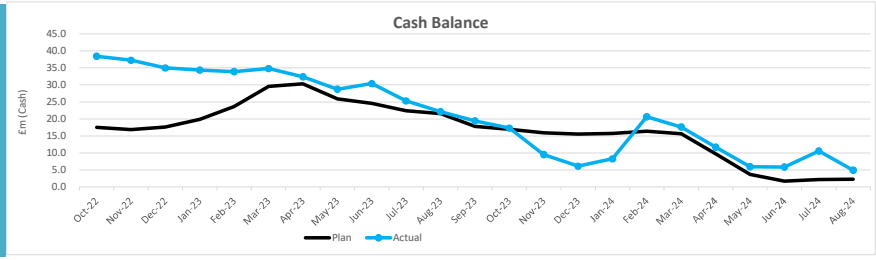
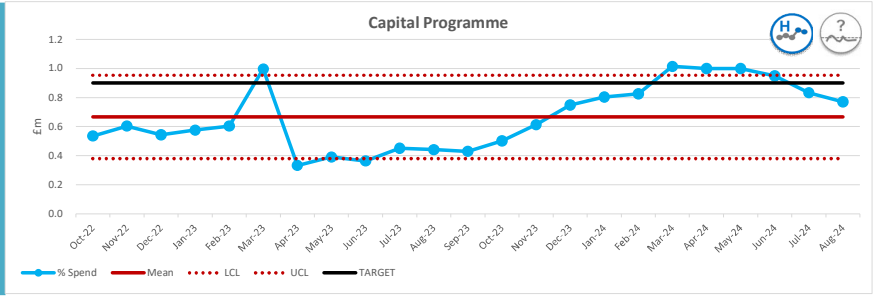
Trust Strategy

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
69. Trust Financial Position Target: Plan	The Trust has recorded a deficit position of £17.4m at 31 August 2024 against a deficit plan of £16.4m.			The driver for the deficit being worse than plan is the impact of Industrial Action.	Seek funding to offset the impact of Industrial Action. In addition, work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity to ensure delivery of the financial plan.
70. Cash Balance Target: On or better than plan	UoR The cash balance at 31 August 2024 is £4.9m. RR134			The current cash balance is £4.9m which is £2.7m higher than the cash plan. This is due to the timing of receipt of income and payment of capital creditors. Of the £4.9m cash, £3.7m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £5.1m was submitted and approved for July 2024. No cash was required for August. A submission of £5.2m was submitted for September however only £4m has been approved. The Trust has been allocated a share (£16.458m) of the £150m deficit support provided to the Cheshire and Merseyside ICS.
71. Capital Programme Target: On plan 90%-100%	UoR Capital expenditure at the end of month 5 is £4m against a plan of £5.1m.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The annual Trust Capital Plan of £23.3m is oversubscribed by £0.2m against £23.1m of capital funding. Capital expenditure at month 5 is £0.9m behind the Trust internal plan of £4.8m at month 5. This is due to timing and is expected to catch up later in the year.	The reason for the year to date variance is due to timing and is expected to catch up later in the year. Work has also started on planning for the 2025/26 capital programme with schemes being flagged if they could be brought forward to 2024/25 if required.

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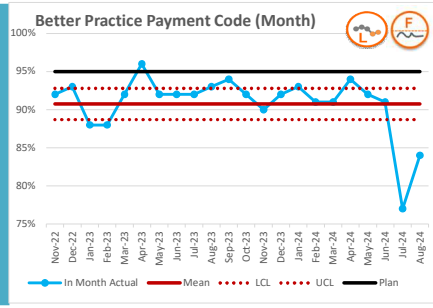
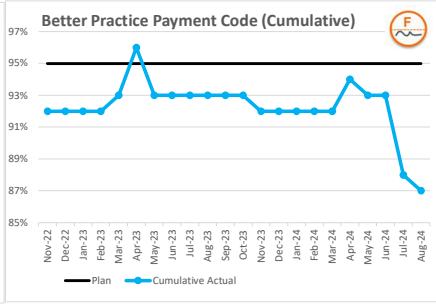
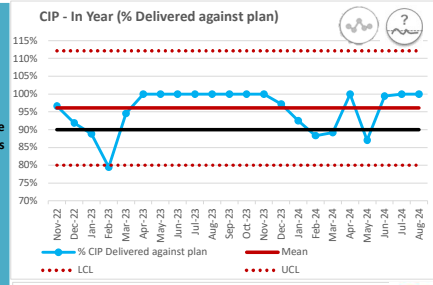
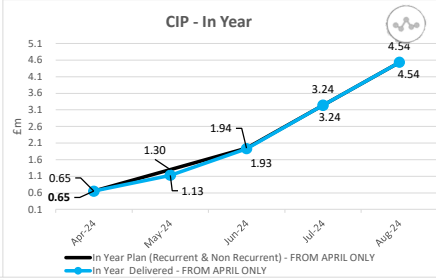
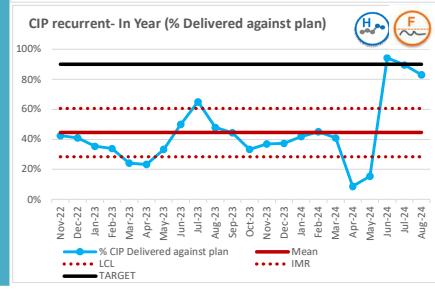
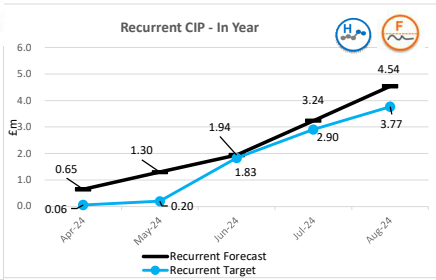
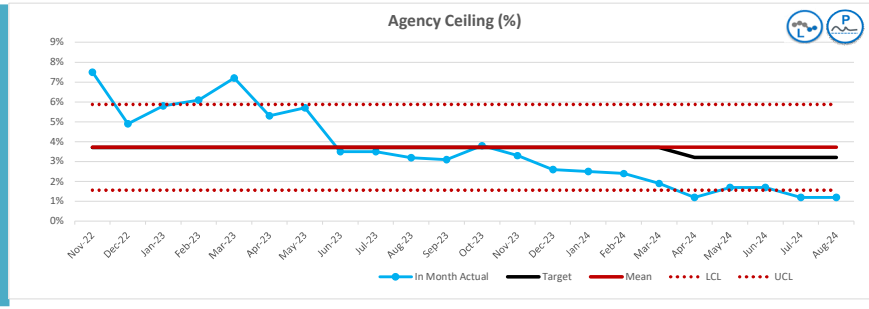
72. Better Payment Practice Code Target: Cumulative performance 95%	Cumulative BPPC performance is 87% which is below the national target of 95%.			Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	Timely raising of requisitions, matching of purchase orders and approval of invoices enables invoices to be paid within the 30 day threshold for Better Payment Practice Code (BPPC). There are some occasions where this is not always possible which has led to the achievement of 87%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.
73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date Target: >90% plan delivered YTD	The month 5 year to date CIP plan is £4.5m and has been fully delivered.			Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	Although CIP has been fully delivered at M5, it should be noted that £0.4m has been achieved from non-recurrent central items.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. These savings are dependant on achieving the 104% which was achieved at June 2024 freeze. The Trust has now identified all of the £19.4m CIP programme and work is ongoing to deliver the identified schemes. Schemes will continue to be identified in excess of the £19.4m to mitigate against any high risk
74. Cost Improvement Programme (recurrent) – In year performance to date Target: Recurrent Forecast is more than 90% of annual target	£3.8m CIP has been delivered recurrently against the target of £4.5m.			Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.	The Trust is continuing to identify recurrent CIP schemes for 2024/25. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT are being used.
75. Agency Ceiling Target: Agency spend should not exceed 3.2% of total pay (ICS target)	The Trust Agency spend in month is 1.2% against a target of 3.2%.			Assurance: The Trust consistently passes the target Variation: Special Cause Variation of an improving nature.	The national agency ceiling is 3.2% in 2024/25. Trust agency spend is still significantly below the target at 1.2%.	Agency spend continues to be monitored even though the target has been consistently achieved so that any actions can be taken if required. In addition, bank expenditure is now the focus of further scrutiny to control overall pay expenditure and ensure appropriate use.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR - August 2024 Detail
2nd October 2024

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There are **3 indicators that are both failing and have special cause variation of a concerning nature**, these are:

Quality:

- **5.** Healthcare Acquired Infections (CDI)

Access and Performance:

- **61.** Uncapped Theatre Utilisation

Finance and Sustainability:

- **72.** Better Payment Practice Code **(NEW)**

Introduction

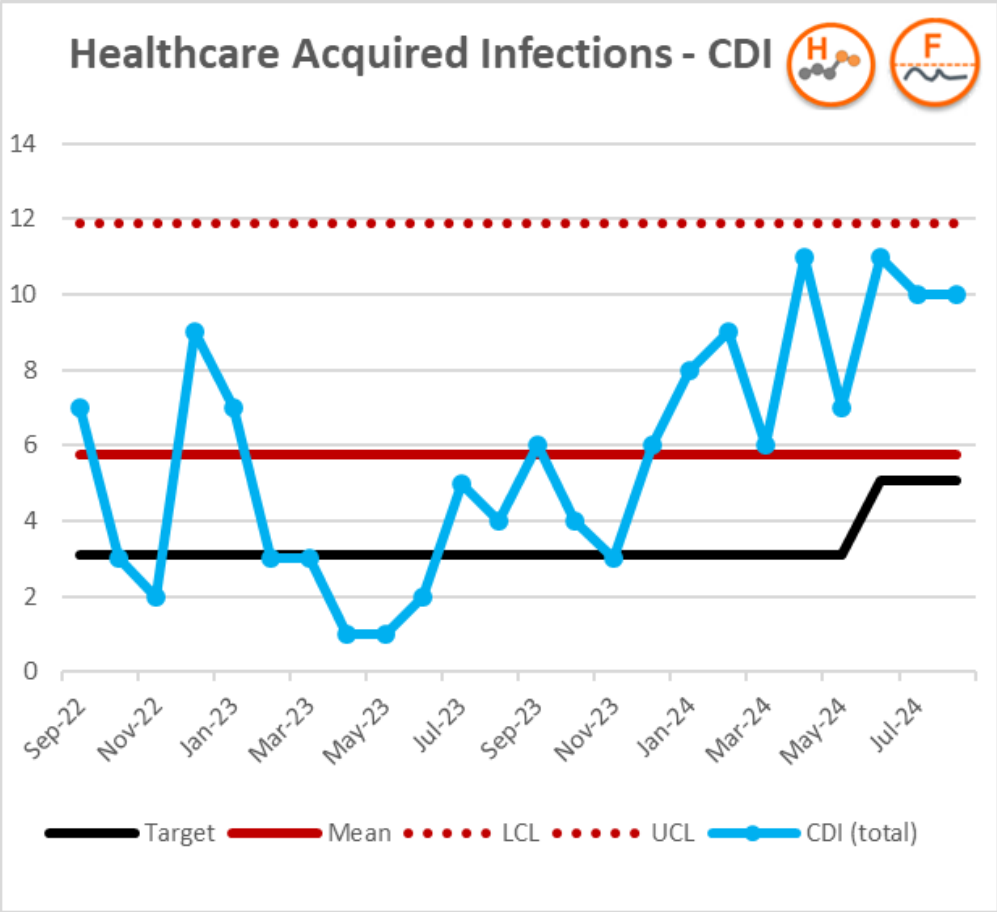
Warrington and Halton Teaching Hospitals NHS Foundation Trust

The below 2 categories have improved in either variation or assurance since last month:

- ***10.*** *VTE Assessment*
- ***41.*** *Ambulance Handovers within 15 minutes*

5. Healthcare Acquired Infections (CDI)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

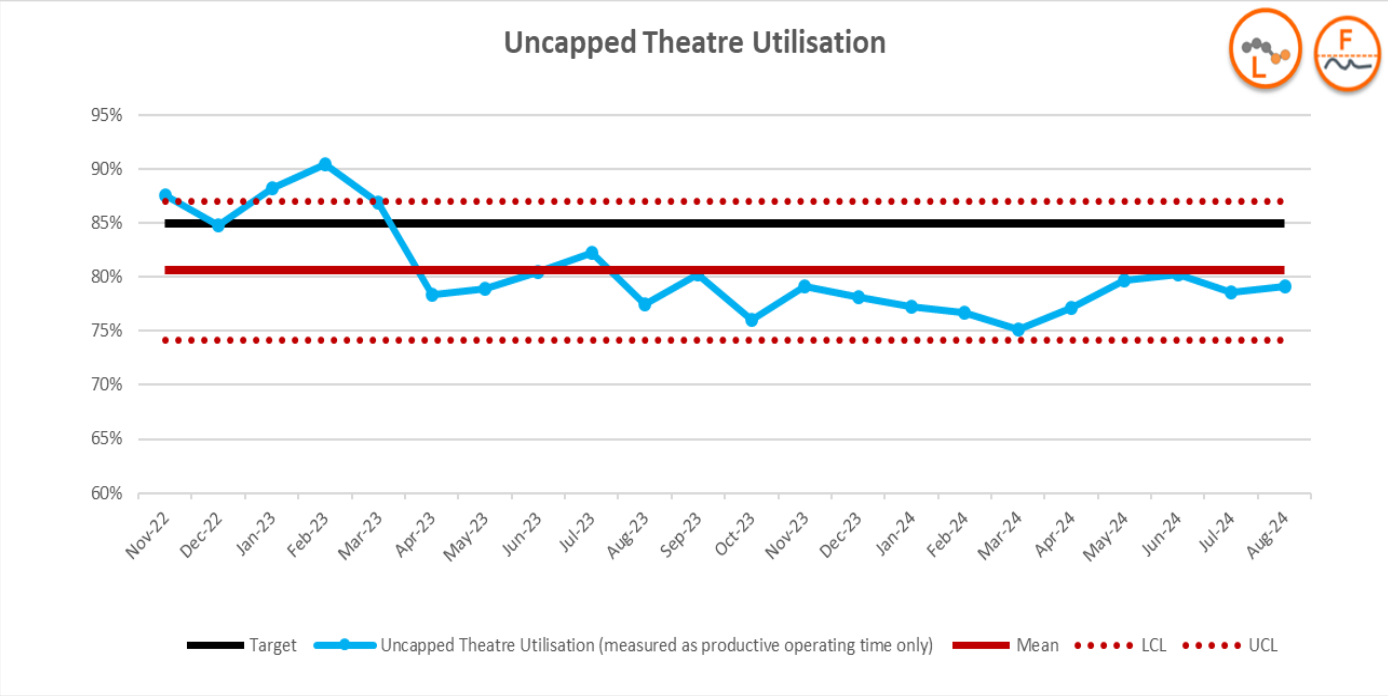


- National and regional increase in CDI cases
- WHH remains a low outlier compared to other NW Trusts
- Slight decrease in Antibiotic Point Prevalence Audit (85%) and IVOS CQUIN increase (38%*) being addressed by Consultant Microbiologists
- Trust-wide Deep Clean implemented
- Audit findings (2023/24 cases) learning shared and action plan implemented
- Annual plan of CDI training in progress
- Awareness raising events: IPC October and Antibiotics November

* Lower % is better

61. Uncapped Theatre Utilisation

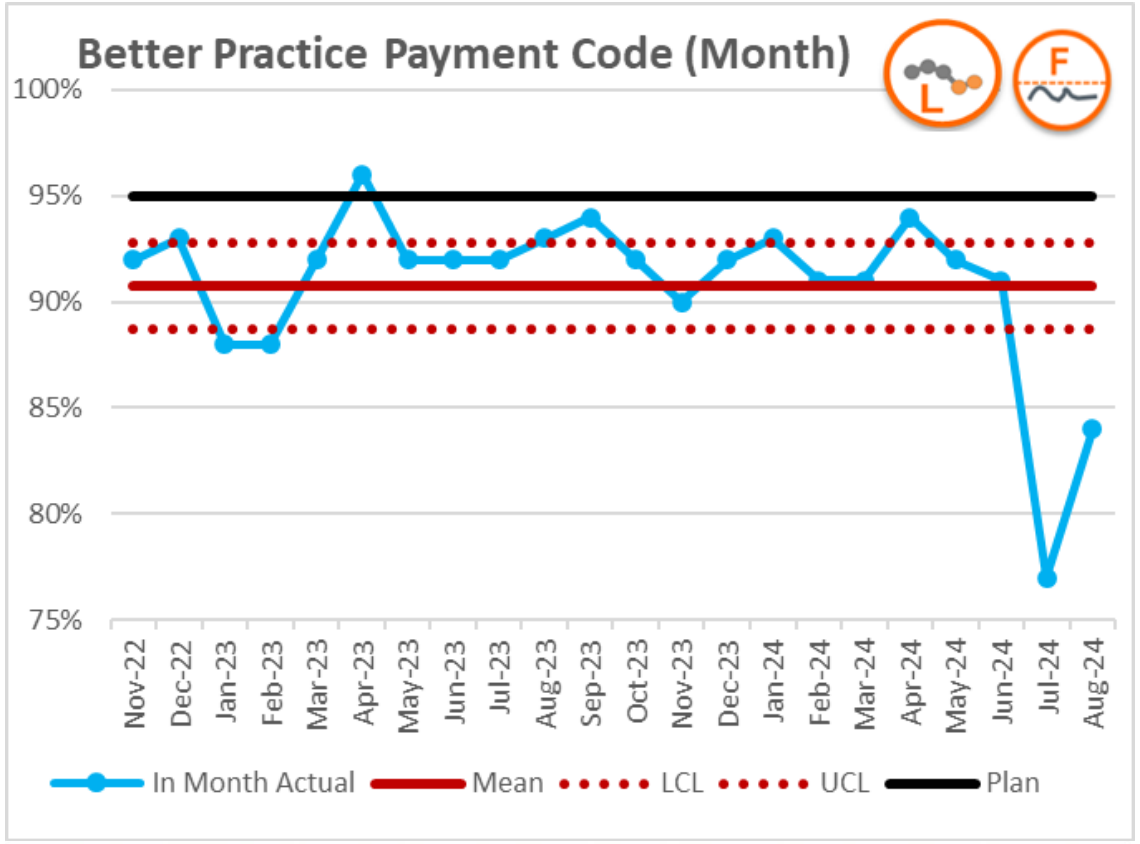
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



- Uncapped Utilisation is the total operating time and inclusive of any early starts or late finishes
- Achieved 79.1% in August against a target of 85%
- Moved from bottom quartile to a mid position in model hospital benchmarking over the last 6 months
- Focus on start times and cases per list in worst performing specialties
- Focus on, on the day cancellations

72. Better Payment Practice Code

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Ledger Short Name	BPPC Paid Period	Invoice Count	Invoice Count (Passed)	% Passed	BPPC Amount	Invoice Amount (Passed)	% Amount Passed
RWW	APR-24	4126	3868	93.75%	15,339,425.46	13,552,719.76	88.35%
RWW	MAY-24	3323	3074	92.51%	10,701,932.20	10,171,000.57	95.04%
RWW	JUN-24	2297	2086	90.81%	8,161,219.35	7,511,681.59	92.04%
RWW	JUL-24	3959	3030	76.53%	9,997,486.27	8,096,833.88	80.99%
RWW	AUG-24	3277	2766	84.41%	8,352,144.49	7,879,197.36	94.34%
RWW	SEP-24	3272	3101	94.77%	7,419,070.78	7,040,675.33	94.90%

- The decrease in BPPC in July and August is due to invoices not being place on hold / in query or transferred to an alternative approver whilst the budget managers were on annual leave.
- If an invoice is place on hold / in query this stops the clock with respect to BPPC.
- Guidance is routinely emailed to budget managers advising them of this.
- This guidance is to be re-enforced especially at times when higher annual leave is expected such as July / August and across the Christmas period.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 3 failing IPR indicators

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/10/98a (i)	Meeting	Trust Board	Date Of Meeting	2 October 2024

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

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/08/107	**HOT TOPIC – DELAYS TO FOLLOW UP**	The Committee received the Hot Topic in relation to the Outpatient follow up tracking. • Significant increase in waiting lists noted. • High-risk areas identified improvement plans in place for most specialities. (Ophthalmology requires additional focus) being reviewed and reported via Fragile Services Reports to Patient Safety and Clinical Effectiveness. • Overview included a review of associated risk register. Points of note include: • Further assurance requested relating to Ophthalmology. • Further discussions required regarding costing implications to reduce backlog either by Limited Liability Partnership (LLP) or waiting List Initiative (WLI). Further updates to be provided	**Moderate:** Further work required in relation Ophthalmology Services.	**Substantial:** Monthly reporting with Executive oversight through Patient Safety and Clinical Effectiveness escalating to Quality Assurance Committee.	**PSCESC September**
QAC/24/08/108	**DEEP DIVE – MEDICATION ERRORS**	The Committee received a Deep Dive Presentation on Medication Errors. The following key challenges, risks and actions were highlighted:	**Moderate:** Further review of training needs analysis required to align with other Trusts.	**Substantial:** Monthly reporting to Medicines Safety Group oversight	**PSCEC September QAC November**

		• WHH benchmark in middle compared to other Cheshire and Mersey Trusts • Pharmacy Safety Team includes – Medicines Safety Officer, Medicines Safety Nurse and a Specialist Technician for Medicines Storage The Committee agreed on the importance of ongoing monitoring and improvement in Medicines Safety, a further report will be received by the Quality Assurance Committee in November.		through PSCESC Escalation processes in place	
QAC/24/08/110	**PATIENT SAFETY AND CLINICAL EFFECTIVENESS SUB-COMMITTEE EXCEPTION REPORT**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee which included reporting on Fragile Services: Of the items escalated from the Sub-Committee, of particular note was: • Urology – Improvement in waiting times. • ENT- a deteriorating workforce position. Continued work with the LLP/insourcing/outsourcing was taking place to manage waiting lists. • Fractured Neck Of Femur- remains a challenge, concerns over resignation of consultant Geriatrician – plans being work through to mitigate. • Gynaecology – Increasing waiting lists, workforce gaps continue. Aging equipment risk now resolved.	**Moderate:** Backlog in Gynaecology waiting lists. ENT backlog	**Substantial:** Monthly reporting with Executive oversight through PSCESC Escalation processes in plac**e**	**PSCEC September 2024**
QAC/24/08/112	**Sepsis high level Q1 update**	The Committee received Q1 sepsis performance. Further points noted. • Improving performance for antibiotics administered within 3 and 6 hours. • WHH noted as 5th best performing Trust in Cheshire and Mersey on Aqua sepsis metrics. • WHH pilot Trust for new NG51 Sepsis guidance for Launch on 13 September 2024.	**Moderate** Further improvement with Screening Compliance required.	**Substantial:** Monthly oversight through PSCESC	**PSCESC September**
QAC/24/08/116	**ED Improvement Update**	The Committee received an update on the ED Improvement Programme and noted the following:	**Moderate**	**Substantial:**	**QAC**

		• Long Waits – hoping to achieve 78% by March 2025 • Challenging month re ambulance attendances • Improvement in 0–15 minute handover. 15–30-minute handover sustained. • Hub Wait 2 opened in July– 5 bed curtained area reducing the number of patients being nursed on the corridor. • ED attends marginally decreased	12 hours in department times need to further improvement	Monthly reporting to Quality Assurance Committee	**September**
QAC/24/08/118	**Mental Health Update**	The Committee received an update on Mental Health And specifically noted the following: • Number of patients seen by Core 24 since 2017/18 has increased by 65%. • Right Care Right Person implementation underway • More out of area patients presenting to WHH. • WHH seen improvement in policies/legal frameworks, training for staff, CAHMs responses. • WHH has 24 hr Health Assessment area in ED available.	**Moderate** Long length of stay in Department for mental health patients due to limited availability of acute mental health beds	**Substantial:** Non-Executive and Executive oversight via Quality Assurance Committee	**QAC November**

The Committee also received the following items.

QAC/24/08/111	New approach to 7 Day Services workstream
QAC/24/08/113	Compliance Q1 update
QAC/24/08/114	Quality IPR Metrics
QAC/24/08//115	Maternity Update
QAC/24/08/117	Runcorn Health Education Hub
QAC/24/08/119	Learning from Experience Update Q1
QAC/24/08/120	Infection Prevention and Control Q1 update
QAC/24/08/121	High level enquiries and external assessment/inspections

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/10/98a (ii)	Meeting	Trust Board	Date Of Meeting	2 October 2024

Date of Meeting	10 September 2024
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/09/128	**Organ Donation**	The Committee received a Patient Story and an overview of the Organ Donation Service This included • Background to organ donation. • Overview of honorary contract / Memorandum of Understanding (MoU) with every Trust in country. • Patient Story resulting in 5 patients receiving organs. • Overview of Organ Donation Framework • Statistical data of number of patients on the list/successful transplants since April 2024. • Details of Guard of Honour Ceremony held for the patient to express gratitude for donation of organs.	**Substantial:** The Committee were assured that the that a collaborative team approach was in place	**Substantial:** Strong Policies and frameworks to support Organ Donation**.**	**As required**
QAC/24/09/129	**HOT TOPIC – Impact on quality considerations in UTC and ITU**	The Committee received a Hot Topic Presentation on two additional cost improvement programme schemes These were: • Reduction of GP hours at Halton UTC - The presentation outlined the risks, mitigation strategies, and monitoring plans associated with these changes. • Closure of 1 ITU bed - The presentation noted SPC analysis of occupancy data	**Moderate:** Ongoing Culture work in Theatres – not yet concluded	**Substantial:** Monthly oversight vis Patient Safety and Clinical Effectiveness escalating to Quality	**PSCESC October**

		The committee noted the risks and received assurance regarding the mitigations and monitoring in place for these schemes and agreed further update on culture work will be seen at QAC		Assurance Committee	
QAC/24/09/130	**Reflections on the surgical failings at Great Ormerod Street**	The Committee discussed the case of the surgeon who had performed operations on 700 patients resulting a number of cases of patient harm The committee noted WHH has good Freedom to Speak up processes	**Moderate** Culture work ongoing	**Substantial** Theatre services is a reviewed as a fragile service. With oversight at Patient Safety and Clinical Effectiveness monthly and reported to the Board	**Presented as the Hot Topic in October QAC**
QAC/24/09/132	**Delays to Follow up – Outpatient backlog**	The Committee received an update on the outpatient backlog highlighting • Plans to reduce and mitigate backlog • Increase in backlog • Impact of Elective Recovery Fund activity and industrial action on backlogs • Breakdown of low/high risk categories	**Moderate** Increases in backlog	**Substantial:** Oversight through Patient Safety and Clinical Effectiveness escalating to Quality Assurance Committee	**QAC November**
QAC/24/09/134	**Paediatric Audiology Biannual Update**	The Committee received presentation in response to serious incident (2 February 2023) following which the Audiology Brainstem Response Service was paused The presentation noted • Mutual aid offered • Through review of 200 cases concluded (73 no further intervention required)	**Substantial** All cases have been reviewed – 3 children remain who are being	**Substantial** Regular reports have been received at QAC and Board	**QAC following PASQAT (part 2) Visit**

		• PLACE closed the incident • Follow up Paediatric Audiology Assurance Quality Assessment Tool (PASQAT) part 2 visit expected – await date.	monitored closely		
QAC/24/09/138	**Prevention of Future Deaths**	The Committee received an overview of a recent Coroner inquest and next steps for future Prevention of Deaths response to the coroner.	**Substantial** Response completed – Actions remain on track	**Substantial** Response to Coroner provided within timescales	**n/a**

The Committee also received the following items.

QAC/24/09/131	Patient Safety and Clinical Effectiveness Sub Committee Exception Report
QAC/24/09/133	Infection Prevention Control – Audit Findings
QAC/24/09/135	Ed Improvement Update
QAC/24/09/115	Maternity Update
QAC/24/09/138	Learning from Death Update Q1
QAC/24/09/139	Quality Priorities
QAC/24/09/141	High level enquiries and external assessment/inspections

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference		Meeting	Trust Board	Date Of Meeting	2 October 2024

Date of Meeting	Wednesday 21 August 2024
Name of Meeting and Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPC/24/08/76	GP Collective Action	**Paul Fitzsimmons: Executive Medical Director** An update to the Committee was provided on the GP collective action as a result of instability in primary care from national contract negotiations, workload issues and commissioning issues. The Committee were assured that the organisation have undertaken a lot of work in partnership with the Primary Care Networks and Primary Secondary Interface group and are proud of the relationship with local GPs. The Committee were advised of the suggested collective action that are likely to have the greatest impact on WHH including the limiting of daily GP contacts, stopping the engagement with e-referral advice and guidance, stopping locally agreed	**Moderate** assurance was received as there are mitigations and systems in place within WHH to respond and mitigate any risks but there is still further assurances to receive from the wider Primary Care Network which is outside of the organisation's control.	**Substantial** assurance was received in relation to the governance infrastructure that has been embedded and that the organisation are part of to mitigate any risks to patient care.	September 2024

		measures and stopping the rationing referrals, investigations and admissions. The collective action is identified on an individual practice level and can be highly variable and unpredictable.			
SPC/24/08/78	Workforce Race Equality Standard report (WRES)	**Adam Harrison-Moran: Head of Culture and Inclusion** The Committee were presented with the annual Workforce Race Equality Standard report whose data is taken from a variety of sources such as ER casework, national staff survey results and recruitment activity. The Report provided an action plan, which included an overview of 2022-23 actions to capture any substantial changes. Key finding included that the Trust overall is more diverse when compared with its local population and there have also been improvements in the relative likelihood of shortlisting which is the best score that the Trust has received. There is still more work to do regarding bullying and harassment. The Committee requested further assurance on the Trusts activities and responses to patient incidents of harassment, bullying and discrimination towards staff which will be reported at the next meeting as part of the Workforce EDI strategy update. The Committee approved the WRES Action Plan for publication.	The Committee received **substantial assurance** on the delivery of the WRES actions for 2024-25	The Committee received **high assurance** on the governance mechanisms in place to respond to the WRES data.	September 2024

SPC/24/08/79	Workforce Disability Equality Standard Report (WDES)	**Adam Harrison-Moran: Head of Culture and Inclusion** The Committee were presented with an annual overview of the Workforce Disability Equality Standard Report whose data is taken from a variety of sources such as ER casework, national staff survey results and recruitment activity. Highlights included workforce disability declarations have improved year on year, and that the reasonable adjustments question reflected in the staff survey is above the national average. There is still work to do in terms related to representation within the workforce when compared with the local population and declaration rates amongst senior colleagues. The WDES action plan was received and approved by the Committee.	The Committee received **substantial assurance** on the delivery of the WRES actions for 2024-25	The Committee received **high assurance** on the governance mechanisms in place to respond to the WRES data.	September 2024
SPC/24/08/81	Chief People Officer Report	**Michelle Cloney: Chief People Officer** The Committee received an update on initiatives relating to the workforce which included the annual EDI returns that the organisation has implemented, the support provided to staff in the wake of the ongoing unrest during a challenging period and the development of the Staff Voice Forum in response to staff survey results and the organisation's culture work. The Committee will receive an update and a full WHH response to the NHSE letter regarding the	The Commttee received **high** assurance on the work to respond to the needs of the workforce.	The Committee received **high assurance** on the ongoing monitoring of the issues that are important to the workforce.	September 2024

		unrest in the September 2024 Workforce EDI Strategy update.			
SPC/24/08/83	Midwifery Staffing Report Q1	**Ailsa Gaskill-Jones: Director of Midwifery** The Committee received an overview of the midwifery staffing report which highlighted the lowest vacancy rate but this is likely to increase in the next report due to a number of upcoming retirements. The team are currently inundated with students who wish to work at WHH, which is testament to the hard work undertaking in the team to improve culture which is reflected in retention themes. The Midwifery Workforce plan was formally endorsed and approved by the Committee.	**Substantial assurance** was provided on the actions that continue to be taken to improve midwifery retention, staffing and outcomes.	The Committee received **substantial assurance** on the governance processes that monitor this work.	November 2024

Other reports received by the Committee:

- SPC/24/08/77 – Board Assurance Framework
- SPC/24/08/90 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPC/24/08/82 – Monthly Safe Staffing Report
- SPC/24/08/84 – Guardian of Safe Working Report Q1
- SPC/24/08/85 – Integration update
- SPC/24/08/86 – Workforce Inclusion and Culture Sub-Committee Chairs Log
- SPC/24/08/87 – Workforce Review Group Chairs Log

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/10/98	Meeting	Trust Board	Date Of Meeting	2 October 2024

Date of Meeting	Wednesday 18th September 2024
Name of Meeting and Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPC/24/09/93	Deep Dive – Reward & Recognition	**Rebecca Patel: Associate Chief People Officer** An overview was provided to the Committee on the Reward and Recognition offer within the Trust. This was asked for due to a concern from the Committee that some staff were unable to access some rewards. An update was provided on employer responsibilities and compliance with NLW, legislation and tax rules. An update was provided on the Trusts recognition package that has been developed. Reward and recognition is aligned to the NHS People Promise, considering best practice, are equality impact assessed and reviewed annually.	The Committee received **moderate assurance** on the deep dive update on Reward & Recognition. The Committee has asked for further staff communications r.e. affordability of schemes to manage expectations, and communications on the intranet.	**Substantial assurance** was received in relation to the reward and recognition offer that has been embedded within the organisation.	N/A

		The Committee were assured that the organisation have undertaken a lot of work in relation to reward and recognition and recognises that there are some limits as to how the Trust can influence reward. The Committee were informed that the capacity to expand the offer was limited in light of the Trust's financial position and reduction in headcount in the People Directorate.			
SPC/24/09/94	Hot Topic – Impact of CIP on Workforce Strategic Priorities	**Michelle Cloney: Chief People Officer** The Committee were presented with an update regarding the impact of cost improvement programmes (CIP) on workforce strategic priorities due to the reduction in non-clinical roles which is having a direct impact on the People Directorate. People Directorate CIP plans are from opportunities presented rather than taking a pre-planned approach, with opportunistic headcount reduction following resignations that has not resulted in like for like replacements. It has also had a direct impact on the diversity agenda as not able to recruit externally, recruiting from within. The Committee also received an update from the Finance team and not replacing vacancies impacting on responsiveness, time to develop, stepping down, etc. and reducing the hours in the Cash Office.	The Committee received **limited assurance** on the update provided due to the impact on the delivery of workforce priorities. Further update to be brought back to the Committee with regards to reprioritisation. Assurance to be discussed at Board.	The Committee received **substantial assurance** on the governance around the mechanisms in place to respond to CIP process.	October 2024

		Most recent People Pulse survey had a number of comments from staff regarding the impact of CIP, likely this impact will also be replicated in the Staff Survey which has just launched, and the Trust were recognised for excellent results last year. PWC and Bridgewater integration are additional priorities which will require resource to deliver. People Directorate coming together next week to prioritise and deprioritise and will report back to SPC next month. Updates provided from Executive Directors regarding concerns of the resources required for Bridgewater integration.			
SPC/24/09/99	Freedom to Speak Up Annual Report	**Deb Carter: Freedom to Speak Up Guardian** The Committee were presented with the annual Freedom to Speak Up Report for assurance. Highlights included 31 disclosures received in 23/24. Predominately similar themes r.e. culture, behaviour, relationships and unfairness. Quarterly break down of reporting which is reflective of new reporting requirements. New Guardian training linked to equalities agenda and for non-executive colleagues, training available in ESR. Training will be targeted for areas that are hot spots. New policy is under development along with a FTSU strategy.	The Committee received **substantial assurance** on the Freedom to Speak Up Annual Report delivery.	The Committee received **substantial assurance** on the governance mechanisms relating to the Freedom to Speak Up Annual Report.	March 2025

		October FTSU month with communications and delivery plan. Nationally the number of those speaking up has increased. A number of important reports that have been published have been reviewed. Roll out of Martha's rules summarised in the paper.			
SPC/24/09/96	Chief People Officer Report	**Michelle Cloney: Chief People Officer** The Committee received an update on initiatives relating to the workforce which included an update regarding Band 2-3 Rebanding Resolution framework, delivery of lunch and learn sessions, 2024 Staff Survey approach, 2024 winter vaccination approach, an update regarding the continued support provided to staff in the wake of the Southport stabbings in the summer and subsequent public disorder, and the Supported Internship programme that the Trust rolled out in September 2023 which concluded in July 2024. The Committee will highlight to Trust Board that the Trust has been proactive, listened to feedback and changed the language regarding summer public disorder in their communications.	The Committee received **high** assurance on the work to respond to the needs of the workforce.	The Committee received **high assurance** on the ongoing monitoring of the issues that are important to the workforce.	October 2024
SPC/24/09/101	General Medical Council (GMC) Revalidation Annual Report	**Paul Fitzsimmons: Medical Director** The Committee received the GMC Revalidation Annual Report / NHSE Statement of Compliance for approval.	**Substantial assurance** was provided on the update GMC Revalidation Annual Report /	The Committee received **substantial assurance** on the governance	September 2025

	/ NHSE Statement of Compliance	Key findings were 321 doctors attached to WHH. Resident Doctors in training under Lead Employer approx. 151. 81 appraisers and an increasing number of SAS doctors acting as an appraiser. 149 fully signed off appraisal, 44 missed an appraisal due to valid reason e.g. sickness absence, maternity leave, 8 doctors have missed an appraisal without good reason. 85% completion rate which is good. 54 doctors were due for revalidation, 45 were revalidated, 9 deferrals were made of which the vast majority did not meet the required number of appraisals required for revalidation and the first stage is to defer for 12 months to give the opportunity to get the required number up to date. The Trust is regularly in communication with GMC Revalidation Officer. The Revalidation Annual Report / NHSE Statement of Compliance was formally received and approved by the Committee to go to Board.	NHSE Statement of Compliance.	processes that monitor this work.	

Other reports received by the Committee:

- SPC/24/09/97 – Workforce Integrated Performance Report
- SPC/24/09/96 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPC/24/09/98 – Monthly Safer Staffing Report
- SPC/24/09/102 – Integration and workforce update
- SPC/24/09/103 – Operational People Committee Chairs Log
- SPC/24/09/104 – Workforce Review Group Chairs Log

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/98c(i)	Meeting	Trust Board	Date Of Meeting	2 October 2024

Date of Meeting	28 August 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/08/88	**EPR Procurement Update**	The Committee received the presentation noting:- • Following receipt of advice from the Counsel, the Trust abandoned the Procurement of EPR on 20 August 2024. • Cost of abandoning the process includes legal fees, appointment of counsel and cost of extending Lorenzo contract. • Frontline Digitalisation fund – to be spent on the things we would've spent in the programme, although also looking at options available to maximise the funding that has been allocated • Review to be undertaken to understand and identify lessons learnt • Summary of the costs, updated timeframe, redress, next steps to be reported next month	The Committee received **limited** assurance based on delivery of the EPR procurement	The Committee **noted** and discussed the presentation receiving **limited** assurance around the procurement process in place.	**FSC September 2024**
FSC/24/08/89	**Hot Topic – C&M Mandated Support**	The Committee received the presentation noting:- Mitigating the gap • Risk adjusted financial forecast had been submitted with £12.4m gap. • Mitigation identified and has reduced forecast to £8.4m	The Committee received **moderate** assurance based on delivery of the actions identified	The Committee **noted** and discussed the presentation receiving	**FSC September2024**

		• WHH has been selected as one of the 4 Trusts to receive external support PWC draft report • Recommendations provided in the draft PWC report has an executive lead assigned to each recommendation - only 1 area rag rated red. • Variable pay, recruitment and non pay controls that took place in Leeds has been received and will be reviewed and implemented locally Deep Dive Request for next month • Establishment - volume and value – demonstrate where we are • Productivity – cases per week, down to specialty • Unpalatable items – impact • Demand v Acuity v LOS • Urgent and emergency agenda		**substantial** assurance around process and procedures in place.	
FSC/24/08/90	**Deep Dive – Benefits Realisation – Urology**	The Committee received the presentation noting:- • Utilisation of clinic space has been maximised and undertaking more minor surgical procedures • Expanding he 'Hot Clinics' in UIU to support acute pathways • Specialty Doctors recruited and enabled 24/7 three tier on call rota • Work is still required to continue to improve delivery and performance	The Committee received **substantial** assurance based on delivery of the implementation of the UIU project.	The Committee **noted** and discussed the presentation receiving **substantial** assurance around the benefits.	
FSC/24/08/92	**Corporate Performance Report**	The Committee received the report noting:- • Tier 1 – improvement in 4hr and 14 day LOS • 12 hours wait is still key area • UEC improvement work on going • UCR group – working with wider system in delivering better service for patients, identifying opportunities	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the report receiving **substantial** assurance around level of detail reported	**FSC September 2024**

		• Tier 2 – forecasting will treat last 65 week waiter by end of March			
FSC/24/08/96	**Monthly CIP Update**	The Committee received the report noting: • Fully identified £19.4m schemes, of which £1.2m is non recurrent and £3.9m is high risk. • Month 4 CIP position is on plan £3.2m achieved – however stepped increase in the plan in the later part of the year.	The Committee received **moderate** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **substantial** assurance around plans in place	**FSC September 2024**
FSC/24/08/97	**Monthly Productivity Improvement Update – inc UEC & Integration**	The Committee received the report noting:- Outpatients improvement • Further work to be done on DNAs and New to Follow Up Ratio Theatres • Utilisation levels impacted by cancellations and DNAs. • Short notice cancellation is being picked up in PIOG as a deep dive • Funded sessions v actual sessions delivered • Late starts – improvements seen over the last 6 to 12 months, however, still further work to improve performance for each specialty. Forward wait / admission lounge is required to improve utilisation Integration • £5m target across both organisation • Data sharing agreement requires approval to progress ability to share information to quantify what potential savings identified	The Committee received **limited** assurance on the delivery of the improvement savings	The Committee **noted** and discussed the report receiving **moderate** assurance of the plans in place	**FSC September2024**
FSC/24/08/99	**Cost pressures M4**	The Committee received the report noting:- • Cost pressures have continued, the majority relating to nursing and medical requirements • Forecast overspend has reduced from £4.8m in month 3 to £4.6m • Peer review by the Executive Team continues to be in place with an aim to reduce cost pressures further	The Committee received **limited** assurance based on the continued overspend on cost pressures	The Committee **noted** and discussed the report receiving **substantial** assurance of the ongoing review	**FSC September 2024**

FSC/24/08/101	**Cash Support Q2 Update**	The Committee received the report noting:- • The original revenue cash support request for Q2 was £10.373m. £5.145m was drawn in July with an expected draw of £5.228m in September • Support for Q3 request of £14.954m. This includes temporary support of £9.475m if there is a timing delay in receiving funding from the ICB to cover the agenda for change pay award and back pay	The Committee received **substantial** assurance on the monitoring of cash requirements	The Committee **noted** the report receiving **substantial** assurance and **supported** the cash request for Q3	**Trust Board September2024**
FSC/24/08/103	**Monthly Finance position – month 4**	The Committee received the report noting:- • £14.6m deficit with an adverse variance to plan of £1.0m which is the impact of Industrial Action (IA). Indications are that there will be no additional funding for this. • Risks around cost pressures overspends, under delivery of CIP, risk of activity delivery to achieve the 104% income target and the impact of IA • Revenue requests supported by the Executive Team highlighted in the report	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance	**FSC September2024**
FSC/24/08/104i	**Capital Position Month 4**	The Committee received the report noting:- • M4 capital spend is £0.9m behind plan • Movement in capital contingency was approved • Supported review to be undertaken to confirm £83k will be for either Accommodation – EPCMS or CHP efficiency scheme • RMO – additional £22k required from contingency was approved	The Committee received **moderate** assurance due to spend being behind plan.	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the contingency changes	**FSC September 2024**
FSC/24/08/104ii	**Schemes over £500k**	TIF / Endoscopy • Overall handover of decontamination will be completed end of September and now moving into the final phase of the project. • Elective theatres will be reorganised due to the closure of the Nightingale in order for this final phase • Signed contract to be in place to ensure all works completed by March 2025. Version 4 cost submission is £67k above Trust budget, however mitigations have been identified. • Support entering the contract of £3.313m with Kier.	The Committee received **moderate** assurance due to risks to the delivery of the scheme within budget.	The Committee **noted** the paper receiving **substantial** assurance and **support** the contract based on version 4 cost submission	

Items for noting

FSC/24/08/91 Board Assurance Report & Corporate Risk Register
FSC/24/08/93 Recovery Update
FSC/24/08/94 Medical Workforce Review Group Q1 Update
FSC/24/08/95 Benefits Realisation Q1 Update
FSC/24/08/98 Runcorn Town Deal Collaboration Agreement
FSC/24/08/100 Pay assurance report
FSC/24/08/102 Revenue Request – None to report this month
FSC/24/08/104ii Schemes over £500k
FSC/24/08/105 Digital Strategy Group Update
FSC/24/08/106 EPRR Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/10/98c(ii)	Meeting	Trust Board	Date Of Meeting	2 October 2024

Date of Meeting	23 September 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/09/112	**Matters arising – PWC Update**	The Committee received the presentation noting:- • All trusts in Cheshire and Merseyside have received a report from PwC and this report will also be presented to Private Board • Recommendations raised by PwC have been included in an action plan which is being reviewed and discussed by the Executive Team • Follow up meeting with PwC took place to identify areas of focus • System wide Chairs of Finance Committees met they noted tangible actions across the System are not being seen	The Committee received **moderate** assurance based on the initial action plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance around process and procedures in place	**Trust Board October 2024**
FSC/24/09/113	**Hot Topic – Theatre & Outpatient Productivity**	The Committee received the presentation noting:- • 2024/25 activity is tracking above 104% of 2019/20 activity, note that this is not income which is below plan due to case mix • Significant increase in outpatients productivity mainly • Capped utilisation has improved since 2020/21 moving from Quartile 1 to Quartile 2 on the Model Health System Deep dive into on the day cancellations, key themes consistent across last 2 months	The Committee received **moderate** assurance based on delivery of the actions identified	The Committee **noted** and discussed the presentation receiving **substantial** assurance around process and procedures in place	

FSC/24/09/114	**Deep Dive – Establishment**	The Committee received the presentation noting:- • Workforce plan has increased by 617 between April 2019 and April 2024 due to investments, cost pressures and external funding • Significant pay CIP schemes including the 2% WTE reduction with a non-clinical focus and the recurrent vacancy factor from 2023/24 • At month 5, 72 WTE higher than plan and £2.4m overspend year to date (due to Industrial Action and the medical pay award) • Impact of sickness, annual leave usage and cost pressures driving the overspends in each staff group in month 5 • Controls in place around the ECF process and the additional controls following receipt of recommendations from external reviews	The Committee received **moderate** assurance based on delivery against plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance around process and procedures in place.	
FSC/24/09/115	**Corporate Performance Report**	The Committee received the report noting:- • Continued improvement in the 12 hour performance standard, however behind trajectory for 4 hour performance • Reduction in Type 1 attendance (seasonal variation), decrease in walk in however increase in more complex ambulance attends • Stabilisation of patients waiting over 6 weeks, issues continue in Echo, Sleep and Cystoscopy • Outpatient Follow up – increase in patients waiting over 17 weeks, review underway to understand this increase	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the report receiving **substantial** assurance around level of detail reported	**FSC October 2024**
FSC/24/09/117	**Bank Reduction Plan**	The Committee received the report noting:- • Agency in wards requires Chief Nurse or Deputy sign off • Weekly Lead Nurse meetings and cost pressure clinics in place • Stopped enhanced rates for speciality nurses • Review of supernumerary status eg ward managers working one clinical shift per week • Daily review of bank requests implemented	The Committee received **moderate** assurance given the reduction, continuation of reduction required to move to substantial	The Committee received **substantial** assurance given the plans in place	
FSC/24/09/118	**Elective Recovery**	The Committee received the report noting:-	The Committee received **moderate**	The Committee received	

	Update – 65 week wait	• Gynae and Max Fax are high risk for achieving the 65 week target • The estimated final position is a potential 21 capacity breaches • Circa £500k behind where spend expected to be at month 5 • Improved 65 week position compared to other trusts in the region and commended for this	assurance given the progress that has been made	**substantial** assurance given the plans in place	
FSC/24/09/119	**EPR Procurement Update**	The Committee received the presentation noting:- • NHSE Frontline Digitisation independent review in procurement and implementation challenges underway (nine trusts in total nationally) • Two options proposed, a full procurement or a re-launch with reduced timescales which is expected to be recommended • Financial Impact Analysis undertaken to agree a plan for the Investment Agreement for funding in the current financial year, discussions ongoing with the FD team around deferral of funding in line with the revised timetable • WHH internal lessons learned review underway	The Committee received **moderate** assurance based on delivery of the EPR procurement	The Committee **noted** and discussed the presentation receiving **moderate** assurance around the procurement process in place.	**FSC October 2024**
FSC/24/09/120	**Monthly CIP Update**	The Committee received the report noting: • Month 5 CIP position is on plan £4.5m achieved – however stepped increase in the plan in the later part of the year. • Fully identified £19.4m schemes, of which £1.5m is non recurrent and £3m is high risk (£2.5m relating to the Improvement Schemes).	The Committee received **moderate** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **substantial** assurance	**FSC October 2024**
FSC/24/09/123	**Cost pressures M5**	The Committee received the report noting:- • Cost pressures continue, the majority relate to nursing and medical • Nursing expected to decrease with the additional controls in place • Forecast overspend is currently £4.7m, with £2.3m year to date variance currently being offset in the current financial position • Additional emerging cost pressures highlighted this month (£3.4m forecast overspend), £1.6m year to date is currently being offset • More detail on the top three additional cost pressures requested	The Committee received **limited** assurance based on the continued overspend on cost pressures	The Committee **noted** and discussed the report receiving **moderate** assurance of the ongoing review	**FSC October 2024**

FSC/24/09/127	**Monthly Finance position – month 5**	The Committee received the report noting:- • £17.6m deficit with an adverse variance of £1.0m due to Industrial Action. Indications are this will be funded but may not be 100% • Risks around cost pressures, CIP and collaboration target, risk of delivering the 104% income target and the impact of IA • Revenue requests supported by the Executive Team included • £4m of the £5.2m September cash request has been approved, £16.4m deficit support to be received by the Trust (share of the £150m Cheshire and Merseyside ICS deficit) • Forecast variance to plan of £8.4m reduced to £4.7m through identification of further mitigations, work continues to improve	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance	**FSC October 2024**
FSC/24/09/128	**Capital Position Month 5**	The Committee received the report noting:- • Month 5 capital spend is £0.9m behind plan, expected to catch up later in the financial year • Movement in capital contingency was approved • Aseptic Unit £290k ringfencing in 2025/26 Capital Programme approved	The Committee received **moderate** assurance due to spend being behind plan.	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the changes and 2025/26 ringfencing	**FSC October 2024**

Items for noting

FSC/24/09/116 Winter Planning
FSC/24/09/121 Monthly Productivity Improvement Update – inc UEC & Integration – covered in Hot Topic
FSC/24/09/122 CDC Activity
FSC/24/09/124 Pay Assurance Report
FSC/24/09/125 Integration Update
FSC/24/09/126 Revenue Requests – None to report this month
FSC/24/09/128 Schemes over £500k
FSC/24/09/129 Senior Information Risk Owner (SIRO) Report
FSC/24/09/130 Digital Strategy Group Update
FSC/24/09/131 EPRR compliance submission update

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/10/98d	Meeting	Trust Board	Date Of Meeting	2 October 2024

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

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
AC/24/08/47	**Committee Chair's Annual Report**	The committee received the Annual Report from the Committee Chair which set out the work that the committee had undertaken during 2023/24.	**High –** the committee received evidence that there was a strong system of internal control to meet the Committee objectives.	**High –** the committee received evidence that there was a strong system of internal control to mee the Committee objectives.	**n/a**
AC/24/08/48	**Progress Report on Internal Audit Follow Up Actions**	The committee received the progress report on internal audit follow up actions and noted that there were 3 overdue management actions, however since the last meeting the action relating to Badgernet had been closed.	**Substantial –** the committee received assurance the actions were being reviewed and progress updates to the committee would continue.	**Substantial –** the committee received high assurance on the systems and processes in place to review actions.	**n/a**
	Internal Audit Progress Report	The Committee received the report which provided progress on outcomes of reviews completed since the last Audit Committee meeting. It was noted that 4 reports had been issued since the last meeting and 1 review was in progress	**Substantial** - The Committee received substantial assurance on the progress of actions	**Substantial** - The Committee received substantial assurance on the progress of the internal audit plan.	

AC/24/08/52	**Renewal/Refresh of External Audit Contract**	The Committee were advised that the tender process was ongoing, given the limited tenders received. The committee discussed the lack of competition in the market for NHS auditors and the risk of the Trust being unable to appoint an External auditor. The single tender received was being reviewed as the Trust had raised a number of queries. The committee were reassured that the Governance process for appointing Auditors to an NHS FT were be followed. Updates would be provided to the committee when available.	**Limited** –until the queries had been answered the Trust was not yet able to move forward with the process for appointing an External Auditor	**High –** The Trust was following the appropriate Governance and procurement systems and process to appoint an External Auditor.	**a.s.a.p.**
AC/24/08/56	**Risk Management Strategy Annual Report 2023/24**	The committee received the Annual Report on Risk Management arrangements for 2023/24. The committee received assurance on the risk management systems and processes in place across the Trust along with the actions taken in year to strengthen risk management at both corporate and strategic levels. The committee were provided with a list of actions to further strengthen risk management during 2024/25.	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust had substantial Governance systems and processes in place to manage risk.	n/a

Other agenda items:
AC/24/08/45 – Board Assurance Framework
AC/24/08/46 - Committee Assurance update from Chairs of FSC, SPC, QAC
AC/24/08/49 - Internal Audit Progress Report follow up actions (MIAA)
AC/24/08/50 - Internal Audit Progress Report (MIAA)
AC/24/08/51 - Anti-Fraud Progress Report (MIAA)
AC/24/08/53 - Review Losses & Special Payments
AC/24/08/54 - Review of Quotation + Tender Waivers
AC/24/08/55 – Treasury Management Policy
AC/24/08/57 – On-Call and Overtime Annual Update Report
AC/24/08/58 – NW Skills Development Agency Bi-Annual Report
AC/24/08/59 – ICON Programme Bi-Annual Update

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/10/98e	Meeting	Trust Board	Date Of Meeting	2 October 2024

Date of Meeting	12 September 2024
Name of Meeting & Chair	Charitable Funds Committee, Chaired by Steve McGuirk
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
CFC/24/09/04	**Fundraising Report and Quarterly Workplan**	CFC noted the quarterly fundraising report, including updates on campaigns, NHS Charities Together developments, progress on discussions with the CANsupport Charity at the Delamere Centre, and progress against the charity's three-year strategy. Board members are asked to consider how they may support the charity with dedicated fundraising activity. **Lead:** Kate Henry	**The Committee received substantial assurance as the Charity is on track for delivering against its strategy**	**The Committee received high assurance as performance is monitored at each meeting of the Committee and a Charity Leadership meeting has been established**	**December 2024**
CFC/24/09/06	**Finance Report Q1 Update**	CFC noted the financial position for quarter 1 (1 April to 30 June 2024) is as follows: • Income is £174k against a plan of £26k, £148k above plan. • Expenditure (overheads) is £32k against a plan of £27k, £5k above plan. • Expenditure (disbursements of funds) is £38k in quarter 1. • The net fund balance is £541k. • The balance after commitments for purchases, reserves and overheads is £71k.	**The Committee received substantial assurance as income is ahead of plan**	**The Committee received high assurance as sufficient processes and reporting are in place**	**December 2024**

		Lead: Jane Hurst			
CFC/24/09/07	**Bid Applications**	One bid approved by CFC to fund two intermittent pneumatic compression pumps for the Lymphoedema Service at Halton Hospital. Update provided on bids under £5k approved since the last committee meeting, either by the director of comms and engagement (up to £1k) or by execs (up to £5k). **Lead:** Kate Henry	**The Committee received high assurance that the approved bids will be delivered and any unspent funds returned**	**The Committee received high assurance as the application process is robust, proportionate, and aligned with the Governing Document**	**December 2024**
CFC/24/09/12	**Update to the Governing Document**	Approved changes to the Charity's Governing Document: • Inclusion of a process for reclaiming unspent funds • Inclusion of a process to authorise new campaigns **Lead:** John Culshaw	**The Committee received high assurance as processes set out in the Governing Document are followed**	**The Committee received high assurance as all updates to the document are approved by the Committee**	**September 2025**

The committee also received reports on:

- CFC/24/09/05 Charity Annual Impact Report
- CFC/24/09/08 Review of Reserves Policy
- CFC/24/09/09 Proposed new Maternity Campaign
- CFC/24/09/10 Charity Risk Register & Risk Statement
- CFC/24/09/11 Annual Report & Accounts (DRAFT)
- CFC/24/09/13 Committee Chair's Annual Report

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/99**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	Y
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="3">This paper aims to provide assurance with regards to the Trust's oversight of Fragile Clinical Services.

A high-level update is provided on the services currently designated as fragile:
Urology
Orthopaedics – Fractured Neck of Femur
ENT
Theatres – procedural safety

Services de-escalated from Fragile Services oversight since last report:
Stroke
Gynaecological surgery

Services entering Fragile Services oversight since last report:
Cardiorespiratory/Cardiology Services</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note ✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">Trust board is asked to:
• Note the current list of Fragile Services, associated clinical risk and high-level progress updates
• Note emerging risk posed by growing high risk follow up patient backlogs
• Note progress towards stabilising the ENT staffing position with plans to the reduce cost of these mitigating actions moving forwards
• Receive further Fragile Service Oversight reports</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Choose an item.</td></tr>
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REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/24/10/99

1. BACKGROUND/CONTEXT

Following recognition of a need for a systematic oversight mechanism for Fragile Services a formal process for oversight of Fragile Services has been incorporated into the PSCESC Agenda reporting to QAC and on to Trust Board since July 2023.

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

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

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

Gynaecological Surgery

- Significantly sustained improvement in position, staffing sustainability, resolved infrastructure/equipment issues and cancer performance
- No further delay related patient harm identified
- Increased consultant capacity – now fully established
- Full suite of hysteroscopes operational
- Sustainable dedicated 2WW / CFT clinics and lists have ensured no cancer breaches for 10 months
- Innovative 'one stop' clinics improving new patient waiting list position
- Demand and capacity mismatch remains a challenge particularly for FU patients – however this is improving and will be monitored at Performance Review Group
- Ongoing residual risk to be monitored at PRG with a assurance report update to PSCESC in 6 months

Stroke Services

- Improved position with <10% of admissions being direct admissions on the Warrington Site
- Improved SSNAP National Stroke Audit Performance to – B – Last achieved in 2019
- Improved governance and cross site MDT review process for delayed repatriations and direct admissions to the Warrington site
- Ongoing residual risk to be monitored at PRG with a assurance report update to PSCESC in 6 months

3. SER VICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

Cardiorespiratory Services / Cardiology

- Escalated at PSCESC 24/9/24
- Concerns regarding diagnostic delays and fragility of cardiology medical staffing
- Analysis and plan to November QAC as Hot Topic

4. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

Summary

Improving waiting list position, however service remains fragile from staffing and capacity / demand profile perspectives

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- P2 – P4 waiting lists show a positive reducing trend, although an uptick was noted in August
- Significant volume of high-risk patients confirmed by AI list validation
- Transperineal prostate biopsy position shows sustained improvement (>75% reduction in undated witing list patients in year 120->30)
- Surveillance cystoscopy position very significantly improved from peak, however waiting list exceeded 100 patients in August for first time in 6 months
- Emerging risk posed by growing high risk follow up patient backlog
- Ongoing risk of harm remains given P2/Stone, surveillance cystoscopy and high risk follow up backlogs
- Service exceeding clinical activity targets (>104% of 19/20 activity)

- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved and actioned
    - 3 Middle Grade doctors commenced in post – require additional training before full effect will be felt
    - Locum consultants commenced in post
    - Successful transfer of cystoscopy into UIU
    - Some weekend P3 outsourcing capacity diverted to deliver P2 activity in week
    - UIU have increased cystoscopy case numbers per list.

- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site
    - PCNL Stone patients transferred to Chester
    - Ongoing harm review process

- Ongoing improvement plan actions:
    - Urology Specialty Doctors require additional support to move to independent practice MD to meet with CD and Consultants to agree plan
    - Specialist nurse delivered cystoscopy training plan now underway
    - Follow up backlog plan requires further development – some insourcing capacity being diverted to service high risk follow up demand
    - Plan to reintroduce PCNL at Warrington site as IR radiologist now in post – repatriation requires further planning, however no patients currently waiting for PCNL

Orthopaedics – Fractured Neck of Femur

Summary

Prompt surgery / Time to theatre remains the outstanding unresolved quality and performance issue

- Demand and capacity mismatch – driven predominantly by increased demand and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery is the remaining significant challenge with some risk orthogeriatrician review performance given recent leavers in geriatrics
- Current mitigations:
  - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
  - Additional orthogeriatric consultant sessions & orthogeriatric fellow in post
  - Additional ad hoc fractured neck of femur lists utilising bank locum consultant
- Ongoing improvement plan actions:
  - Focused improvement plan to deliver 'prompt surgery' – revenue request in development to support extended trauma capacity
  - Implement SOP to ensure that prolonged delays to theatre are escalated and managed appropriately triggered by wait time as well as numbers waiting

Ear Nose and Throat Surgery

Summary

Waiting list position improved predominantly due to insourcing. Mitigations in place for medical staffing challenges, currently a significant cost pressure – cost reduction plan in progress.

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Significant medical staffing challenges – deteriorating position now mitigated before
- ENT currently has the Trust's largest backlog
- No harm reported to date
- Additional capacity via LLP is supporting the reduction of patients awaiting 1st OPD appointment within the 65 week wait cohort
- New OP waiting list has reduced significantly from >3500 to <1500.
- FU OP waiting lists remain a challenge
- High risk FU patients continue to be prioritised

- Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
  - Additional ENT stacker and scope in procurement for Warrington site

- Current mitigations
  - Outsourced sessions funded and underway
  - AI aided Harm Review process in place
  - 2 Trust F2 doctors to commence in post August 2024

- Ongoing improvement plan actions:
    - ENT Medical staffing review and intensive support plan
    - NHS locum interviews October 2024
    - Strategic conversation with MWL and LUHFT regarding process to develop a sustainable ENT model for Mid and North Mersey
    - GIRFT Further, Faster baseline assessment and action plan outstanding
    - Incorporate Triage and clinical waiting list validation into job plans
    - Develop Local Anaesthesia biopsy service

Theatres (Procedural Safety)

Summary
Improved performance, ARHQ Safety Culture survey completed and will guide next phase of improvement work

- Increased incidence of procedural never events in last 18 months
- After initial interventions, actions and reporting via PSCESC and QAC oversight of improvement to be managed through Fragile Services program
- No Never Events for last 6 months
- 26% reduction in all-cause procedural incidents in last 2 months

- Completed actions
    - Procedural Safety Steering Group (PSSG) established to monitor and triangulate all aspects of procedural safety (for Theatres and non-theatre procedural areas)
    - 9/11 recommended actions completed from action plan formulated after theatres safety day and external review of procedural safety
    - Safe Surgery Audit standards refined and improved with a 5-fold increase in daily sample size
    - Band 7 theatre staff have undertaken Human Factors training
    - Safety simulation exercises have been undertaken on both sites
    - SAFE stops / suture magnets / action cards fully implemented
    - NATSSIPs2 infographics cascaded to all governance leads for presentation
    - Updated Medical Internal Professional Standards published
    - ARHQ AQUA Safety Culture Survey results received and presented to PSCESC

- Ongoing improvement plan actions
    - Present ARHQ AQUA Safety Culture Survey results and resulting updated theatres safety project plan to QAC
    - 2 actions from external review of theatres safety day in progress - MIAA external audit (launch Oct 2024) & formation of theatre culture working group (dependent on ARHQ AQUA results)
    - Human Factors training for wider theatres and surgical team
    - Swabsafe trays are being trialled
    - Incivility behavioural data is available and will be a focus for Theatre Safety Culture/ Theatre Civility work

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note the escalation of Cardiorespiratory Services / Cardiology into the Fragile Services oversight program
- Note the de-escalation of Stroke Services and Gynaecological Surgery out of the Fragile Services oversight program
- Note the stabilised position with regards to ENT Medical Staffing, associated cost pressures and the plan to reduce these
- Receive further Fragile Service Oversight reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/24/10/100	
SUBJECT:	**Care Quality Commission (CQC) Compliance Update Report Q1**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Ali Kennah, Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD OF DIRECTORS OF DIRECTORS ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	all	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct.	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not.	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The report includes the Q1 Items reported to the Quality Assurance Committee Meeting held on 13 August 2024 which are summarised below: • Maternity Update • Warrington Living Well Hub 3 • Compliance Group & Mock Inspection Programme • Care Quality Commission (CQC) Engagement and Risk Meeting – January 2024 and April 2024			

	• Single Assessment Framework From 2024/25 Q1 this report will be extended to provide oversight of wider regulatory compliance and inspections e.g. Health and Safety, Health Technical Memorandums (HTMs). These will be noted within the report whist scrutiny will continue via the relevant sub committees		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board of Directors is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/08/112**	
	Date of meeting	**13 August 2024**	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		

REPORT TO TRUST BOARD OF DIRECTORS

SUBJECT	QOC Compliance Update Q1 2024/25	AGENDA REF:	BM/24/10/100

1. BACKGROUND/CONTEXT

- The CQC is the independent regulator of health and adult social care in England.
- Their role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.
- The CQC monitor, inspect and regulate services and publish findings. Where poor care is found, the CQC have powers to act.
- Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) continues to make sure it provides people with safe, effective, caring, and responsive services and that it is 'Well-Led', in line with the CQC standards.
- To monitor performance in relation to Trust compliance obligations, a Quality Compliance Oversight Group (QCOG) was formed, and the first meeting took place on 8 July 2024.
- In addition to items that have been reviewed by CQOG, this report contains information about Health and Safety compliance visits from other agencies. These visits are reported through the Health and Safety Sub Committee.

2. KEY ELEMENTS

Q1 items reported to the Quality Assurance Committee Meeting held on 13 August 2024 are summarised below:

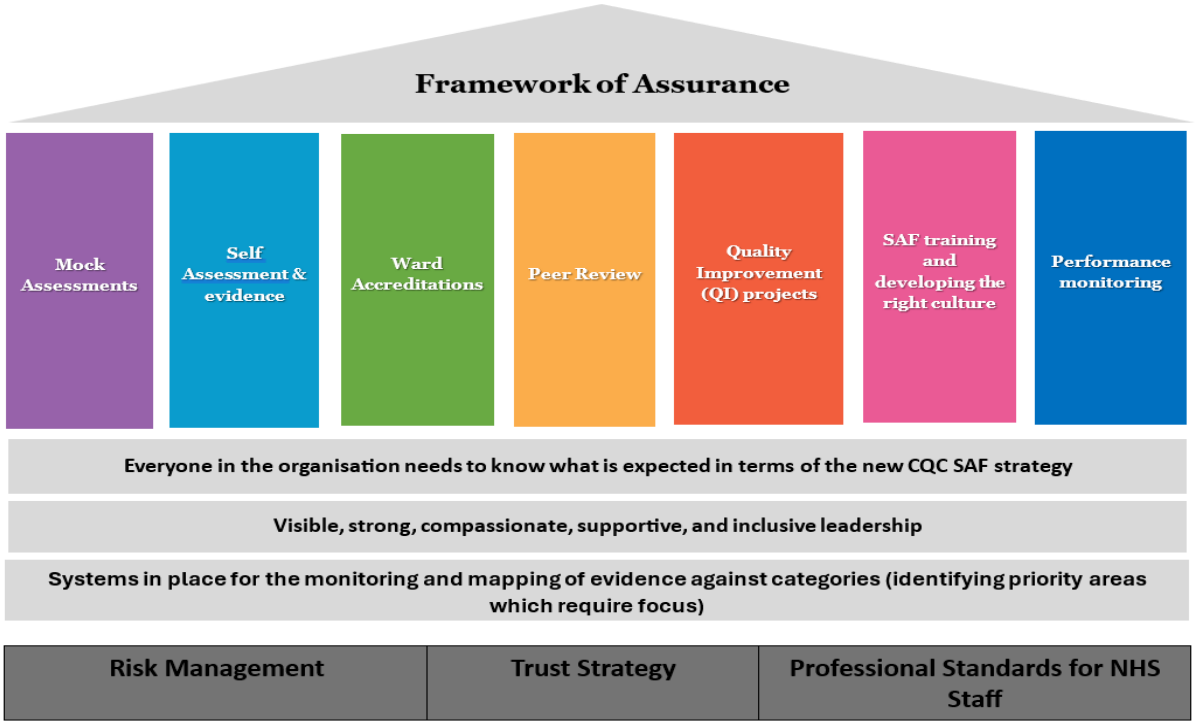
- Draft Terms of Reference for QCOG
- Framework of Assurance – Compliance Pillars
- Mock assessment (inspection) of UEC
- Single Assessment Framework preparation
- Should Do's and Must Do's
- CQC enquiries
- Health and Safety Inspections

3. TERMS OF REFEREENCE FOR QCOG

Terms of Reference were discussed and agreed, subject to minor amendments. There alterations were made, and the document was recirculated for final comments.

4. FRAMEWORK OF ASSURANCE – COMPLIANCE PILLARS

A visual Framework of Assurance has been developed. This illustrates all elements of compliance required to provide a robust Framework of Assurance. These elements are illustrated by compliance pillars. The pillars are underpinned by the foundations of Risk Management, Trust Strategy and Professional Standards for NHS Staff. In addition, a definition key was included, to support understanding of the key elements.



Framework of Assurance – Compliance Pillars

5. MOCK ASSESSMENT (INSPECTION) OF URGENT AND EMERGENCY CARE (UEC)

The CQC launched a new approach to assessing and regulating services for both Health and Social Care Services, namely a Single Assessment Framework (SAF). Following the launch of the SAF, the focus is on a more risk-based approach, and it involves the CQC "horizon scanning" and looking for potential red flags. This is undertaken by the CQC actively engaging with other organisations, patients, and members of the pubic, as well as monitoring Trust performance against targets, etc. Inspections are more likely to occur if the CQC have concerns about a specific area of the Trust, and their other fact-finding methods have not given them the assurance they require. It is still fundamentally important for all staff to be prepared for CQC inspection and assessment. Therefore, routine mock assessments will continue as planned. Assessments have been designed to support, and critique, not criticise. The method is for assessors from all different disciplines (e.g. Nursing, Medical, Pharmacy, Patient Experience Teams, Safeguarding and Infection Prevention Teams) to use a "fresh eyes" approach when assessing a service/department, with the aim to identify notable areas of good practice, as well as highlight areas and aspects of care that represent risk, and require closer scrutiny as well as action for improvement.

The mock assessors visited the Urgent and Emergency Care Department (UEC) over 2 days and at different times during each day. The visits took place on 13 and 14 June. The UEC was chosen as the focus for the initial mock assessment visit as, like other UEC's, it typically is a high-risk area. In addition, the service continues to carry four regulatory breeches, since the CQC inspection in February 2019. The primary cause of the breaches is capacity and demand as outlined below:

- Crowding in the Emergency Department is reduced so that patients do not have to wait on trolleys in corridors. Regulation 12(2)(b)
- Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals. Regulation 12(2)(a)(b)
- There are sufficient suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department. Regulation 18(1)
- There are sufficient suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department. Regulation 18(1)

WHH has mitigation plans in place, which are continually monitored and revised as necessary, to minimise any risks to patients, staff and others.
Initial Mock Assessment feedback from UEC staff suggests the way in which the assessment was undertaken was unobtrusive and less pressurised than at previous inspections. The verbal feedback indicated that some of the Assessment Team did not introduce themselves. This was a lesson learned for the team and was addressed prior to the second day of the assessment.
The Assessment Team found no safety issues that required immediate escalation. The positive team culture was evident throughout the assessment and the environment was calm and well managed. Staff were knowledgeable, thorough, and interacted well amongst themselves and with patients. There were, some areas that required action, as outlined below, and these were immediately progressed.

A schedule of mock assessments is being prepared. The next mock assessment taking place in September will be a full review of Theatres, starting with the Warrington site. This area of focus was selected due to recent known risks that caused Theatres to become a Fragile Service.

Care Group Single Self Assessments (SAF) are currently underway, the results of which, based on risk, will inform the scheduling order of future mock assessments.

6. PREPARATIONS FOR CQC ENGAGEMENT VISIT

There has been an ongoing focus of discussions with the CQC relating to UEC performance and the capacity challenges for WHH. In addition to providing information about performance assurance, the Trust extended an invitation to CQC colleagues to visit UEC. The informal visit did, in fact, take place on 6 August, in line with the planned CQC Engagement Meeting. CQC colleagues gave verbal feedback at the end of the Engagement Meeting, and it was extremely positive. The visit enabled them to speak to staff, patients and families on the ground, as well as to see and hear about some of the positive initiatives that are taking place to improve capacity and demand pressures and enhance patient experience. A comprehensive update will be provided in the Q2 report.

7. SINGLE ASSESSMENT FRAMEWORK (SAF) PREPARATION

Work is underway with all individual Care Groups currently completing self-assessment score ratings against each of the new SAF evidence categories. The next step for the Care Groups will be to gather and submit evidence against each category to support the allocated ratings. This is a significant piece of work; however, this work will enable the Trust to have a clear understanding of the position and monitor progress with compliance going forward. The intention is for the ratings to also influence the order of future mock assessments in terms of identifying priority risk areas.

Self-assessment ratings will be recorded, updated, monitored and regularly reported on behalf of Care Groups by the Compliance Team. A more sophisticated, interactive IT solution is being explored, which will provide the functionality for teams to effectively and efficiently track their own evidence and Trust status against each of the CQC categories in real time.

8. CQC SHOULD DOs AND MUST DOs

ED Inspection visit of 16 February 2019 and published on 15 April 2019

The visit identified 4 ‘must do’ actions. Breaches still in place due to capacity and demand. There were also 2 ‘should do’ actions identified.

	Must Do’s	Current position
1.	Crowding in the Emergency Department is reduced so that patients do not have to wait on	There is ongoing work and a robust plan in place to mitigate the risk to patients’ staff and others, as far as possible. The plan is continually monitored and revised as

	trolleys in corridors. **Regulation 12(2)(b)**	required. Operational performance is monitored and reviewed at Performance review Group (PRG) at an operational level. The Trust has implemented a number of actions to improve the identification and response to the deteriorating patients these include; • Electronic NEWS eNEWS system standardising approach across clinical areas and allowing regular audit and reporting of NEWS frequency and response compliance which are managed by the Deteriorating Patient Group and reported to PSCESC with escalation to QAC as required. • Additional investment in ED nursing staff to ensure the Trust has adequate capacity to identify and respond to deteriorating patients in spite of increasing demand /attendances. • Introduction of Manchester Triage System to ED. • Introduction of waiting room nurse to ensure any patients deteriorating whilst in the waiting room are promptly identified and escalated. • Introduction of 'Call for Concern' as a precursor to the introduction of Martha's Rule.
2.	Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals. **Regulation 12(2)(a)(b)**	
3.	There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department. **Regulation 18(1)**	
4.	Information about the performance of the Service is accurate and properly analysed and reviewed by the leadership team. **Regulation 17(2)(a)**	

The visit also identified 2 'should do' actions.

Area	Number	Status
Warrington	2	Information against these actions is currently being sourced

CQC inspection & Well-led review 29 March - 2 May, 2019 and published in 24/7/2019

The visit identified 31 'should do' actions.

Area	Number	Status
Trust-wide	9	8 completed with information against the other 1 currently being sourced
Warrington	16	13 completed with information against the other 3 currently being sourced
Halton	6	6 completed

Maternity Services at Warrington Hospital – published 17 January, 2024

Area	Number	Status
Warrington	5	5 completed

A summary update report detailing progress against all actions will be provided at the next QCOG meeting. QCOG will continue to monitor progress with actions, until closure. Only then will the necessary assurance be provided to QAC.

9.CQC ENQUIRIES

There were 2 new CQC enquiries raised in Q1.

Reg 28 - Coroner in relation to death	Awaiting closure
Death in Custody	Open Evidence sent to CQC 1.7.24.

10.OTHERCOMPLIANCE VISITS AND REVIEWS Q1

Environmental Health Officer (EHO)	Inspection took place 19 June 2024 at Halton and the outcome was very positive. Halton maintained their 5-star food hygiene rating.	A further inspection to be scheduled for August 2024 – Date TBC

11. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/24/10/101	
SUBJECT:	Maternity & Neonatal Update	
DATE OF MEETING:	2nd October 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate***)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		

	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an overview of activity, performance and quality within the maternity and neonatal services. The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 *(Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues)* alongside emerging local and regional matters. This paper also provides a summary in relation to the following reports for oversight and discussion: • August Maternity Quality & Safety update – appendix 1 • September Maternity Quality & Safety update – appendix 2 • Maternity Incentive Scheme Year 5 and 6 – appendix 3 • Transitional Care Q4 2023/24 – appendix 4 • Ockenden position – appendix 5 • PMRT Q1 2023/24 – appendix 6 • Q1 Midwifery Summary Safe Staffing Report and annual workforce plan – appendix 7a and appendix 7b		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee and Strategic People Committee	
	Agenda Ref.	QAC/24/08/114 QAC/24/09/136 SPC/24/08/81	
	Date of meeting	13th August 2024 10th September 2024 21st August 2024	
	Summary of Outcome	Noted and approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update Summary Report	AGENDA REF:	BM/24/10/101

1. BACKGROUND/CONTEXT

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

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

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

- August Maternity Quality & Safety update – appendix 1
- September Maternity Quality & Safety update – appendix 2
- Maternity Incentive Scheme Year 5 and 6 – appendix 3
- Transitional Care Q4 2023/24 – appendix 4
- Ockenden position – appendix 5
- PMRT Q1 2023/24 – appendix 6
- Q1 Midwifery Summary Safe Staffing Report and annual workforce plan – appendix 7a and 7b

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

2. QUALITY & SAFETY MEASURES & METRICS

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

2.1 Patient Safety Events

In June and July 2024 themes from patient safety events were as follows:

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

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

As referenced at previous meetings of Trust Board, a thematic (cluster) review was undertaken to review all cases referred to the Maternity and Newborn Safety Investigations programme (MNSI) in 2023. In total there were seven cases within this cluster (all relating to babies transferred for cooling) albeit only three were progressed by MNSI. In those cases

where the case did not move to a full MNSI investigation and report, the case was reviewed utilising the rapid review/ISR findings and other local learning.

Much of the learning identified as part of the cluster review was learning already identified via the ISR or MNSI review process. However the cluster review did identify some additional themes as detailed below:

- Three of the seven women were non white British ethnicity
- Three of the women did not have English as their first language although translation services were used in two of the cases
- Four of the seven cases occurred 'out of hours' (one Friday evening, one Saturday day, one Saturday evening, one Sunday overnight)

This additional learning will be shared via Women's Health Governance and CBU audit meetings to facilitate multidisciplinary discussion and exploration of the issues identified.

2.2 Workforce metrics

Work remains ongoing across the maternity and neonatal teams to improve and sustain compliance with mandatory training and completion of staff appraisals. At the end of July compliance for Trust mandatory training across maternity and child health colleagues is 88.71% for Trust mandatory training (including safeguarding training), 87.77% for role specific training. This excludes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge. Rates in July (excluding those with a long term absence) for maternity and child health services is 65.84%. This is being reviewed weekly.

Compliance with maternity specific training remains good, this in monitored monthly to ensure progress is sustained.

Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	98.4%	91.7%	94.4%	96.9%	64.1%
Obstetric Consultants	100%	90%	72.7%	n/a	n/a
Other Obstetric	100%	100%	83.3%	n/a	n/a
Obs Anaesthetic Consultants	100%	n/a		n/a	n/a
Maternity Support Workers	95.8%	n/a		n/a	36%

*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track
#Medical non-compliance relates to two medics – plan in place

Turnover for maternity and child health staff (permanent staff) has decreased from June to 11.49% and is below the Trust target. Turnover has remained below the Trust target of 13% since December 2023.

The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 2.54% in July 2024, significantly below the Trust target. At the end of July 2024, the vacancy rate for registered midwives was 1.71%

2.3 Service User Feedback

Individual feedback has been received and is included in appendix one for information.

The midwifery team have recently responded to a formal complaint. Within the complaint there was considerable feedback regarding the experience of the family. This included:

- Lack of clear explanation of clinical picture leading to lack of trust in staff
- Lack of effective care planning and communication of same across the maternity team
- Poor attitude of staff when discussing care pathways with service users
- Concerns regarding the method used to obtain blood samples and how phlebotomy appointments are arranged

As a result of learning from this complaint a number of actions have been completed:

- Patient story has been shared with the multidisciplinary team (including verbatim feedback) at both the Women's Health Governance meeting and Women's Health Audit meeting.
- Learning shared around indications and contraindications of actim PROM, performing the test and the interpretation of findings with maternity triage staff
- Learning shared regarding compassionate communication with women and the impact of providing conflicting information to women and the confusion this can cause
- Learning shared in relation to correct blood sampling and ensuring women are not invited back for multiple appointments if care can be offered at the time, i.e. a different practitioner to complete venepuncture

The learning and feedback from this complaint will also be used as case study as part of the wider culture work underway within the service.

2.4 Staff feedback

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

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

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

The insights/feedback from these sessions were shared with the Quadrumvirate in a further feedback session and feedback has formed the basis of the PCLP action plan. This was shared and approved at quality Assurance Committee in August.

A Maternity Safety Champion walkaround took place on August 13th 2024. The team visited all areas within the maternity unit including the recently opened induction of labour space. The Safety Champions spoke to a number of staff including student midwives.

No concerns were raised by staff and feedback from the team particularly in relation to the new induction of labour space was good. Staff described the improvement in the experience of families undergoing induction as well as how the new space provided an improved working environment.

Student midwives talked openly about their positive experience at WHH and expressed a real desire to obtain roles at WHH on qualification as registered midwives. The Safety Champions noted some issues in relation to the estate and plans to resolve these were discussed with managers and the wider leadership team.

2.5 Maternity Triage

In July 2024 582 triage attendances were recorded on the BadgerNet patient record system. This reflects the sustained increase in Triage attendance since the beginning of 2024:

Triage attendances Dec 23 - July 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8

In July 2024 88% of attenders were seen within 15 minutes of arrival (best practice guidance). This was a significant reduction from 96% in June 2024 and does not meet the KPI of 90% review within 15 minutes. 96.6% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is also a reduced performance from previous months but is beyond the KPI of 95% review within 30 minutes.

A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. This paper has been

presented to the Trust Executive Team who have requested further information. An updated paper has been drafted and is under review.

To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways.

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

2.6 Induction of Labour

Data from the LMNS for June and July highlights WHH performing less well with regard to timeliness of IOL activity compared to other local providers, in particular those providers of a similar size to WHH:

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	45	137	52	60	101	90	64	549
Total Delayed	4	26	7	3	22	30	37	129
% of Total	8.89%	18.98%	13.46%	5.00%	21.78%	33.33%	57.81%	23.50%

33.33% of IOL at WHH were delayed in July 2024, this is a similar position to June 2024 (30.43% delayed).

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

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
01/07/2024	2	5		1	5	17	25	55	42.64%
08/07/2024		7	5	0	1	8	4	25	19.38%
15/07/2024	2	7	2	2	12	2	3	30	23.26%
22/07/2024		6			4	3	4	17	13.18%
29/07/2024		1					1	2	1.55%
Grand Total	4	26	7	3	22	30	37	129	100.00%
% of Total	3.10%	20.16%	5.43%	2.33%	17.05%	23.26%	28.68%	100.00%	

23.26% of delayed IOL across Cheshire & Mersey in July 2024 were at WHH.

Improvement work to improve IOL pathways has commenced, the action plan is not yet complete but is being drafted and will be shared to October QAC.

2.7 Maternity Continuity of Care - Update

A detailed update in relation to the Trust position with regard to Maternity Continuity of Care was provided to Quality Assurance Committee in September 2024. Continuity of Care (CoC) data is extrapolated from BadgerNet on a monthly basis and shared with the LMNS. Measures include:

- percentage of women at 29 weeks gestation on a CoC pathway

- percentage of Black, Asian or Mixed Ethnicity women at 29 weeks gestation on a CoC pathway
- percentage of women in bottom decile of deprivation at 29 weeks gestation on a CoC pathway.

There remain no national targets for the implementation of CoC.

The percentage of women receiving continuity at 29 weeks gestation has consistently ranged from 43-54% since April 2023 when community services were streamlined and the number of continuity teams was reduced.

The other outcome measures vary dependant on the population of women at 29 weeks gestation in each given month; for women in the bottom decile, continuity varies from 17% to 45% and for black, Asian and mixed ethnicity women, this varies from 60% to 90%.

Measures are in place to ensure that vulnerable groups who do not formally receive continuity of carer, are supported. These include:

- Antenatal and postnatal team case-holding for all service users
- The work of the recently appointed enhanced maternity support workers who provide financial advice, signposting to voluntary agencies, smoking cessation, healthy lifestyle advice to all women
- Specialist midwives to support with smoking cessation, mental health, diabetes, multiple pregnancy, preterm birth and infant feeding
- Baby shower' events held in Halton, which provide a drop-in for infant feeding support, smoking cessation, the homebirth team and community midwives.

In addition to this, Team River is an enhanced continuity team which does not work geographically but will casehold women who are considered particularly vulnerable. This includes women experiencing teenage pregnancy, women experiencing or with a history of poor mental health, women with social care involvement (level three and above), bereaved women, women affected by substance misuse, women for whom English is not their first language and women who are seeking asylum.

A full action plan is due to be implemented to increase CoC for all service users, this has been delayed due to awaiting the 2024 staffing workforce tool. A further update will be provided to Quality Assurance Committee in December 2024.

2.8 Complaints

Eight complaints were received in the CBU in June and July 2024, two of which were related to care within the maternity and neonatal services.

Specialty	Description	Complaint Opened	Current Stage
Maternity	Concerns relate to the midwifes panicked demeanour and behaviour which led to an increased state of anxiety and fear in the patient during and leading up to the birth of her baby.	23/07/24	Investigation completed and meeting with family arranged.
Maternity & Paediatrics	Unacceptable care post-delivery on ward. Inadequate care from Community Midwife Team. Unacceptable treatment during Safeguarding process.	23/07/24	ISR completed. Meeting to be arranged with family.

2.9 All-Party Parliamentary Group (APPG) on Birth Trauma

A report by The All-Party Parliamentary Group (APPG) on Birth Trauma was published in May 2024. The APPG identified a number of concerns/areas for improvement, many of which reflected the findings of other national reports/inquiries into maternity care.

A gap analysis was completed comparing WHH practice against the new recommendations and an overview position was presented as a Hot Topic to Quality Assurance Committee in June 2024 and Trust Board in August 2024. This identified a good position albeit with further progress required. The position has been further reviewed and an action plan to meet all recommendations from the APPG was approved at Quality Assurance Committee in August 2024. An update with regard to this action plan will be provided to QAC on a quarterly basis for overisght and assurance.

2.10 Coroner Enquiries

No Regulation 28 enquiries have been received

3. MATERNITY INCENTIVE SCHEME (MIS)

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

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

Regular assurance meetings are held with the LMNS to review progress against the actions. Previously the LMNS have been assured by the service's progress. The next quarterly meeting with LMNS was scheduled for 4 September 2024.

Following this meeting, progress against each safety action will be collated and progress will be reported in detail to Quality Assurance Committee in October 2024.

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

4. Q1 2024/25 TRANSITIONAL CARE

The Q1 2024/25 Transitional Care Audit was presented to Quality Assurance Committee in September 2024 and is included as appendix 4.

During Q1, 15 babies met the criteria for TC. An audit of these cases has identified the following:

Admitted direct to TC	1
Appropriately received NNU care and stepped down to TC when well enough	10
Allocated to PEEP for 30 pathway	3
Did not received TC	1

Of the 15 babies who met the criteria in Q1, only one baby was admitted straight to TC from birth due to the other babies requiring respiratory support. The other 14 babies who met the broad TC criteria in Q1 required some level of respiratory support and were initially provided with care via NNU.

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

- Improvement seen in the early recognition of babies who can step down to TC
- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Sharing of audit outcomes across the MDT with both midwifery and neonatal teams to ensure learning is communicated.
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Band 6 TC Midwifery champion in place, attending TC training and attends working group (protected time each month).
- Review of Enhanced Care criteria completed, disseminated to all staff and displayed in all areas.
- Revisited and redesigned the TC Audit. This is now lead by the NNU Matron. Audit information is reported to QAC.
- “Think TC” Boards in each clinical area – to remind staff of TC admission criteria. Includes updates re progress with TC project.

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

- Time to be given to TC midwifery champion to complete TC programme.
- Focussed learning from TC review to be included on Neonatal Natter and OWL
- Staffing – Continue to ensure neonatal staff are allocated to TC babies.
- NNU Matron to review occasions where NHSP has been utilised to support TC staffing to support long term staffing plan.

- Following NHSP review, finance to provide costings for Band 4 nursery nurses to support long term staffing plan and inform a potential future revenue request.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

Outstanding actions from action plan;

- Ongoing TC audit which will be reported through Quality Assurance Committee and to Trust Board.
- Policy review and staffing model to be completed
- TC Bay on C23 to be established now induction of labour activity transferred to new space on Birth Suite.

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

5. OCKENDEN RECOMMENDATIONS UPDATE

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

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

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

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

A meeting of the Quadrumvirate will now be arranged to complete a final review of the Ockenden action plan and ensure all assurance has been received. This will facilitate the formal closure of all Ockenden action plans. The outcome of this review will be reported to October 2024 Quality Assurance Committee.

Four actions have been transferred to an issues log for continued monitoring.

6. PERINATAL MORTALITY REVIEW/AUDIT – Q1 2024/245

During Q1, WHH reported one baby to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK):

One stillbirth:

- One baby born at 38+4 weeks

The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 2 2024/25 report to Quality Assurance Committee following completion of the PMRT review panel.

WHH stillbirth rate for Q1 2024/25 was 1.60 per 1000 births. WHH annual mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.

WHH Neonatal mortality rate during Q1 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

During Q1, WHH undertook five PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed:

One late fetal loss:

- One baby born at 23+6 weeks

Four stillbirths:

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

When care provided to the mother up to the point that her baby was confirmed as having died was reviewed, this was graded B in two cases, C in one case and D in two cases.

When care provided to the mother following confirmation of the death of her baby was reviewed, this was graded A in one case, B in three cases and C in one case.

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. Detailed findings and actions are included in appendix 6.

Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.

7. MIDWIFERY SAFE STAFFING

7.1 Midwifery establishment

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

The most recent paper to Strategic People Committee provided an overview of the staffing position at as 30th June 2024 and red flag position for the period April-June 2024 alongside other key workforce metrics.

A full maternity workforce planning review using the nationally recognised Birthrate Plus® workforce planning tool was completed at the beginning of 2022. The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust at that time was 116.70wte, this included an additional 10% for non-clinical roles.

The maternity funded establishment at the 30th June 2024 is 125.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 30th June 2024 shows a positive variance of 8.564wte. This further variance is the result of the addition of a number of new full time and part specialist midwifery roles to the midwifery establishment since January 2022 alongside an increase in WTE in some existing posts.

These changes have been made to meet the requirements of external reviews, national recommendations and frameworks including the Ockenden Report recommendations and the Maternity Incentive Scheme Years 4 and 5 (incorporating the Saving Babies Lives Care Bundle. All new posts have been funded within the service via reallocation of existing establishment or via external funding streams.

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

7.2 Midwifery red flags

Within the maternity service, staffing red flags across the maternity service are recorded within the SafeCare module of the health roster. As part of Maternity Incentive Scheme Year 6 - Safety Action 5 there is a requirement to closely monitor two key measures:

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

In the period 1st April 2024 – 30th June 2024 there are 2 episodes recorded in SAFECARE/BR+ where the midwifery coordinator in charge is NOT supernumerary. Both occasions occurred at times of high acuity and were for a short period of time while other clinical staff could be redeployed:

In the period 1st April 2024 – 30th June 2024 there was one episode recorded in SafeCare where a woman in active labour is NOT receiving one-to-one care.

In this case the woman arrived in Maternity Triage in active labour. The triage midwife was unable to provide 1:1 support to the woman for a short period while transfer to Birth Suite for ongoing care was arranged.

7.3 Workforce metrics

The vacancy rate for registered staff as at 30th June 2024 is 0.65%. This is a significant decrease from the end of Q4 2023/24 when the rate was 5.66% and continues the significant improvement from the from end of January 2023 when the vacancy rate was 18.29%.

Midwifery retention rates remain good with turnover at 8.32% at the end of June 2024. Rates below the Trust target have been maintained since December 2023. Sickness rates for June 2024 for registered midwifery staff were 6.27%, this is an increase from May 2024. It is

however a decrease when compared to June 2023 when the rate was 7.2%. The rolling 12 month rate is 6.9%.

7.4 Annual maternity and neonatal workforce plan

The Maternity and Neonatal Workforce Plan for 2024/25 was presented to Strategic People Committee for discussion and approval. The plan is included in appendix 7b and has been developed to reflect the recommendations of national guidance related to the neonatal, obstetric and maternity workforce as well as other local priorities such as ongoing work related to improving workplace culture.

The plan has been developed in collaboration with the senior CBU team and with the support of colleagues from the People Directorate and includes actions which reflect insight gained from completing the Trust workforce planning template.

The plan will inform existing and new workstreams across the CBU. Progress against the plan will be discussed as part of the quarterly 'Quad' meetings with the Maternity Safety Champion, CBU Governance meetings and will report to Strategic People Committee quarterly.

8. MONITORING/REPORTING ROUTES

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

9. ASSURANCE COMMITTEE

The contents of this report has previously been noted and discussed at Quality Assurance Committees on 13th August 2024 and 10th September 2024 and at Strategic People Committee on the 21st August 2024.

10. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/10/101 – Appendix 1</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Monthly Maternity & Neonatal Quality Update – June 2024</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">2 October 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Aila Gaskill-Jones – Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.
SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future
SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.</td><td>✓
✓
✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="5"></td></tr>
<tr><td rowspan="6">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes
X</td><td>No</td><td>N/A</td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes
X</td><td>No</td><td>N/A</td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A
X</td><td></td></tr>
<tr><td colspan="5">Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to maternity and neonatal care focussing attention on improving outcomes for this protected group.</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">This paper provides an update in relation to maternity and neonatal quality and provides Trust Board with oversight of key matters to provide assurance on maternity and neonatal safety and quality issues.</td></tr>
</table>

	In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position There were two moderate harm and one, severe harm event in the CBU in June 2024. Themes from maternity/neonatology patient safety events in June are as follows: • Admission of term babies admitted to Neonatal Unit (NNU) • PPH >1500ml • Postnatal readmission A quarterly cluster view of postnatal readmissions has been completed, themes identified and actions to reduce underway. Work remains ongoing with regard to reduction in rates of PPH and in term admissions to NNU. At the end of June compliance for Trust mandatory training across maternity and child health colleagues is 88.88% for Trust mandatory training (including safeguarding training), 87.31% for role specific training. This excludes staff who are currently absent from work on a long term basis. Compliance with PDR completion remains a challenge. Rates in June (including those with a long term absence) for maternity and child health services is 74.92%. An action plan remains in place. The NHSE Perinatal Cultural Leadership Programme (PCLP) is reaching completion at WHH. As part of this a SCORE Cultural Survey of maternity and neonatal colleagues was completed and has informed the development of an action plan. In June 96% of attenders were seen within 15 minutes of arrival (best practice guidance), 99.2% of attenders were seen within less than 30 minutes of arrival (NICE guidance). For both measures the service is meeting

	agreed KPIs. Work is ongoing to ensure a sustainable staffing model for Maternity Triage. June data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour (IOL) activity when compared to other local providers. A task and finish group is in place which will focus on IOL delays alongside wider work in relation to experience of IOL pathways. The All-Party Parliamentary Group (APPG) report on Birth Trauma was published in May 2024. The maternity service have developed an action plan to meet all recommendations. Three complaints were received in the CBU in May 2024. None related to care in the maternity and neonatal services. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **X**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/08/114iii**	
	Date of meeting	13 August 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Monthly Maternity & Neonatal Quality Update – June 2024	AGENDA REF:	BM/24/10/101 - Appendix 1

1. BACKGROUND/CONTEXT

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

The paper provides Quality Assurance Committee (QAC) with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 6 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

2. HARM EVENTS

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

Severity	May 24	June 24
1 – No Harm	102	68
2 – Low Harm	39	24
3 – Moderate Harm	0	2
4 – Severe Harm	0	1
5 – Fatal	0	0
Total	141	95

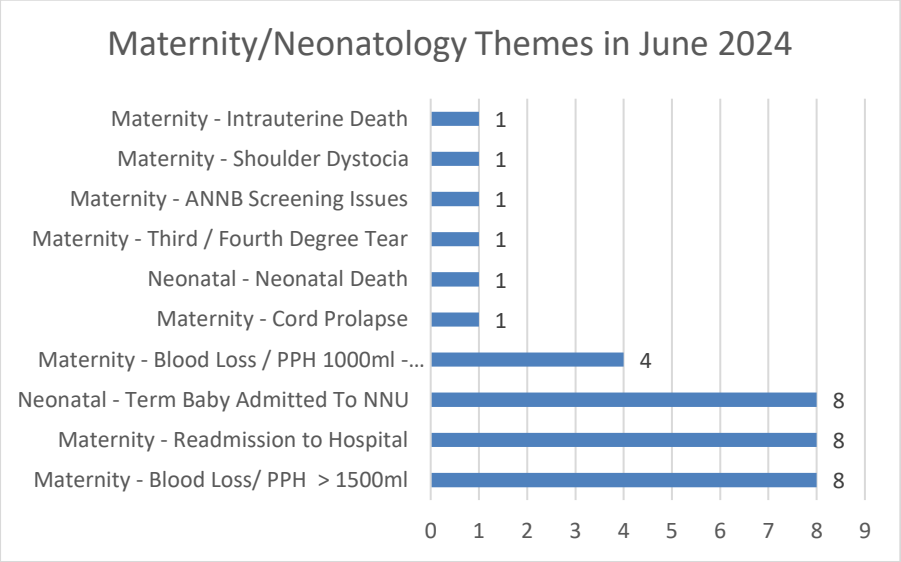
There were two moderate harm and one severe harm events in June 2024.

The moderate harm events related, in the first case, to a 3rd degree perineal tear. This was reviewed at Intrapartum Review Group and no concerns with care identified.

The second moderate harm event related to an intrauterine death (IUD) at 38+1 weeks gestation. In this case the IUD was identified following attendance at Maternity Triage due to decreased fetal movements (first episode). An initial safety review (ISR) has been completed and no immediate safety actions identified. This case will be reviewed fully via the PMRT process.

Ther severe harm event related to a baby born at home who collapsed following birth and was transferred to a tertiary unit for ongoing care. This baby was subsequently diagnosed with Meconium Aspirate Syndrome (MAS) and Persistent Pulmonary Hypertension of the Newborn (PPHN). An ISR was completed. No care concerns were identified however there were some immediate actions to ensure both the staff and family were well supported. The case was referred to MNSI for external investigation but has been rejected due to not meeting the required criteria. A formal debrief with the Consultant Midwife has been offered to the family. The baby is now doing well.

Themes from maternity/neonatology patient safety events in June 2024 are detailed in the table below:



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

Eight postnatal readmissions were reported in June 2024. As advised to July QAC, a quarterly cluster review of readmissions has been completed.

In quarter one, there were 30 postnatal readmissions from 615 births (4.87%). Of these readmissions, three were deemed avoidable. Two women who experienced pregnancy loss were subsequently readmitted with retained products of conception (RPOC), which could have been avoided if the USS prior to discharge home had not been cancelled.

One patient was readmitted with a wound infection for a second time. The second readmission could have been prevented if the women had been reviewed by the tissue viability team prior to discharge home.

Actions implemented to prevent events of this type in the future:

- Those who have experienced pregnancy loss to be offered a bedside USS prior to discharge from Birth Suite to rule out RPOC.

- Those admitted with a wound infection to be discussed with Trust tissue viability team (TVN) prior to discharge home.

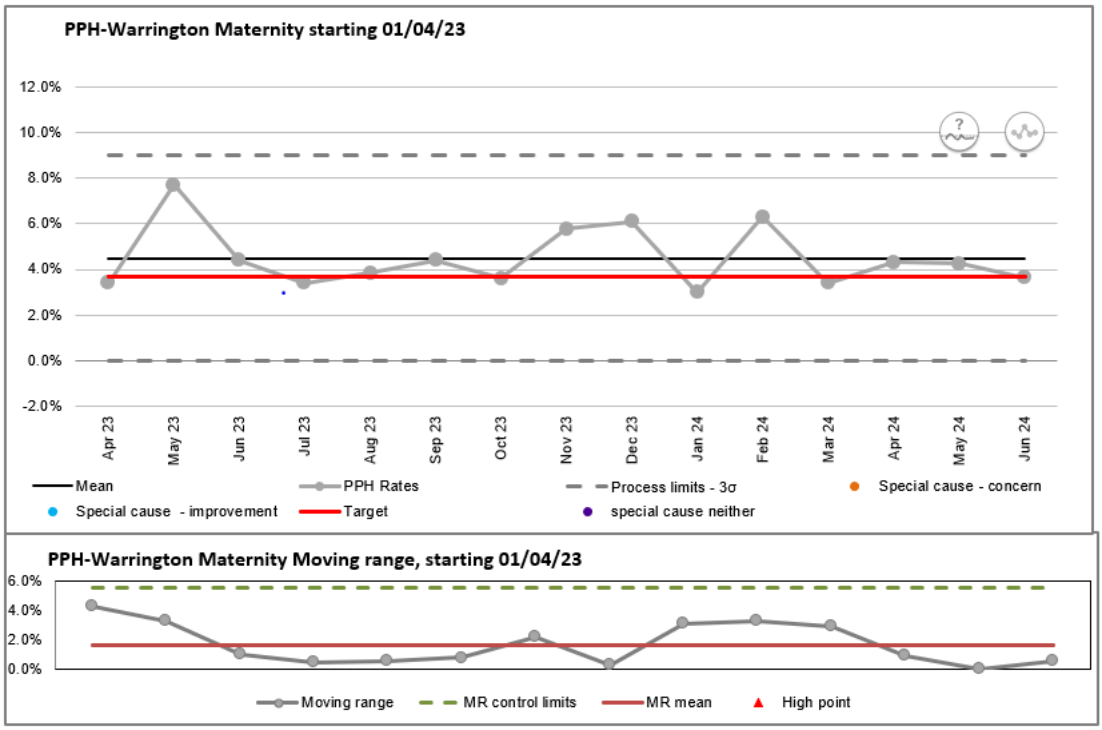
Of the 30 postnatal readmissions, 12 occurred due to RPOC, eight were due to wound infections, two were due to post dural puncture headaches, two were readmitted due to hypertension and five were categorised as generally unwell or ‘other’. RPOC and wound infections were identified as key themes for quarter one.

With respect to RPOC, discounting women who suffered a bereavement, no individual concerns/patterns were identified. Work is underway with the Specialist Midwife - Practice Development to review the latest evidence around RPOC. The service ‘Training Train’ will be utilised to share best practice for checking the placenta and membranes prior to discharge home. The service will continue to review the care of women who attend with RPOC to identify any further learning.

With respect to wound infections, 87.5% of women readmitted with a wound infection birthed via caesarean section (N=7). Women were counselled appropriately about the risk of infection when consented for caesarean section. Wound care appeared good. Women were advised to keep the area clean and dry, the dressing was removed as per guidance, wounds were checked regularly on the postnatal ward and during community visits and appropriate safety netting was in place. Work is ongoing with the TVN team and consultant lead to explore different wound dressings to minimise the risk of post operative wound infections. An update to these actions will be provided to QAC in November 2024 as part of the Q2 review of postnatal readmissions.

There were eight cases of PPH ≥1500mls in June 2024. The formal QI project is progressing well. The family of measures have been agreed and the data collection plan and operational definition will be constructed in the next group meeting due on 31st July. The Diver Diagram is to be discussed on 7th of August with whole team.

The SPC chart for PPH ≥1500mls shows no trend at present, the chart shows rates for May 2024 at 3.65% which is below the target of 3.7% (based on historical regional data).



Alongside the QI project, all cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group (IRG), learning shared and any urgent actions completed.

3. WORKFORCE METRICS & MEASURES

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

At the end of June compliance for Trust mandatory training across maternity and child health colleagues is 88.88% for Trust mandatory training (including safeguarding training), 87.31% for role specific training. This excludes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge. Rates in June (including those with a long term absence) for maternity and child health services is 74.92%. An action plan remains in place.

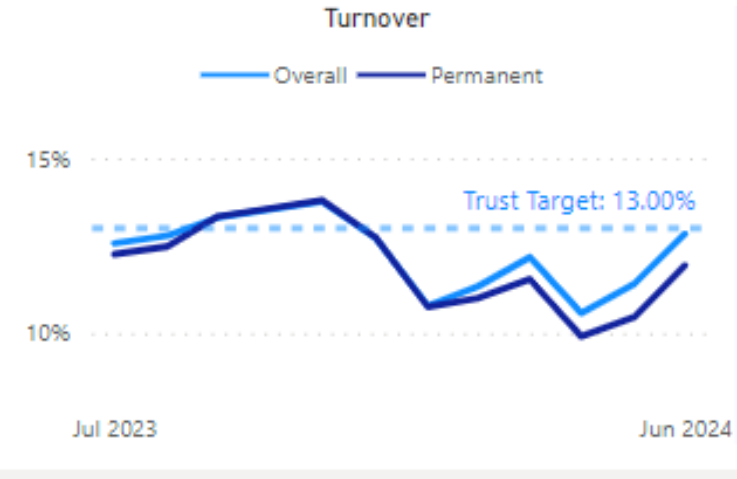
Compliance with maternity specific training remains good, this in monitored monthly to ensure progress is sustained.

Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	96.9%	91.7%	91.4%	93.2%	57.8%
Obstetric Consultants	100%	90%	81.8%	n/a	n/a
Other Obstetric	93.7%	100%	83.3%	n/a	n/a
Obs Anaesthetic Consultants	96%	n/a		n/a	n/a
Maternity Support Workers	95.8%	n/a		n/a	28%

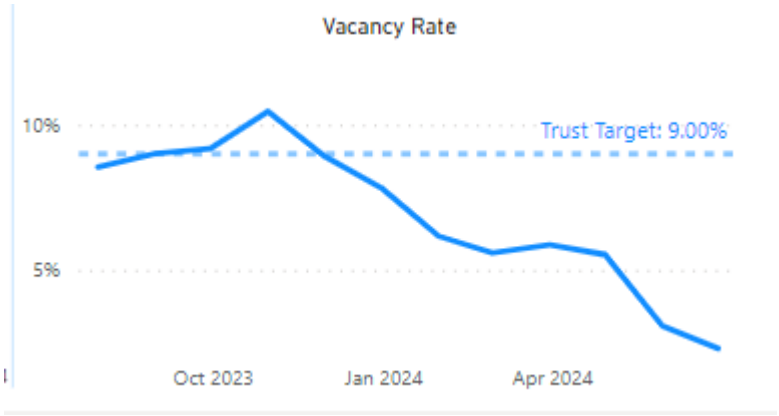
*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track
#Medical non-compliance relates to two medics – plan in place

Turnover for maternity and child health staff (permanent staff) has increased to 11.49% but remains below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:



Reviewing the data via speciality identifies increased turnover amongst both child health and maternity colleagues. Further work will be completed to understand the reasons for this and ensure measures are implemented to sustain the improvement achieved since October 2022.

The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 2.3% in June 2024. This is illustrated in the graph below:



At the end of June 2024, the vacancy rate for registered midwives was 0.65% a continued improvement from the position in March to May 2024.

4. SERVICE USER FEEDBACK

Individual feedback from families has been received and is included in appendix one.

Following the completion of the maternity estates project to relocate the setting for induction of labour, a Maternity and Neonatal Voices Partnership 15 steps challenge is scheduled to take place in the Autumn. In the interim, service user feedback is being collated from those on the IOL pathways and will be shared to a future QAC.

5. STAFF FEEDBACK

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

Details results were received in March 2024 and shared with the CBU Quadrumivirate ('Quad') and to QAC. From this, a series of cultural conversations were held to explore the results further. In total eight cultural conversations were held with representation from all maternity and neonatal teams and representation across all roles.

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

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

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

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

These aspirations have now formed the basis for a PCLP action plan which has been agreed via the Quadrumvirate. This is included in appendix three for approval. Progress against this action plan will be discussed as part of CBU governanace meetings and will be a standing item at the regular Quad/Safety champion meeting. An update with regard to this action plan will be provided to QAC on a quaterly basis for overisght and assurance.

6. MATERNITY TRIAGE

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

Current performance

In June 2024 567 triage attendances were recorded on the BadgerNet patient record system. This reflects the sustained increase in Triage attendance since the beginning of 2024:

Triage attendances Dec 23 - June 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9

- 19.7% of attendees were seen immediately on arrival, a significant improvement from 12.2% in May 2024.
- The longest wait recorded for initial review was 49 minutes, this was due to high acuity
- 96% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes and an improvement from May 2024.
- 99.2% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes and again an improvement from May 2024.
- 0.7% of attendees were categorised as red on arrival. Appropriate ongoing care was provided in all cases.
- 16% of attendees were categorised orange on arrival, this is on a par with May 2024.

Activity in place to support a safe service

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

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

7. INDUCTION OF LABOUR

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

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

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
27/05/2024		2	1		1	4		8	10.96%
03/06/2024	2		5		2	5	1	15	20.55%
10/06/2024		1	4		6	4	1	16	21.92%
17/06/2024	1	1		4	4	2		12	16.44%
24/06/2024		4	7	3	1	6	1	22	30.14%
Grand Total	3	8	17	7	14	21	3	73	100.00%
% of Total	4.11%	10.96%	23.29%	9.59%	19.18%	28.77%	4.11%	100.00%	

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	32	107	63	51	91	69	35	448
Total Delayed	3	8	17	7	14	21	3	73
% of Total	9.38%	7.48%	26.98%	13.73%	15.38%	30.43%	8.57%	16.29%

Work to improve IOL pathways is underway which will be supported by the relocation of the setting for IOL care at the beginning of July. The initial action plan is in draft and will be shared to September QAC.

8. APPG ON BIRTH TRAUMA – WHH POSITION - UPDATE

A report by The All-Party Parliamentary Group (APPG) on Birth Trauma was published in May 2024. In summary, the APPG identified a number of concerns/areas for improvement, many of which reflected the findings of other national reports/inquiries into maternity care. In particular:

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

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

A gap analysis was completed comparing WHH practice against the new recommendations and an overview position was presented as a Hot Topic to Quality Assurance Committee in June 2024. This identified a good position albeit with further progress required. The position has been further reviewed and an action plan to meet all recommendations from the APPG has been drafted. This is included in appendix four for approval. Progress against this action plan will be discussed as part of CBU governanace.

An update with regard to this action plan will be provided to QAC on a quaterly basis for overisght and assurance.

9. COMPLAINTS

Three complaints were received in the CBU in June 2024. None of these related to care within the maternity and neonatal services.

10. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

11. MONITORING/REPORTING ROUTES

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

12. ASSURANCE COMMITTEE

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

13. RECOMMENDATIONS

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

Appendix One – Family Feedback

Individual feedback received:

Feedback from a family who birthed with WHH, receiving care from Team Lunar, (RM KL and St RM SH) and colleagues from the wider Birth Suite team. The family shared their experience with the Specialist Midwife – Pelvic Health as part of a debrief process:

I just wanted to share this lovely patient feedback I received today whilst conducting a debrief with HS. She attended with her partner and third baby. HS suffered a third degree tear this time around following her home birth and had a very traumatic experience with her first born. At the end of her debrief HS and her partner wanted to express their eternal gratitude for all the staff who had cared for them during this pregnancy. They both have worked in the NHS and understand the pressures we are all under but both said that they don't know what they would have done without all staff they came into contact with being supportive, understanding, and thorough. HS got emotional when speaking of you KL, you are her 'earth angel' she doesn't know what she would have done without you and also wanted to express her thanks to the student midwife who worked alongside you and was present at the home birth, they said she was so professional and so helpful at home especially when H had to be transferred back in for repair of her 3rd degree.

The couple shared how KL had gone above and beyond for this family - ensuring H's partner could be in theatre with her along with baby whilst she underwent the repair, this was extremely important to her and again they wanted to say a huge thank you for this. HS felt that when she was transferred in the staff on Birth Suite were kind, caring and again supportive. They facilitated discharge back home as soon as possible the following morning as per H's wishes and her postnatal follow up was excellent. The family also wanted to extend their thanks to Team Lunar and the support from the community team who they came into contact with, HS reports that compared to having her first child in 2020 up to now she has seen a huge change in staff attitudes and their language, she really felt cared for and listened to. They felt no stone was unturned regarding their care and having care outside of guidelines was supported along with the appropriate, correct evidence..”

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix Two – PPH QI Project Action Plan

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

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

Actions- 3.6.24			
KF now part of the regional team to develop a regional PPH guideline	KF	24.5.24- Had a discussion with regional team- Andrew Weeks Consultant Obstetrician leading. Local guidelines shared. 17.7.24-Working group now developed	
Actions-26.6.24			
KF to update meetings to weekly as per governance oversight.	KF	Completed	
To plan a meeting to discuss a data collection plan.	ALL	Arranged for next meeting	
CH to send the raw data to Sarah Delooze for review	CH	Sent during meeting	
SD to compile SPC charts for all necessary measures and distribute so that decisions can be made re. the current problem and aim statements.	SD	17.7.24-ONGOING	
SD to complete and circulate the fishbone diagram	SD	17.7.24-COMPLETE	
Gantt chart to be compiled for all actions until now	SJ	17.7.24-ONGOING	
Actions-17.7.24			
Data planning	SJ/SD/ CH/KF	To continue discussion at next meeting	

Appendix Three – PCLP Action Plan

PCLP Culture workplan

No	Action Required	Lead	Progress	Initial due date
PCLP1	Roll out the day in the life framework offering shadowing opportunities to promote cross role and area awareness. This will be spotlighted bi-monthly in weekly newsletters and shared on digital platforms for the next 12 months.	Quad/Emma Bentham		30th Sept 2024
PCLP2	Creation of a Women's & Children's Facebook group specifically to share updates and celebrate good news stories. This will be updated at least weekly using teams to collaborate and generate ideas with implementation in the next 2 months.	Quad/Emma Bentham		31st August 2024
PCLP3	Implementation of a meet the team proforma which specifically asks questions not related to work. This will be shared on the newly founded Facebook group with a nomination system to be ongoing until the next staff survey.	Quad/Emma Bentham		30th Sept 2024
PCLP4	Development of a programme of "Meet the Quad" Teams sessions to share key updates	Quad/Emma Bentham		30th Sept 2024
PCLP5	Series of ideas events to be completed to focus on team working and to further explore barriers to effective team working and how we can ensure the team feel involved in decision making	AGJ/LJ/TM		30th Sept 2024
PCLP6	Maternity & Neonatal Working group to be established focus on wellbeing, emotional recovery and burnout	LJ		31st December 2024
PCLP7	Communication to be completed to clarify leadership structure	AGJ - DOM		31st August 2024

PCLP8	To utilise the "You said, we did" feedback tool quarterly to demonstrate progress against actions from the culture workstreams (from Q3 2024)	Quad/Emma Bentham		31st December 2024
PCLP9	To engage fully with the Trust culture plan and communicate this to the maternity and neonatal team	All		31st December 2024
PCLP10	To implement system to capture/triangulate staff satisfaction/culture related learning and ensure oversight via the Quad and Maternity & Neonatal Safety Champions	AGJ - DOM		31st December 2024
PCLP11	To ensure feedback from exit interviews is captured and used to support improvement activity	Tina Moors - Dep DoM		30th Sept 2024
PCLP13	To complete regular temperature check surveys with the team to support triangulation of data from other sources (e.g. informal feedback, learning from complaints, exit interviews) and identify improvement activity	Matrons		31st October 2024
PCLP14	To implement programme of development opportunities (shadowing, mentoring, formal training) to support staff in career development and retention	Pam Aldred - Retention Midwife		31st March 2025
PCLP15	To review PCLP action plan as part of Quad/NED meetings	Quad/Emma Bentham		31st August 2024
PCLP16	To report progress against PCLP quarterly to QAC (next update Nov QAC)	AGJ		12th November 2024

Appendix Four – Birth Trauma Recommendations Tracker (July 2024 Position)

RAG	
Red	Not started
Amber	Work underway - risk to completion
Green	Work underway - on track
Blue	Complete - ongoing work to sustain as part of BAU in place
Grey	Awaiting national guidance

Recommendation	Owner	WHH lead	WHH position (May 2024)	Update/Next Steps (July 2024)	RAG
Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services	WHH	AGJ/TM	WHH good position re recruitment and retention. Vacancy rate for medical and midwifery colleagues low	Good retention and vacancy rate maintained. Work ongoing to sustain improvement in these workforce metrics. 2024/25 workforce plan to SPC August 2024.	
Provide mandatory training on trauma-informed care.	WHH	SN	Not in place	Silver Birch have agreed to deliver training to WHH team. Dates scheduled for October 2024.	
Make sure all NHS trusts offer antenatal classes to inform parents of what to expect from birth and to outline their options.	WHH	SE	Antenatal classes commenced March 2024. Delivered by each individual community team, content revised for specific women, e.g. River women. Outstanding action is to implement this in ANC for out of area women.	Work ongoing to identify resource within ANC to deliver ANC. Feedback to be collated for each team, with MVP input to review what is being offered	
At the 34-week appointment, discuss with women their options during birth, including the risk factors relating to instrumental and caesarean birth.	WHH	SE/SN	Parent education offered to all women booked at WHH from 34/40. Signposted to this at 34/40 antenatal appointment. 36 week appointment discusses birth preferences with CMW.	Team collating feedback from parent education to ensure meeting need	
Offer regular CPD training to maternity professionals on communicating risk.	WHH	AGJ/TM	Awaiting national guidance	Awaiting national guidance	

Recommendation	Owner	WHH lead	WHH position (May 2024)	Update/Next Steps (July 2024)	RAG
Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.	WHH	SN/Obs	WHH have completed RCOG OASI training for the first care bundle. OASI included as part of mandatory maternity training	Awaiting national guidance. WHH will use BadgerNet to provide women with the information and adopt any change to the RCOG consent forms for these procedures, which are necessary when performed in theatre.	
Maternity units to adopt the recommendations of the consensus statement on instrumental birth, to be published this year.	WHH	Obs	Await consensus statement	Await consensus statement	
Maternity units to implement NHS England's Perinatal Pelvic Health service specification, which includes providing information for women in antenatal period, such as the importance of pelvic floor exercises; increased education for health professionals including GPs; and early access to care for symptoms of incontinence. Women with perineal injuries to be seen by specialists in pelvic health clinics.	WHH	SN	PPHS pathway in place including access to advice and support in antenatal and postnatal periods via specialist midwifery and physiotherapy input PN birth reflections/ debriefs for women in place via Specialist RM - Pelvic Health for those who have experienced a 3rd/4th degree tear. Pelvic health is included within parent education classes and is part of mandatory training for staff on MAMU3	Monthly Perinatal pelvic health update to staff established. Pelvic Girdle Pain webinar introduced for service users with bespoke option for those for whom English is not their first language. Development of further resources for service users is underway alongside work to a streamline pathways across obstetrics, physiotherapy and midwifery. Plans underway for introduction of a single point of access MDT perineal clinic for those who have experienced perineal trauma. Awaiting confirmed start date. Ensure pathways shared with primary care colleagues.	
Offer mental health screening to partners after birth. This could be in the form of one or two questions from a health professional.	WHH	SE	At primary post-natal visit both parents asked how are you feeling? ICON messages promoted. Referral pathways for partners in place via the local authority, talking therapies and Dads Matters. Birthing women are offered debrief appts, partners are encouraged to attend. Partners made aware signs of declining mental health and crisis numbers on BadgerNet at discharge.	WHH staff have attended Fatherhood Champion training. Paternal mental health being added to education plan for 2025. Effectiveness of training will be audited.	

Recommendation	Owner	WHH lead	WHH position (May 2024)	Update/Next Steps (July 2024)	RAG
Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women.	WHH	SN/SE/ AGJ	Equality & Equity action plan in place and ongoing. Team River have developed specific resources for non-English speaking women. Team River can now provide antenatal education classes to families who do not speak English as a first language. Team River have also launched a Health Flashcard document which contains key words and phrases next to an image. These visual aids are to be used alongside Trust approved translation services. 3.0wte Enhanced Maternity Support Workers in post to support with signposting and provide additional support to families with higher level of need	Continue to collate continuity data. Involve MNVP for service user feedback for how services can be improved for this group of women. To continue with Equality & Equity Action plan	
Launch a national NHS-wide campaign to publicise the importance for Black and Asian women of taking Vitamin D during pregnancy.	NHSE/ WHH	SE	Vitamin D recommended as part of routine antenatal care Vitamin D supplementation captured as a part of the SBL element 2 data, however currently not broken down into ethnicity.	Audit completed (April 2024 data). 54% of Black and Asian women were offered vitamin D supplementation. Community manager working with team to improve. Will reaudit October 2024.	
Introduce specialist midwives for young parents who understand the intersection with other vulnerabilities, such as deprivation or care experience.	WHH	SE	Team River are an enhanced continuity team that provide continuity of carer to vulnerable women and families, includes young parents. Bespoke antenatal education delivered for these women. Band 3 MSWs recruited to signpost women to support that is available to them, i.e. Koala, financial support, infant feeding etc. Excellent collaborative working between WHH and the Family Nurse Partnership to support young families	Plan for MNVP to ensure voices of young parents captured included as part of 2024 MNVP workplan.	

Recommendation	Owner	WHH lead	WHH position (May 2024)	Update/Next Steps (July 2024)	RAG
Oversee the national rollout of standardised post birth services, such as birth reflections, to give all mothers a safe space to speak about their experiences in childbirth	NHSE/ WHH	SN	Consultant led monthly debrief clinic in place for those who have had a complex outcome. All women who birth at WHH are eligible for a birth reflection appointment. Service is led by the Consultant Midwife and is supported by specialist and senior midwives across the maternity service. Birth reflections survey to completed and feasibility of a bespoke space to deliver birth reflection and rainbow service to be explored.	Birth reflections survey underway. WHH awaiting the RCOG workforce report which will confirm if any further changes to job planned sessions are required e.g. postnatal lead. Charities bid developed to support creation of bespoke space to deliver birth reflection and rainbow service. Awaiting final costings from estates and will be progressed. Requirement for fundraising plan with support of WHH charities team.	
Respect mothers' choices about giving birth and access to pain relief and keep mothers together with their baby as much as possible	WHH	SN	A recurring theme from birth reflections is that women felt the rationale for decision making could have been communicated better by the medical team. Of 76 birth reflections completed since Sept 2023, no cases where lack of pain relief, not listening or lack of consent notes as an issue	Consultant Midwife leading piece of work with MNVP re communication with families. Learning from women's experiences to be included as part of MAMU2 in 2025 training plan. ATAIN and Transitional Care action plans ongoing to reduce unnecessary separation.	
Provide support for fathers and ensure nominated birth partner is continuously informed and updated during labour and post-delivery	WHH	SE	Birth partners encouraged to attend birth reflections process. Of 76 birth reflections completed since Sept 2023, two cases where fathers have expressed difficulty of experience. Did not relate to not being kept informed. Where birth partner expresses trauma, pathways are in place via Parents in Mind, Dads Matters and GP led mental health support	To further develop support pathways for birth partners. Piece of work to be completed to ensure effective processes for maintain good communication with birth partners during labour and post birth	
Provide better continuity of care and digitise mother's health records to improve communication between primary and secondary health care pathways. This should include the integration of different IT systems to ensure notes are always shared	WHH	SE	Automated discharge notification process in place via BadgerNet to provide information to health visiting and GP.	Further improvement to communication pathways to be included as part of ongoing Better Birth workstream between maternity services and 0-19 services. Project will include enhancing communication processes with primary care partners	

Recommendation	Owner	WHH lead	WHH position (May 2024)	Update/Next Steps (July 2024)	RAG
Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery	NHSE/ WHH	SE	MDT Pathways in place to support perinatal mental health across the spectrum of need including access to and referral pathways via external services. Team River provide continuity of care to those with history of poor mental health throughout the pregnancy continuum. Specialist Midwife – Perinatal Mental Health in place supporting holistic care planning	To continue to develop pathways and ensure WHH engaging with external offer	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="2">BM/24/10/101 - Appendix 2</td></tr>
<tr><td>SUBJECT:</td><td colspan="2">Maternity & Neonatal Quality Review – July 2024</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="2">2 October 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="2">Aila Gaskill-Jones – Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="2">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td>SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.
SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future
SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.</td><td>✓
✓
✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="2"></td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="2">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes
X</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes
X</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A
X</td></tr>
<tr><td colspan="4">Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to maternity and neonatal care focussing attention on improving outcomes for this protected group.</td></tr>
</table></td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="2">This paper provides an update in relation to maternity and neonatal quality and provides Trust Board with oversight of key matters to provide assurance on maternity and neonatal safety and quality issues.</td></tr>
</table>

In particular:

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

There were five moderate harm and one severe harm event in the CBU in July 2024.

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

- Admission of term babies admitted to Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH) >1500ml
- Postnatal readmission

Work remains ongoing with regard to all of these themes reduction in rates of PPH and in term admissions to NNU.

A cluster review of all cases was undertaken to review all cases referred to the Maternity and Newborn Safety Investigations programme (MNSI) in 2023. Much of the learning identified as part of the cluster review was learning already identified via the ISR or MNSI review process.

However the cluster review did identify some additional themes which will be shared via Women's Health Governance and CBU audit meetings to facilitate multidisciplinary discussion and exploration of the issues identified:

At the end of July compliance for Trust mandatory training across maternity and child health colleagues is above the Trust target. Compliance with PDR completion remains a challenge, a targeted piece of work is underway.

Feedback and learning from a recent complaint is included for information.

A Maternity Safety Champion walkaround took place on 13th August 2024. No concerns were noted.

	In July 2024 88% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance). This is a significant reduction from 96% in June 2024 and does not meet the KPI of 90% review within 15 minutes. 96.6% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is also a reduced performance from previous months but is beyond the KPI of 95% review within 30 minutes. Work is ongoing to ensure a sustainable staffing model for Maternity Triage. July data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour (IOL) activity when compared to other local providers. A task and finish group is in place which will focus on IOL delays alongside wider work in relation to experience of IOL pathways. An update is provided for information and discussion with regard to the service position in relation to the implementation Continuity of Carer (CoC) at WHH. Five complaints were received in the CBU in July 2024. Two related to care within the maternity and neonatal services. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **X**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/09/136iv**	
	Date of meeting	10 September 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Maternity & Neonatal Quality Review – July 2024	AGENDA REF:	BM/24/01/101 – Appendix 2

1. BACKGROUND/CONTEXT

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

The paper provides Quality Assurance Committee (QAC) with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 6 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

2. HARM EVENTS

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

Severity	June 24	July 24
1 – No Harm	71	113
2 – Low Harm	25	45
3 – Moderate Harm	2	5
4 – Severe Harm	1	1
5 – Fatal	0	0
Total	99	164

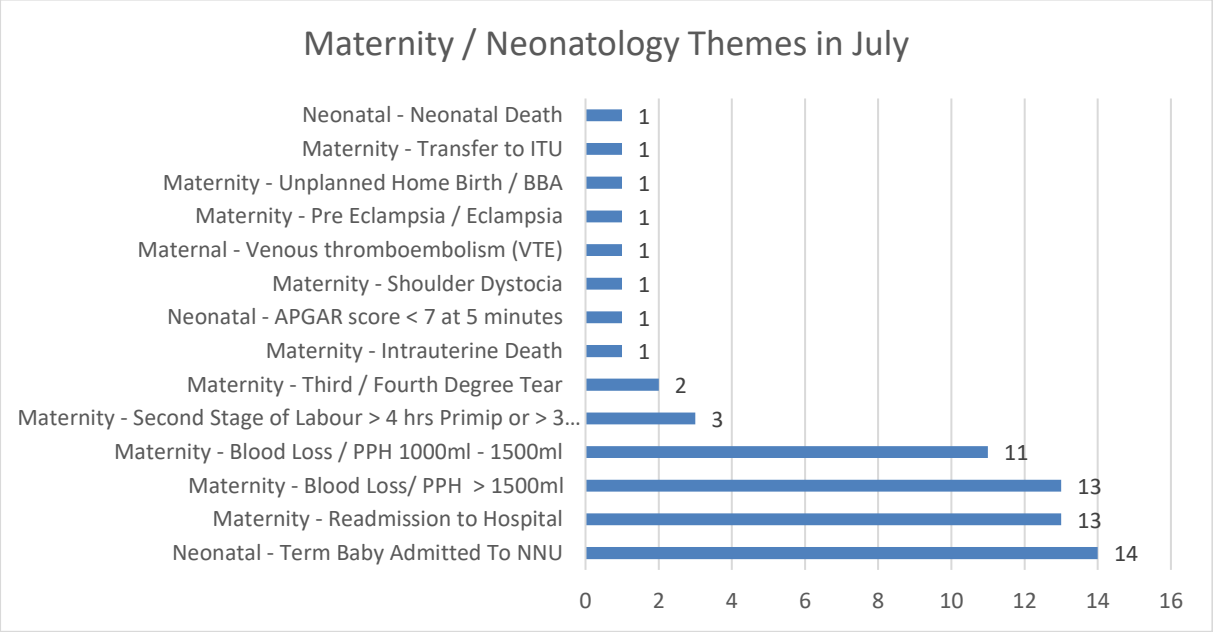
There were six moderate harm and one severe harm events in July 2024.

The moderate harm events are as follows:

- One term admission to the neonatal unit and subsequent transfer to a tertiary unit for cooling – MDT review arranged for September including representation from Liverpool Women's Hospital
- Two 3rd degree tears - reviewed at Intrapartum Review Group - no concerns with care identified.

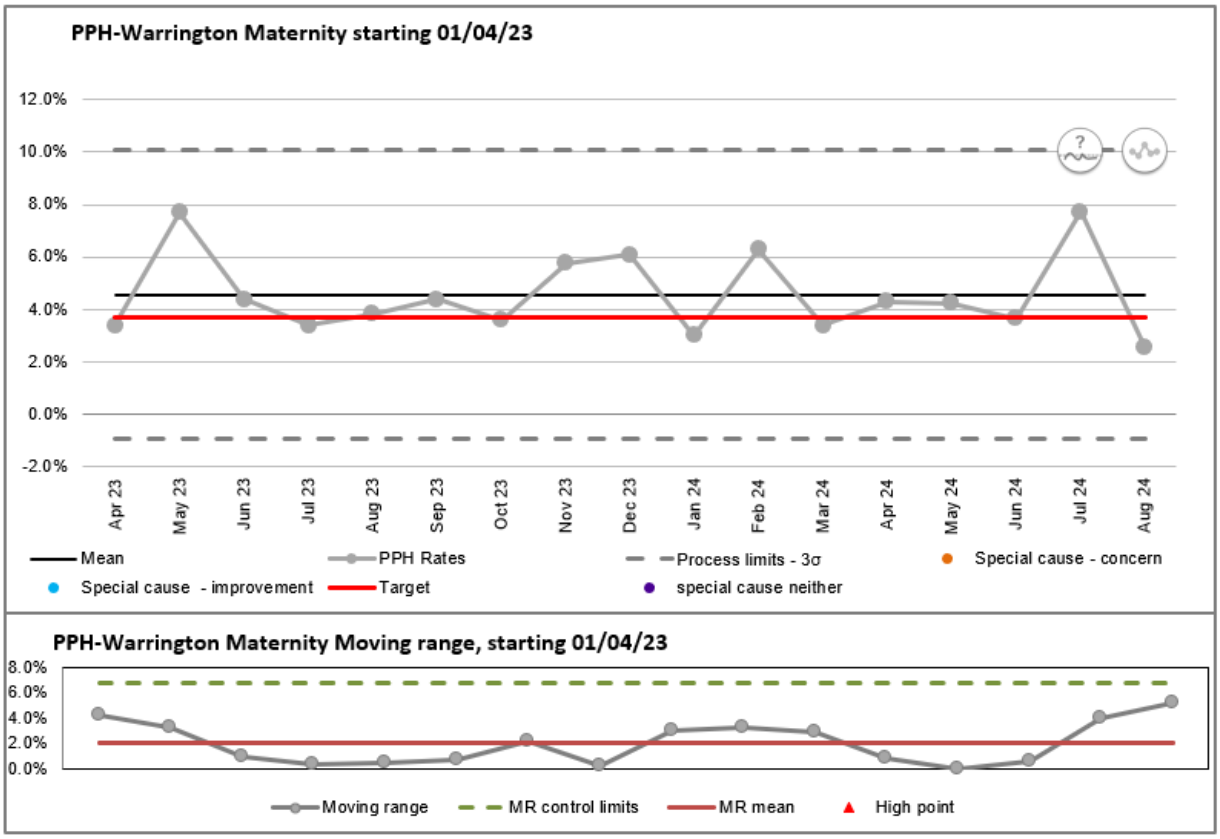
- One intrauterine death (late fetal loss) at 19+6 weeks gestation. Did not meet criteria for PMRT due to gestation. Initial Safety Review completed. No concerns with care identified.
- One 22+1 gestation baby born alive. This was a complex case of medical termination due to poor prognosis. Rejected by MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). Initial Safety Review completed. Some local learning identified in relation to the pathway in cases such as this.
- The severe harm event related to a case of PPH where the B-Lynch suture method was utilised as a method to stop the PPH and to avoid for hysterectomy, thus maintaining the woman's fertility. This case was graded as severe harm in line with the Learning From Patient Safety Events (LFPSE) criteria which categories severe harm as (amongst others), harm when the following applies "needed immediate life-saving clinical intervention". This categorisation is applied even if the harm was not caused by acts or omissions by the Trust.

Themes from maternity/neonatology patient safety events in July 2024 are detailed in the table below:



- 14 term babies were admitted to the neonatal unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC.
- 13 postnatal readmissions were reported in July 2024. As advised to July QAC, a quarterly cluster review of readmissions has been completed and a piece of improvement work in underway.
- There were 11 cases of PPH 1000ml-1500ml and 13 cases of PPH ≥1500mls in July 2024. The formal QI remains in progress.

The SPC chart for PPH ≥1500mls shows no trend at present, The SPC chart continues to show common cause variation.



Alongside the QI project, all cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group (IRG), learning shared and any urgent actions completed.

As referenced at previous Quality Assurance Committees, a thematic (cluster) review was undertaken to review all cases referred to MNSI in 2023. In total there were seven cases within this cluster (all relating to babies transferred for cooling) albeit only three were progressed by MNSI. In those cases where the case did not move to a full MNSI investigation and report, the case was reviewed utilising the rapid review/ISR findings and other local learning.

Much of the learning identified as part of the cluster review was learning already identified via the ISR or MNSI review process. However the cluster review did identify some additional themes as detailed below:

- Three of the seven women were non white British ethnicity
- Three of the women did not have English as their first language although translation services were used in two of the cases
- Four of the seven cases occurred ‘out of hours’ (one Friday evening, one Saturday day, one Saturday evening, one Sunday overnight)

This additional learning will be shared via Women's Health Governance and CBU audit meetings to facilitate multidisciplinary discussion and exploration of the issues identified.

3. WORKFORCE METRICS & MEASURES

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

At the end of July compliance for Trust mandatory training across maternity and child health colleagues is 88.71% for Trust mandatory training (including safeguarding training), 87.77% for role specific training. This excludes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge. Rates in July (excluding those with a long term absence) for maternity and child health services is 65.84%. This is being reviewed weekly.

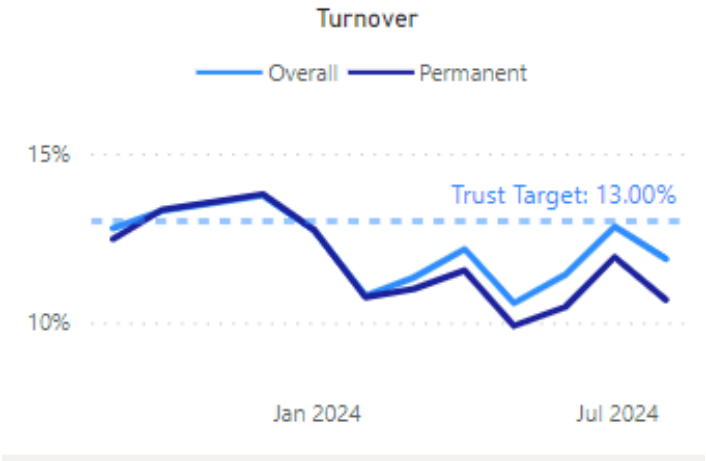
Compliance with maternity specific training remains good, this in monitored monthly to ensure progress is sustained.

Current position – Training compliance - maternity specific

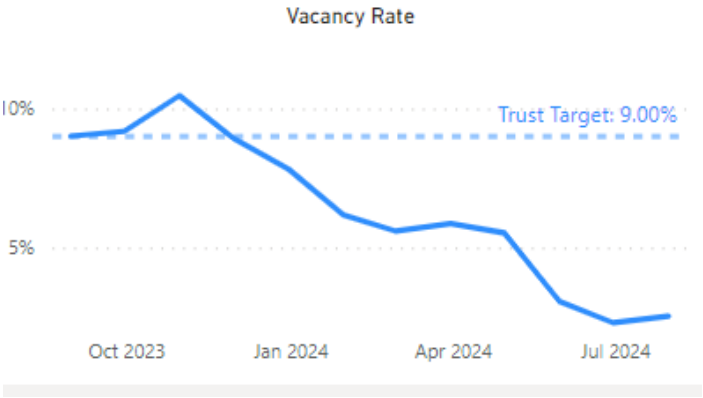
	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	98.4%	91.7%	94.4%	96.9%	64.1%
Obstetric Consultants	100%	90%	72.7%	n/a	n/a
Other Obstetric	100%	100%	83.3%	n/a	n/a
Obs Anaesthetic Consultants	100%	n/a		n/a	n/a
Maternity Support Workers	95.8%	n/a		n/a	36%

*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track
#Medical non-compliance relates to two medics – plan in place

Turnover for maternity and child health staff (permanent staff) has decreased from June to 11.49% and is below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 2.54% in July 2024, significantly below the Trust target. This is illustrated in the graph below:



At the end of July 2024, the vacancy rate for registered midwives was 1.71%.

4. SERVICE USER FEEDBACK

The midwifery team have recently responded to a formal complaint. Within the complaint there was considerable feedback regarding the experience of the family. This included:

- Lack of clear explanation of clinical picture leading to lack of trust in staff
- Lack of effective care planning and communication of same across the maternity team
- Poor attitude of staff when discussing care pathways with service users
- Concerns regarding the method used to obtain blood samples and how phlebotomy appointments are arranged

As a result of learning from this complaint a number of actions have been completed:

- Patient story has been shared with the multidisciplinary team (including verbatim feedback) at both the Women's Health Governance meeting and Women's Health Audit meeting.
- Learning shared around indications and contraindications of actim PROM, performing the test and the interpretation of findings with maternity triage staff
- Learning shared regarding compassionate communication with women and the impact of providing conflicting information to women and the confusion this can cause
- Learning shared in relation to correct blood sampling and ensuring women are not invited back for multiple appointments if care can be offered at the time, i.e. a different practitioner to complete venepuncture

The learning and feedback from this complaint will also be used as case study as part of the wider culture work underway within the service.

5. STAFF FEEDBACK

A Maternity Safety Champion walkaround took place on August 13th 2024. The team visited all areas within the maternity unit including the recently opened induction of labour space. The Safety Champions spoke to a number of staff including student midwives.

No concerns were raised by staff and feedback from the team particularly in relation to the new induction of labour space was good. Staff described the improvement in the experience of families undergoing induction as well as how the new space provided an improved working environment.

Student midwives talked openly about their positive experience at WHH and expressed a real desire to obtain roles at WHH on qualification as registered midwives. The Safety Champions noted some issues in relation to the estate and plans to resolve these were discussed with managers and the wider leadership team.

6. MATERNITY TRIAGE

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

Current performance

In July 2024 582 triage attendances were recorded on the BadgerNet patient record system. This reflects the sustained increase in Triage attendance since the beginning of 2024:

Triage attendances Dec 23 - July 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8

- 14.6% of attendees were seen immediately on arrival, a reduction from 19.7% in June 2024 but improvement from 12.2% in May 2024.
- The longest wait recorded for initial review was 142 minutes, this was due to high acuity
- 88% of attenders were seen within 15 minutes of arrival (best practice guidance). This is a significant reduction from 96% in June 2024 and does not meet the KPI of 90% review within 15 minutes.
- 96.6% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is also a reduced performance from previous months but is beyond the KPI of 95% review within 30 minutes.
- 1% of attendees were categorised as red on arrival. Appropriate ongoing care was provided in all cases.
- 14.8% of attendees were categorised orange on arrival, this is on a par with previous months.

Activity in place to support a safe service

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

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

7. INDUCTION OF LABOUR

July data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers, in particular those providers of a similar size to WHH:

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	45	137	52	60	101	90	64	549
Total Delayed	4	26	7	3	22	30	37	129
% of Total	8.89%	18.98%	13.46%	5.00%	21.78%	33.33%	57.81%	23.50%

33.33% of IOL at WHH were delayed in July 2024, this is a similar position to June 2024 (30.43% delayed).

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

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
01/07/2024	2	5		1	5	17	25	55	42.64%
08/07/2024		7	5	0	1	8	4	25	19.38%
15/07/2024	2	7	2	2	12	2	3	30	23.26%
22/07/2024		6			4	3	4	17	13.18%
29/07/2024		1					1	2	1.55%
Grand Total	4	26	7	3	22	30	37	129	100.00%
% of Total	3.10%	20.16%	5.43%	2.33%	17.05%	23.26%	28.68%	100.00%	

23.26% of delayed IOL across Cheshire & Mersey in July 2024 were at WHH.

Improvement work to improve IOL pathways has commenced, the action plan is not yet complete but is being drafted and will be shared to October QAC.

8. MATERNITY CONTINUITY OF CARE - UPDATE

1.1 Background

The WHH Continuity of Carer model (CoC) was implemented in June 2020. The WHH model as implemented met the criteria of Better Births (continuity across the antenatal, intrapartum and postnatal pathways) and comprised a core hospital team staffed by midwives who work across all inpatient areas and hospital based antenatal services (including consultant led clinics). Initially six continuity teams were planned, this increased to seven following the transfer of services from Bridgewater Community Health in November 2021. This model allowed WHH to meet the national targets for CoC and following implementation WHH performed consistetly well albeit with an ongoing action plan to further develop service delivery.

In October 2022 national targets for CoC were removed. At WHH some concerns were raised via the Royal College of Midwives and the Maternity Voices Chair in relation to the sustainability of the WHH CoC model particularly in relation to its impact on staffing and on staff morale. There were also other wider issues identified as part of the rapidly changing nature of maternity services which needed solutions. In particular, the staffing model and location for Maternity Triage and the need for a sustainable staffing model for the midwife led unit, “The Nest.” As a result, a full review of CoC at WHH was completed and a number of changes to the model were implemented.

- The number of community based teams was reduced from seven to six.
- Four teams were maintained within the CoC model providing care across the antenatal, intrapartum and postnatal pathways.
- Two teams to work within a traditional community model of care focussing on excellence in the antenatal and postnatal period.
- Release of 5.4fte Band 6 continuity posts to the Core Team (the team working in the hospital across Birth Suite, the Nest, Antenatal Services and maternity ward) to support a more robust triage staffing model.
- These changes were implemented in early 2023. Subsequently the number of women receiving full continuity in line with the national definition has reduced.

8.2 Current position

Continuity of Carer (CoC) data is extrapolated from BadgerNet on a monthly basis and shared with the LMNS. Measures include:

- percentage of women at 29 weeks gestation on a CoC pathway
- percentage of Black, Asian or Mixed Ethnicity women at 29 weeks gestation on a CoC pathway
- percentage of women in bottom decile of deprivation at 29 weeks gestation on a CoC pathway.

There remain no national targets for the implementation of CoC.

The percentage of women receiving continuity at 29 weeks gestation has consistently ranged from 43-54% since April 2023 when community services were streamlined and the number of continuity teams was reduced.

The other outcome measures vary dependant on the population of women at 29 weeks gestation in each given month; for women in the bottom decile, continuity varies from 17% to 45% and for black, Asian and mixed ethnicity women, this varies from 60% to 90%.

It has been identified women who are booked to receive their intrapartum care at WHH, but live outside of the geographical catchment area for community services ('out of area women'), are included in this data. On average, 15-25% of service users are 'out of area' and are therefore not eligible for continuity of carer as WHH are unable to provide the postnatal element of care. This factor will negatively affect continuity statistics.

As described, it has previoulsy been difficult to balance full implementation of continuity of carer with safe inpatient staffing and retention of community staff. To improve retention of midwives within the community service midwives are able to work in a traditional model (antenatal and postnatal continuity only), a rostered continuity model or birth availability model (both of which include the intrapartum element). Famillies in receipt of traditonal community care do not meet the criteria to be counted as in receipt of continuity.

Measures are in place to ensure that vulnerable groups who do not formally receive continuity of carer, are supported. These include:

- Antenatal and postnatal team case-holding for all service users
- The work of the recently appointed enhanced maternity support workers who provide financial advice, signposting to voluntary agencies, smoking cessation, healthy lifestyle advice to all women
- Specialist midwives to support with smoking cessation, mental health, diabetes, multiple pregnancy, preterm birth and infant feeding
- Baby shower' events held in Halton, which provide a drop-in for infant feeding support, smoking cessation, the homebirth team and community midwives.

In addition to this, Team River is an enhanced continuity team which does not work geographically but will casehold women who are considered particularly vulnerable. This includes women experiencing teenage pregnancy, women experiencing or with a history of poor mental health, women with social care involvement (level three and above), bereaved women, women affected by substance misuse, women for whom English is not their first language and women who are seeking asylum.

The Antenatal and Postnatal Services Matron, alongside the Consultant Midwife and Director and Deputy Director of Midwifery regularly review CoC provision with the LMNS. A full action plan is due to be implemented to increase CoC for all service users,

this has been delayed due to awaiting the 2024 staffing workforce tool. A further update will be provided to Quality Assurance Committee in December 2024.

9. COMPLAINTS

Five complaints were received in the CBU in July 2024. Two related to care within the maternity and neonatal services as follows:

Specialty	Description	Complaint Opened	Current Stage
Maternity	Concerns relate to the midwifes panicked demeanour and behaviour which led to an increased state of anxiety and fear in the patient during and leading up to the birth of her baby.	23/07/24	Investigation completed and meeting with family arranged.
Maternity & Paediatrics	Unacceptable care post-delivery on ward. Inadequate care from Community Midwife Team. Unacceptable treatment during Safeguarding process.	23/07/24	ISR completed. Meeting to be arranged with family.

10. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

11. MONITORING/REPORTING ROUTES

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

12. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 20 September 2024.

13. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix One – PPH QI Project Action Plan

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

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

Actions- 3.6.24			
KF now part of the regional team to develop a regional PPH guideline	KF	24.5.24- Had a discussion with regional team- Andrew Weeks Consultant Obstetrician leading. Local guidelines shared. 17.7.24-Working group now developed	
Actions-26.6.24			
KF to update meetings to weekly as per governance oversight.	KF	Completed	
To plan a meeting to discuss a data collection plan.	ALL	Arranged for next meeting	
CH to send the raw data to Sarah Delooze for review	CH	Sent during meeting	
SD to compile SPC charts for all necessary measures and distribute so that decisions can be made re. the current problem and aim statements.	SD	17.7.24-ONGOING	
SD to complete and circulate the fishbone diagram	SD	17.7.24-COMPLETE	
Gantt chart to be compiled for all actions until now	SJ	17.7.24-ONGOING	
Actions-17.7.24			
Data planning	SJ/SD/ CH/KF	To continue discussion at next meeting	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/10/101 – Appendix 3</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Maternity Incentive Scheme Year 6 Update</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">2 October 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Ailsa Gaskill-Jones – Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>✓

</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="5"></td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes
X</td><td>No</td><td>N/A</td></tr>
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<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes
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<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A
X</td></tr>
<tr><td colspan="4">Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.</td></tr>
</table></td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">NHS Resolution’s (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions which support the national maternity ambition to reduce the</td></tr>
</table>

	number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. NHSR is now operating Year six of the Clinical Negligence Scheme for Trusts (CNST) MIS following publication of guidance on 2 April 2024. Conditions of eligibility for payment under the Scheme are set out in the guidance and a completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025. Regular assurance meetings are held with the LMNS to review progress against the actions. The next quarterly meeting with LMNS is scheduled for 4 September 2024.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **X**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/09/136iii**	
	Date of meeting	10 September 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Maternity Incentive Scheme Year 6 Update	AGENDA REF:	BM/24/01/101 – Appendix 3

1. BACKGROUND/CONTEXT

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

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

2. CURRENT POSITION

1.1 Overall position

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024 and circulated to all providers of maternity services.

Following the launch of MIS Year 6 on 29 April 2024, meetings with leads for all 10 Safety Actions have continued monthly to review progress towards meeting the required specifications for each action. Support is available from the senior leadership team as and when required.

Regular assurance meetings are held with the LMNS to review progress against the actions. Previously the LMNS have been assured by the service's progress. The next quarterly meeting with LMNS is scheduled for 4 September 2024.

Following this meeting, progress against each safety action will be collated and progress will be reported in detail to Quality Assurance Committee in October 2024.

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

Progress against SBLCBv.3 is ongoing with further evidence uploaded to the national portal. This evidence will be externally reviewed by the LMNS and feedback provided as part of the meeting with the LMNS on 4 September 2024.

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 10 September 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/101 – Appendix 4**	
SUBJECT:	**Quarter 1 2024/25 Transitional Care (TC) Report**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery, Jill Tomlinson – Lead Nurse for Paediatrics & Gynaecology, Erica Wiles – Neonatal Matron	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

Further Information:

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

Further Information:

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

Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.

EXECUTIVE SUMMARY *(KEY ISSUES):*	The paper provides an overview of babies who required Transitional Care (TC) in the period April 2024 - June 2024.

	An audit of babies who received TC within Q1 2024/25 has been undertaken and results of this will be described within this paper along with any identified learning. Key points to note: • Following the CQC inspection of Maternity Services at WHH in September 2023, a full review of the current Transitional Care (TC) Model has taken place. • A working group was created with representatives from both maternity and neonatal services and is led by the Lead Nurse for Paediatrics & Gynaecological Services and the Deputy Director of Midwifery. • A robust action plan has been developed. • The Transitional Care Action Plan is monitored via WCH Governance and the Neonatal Oversight Meeting. • A quality improvement project continues in order to further enhance our transitional care offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **X**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/09/136v**	
	Date of meeting	10 September 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Quarter 1 2024-2025 Transitional Care (TC) Report	AGENDA REF:	BM/24/01/xx – Appendix 4

1. BACKGROUND/CONTEXT

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

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

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

Following the CQC inspection of Maternity Services at WHH in September 2023, a review of the current transitional care model has taken place, from this a working group was created and a robust action plan developed. Alongside this, an audit of babies who received TC within Q1 2024/25 has been undertaken and results of this will be described within this paper.

2. KEY ELEMENTS

2.1 WHH Transitional Care Position

The findings of this report have been collated from a review of all babies who met the criteria for TC during the Q1 reporting period from 1st April 2024 to 31st May 2024.

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

WHH Transitional Care Criteria

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

Any baby requiring one or more of the following:

- Infants requiring intravenous antibiotics with risk factors
- Additional support with feeding via nasogastric tube
- Haemolytic disease requiring phototherapy and assessment of serum bilirubin 4-6 hourly
- Infants with Neonatal Abstinence Syndrome requiring medication on a weaning regime and on regular observations (4 hourly or more frequently)
- Babies requiring observations more frequently than 4 hourly
- Management of hypoglycaemia to be controlled with a minimum of 2 hourly feeding

2.2 Summary of Babies who met the Transitional Care Criteria

During Q1, 15 babies met the criteria for TC. An audit of these cases has identified the following:

Admitted direct to TC	1
Appropriately received NNU care and stepped down to TC when well enough	10
Allocated to PEEP for 30 pathway	3
Did not received TC	1

Of the 15 babies who met the criteria in Q1, only one baby was admitted straight to TC from birth due to the other babies requiring respiratory support.

The other 14 babies who met the broad TC criteria in Q1 required some level of respiratory support and were initially provided with care via NNU. Of these:

- One baby was not suitable for TC due to safeguarding concerns and the baby requiring genetic investigations.
- Ten babies were appropriately stepped down to TC when clinically indicated. As part of the audit an improvement was seen in relation to the timely step down of these babies.
- Three followed the PEEP for 30 pathway. This pathway is part of a QI project the neonatal team are undertaking where babies, who at 30 minutes post birth are still requiring respiratory support, will go to NNU and be commenced on vapotherm with NO formal admission for the first hour. This is to establish if they can be weaned quickly. If successful the baby will then go back to mum with a TC plan to establish feeding alongside regular observations.

Reasons for admission to the NNU are highlighted in the table below, it is to be noted that significant improvements in relation to the timely step down of these babies to TC have been seen this quarter due to continuous education and collaboration between the midwifery and neonatal services;

	Reason baby admitted to NNU from delivery	Actions to reduce occurrence
1	Babies requiring respiratory support	• Repeat audit to be undertaken to review length of time baby required respiratory support

2.3 Good Practice:

- Improvement seen in the early recognition of babies who can step down to TC
- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Sharing of audit outcomes across the MDT with both midwifery and neonatal teams to ensure learning is communicated.
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Band 6 TC Midwifery champion in place, attending TC training and attends working group (protected time each month).
- Review of Enhanced Care criteria completed, disseminated to all staff and displayed in all areas.
- Revisited and redesigned the TC Audit. This is now lead by the NNU Matron. Audit information is reported to QAC.
- “Think TC” Boards in each clinical area – to remind staff of TC admission criteria. Includes updates re progress with TC project.

2.4 Recommendations:

- Time to be given to TC midwifery champion to complete TC programme.
- Focussed learning from TC review to be included on Neonatal Natter and OWL
- Staffing – Continue to ensure neonatal staff are allocated to TC babies.
- NNU Matron to review occasions where NHSP has been utilised to support TC staffing to support long term staffing plan.
- Following NHSP review, finance to provide costings for Band 4 nursery nurses to support long term staffing plan and inform a potential future revenue request.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

2.5 Outstanding actions from action plan

- Ongoing TC audit which will be reported through this committee.

- Review of IV policy required to enable midwifery staff to undertake IV antibiotics on babies, pharmacy input required.
- TC Bay on C23 to be established now induction of labour activity transferred to new space on Birth Suite.

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 10 September 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/10/101 – Appendix 5</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Maternity Update Ockenden Report</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">2 October 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Ailsa Gaskill-Jones – Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>✓

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<tr><td colspan="4">Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.</td></tr>
</table></td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates. This paper provides the Quality Assurance Committee (QAC) oversight of the update with regards to</td></tr>
</table>

<table>
<tr><td></td><td colspan="3">Ockenden recommendations, and the report will also be noted at Trust Board.

In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second report. The WHH Ockenden update as of 31st July 2024 is:
• Ockenden Part 1a: WHH is 100% compliant.
• Ockenden 1b: WHH is 100% compliant.
• Ockenden 2: WHH is 100% compliant. The remaining one outstanding action has been completed.

A meeting of the quadrumvirate will now be arranged to complete a final review of the action plans and ensure all assurance has been received. This will facilitate the formal closure of the action plans. The outcome of this review will be reported to October 2024 Quality Assurance Committee.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to receive and discuss this report as per Ockenden recommendations.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">QAC/24/09/136i</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">10 September 2024</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/24/01/101 – Appendix 5

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:

RAG

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring
LMNS	LMNS action
Duplicate	Action duplicated/combined with another action
BN Issue Log	Transferred to BN Issues Log

2. KEY ELEMENTS

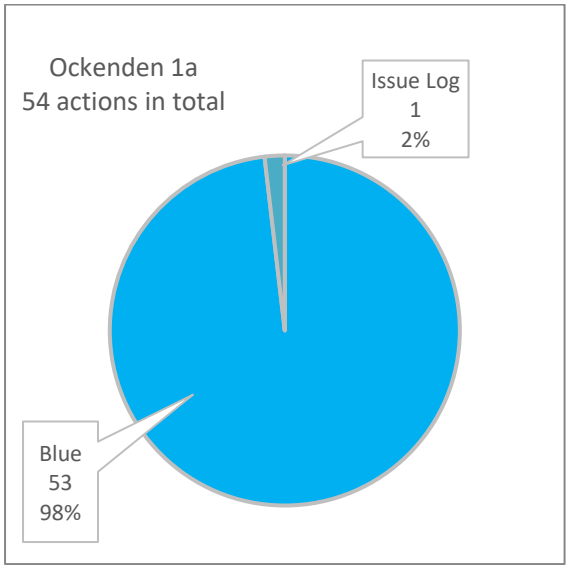
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

2.1.1 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance

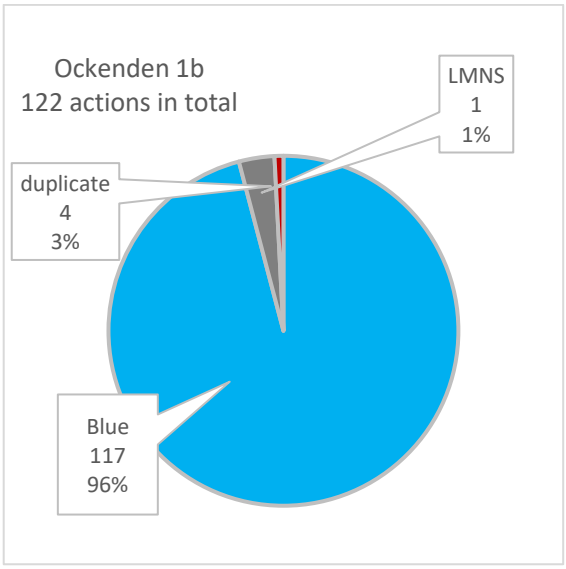


Excluding the LMNS action, Ockenden Part 1a action plan is 100% compliant. This action plan closed following agreement at Moving to Outstanding in February 2022.

2.1.2 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

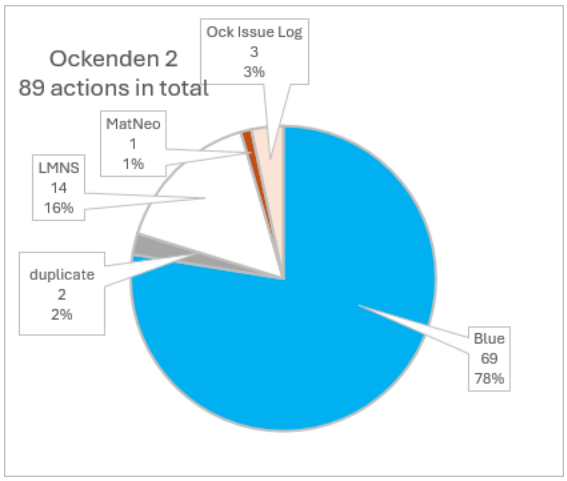


Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is 100% compliant.

2.1.3 WHH Compliance with Ockenden 2 Report

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

Chart 3: WHH Ockenden 2 Compliance



Excluding the following 20 actions from the initial 89:

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

The Ockenden 2 action plan is 100% compliant.

WHH Risks for Escalation

- None

a. Ockenden Summary

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

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

A meeting of the Quadrumvirate will now be arranged to complete a final review of the Ockenden action plan and ensure all assurance has been received. This will facilitate the formal closure of all Ockenden action plans. The outcome of this review will be reported to October 2024 Quality Assurance Committee.

Four actions have been transferred to an issues log for continued monitoring.

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.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 10 September 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/101 – Appendix 6**	
SUBJECT:	**Quarter 1 2024-25 Perinatal Mortality Review/Audit**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales.

NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 6) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports.

This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 1 (Q1) PMRT report for the period covering 01/04/2024 – 30/06/2024.

During Q1, WHH reported one baby to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK):

One stillbirth:

- One baby born at 38+4 weeks

The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 2 2024/25 report to QAC following completion of the PMRT review panel.

WHH stillbirth rate for Q1 2024/25 was 1.60 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.

WHH Neonatal mortality rate during Q1 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

During Q1, WHH undertook five PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed:

One late fetal loss:

- One baby born at 23+6 weeks

When care provided to the mother up to the point that her baby was confirmed as having died was reviewed, this was graded B in two cases, C in one case and D in two cases.

	When care provided to the mother following confirmation of the death of her baby was reviewed, this was graded A in one case, B in three cases and C in one case. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **X**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/08/114iv**	
	Date of meeting	13 August 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Quarter 1 2024-25 Perinatal Mortality Review/Audit	AGENDA REF:	BM/24/01/101 Appendix 6

1. BACKGROUND/CONTEXT

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

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 6 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 1 PMRT audit data for 2024/2025 and highlights good practice and lessons learned during the mortality reviews. Q1 covers the reporting period from 01/04/2024 to 30/06/2024.

Definitions:

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

2. KEY ELEMENTS

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

During Q1 reporting period one case was reported to MBRRACE-UK:

One Stillbirth:
One baby born at 38+4 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 16 September 2024 and will be included in the Q2 2024/25 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 1. WHH Stillbirth Rate:

- WHH Q1 stillbirth rate for 2024/2025 is 1.60 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.
- WHH had no intrapartum stillbirth.
- WHH had one term stillbirth (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning.

WHH current annual stillbirth rate for Q1-Q4 2023/24 is 3.71 per 1000 births. Rolling year Q2 2023/24-Q12024/25 rate is 3.69 per 1000 births. The MBRRACE-UK national rate is 4.1 per 1000 births.

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

Metric	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	12-month total
Number of live births	600	627	591	615	2433
Total number of stillbirths >24 weeks	2	1	5	1	9
Total Stillbirth Rate >24 weeks (per 1000 births)	**3.32**	**1.59**	**8.50**	**1.60**	**3.69**
Number of intrapartum still birth rate	0	0	1	0	1
Number of stillbirths >37 weeks	0	0	2	1	3

2.2 Q1. WHH Neonatal Mortality Rate:

WHH Neonatal mortality rate during Q1 2024/2024 was 0.0 per 1000 live births. The MBRRACE-UK national rate is 2.7/1000 live births.

2.3 Quarter 1 PMRT Review Panel Key Findings

Synopsis of Findings

One baby born at 23+6 weeks gestation was a late fetal loss. The cause of death identified at post-mortem was determined to be acute placental abruption with severe maternal vascular malperfusion.

One baby born at 39+4 weeks gestation was a stillbirth. The cause of death was confirmed as placental abruption.

One baby born at 40+5 weeks gestation was a stillbirth. The cause of death identified at postmortem was fetal vascular malperfusion with an over-coiled umbilical cord.

One baby born at 29+0 weeks gestation was a stillbirth. The cause of death was chorangiosis with maternal vascular malperfusion.

One baby born at 40+0 weeks gestation was an intrapartum stillbirth during the induction of labour process. The cause of death identified at post-mortem was determined to be acute asphyxia.

Surveillance Findings:

- All the babies were of a singleton pregnancy.
- Two women were aged between 22-26.
  Three of the women were aged between 30-37.
- Four of the women were identified as white ethnicity.
  One woman was Asian.
- Four of the women spoke English as their first language. One woman was Chinese, with English as a second language.
- None of the women had any communication problems because of learning difficulties/hearing problems.
- Two women were of a healthy BMI between 18.5 - 24.9.
  Three women had a BMI of greater than 30 (associated with an increased risk of complications in pregnancy).
- Four of the women were non-smokers and had a carbon monoxide (CO) level below 3 parts per million (PPM).

  One woman was a smoker who declined smoking cessation support in the pregnancy.

- One of the woman booked late in the pregnancy.
- In all cases there were no issues identified with the care provided in relation to safeguarding matters.

The surveillance findings from PMRT will feed into the maternity Equality & Equity Action plan.

2.4 PMRT Grading of Care

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

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

2.4.1 PMRT Grading of Care – Late Fetal Loss/Stillbirth

During Q1 five PMRT review panels took place. Parental perspective of the care they received were sought. Table 3 provides the grading of care for each late fetal loss/stillbirth.

In one of the cases care was graded C, identifying care for the mother and baby up to the point that the baby was confirmed to have died that may have made a difference to the outcome for the baby.

In two of the cases care was graded D, identifying care of the mother and baby up to the point that the baby was confirmed to have died which were likely to have made a difference to the outcome for the baby. In one case, it was identified the cardiotocography (CTG) should have remained in situ for longer, potentially provider a more accurate reflection of fetal wellbeing. This learning had already been noted as part of the initial safety review (ISR) and immediate learning from this case was shared with the team via “case on a page.”

The second case related to a missed opportunity to diagnose gestational diabetes which would have changed the woman’s care pathway and would have led to an offer of induction of labour before term. The PMRT process identified the non-pregnant parameters for the glucose tolerance test (GTT) were being used in error when reporting GTT of pregnant women. A significant piece of work has been completed in collaboration with wider Trust colleagues to resolve this reporting error alongside a review of all cases to ensure this error had not affected any other women. No other women were affected.

In one of the cases, there were issues identified with the care of the mother following confirmation of the death of her baby which may have made a difference to the outcome for the mother. This related to postnatal communication pathways for women residing outside of the Warrington and Halton footprint.

Table 3: Q1 WHH Grading of Care following a Late Fetal Loss/Stillbirth.

PMRT grading	Care provided to the mother up to the point that her baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A The review group concluded that there were no issues with care identified	-	1
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	2	3
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	1	1
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	2	0
Not Graded		
Total Cases	5	5

2.4.2 PMRT Grading of Care – Neonatal Death

During Q1 there were no neonatal death PMRT review panels

2.4.3 PMRT reporting for Saving Babies Lives Care Bundle v3- Q1 2024/25:

As part of the Saving Babies Live Care Bundle version three, there is also a requirement to consider whether fetal growth restriction (FGR) identification and management, reduced fetal movement (RFM) management and/or intrapartum monitoring were a contributory factor to perinatal mortality. Table 5 details the outcome of the PMRT reviews completed in Q1 assessed against these interventions:

Table 5 – Saving Babies Lives interventions.

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

2.5 Q1. WHH PMRT Panel Attendance

There have been five PMRT panel reviews in Q1 which were attended by multidisciplinary internal and external panel members.

Table 6: Q1 WHH PMRT Panel Attendance

Number of participants involved in PMRT reviews. Total number of reviews from 01/04/2024 – 30/06/2024 = 5			
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	4	1	5
Admin/Clerical	0	0	0
Bereavement Midwife	4	1	5
External Rep	4	1	5
Management Team	4	1	5
Midwife	4	1	5
Neonatal Nurse	0	0	0
Neonatologist/Paediatrician	0	1	1
Obstetrician	4	1	5
Other	1	0	1
Governance Manager	4	1	5
Safety Champion	0	0	0

2.6 Maternity Incentive Scheme Year 6 Compliance

WHH is compliant with all elements of PMRT in line with the requirements of Maternity Incentive Scheme Year 6 as per table 7.

Table 7: PMRT MIS Safety Action 1 Compliance

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Standard Required		**Compliant Y/N**
a)	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days for deaths from 8 December 2023 to 30 November 2024.	Assessed as compliant
b)	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 8 December 2023.	Assessed as compliant
c)	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed within six months.	Assessed as compliant
d)	Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Assessed as compliant

2.7 Learning and Good Practice

- The handover of women who have experienced pregnancy loss and who live out of the Warrington and Halton footprint can be fractured creating a risk of inadequate handover to other providers.
- It was identified the non-pregnant parameters for GTT were being used when reporting GTT of pregnant women. This risked women with gestational diabetes being on the incorrect pregnancy pathway.
- Learning was identified with regard to inviting women into Maternity Triage particularly in the latent phase of labour.
- Parental involvement was sought in all cases as part of PMRT panel review.
- The one case of stillbirth which occurred in the quarter has been notified to MBRRACE and surveillance completed within the required timescale.

Learning from these cases is included in the PMRT Action Plan (Table 8).

2.8 Action Plan Summary

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

There were 10 actions recorded from the Q1 2024/25 PMRT review panels and 8 actions are complete:

Table 8: PMRT Action Plan

Action	Lead	Start date	Due Date	RAG rating
Community/Continuity lead midwives will share the learning and highlight that further attempts to undertake a routine enquiry must be documented in the maternity records during pregnancy to correctly risk assess women and their families	Community/ Continuity Manager	29/04/2024	30/09/2024	
The details of the mother will be included in the handover document for doctors so that they have all the information required to inform sensitive conversations when reviewing women and their families for care	Consultant Obstetrician & PMRT Lead	29/04/2024	30/09/2024	
The Butterfly Team will share the learning as part of the mandatory training sessions for all staff in maternity that the Partogram should be used for women in labour with a fetal loss.	Specialist Bereavement Midwife	29/04/2024	30/09/2024	
The Matrons for maternity and gynaecology will work together to improve the pathways of care for women in early pregnancy.	Women's Health Matrons	29/04/2024	30/09/2024	
Share learning for following BSOTS guideline to consider/recommend attendance to maternity triage in women who call multiple times.	Maternity Matron	29/04/2024	30/09/2024	
Share learning on the use of the Dawes Redman criteria when performing a CTG in women with uterine activity.	Maternity Matron	29/04/2024	30/09/2024	
Review the BSOTs admission criteria for women who report any blood loss should be invited for assessment	Maternity Matron	29/04/2024	30/09/2024	
Review and audit of the GTT criteria to ensure samples are processed using the antenatal criteria and not the non-pregnant criteria.	Clinical Scientists	04/06/2024	21/06/2024	

Review of the early pregnancy care guideline to include Progesterone to be prescribed for pregnant women with bleeding under 16 weeks gestation.	Consultant Lead for early pregnancy care	20/05/2024	30/08/2024	
Butterfly team to complete handover to community for women in and out of the Warrington area	Specialist Bereavement Midwife	20/05/2024	30/08/2024	

2.9 Summary

- WHH Q1 PMRT audit recorded one baby reported to MBRRACE who was born between 01/04/2024 and 30/06/2024.
- The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 2 2024/25 QAC report following the PMRT review panels due to be held on 16 September 2024.
- WHH stillbirth rate for Q1 2024/25 was 1.60 per 1000 births. WHH annual Mean stillbirth rate is 2.71 per 1000 births which is below the 2022 MBRRACE-UK national rate 4.1 per 1000 births.
- WHH Neonatal mortality rate during Q1 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- Five PMRT review panels were held in Q1 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.
- When care provided to the mother up to the point that her baby was confirmed as having died was reviewed, this was graded B in two cases, C in one case and D in two cases.
- When care provided to the mother following confirmation of the death of her baby was reviewed, this was graded A in one case, B in three cases and C in one case. Parental perspective of the care they received were sought in all cases.
- Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee and all Q4 PMRT actions are complete.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

3. MONITORING/REPORTING ROUTES

This report was shared at the Women's and Children's Clinical Business Unit Governance Meeting in September 2024.

4. ASSURANCE COMMITTEE

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

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/101 – Appendix 7a**
SUBJECT:	**Q1 Midwifery Summary Safe Staffing Report and annual workforce plan**
DATE OF MEETING:	2 October 2024
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	The purpose of this paper is to provide assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and

	triangulation against maternity red flag incidents. This paper provides an overview of the staffing position at as 30th June 2024 and red flag position for the period April-June 2024 alongside other key workforce metrics. This paper will also provide specific assurance in relation to safety standards as follows: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. • Evidence the maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. • The midwife: birth ratio The annual workforce plan for Maternity and Neonatal Services is also provided for discussion and approval. The calculated total midwifery workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 116.70wte, which includes an additional 10% for non-clinical roles. The midwifery funded establishment at the 30th June 2024 was 125.36wte. The vacancy rate for registered midwifery staff as at 30th June 2024 is 0.65%, an excellent position. Midwifery retention remains good with turnover at 8.32% at the end of June 2024. Rates below the Trust target have been maintained since December 2023. Sickness rates for June 2024 for registered midwifery staff were 6.27%, this is an increase from May 2024. It is however a decrease when compared to June 2023 when the rate was 7.2%. Monitoring of safe staffing levels is a requirement of the Maternity Incentive Scheme (MIS) Safety Action 6. Within

	the maternity service, staffing red flags across the maternity service are recorded within the Safe Care module of the health roster. As part of Safety Action 6 there is a requirement to closely monitor two key measures: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour In the period 1st April 2024 – 30th June 2024 there were two occasions where the midwifery coordinator in charge was not supernumerary (for a short period). This equates to 1.6% of shifts and occurs rarely. In the period 1st April 2024 – 30th June 2024 there was one episode recorded in SafeCare where a woman in active labour did not receive one-to-one care. This was for a short period while transfer to Birth Suite for ongoing care was arranged. A woman in active labour not receiving one-to-one care occurred in 0.83% of shifts and occurs rarely. A deep dive remains underway to review all workforce and acuity related data and metrics, the findings and actions of which will be included in the next Midwifery Staffing Summary to Strategic People Committee in November 2024.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **X**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPC/24/08/81**	
	Date of meeting	21 August 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Q1 Midwifery Summary Safe Staffing Report and annual workforce plan	AGENDA REF:	BM/24/01/101 – Appendix 7a

1. BACKGROUND/CONTEXT

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

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

This paper provides an overview of the midwifery staffing position at as 30th June 2024 and red flag position for the period for Q1 2024/25 (January – March 2024) alongside other key workforce metrics.

The annual workforce plan for Maternity and Neonatal Services is also provided for discussion and approval.

2. MIDWIFERY ESTABLISHMENT

This report summarises the current funded and actual staffing establishment as of the 30th June 2024 in comparison to the Birthrate Plus® report and recommendations.

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

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

The Maternity funded establishment at the 30th June 2024 is 125.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 31st March 2024 shows a further positive variance of 3.04wte. This further variance is the

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

These changes have been made to meet the requirements of external reviews, national recommendations and frameworks including the Ockenden Report recommendations and the Maternity Incentive Scheme Years 4 and 5 (incorporating the Saving Babies Lives Care Bundle. All new posts have been funded within the service via reallocation of existing establishment or via external funding streams.

Review of the maternity workforce using the Birthrate Plus® workforce planning tool is required every three years. Accordingly, a full review will be required to be completed by March 2025 in line with Maternity Incentive Scheme Year 6 - Safety Action 5. Work is underway to arrange this assessment and compliance will be monitored as part of the service's usual assurance processes for the Maternity Incentive Scheme.

3. MIDWIFERY RED FLAGS

3.1 Background

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

NICE Midwifery Red Flags include:

- Delay in induction of labour
- Delay in administration of analgesia
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit.
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

3.1 Midwifery Red Flags

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

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

- Delay in ongoing IOL
- Delayed MOEWS
- Missed/delayed observations.
- IOL handover to C23
- Shortfall in RM time
- Birth Suite Coordinator NOT Supernumerary (midwifery coordinator in charge)
- AMBER Alert – Acuity
- AMBER Alert – Staffing
- Inadequate Triage
- Delay in review of a CTG
- Delay in Medical review in triage >30min
- Delay in triage >15mins

3.2 WHH Midwifery Red Flags reported

Where a red flag is raised, this is escalated to the bleep holder and appropriate mitigation/support is provided to resolve the issue. There have been no harm events as a result of issues within the red flag escalation process.

A red flag audit action plan is in place to resolve issues identified as part of the quarterly audit.

Table 1 below details red flags raised in Q1 2023/24.

Table 1 - Midwifery Red Flags reported (April 2024-June 2024)

	Number of Red Flags raised		
Red Flag Reason	April 2024	May 2024	June 2024
Delay in med review triage >30min	69	59	17
Delay in review of CTG	2	1	0
Delay in triage >15min	12	7	11
Delay in triage >30min	4	1	0
Delayed IOL	3	0	5
Delayed MEOWS	1	0	0
Delayed >30min Pain relief	1	0	0
Full clinical examination not carried out when presenting in labour.	0	0	0
Inadequate Triage	0	1	2
Missed Medication	0	1	0
Delay in administration of analgesia	0	0	0
Missed/Delayed Observation	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0
Any occasion where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	0	0
Delay in ONGOING IOL	5	2	5
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0
Shortfall in RM Time	60	28	28
Birth Suite Coordinator NOT supernumerary	1	0	1
AMBER Alert - Staffing	1	1	0
AMBER Alert - Acuity	0	2	2
IOL Handover to C23	24	15	13
Time critical activity	0	0	0
Unable to provide Transitional Care	0	0	0

3.2.1 Birth Suite Coordinator NOT Supernumerary (midwifery coordinator in charge)

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

In the period 1st April 2024 – 30th June 2024 there are 2 episodes recorded in SAFECARE/BR+ where the midwifery coordinator in charge is NOT supernumerary.

Both occasions occurred at times of high acuity and were for a short period of time while other clinical staff could be redeployed:

Case 1 – Service escalated to Amber status. Mitigating actions were taken immediately through the reallocation of community staff and Maternity Matron to provide clinical care thus releasing midwifery coordinator in charge to supernumerary status.

Case 2 – Service escalated to Red status (deflect to other providers). The midwifery coordinator in charge provided care to an antenatal woman for a short period of time. . Mitigating actions were taken with a Specialist Midwife reallocated to take over care thus releasing the midwifery coordinator in charge to supernumerary status**.**

The midwifery coordinator in charge was not supernumerary (for a short period) in 1.6% of shifts and occurs rarely.

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

If there is an occasion where a woman in active labour is NOT receiving one-to-one care the midwifery coordinator in charge will escalate to the Maternity Bleep Holder and mitigating action is taken to address the issue. A red flag is recorded on SafeCare.

In the period 1st April 2024 – 30th June 2024 there was one episode recorded in SafeCare where a woman in active labour is **NOT** receiving one-to-one care.

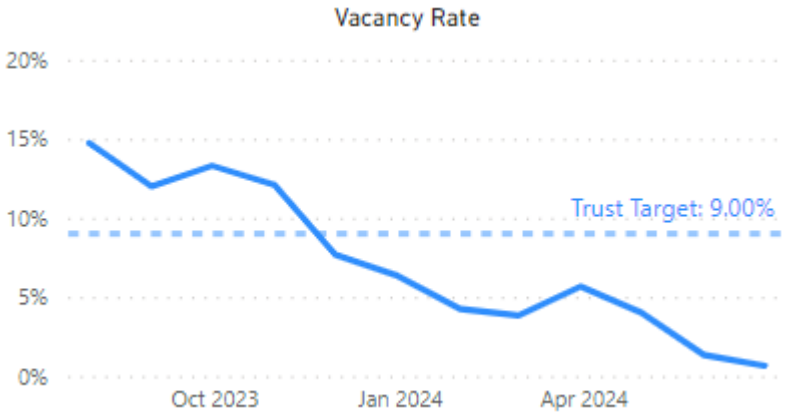
In this case the woman arrived in Maternity Triage in active labour. The Triage Midwife was unable to provide 1:1 support to the woman for a short period while transfer to Birth Suite for ongoing care was arranged.

A woman in active labour not receiving one-to-one care occurred in 0.83% of shifts and occurs rarely.

4. WORKFORCE METRICS

4.1 Vacancy rate

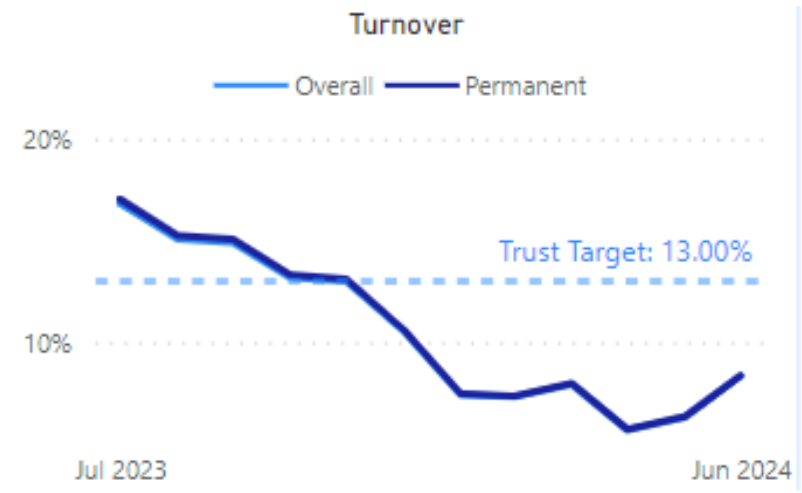
The vacancy rate for registered staff as at 30th June 2024 is 0.65%. This is a significant decrease from the end of Q4 2023/24 when the rate was 5.66% and continues the significant improvement from the from end of January 2023 when the vacancy rate was 18.29%.



Since the end of Q1 a number of midwives have confirmed their intention to retire in Q2 and Q3, there have also been a small number of resignations. Processes are underway to complete recruitment for all vacant posts. This will include a number of posts allocated to newly qualified roles.

4.2 Retention/turnover rate

Midwifery retention rates remain good with turnover at 8.32% at the end of June 2024. Rates below the Trust target have been maintained since December 2023. The rising trajectory has been noted and is being explored by the senior midwifery team.



4.3 Sickness absence

Sickness rates for June 2024 for registered midwifery staff were 6.27%, this is an increase from May 2024. It is however a decrease when compared to June 2023 when the rate was 7.2%. The rolling 12 month rate is 6.9%.

Proactive management of matters relating to workforce are ongoing.

5. ANNUAL MATERNITY & NEONATAL WORKFORCE PLAN

The Maternity and Neonatal Workforce Plan for 2024/25 is included in appendix 1 for discussion and approval. This plan has been developed to reflect the recommendations of national guidance related to the neonatal, obstetric and maternity workforce as well as other local priorities such as ongoing work related to improving workplace culture.

In particular, the Maternity and Neonatal Workforce Plan 2024/25 reflects the workforce requirements of the national Three Year Delivery Plan for Maternity and Neonatal Services published in March 2023.

A key tenet within the Three Year Delivery Plan for Maternity and Neonatal Services was a focus on supporting the maternity and neonatal workforce. This is captured in the theme “Growing, retaining, and supporting our workforce” with responsibilities for Trusts identified via three objectives:

- Grow our workforce
- Value and retain our workforce
- Invest in skills

These three objectives form the basis of the Maternity & Neonatal Workforce Plan 2024-25.

The plan has been developed in collaboration with the senior CBU team and with the support of colleagues from the People Directorate and includes actions which reflect insight gained from completing the Trust workforce planning template.

Once approved, the plan will inform existing and new workstreams across the CBU. Progress against the plan will be discussed as part of the quarterly ‘Quad’ meetings with the Maternity Safety Champion, CBU Governance meetings and will report to Strategic People Committee quarterly.

6. ASSURANCE COMMITTEE

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

7. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Maternity & Neonatal Workforce Plan

2024 - 2025

Development of the plan

The Maternity and Neonatal Workforce plan have been developed to meet the national ambition of safer, more personalised, and more equitable maternity and neonatal services, acknowledging these services can only be delivered by skilled teams with sufficient capacity and capability.

The Maternity & Neonatal Workforce Plan 2024-25 has been developed to reflect the recommendations of a number of national reports, frameworks and enquiries as well as local learning as a result of workforce planning analysis.

Key national documents are as follows:

Three Year Delivery Plan for Maternity and Neonatal Services (2023)
The three year delivery plan was published in March 2023. A key tenet within the Three Year Delivery Plan was a focus on supporting the maternity and neonatal workforce. This is captured within Theme 2: Growing, retaining, and supporting our workforce.

This theme identified three objectives:

- Grow our workforce
- Value and retain our workforce
- Invest in skills

These three objectives form the basis of the Maternity & Neonatal Workforce Plan 2024-25.

Core Competency Frameworks – MSW (2018) and Midwifery (2023)
The core competency frameworks are a welcome tool to ensure consistency and quality in training standards for both maternity support workers and midwives. Developed by HEE (Health Education England) and the NHS Maternity Transformation Programme in collaboration with Royal Colleges, MNSI (Maternity and Newborn Safety Investigations) and the NMC (Nursing & Midwifery Council) they are designed to reduce the impact of variation and poor training standards on harm to women and babies.

Ockenden Report (2020 and 2022)
The Ockenden report reminds us that the impact of serious complications of pregnancy and birth should never be underestimated. The importance of hearing the family voice in contributing to the development of meaningful, sustainable improvements to maternity services is the underpinning message of this report. The Ockenden report also included key actions with regard to workforce in particular with regard to safe staffing, training, preceptorship and succession planning

Kirkup Report (2022)

The Kirkup report in its review of maternity services in East Kent identifies four areas for action:

- Key Action Area 1: Monitoring safe performance – finding signals among noise:
- Key Action Area 2: Standards of clinical behaviour – technical care is not enough:
- Key Action Area 3: Flawed teamworking – pulling in different direction.
- Key Action Area 4: Organisational behaviour – looking good while doing badly

In bringing together the recommendations of these reports/guidance documents alongside local data and intelligence, the Maternity & Neonatal Workforce Plan 2024-25 will ensure a sustainable, skilled maternity and neonatal workforce providing high quality care in a safe and inclusive environment.

Our plan

To enable us to deliver an outstanding maternity and neonatal service, we have set out three workforce objectives to achieve in the period August 2024-July 2025.

The below driver diagram sets out the vision, objectives and outcomes that we aim to deliver.

Vision	Objective	Outcomes
Develop our workforce with the right skills to improve everyone's experience of the maternity and neonatal service	Grow our workforce	To ensure we utilise national and local workforce planning tools alongside local data and intelligence to develop a robust plan to support safe staffing across specialities and achieve further service development in line with national requirements.
	Value and retain our workforce.	A service where staff feel valued at all stages of their career and all staff are included and have equality of opportunity with a safe environment and inclusive culture
	Invest in skills	A service where we invest in our staff by ensuring they have ongoing training and career development opportunities.

Objective one: Grow our workforce

Our planned outcome:
To ensure we utilise national and local workforce planning tools alongside local data and intelligence to develop a robust plan to support safe staffing across specialities and achieve further service development in line with national requirements

What we plan to do:	What does success look like?
Ensure there is an annual workforce assessment across all specialities to inform the develop of an annual workforce plan	• Annual assessment to inform the annual workforce plan will be completed • Annual workforce plan will be developed and approved via Trust governance processes in August 2025 for 2025/26
Ensure safe midwifery staffing levels are achieved and sustained.	• A BirthRate Plus assessment will have been completed • A workforce deep dive will be completed to understand the impact of variables (e.g. sickness absence, other leave, training requirements, changes in complexity of those accessing care) on staffing levels alongside a consideration of workforce intelligence such as retirement profile and skill mix • A dynamic safe staffing action plan will have been developed and implemented in response to the findings of the deep dive
Ensure the maternity and neonatal services embrace all opportunities to grow their workforce including developing existing staff	• A programme will be in place to support those who wish to return to midwifery practice. • A workstream will be in place to maximise the opportunities offered by apprenticeships • The CBU will have reviewed where non clinical roles/digital solutions can support administrative activity to release capacity in the clinical team
Further review the on-call requirement for the Obstetric Consultant workforce to reduce the intensity of on call in line with similar sized units	• The consultant obstetrician workforce will be expanded to decrease the frequency of on call • Increased satisfaction within the Consultant workforce
Ensure compliance with all national standards for the neonatal service	• The AHP workforce within the neonatal service will have grown in line with national recommendations e.g. psychology input • The neonatal service will meet BAPM requirements for the nursing workforce to be qualified in a speciality • The neonatal service will meet BAPM requirements for the medical workforce in relation to Tier 1 provision
Review the consultant provision within the Neonatal Unit to ensure continuity for our patients	• The “Neonatal Consultant of the week” model will have been implemented

Objective two: Value and retain our workforce

Our planned outcome:
A service where staff feel valued at all stages of their career and all staff are included and have equality of opportunity with a safe environment and inclusive culture

What we plan to do:	What does success look like?
Ensure we have a healthy workforce through compassionate leadership, whilst improving recognition of staff and shared learning across services	• Improved 'we are safe and healthy' score from Staff Survey. • Improved 'morale' score from Staff Survey. • Increased up-take in accessing staff Wellbeing programmes and opportunities.
Ensure Workforce Race Equality Standard (WRES)) data is regularly reviewed and develop action plan to support workforce equality.	• Improved results within staff survey.
Ensure we have a robust succession plan in place across the service to develop our future leaders	• A process will be in place for staff to access shadowing opportunities for specialist/ leadership roles • All newly promoted band 7 and 8 midwives will have a robust development plan including an identified mentor • Neonatal colleagues will utilise CPD available via the NWNODN managers development course and Professional Nursing Advocate opportunities • A band 6 Midwifery development programme will be implemented
Ensure a positive learning experience for students and medical trainees working in the neonatal and maternity services	• A robust and dynamic action plan to identify and address issues highlighted in student nurse/midwife feedback surveys will be in place and monitored • Feedback from medical trainees will be collated and GMC action plan will have been completed
Sustain recent improvement in recruitment and retention across the CBU	• Ongoing monitoring of workforce metrics will have taken place including analysis of feedback from exit interviews • A CBU retention improvement action plan will be in place if deteriorating position is identified
Continue to work to improve the workplace culture across the maternity and neonatal services	• The action plan developed as part of the Perinatal Cultural Leadership Programme will be completed by 31/3/2025 • A series of listening events across all teams will have taken place throughout 2024/25 • The WCH CBU will have embraced the opportunities offered by the Trust Culture Plan • A safety culture survey will be undertaken annually and associated action plans will be in place
Continue to create development opportunities for our staff to improve our retention rates and enhance our service offer	• Expansion of consultant roles with obstetric scan experience and fetal medicine experience will be in place • A consultant lead for fertility will be identified • Long Acting Reversible Contraception service will be established • Multidisciplinary perineal pelvic health service will be established

Objective three: Invest in skills

Our planned outcome:
A service where we invest in our staff by ensuring they have ongoing training and career development opportunities.

What we plan to do:	What does success look like?
Sustain recent improvements in mandatory training compliance against local/national standards	• Training compliance data will be monitored on a monthly basis and improvement action plans will have been implemented where compliance is not being met
Support and develop teams and individuals through robust and meaningful PDR plans.	• The Trust appraisal target of 85% will have been achieved. • Staff will have improved access to development and career opportunities.
Develop our workforce with the right skills to improve everyone's experience of our services.	• An annual maternity training needs plan will be completed in line with the core competency framework • The annual training plan for 2025 will be developed and implemented to reflect the annual training needs plan • There will be evidence to demonstrate junior, speciality and associate specialist obstetricians, and neonatal medical staff have received appropriate clinical support and supervision as per national guidance • Maternity Support Workers will have been supported to achieve the MSW competency, education and career development framework
Embed a learning and improvement culture within maternity and neonatal care to promote safer care and improve prevention.	• Staff will have been supported to undertake QI training and attend QI focussed events • There will be a year on year increase in number of staff within WCH who have received QI training
Continue to ensure newly qualified midwives feel supported at the start of their career through a robust preceptorship programme	• The preceptorship programme for NQM will be embedded including supernumerary and protected development time and appropriate 1:1 support via the Retention Midwife and buddy process • Bespoke skills sessions will have been implemented for newly qualified midwives • Feedback from newly qualified colleagues will have been collated to inform ongoing improvements to preceptorship package

Appendix – Glossary of terms

AHP - Allied Health Professional
BAPM - British Association of Perinatal Medicine - BAPM is a professional association and registered charity established to improve standards of perinatal care.
CBU - Clinical Business Unit
CPD – Continued Professional Development
GMC – General Medical Council – The General Medical Council regulates doctors in the United Kingdom. They set standards, hold a register, quality assure education and investigate complaints.
HEE - Health Education England – HEE is the national organisation with the responsibility for ensuring the NHS workforce has the right numbers, skills, values and behaviours to ensure safe care
MNSI - The Maternity and Newborn Safety Investigations programme - MNSI is the statutory body which undertakes investigations into brain injuries in babies and maternal and neonatal deaths and stillbirths
MSW - Maternity Support Worker
NHSE - NHS England – NHSE leads the National Health Service (NHS) in England.
NMC - Nursing & Midwifery Council – The NMC is the independent regulator for nurses and midwives in the UK
NQM – Newly Qualified Midwife
NWNODN – North West Neonatal Operational Delivery Network - The NWNODN works in partnership with families and healthcare professionals delivering neonatal care across the north west, helping each clinical setting to achieve the highest standard of care possible.
QI – Quality Improvement
WCH - Women's and Children's Health
WRES - NHS Workforce Race Equality Standard - The NHS Workforce Race Equality Standard was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/10/102**			
SUBJECT:	2022-2023 Annual Submission to NHS England North West Appraisal and Revalidation and Medical Governance			
DATE OF MEETING:	2 October 2024			
AUTHOR(S):	Anne Robinson, Deputy Medical Director			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	√		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report provides assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust. Doctors who practise medicine in the UK must be registered and hold a licence to practise Both registration and licensing are delivered by the GMC. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All			

	doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise Most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'. The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Anne Robinson. The responsible officer must: 1. Make sure doctors have access to appraisal systems and processes for collecting and holding information 2. Make a recommendation to the GMC every five years, indicating whether the doctor is up to date, fit to practise and should be revalidated. The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using SARD - a web-based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.		
PURPOSE: ***(please select as appropriate)***	Approval √	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the 2023-2024 Annual Submission to NHS England North West Appraisal and Revalidation and Medical Governance		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	SPC/24/09/101	
	Date of meeting	18 September 2024	
	Summary of Outcome	The Strategic People Committee supported the report for approval at Trust Board on 2 October 2024.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England Northwest:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Warrington and Halton Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	NHS

	Name	**Contact Information**
Responsible Officer	Dr Anne Robinson	anne.robinson9@nhs.net
Medical Director	Dr Paul Fitzsimmons	paul.fitzsimmons1@nhs.net
Medical Appraisal Lead	Dr Hilary Furniss	hilary.furniss@nhs.net
Appraisal and Revalidation Manager	Mrs Kate Davidson	kate.davidson4@nhs.net
Additional Useful Contacts	Miss Paula Harris	paula.harris6@nhs.net
	Mrs Andrea Stazicker	andrea.stazicker@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No No

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board:**

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 – Summary and conclusion

Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of *Warrington and Halton NHS Foundation Trust*

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings
Comments:	The Trust MD and CEO have an alternative RO provided by Liverpool University Hospitals to avoid an inverse reporting relationship with the WHH RO
Action for next year:	Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Continue with current processes
Comments:	The Responsible Officer is supported by: a. An Associate Medical Director (AMD) – Dr Hilary Furniss (3 PAs) b. A Revalidation Lead, Andrea Stazicker – 80% WTE c. A Medical Workforce Development Administrator - Paula Harris 1 WTE d. Medical Education Manager - Kate Davidson, who manages the Revalidation Lead and Medical Workforce Development Administrator in addition to duties in Medical Education. e. Band 3 clerical support – Sosanna Thomas 1 WTE to facilitate cross-cover and support and avert single points of failure in working practices. The Trust currently provides SARD, an on-line platform for the management of all doctors' annual appraisals including 360-degree MSF in every 5 year cycle to support the necessary colleague and patient feedback for revalidation. The Trust's appraisers are remunerated 0.125PAs per 4 appraisees or 0.25 for more than 4. The Trust supports appraisers with initial training, refresher training and 2 update forums annually.
Action for next year:	Appointing either Deputy AMD for Appraisal and Revalidation or Senior Appraiser. We hope this will eliminate any single points of failure, allow training of an experienced colleague to support with the review of appraisals and support the team with the workstream to add clarity and structure to the development opportunities for all grades of medical staff

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Continue with current processes
Comments:	Connections to, and removals from, the Designated Body are managed by the Revalidation Lead. Lists of connected doctors and revalidation dates are shared and stored in electronic format in a secure area of the Trust server, which is accessible to ARG members, and updated monthly. The Appraisal and Revalidation group have reviewed and developed policies relating to medical staffing as per actions: • Annual review of Revalidation Policy and Medical Appraisal Policy complete • SOP for Medical Workforce New Starter for Medical Appraisal and Revalidation - to facilitate improved information sharing between the two departments - to support correct and prompt recognition and assignment of doctors, in particular locum doctors. • SARD SOP SARD updates on a daily basis at midnight any changes to the GMC registrations with a license on SARD but it currently doesn't highlight anyone on our designated body who doesn't have a SARD account. This has been identified as an area requiring further investigation and processes have been reviewed to support this.
Action for next year:	Initiation of new processes surrounding cohesive SARD accounts and GMC registrations. We have initially completed a full review of both lists to ensure this matches and appropriate people on both lists. This is now a monthly review completed by the relevant team members together to ensure we have a complete picture and full clarity.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Annual review of the below policies
Comments:	In March 2024 a newly developed Medical Workforce Policy Review Group was set up to ensure that the Trust operates medical workforce policies and procedures which are conducive to the needs of the service. To ensure that medical workforce policies and procedures provide an open and transparent means of treating staff in a fair and equitable manner, and which allows the Trust's objectives to be achieved in a cost-effective manner. The group only review and discuss non-clinical medical workforce policies or procedures. The Revalidation Policy has been ratified and its expiry date is 31st August 2024. The Medical Appraisal Policy is valid until 1 August 2026.

	The Job Planning Policy is valid until 31st March 2027. All Policies go through a 3-step process, Policies and Procedure Group, JLNC and then OPC for final Ratification.
Action for next year:	Revalidation policy has been reviewed and ratified in line with the August deadline. Maintain policy framework and undertaken policy consultation and reviews.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Plan to undertake 23/24
Comments:	Delayed for a number of reasons. An appraisal and revalidation peer review group has been set up between WHH, LUHFT and MWL with a 3 year peer review cycle. WHH is scheduled to have a full peer review of its appraisal and revalidation service in October 2024.The responsible officer has joined the peer review group at Lancs and South Cumbria and has attended an update session on peer review at a recent R/O meeting. It is anticipated that the outcome of the peer review will be included in next years report
Action for next year:	Site visit for review scheduled 3/10/24 Complete by the end of 2024

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continue with current processes
Comments:	The Trust employs locum, bank and short-term placement doctors to fill operational gaps in rotas. This can present some challenges in maintaining oversight of their appraisal and revalidation needs. Some of the junior doctors are unaware of the requirements for appraisal and revalidation but since last year, we have continued to make progress in identifying and contacting these doctors earlier, finding

	out their previous appraisal history, and planning their appraisals ahead. This has resulted in a more effective system. Many trainees take years out of training and work variable hours in the Trust in a variety of named posts, (including 'Trust Grade', 'Trust Bank Doctor', 'LAS', 'Clinical Fellow', 'FY3', 'FY4' etc') and locum in all of these grades. They take these posts in pursuit of increased flexibility, freedom from the structure of a training programme, no exams and to have less rigid and shorter hours. The Appraisal & Revalidation Group receive monthly updates of new starters, leavers, doctors on periods of prolonged leave. A 'change of assignment' category was added in 2021, which aims to identify more accurately the exact capacity in which doctors are employed, for example change from temporary to permanent contract. The Trust also employs oral surgeons who also work in dental practices, or Trusts, but are supported with study leave allowance, and learning opportunities. They are not subject to GMC revalidation, but the Trust supports their appraisal, mandatory training and CPD to maintain their recognition by the General Dental Council. Governance information is received and reviewed from their other employers. The Trust's Physician Associates appraisals follow a similar process to the medical appraisal process in readiness for when they are regulated by the GMC. They have their own separate online appraisal system (from the same provider), which is tailored to better suit their needs. The International Training Fellows (ITFs) are a group of doctors who also fulfil appraisal and revalidation. There is a designated ITF administrator. The team contact these employees to ensure they are aware of the requirements for A&R, provide contact details, appraisal guidance document, and contacting ITFs with relevant information. Although SAS doctors are neither short term, nor temporary employees, the trust recognizes that they have a wide range of needs regarding training, supervision and appraisal. An SAS "Task and Finish Group" was set up in January 2024 with a trust commitment to delivering the SAS Six. This identifies 6 specific actions to support SAS doctors with educational supervision, equivalence of opportunities in development as leaders, educators and toward the Specialist Role. Additionally, all doctors on an LED contract for 2 years or more will be offered the opportunity to move to an SAS contract on national terms and conditions. The trust is already compliant with several of the six criteria and working towards the others through the T&F group. All SAS doctors are included in the annual appraisal process. Specific training opportunities are delivered in the trust through the SAS tutor and regional SAS education team.
Action for next year	Doctors' development portfolio- The RO, AMD for A&R are working with the Trust's organisational development team to summarise the development opportunities that are available to doctors on joining the

	Trust. This is an ongoing workstream and will be supported further with the introduction of the Deputy AMD for Appraisal and Revalidation or Senior Appraiser Ongoing actions/workstreams of the SAS Task and Finish Group

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	• GMP 2024 – Embedding into Internal Professional Standards – Soft Launch April 2024 - Complete • Appraiser and Appraisee Q&A - Complete • Survey of appraisers and appraisees regarding new platform to facilitate any further customisation of the platform - Complete • Development of appraiser QA database to track training and refresher course and forum attendance, their ASPAT (Appraisal Summary and PDP Audit Tool – NHS England) scores and of completing appraisal summaries after meetings. This will be used to provide evidence for the AMD to use in feeding back to individuals and to maintain standards. - Complete
Comments:	All doctors are annually offered an appraisal, which reviews supporting evidence and reflection on • Quality improvement, • Continuing education, • Feedback from colleagues and patients, • Compliments, • Serious incidents, complaints and claims A WHH Appraisal Preparation crib-sheet is provided and updated annually to outline requirements, particularly on focusing the appraisal, quality not quantity, and presenting evidence at the meeting rather than uploading. The Trust Governance Dept provides information on serious incidents, complaints and claims and this is uploaded to appraisal folders for reflection. An Independent Sector Checklist and/or Letter of Good Standing is expected for all work external to WHH.

	All appraisees and appraisers receive individual feedback and guidance regarding their appraisal. ALL ACTIONS COMPLETE
Action for next year:	GMP 2024 – Following the soft launch in April 2024 the future objective will be embedding into this SARD appraisal documentation in order to provide formality, structure and assurances and cascading the changes our to appraisees and appraisers by the end of 2024

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	Continue with current processes
Comments:	All colleagues are treated on an individual basis with particular circumstances considered when entering into discussions. Regular reminders are sent out via the SARD electronic platform and one to one meetings are offered to support confidential discussions and create personal support plans to provide the best opportunity to engage with the process. The Trust prioritises shared understanding of the objectives behind appraisal ensuring the exercise is meaningful and achieves intended outcomes bringing continued professional development to the forefront. If, following the offer of support mechanisms above, engagement continues to be an ongoing concern, a face-to-face appointment is scheduled with the RO in line with the escalation process. In order to ensure triangulation of Doctors having difficulty and the support being offered the RO has open discussion with GMC to provide awareness and assurance.
Action for next year:	Continue with current processes

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Updated and approved last year because of SARD
Comments:	Review due 2026
Action for next year:	Continue operational usage of policy.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Continue annual appraiser refresher training and new appraiser training

Comments:	81 current appraisers 12 scheduled to undertake training Oct 2024 Appraiser refresher training to continue annually. Recruitment of new appraisers and new appraiser training offered annually Regular review of distribution of number of appraisees and appraisers have. Open dialogue with appraisers when making changes to distribution.
Action for next year:	Appraiser training day – booked 2nd October 2024

1 While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	QA appraisers via database, tracking training, forum attendance and, their ASPAT scores and timeliness of completing appraisal summaries after meetings. Continue offer of annual refresher course
Comments:	Complete action and shared with appraisers, appraiser forum to provide assurance
Action for next year:	Aim to reduce overdue appraisals and to complete within the designated appraisal year.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Appraiser QA process included in the Annual Appraisal and Revalidation submission which is shared in the ARG Annual SPC report and then subsequently to Board following approval. Annual Board presentation in September/October.
Comments:	Quarterly Chairs log from ARG is submitted to Operational People Committee (OPC) and included in the reporting schedule in line with ARG meeting dates.
Action for next year:	Appraiser QA reports are to be included in the quarterly Chairs log report to OPC

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practice of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	To continue with revalidation decision making panels
Comments:	We are evaluating utilizing SARD for presenting the relevant information to the revalidation decision making panels rather than collating separate spreadsheets.

Action for next year:	Options appraisal to decide most effective presentation of information.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No outstanding actions
Comments:	Upcoming recommendations are reviewed in advance as per our policy and correspondence shared with Doctors advising them of the date and requirements at least 6 weeks prior. Individual emails are also sent if there is a particular outstanding requirement such as MSF. Panels are scheduled with time prior to the revalidation deadline so if outcome is not positive the Doctor has time to complete outstanding requirements and a further review take place. Anyone still not meeting the criteria when the submission is due will be deferred and contacted with a comprehensive explanation of requirements and timeframe for completion. Total number of recommendations made - 54 Total number of late recommendations - 0 Total number of positive recommendations - 45 Total number of deferrals made - 9
Action for next year:	Continue current processes

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Continue current processes
Comments:	Regular contact is maintained between the appraisal and revalidation group and the Governance department. The governance department supply information on request. • Three reports for annual appraisal documentation relating to any serious events in which the doctor has been named in the appraisal review period. Ongoing claims are reported and any complaints which remain unresolved. Reflection on each area is expected in appraisal documentation and should be covered in appraisal discussion. • Reports to inform the Revalidation Panels in supporting revalidation recommendations, which contain all serious incidents and ongoing claims • Ad-hoc reports to inform governance requests on individual doctors.
Action for next year:	Continue with current processes

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Triangulation meetings ongoing
Comments:	To help monitor case management across the organisation the Trust has the following in place: • Regular triangulation meetings attended by the Medical Director, RO, senior representatives of Human Resources, Governance department, and the AMD for Appraisal and Revalidation. No decisions about case management are made at these meetings. They are used to discuss progress on investigations and open or emerging cases or issues. No notes of these meetings are kept but the tracker (referred to below) is updated with the current position. • A tracker in the form of an excel spread sheet which gives brief details of 'live' matters being considered and their current status. This is used to keep track of progress and for reporting at Revalidation Decision Making panels. Access to the tracker is on a restricted basis. • Regular progress reports on all Employee Relations cases [anonymous basis], are made to the Operational and Strategic People Committees. These committees are held bi-monthly, and the regular reports are presented at each meeting. If alerts are raised by colleagues or via National database audits – these are actioned accordingly Ability to include triangulation precis on SARD
Action for next year:	Use of SARD for documentation to support triangulation Consider use of NCIS data as part of governance reports relevant surgeons appraisals

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Nil
Comments:	SARD - governance reports, Appraiser training dates, previous appraisals, PDPs, MSFs all uploaded
Action for next year:	Continue current processes

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None.
Comments:	The Trust's MHPS policy outlines the process for dealing with concerns in relation to a Doctors' fitness to practice. This policy is due for review in December 2024 (extended to 31st March 2025).
Action for next year:	Commence policy review as planned.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Nil
Comments:	The Trust values include kindness and senior leaders are trained in compassionate leadership. Principles of just and learning culture are embedded into the formal process documents. Training which is inclusive of just and learning culture awareness is provided to those with a formal role within Trust employee relations and specifically MHPS processes. Compassionate leadership training is available to all Trust management staff. The training included a recent lecture on compassionate leadership at the Trust Quality Academy meeting by Professor West. All concerns are taken seriously and, following investigation, results fed back to those who have raised concerns. The Trust has an ongoing compassionate leadership program externally facilitated and available across the working including for all levels of medical staff. All those nominated for undertaking a role within formal employee relations processes are trained to undertake the role for which they are appointed. The Trust employee relations policies include measures in support of just and learning culture including minimum use of suspension, regular suspension reviews, timeline requirements for review to ensure case delays are minimised and managed. Clear responsibilities for communication. Options for welfare referrals to occupational health where required by any stakeholder within employee relations processes. Support for all case roles including hearing chairs, case managements and investigation officers by qualified HR professionals, Medical Triangulation meetings are conducted on a monthly basis chaired by the Medical Director and attended by the Trust RO, these are supported by HR Business Partners. Case oversight meetings are conducted on a monthly basis by the Trust Chief People Officer. Lesson learned processes are conducted on a regular basis for

	employee relations case management processes, including case management for medical staff groups. Formal reporting that is inclusive of quality measures such as timeline to resolution, case patterns/ themes and outcome are presented to the strategic people committee on a bi-annual basis. A process of regular case debriefs and lesson learn processes are undertaken for review of formal case management. An annual HR Dashboard report is produced for the Operational People Committee which feeds into the Trust's Strategic People Committee which includes case themes and protected characteristics.
Action for next year:	Ongoing scheduled reporting.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Continue current processes
Comments:	There is a recognised process for sharing information between Responsible Officers (RO) via a Medical Practice Information Transfer form (MPIT) which is provided by NHS England. This is the way in which we request information for new starters to WHH from their previous employer's RO and is also the way in which we respond to requests we receive to provide information regarding doctors who have previously worked at WHH. However, the MPIT process is not restricted to when doctors change employers and we use this process to share information of note about a doctor as and when the need arises. An example of this would be when a doctor works at WHH as well as an independent healthcare provider and there is information of note which our RO needs to share.
Action for next year:	Continue completion in a timely fashion

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	Continue current processes
Comments:	The Trust has a robust process for undertaking equality impact assessments for all policy developments these are subject to scrutiny by the ratification committee and reviewed on a cycle of at least every three years. This process includes a review of protected characteristics, socioeconomic factors, health inequalities and the Armed Forces and Military Veterans community. This ensures that there is no negative / adverse impact on the grounds of a protected characteristics. In addition, this highlights opportunities for positive impact to ensure processes are free from bias and discrimination.

	A quality assurance process is completed by the Workforce Equality, Diversity and Inclusion Team.
Action for next year:	Continue with current processes

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	• Introduction of the new Patient Safety and Incident Response Framework into the Trust from 1/9/23, will see much more of a focus on system-based learning from incidents with more time spent on the quality improvement work. One would expect this change to slowly be reflected in the appraisal documentation. • Scheduled review of the MHPS policy and procedure, this will include review of the associated equality impact assessment.
Comments:	The MHPS Policy has been extended until 31st March 2025
Action for next year:	MHPS process of being reviewed in line with the Trusts new Disciplinary Policy.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	The GMC released updated 'Good Medical Practice standards' which in addition to the existing standards, include new focus on behaviours and culture. The Trust completed a soft launch in April 2024.
Comments:	Information regarding the changes to the appraisal documentation to include GMP 2024 will be cascaded to appraisees and appraisers via Appraiser Forum.
Action for next year:	Complete inclusion of GMP 2024 into appraisal documentation on SARD in order to provide formality, structure and assurances.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None.
Comments:	The Trust's Recruitment Team ensure that the 6 Employment Checks as per the NHS Employers are carried out for all Doctors recruited into the organisation as follows, with governance processes in place to ensure any risks identified are reviewed in conjunction with the HR Business Partnering Team :- • Identity • Right to Work • Professional Registration & Qualifications • Employment History & Reference Standards • Criminal Record • Work Health Assessment Standards
Action for next year:	Ongoing operational vetting processes.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Introduction of new Internal Professional Standards – Complete April 2024
Comments:	The Trust has an established values framework which underpins the Trust disciplinary standards and rules.
Action for next year:	Continue operational use of values framework, disciplinary rule standards and internal professional standards documents. Continue publication of and communication of the Trust professional standards.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	The Trust has a robust process for undertaking equality impact assessments for all policy developments these are subject to scrutiny by the ratification committee and reviewed on a cycle of at least every three years. This process includes a review of protected characteristics, socioeconomic factors, health inequalities and the Armed Forces and Military Veterans community. This ensures that there is no negative / adverse impact on the grounds of a protected characteristics. In addition, this highlights opportunities for positive impact to ensure processes are free from bias and discrimination.
Comments:	Staff Networks are a core part of the review of policies and processes and are aligned to the equality impact assessment process. Additionally, the Trust has launched a Culture Plan which emphasizes the importance of equality, diversity, compassion and inclusivity. Additional to the protected characteristics, the FREDA (fairness, respect, equality, dignity and autonomy) principles of the Human Rights Act 1998 are aligned to the impact assessment process. The Trust Workforce Inclusion and Culture Sub-Committee additionally monitors risks related to equality, diversity and inclusion as well as culture, by which the Deputy Medical Director is a core member of the group. The Trust produces an annual report on equality, diversity and inclusion – this can be found here: https://whh.nhs.uk/strategy/equality-diversity-and-human-rights
Action for next year:	Continue current process

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	The Trust appointed a substantive Freedom to Speak Up Guardian and Deputy Guardian, both working part time to support the FTSU work.
Comments:	The Trust has a Freedom to Speak up Guardian and a policy based on the national policy, a intranet signposting page and undertakes regular FTSU awareness raising events and signposting.
Action for next year:	Continue to develop the role of the FTSU champions and the links to the culture work at WHH. Build further on the worker wellbeing offer to staff who speak up and ensuring their wellbeing and safety.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Staff survey
Comments:	The Trust has a range of options for staff to ensure that their voice is heard, formally consultation takes place through the JLNC although feedback is also invited informally, via the annual staff survey and in the event, it was required the Trust has a establish resolving workplace disputes policy with informal and formal options for raising disputes. The staff survey allows for a breakdown by staff group which does suggest that Medical and Dental staff across the Trust report a lower experience than the Trust average across all nine themes. When reviewing data from the previous year there was an improvement for Medical and Dental staff compared with the 2022 survey in eight themes, with "we are recognised and rewarded" remaining the same. Additionally, engagement for the review of local internal professional standards has been undertaken to support a review in line with the GMP 2024.
Action for next year:	Actions for next year include further engagement with Medical and Dental staff to increase representation for the staff survey and therefore the utilisation of the data to inform staff voice.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Maintaining quality review of formal and informal disciplinary processes aligned to the workforce equality standards.
Comments:	Annual review of data following Trust's annual report submissions including National WRES (Workforce Race Equality System) and WDES (Workforce Disability Equality). Additional review aligned to sexual orientation and regular review touchpoints included throughout the year, linked the HR Dashboard report.
Action for next year:	Benchmark reporting data against similar Trusts

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher- level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Attendance NWHLRO forums supported by the Revalidation Lead to keep up-to-date and discuss topical issues, comparing regional practises, and ensuring standard practices are observed. Peer review to be arranged - 2024
Comments:	An appraisal and revalidation peer review group has been set up between WHH, LUHFT and MWL with a 3 year peer review cycle. WHH is scheduled to have a full peer review of its appraisal and revalidation service with an onsite visit on 3rd October 2024.The responsible officer has joined the peer review group at Lancs and South Cumbria and has attended an update session on peer review at a recent R/O meeting. It is anticipated that the outcome of the peer review will be included in next years report.'
Action for next year:	Include outcome of peer review in next year's report

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	331

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	279
Total number of appraisals approved missed	44 (includes appraisal meetings not due within that time frame, new to the Trust, new to the NHS/UK, and long term sickness, maternity, sabbatical, inappropriate connection to WHH as designated body)
Total number of unapproved missed	8

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	54
Total number of late recommendations	0
Total number of positive recommendations	45

Total number of deferrals made	9
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	9
Total number of trained case managers	14
Total number of new concerns registered	12

Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March	84 days

Median duration of concerns processes closed	115.5
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	240
Number of new employment checks completed before commencement of employment	240

2F – Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0

Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
• Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings • Annual Policy review in line with schedule • Peer review 2023/24 • GMP 2024 – Embedding into Internal Professional Standards – Soft Launch April 2024 • Appraiser and Appraisee Q&A • Survey of appraisers and appraisees regarding new platform to facilitate any further customisation of the platform • Development of appraiser QA database to track training and refresher course and forum attendance, their ASPAT (Appraisal Summary And PDP Audit Tool – NHS England) scores and of completing appraisal summaries after meetings. This will be used to provide evidence for the AMD to use in feeding back to individuals and to maintain standards. • Continue annual appraiser refresher training and new appraiser training • Appraiser QA process included in the Annual Appraisal and Revalidation submission which is shared in the ARG Annual SPC report and then subsequently to Board following approval. • To continue with revalidation decision making panels • To continue Triangulation meetings • Introduction of the new Patient Safety and Incident Response Framework into the Trust from 1/9/23, will see much more of a focus on system-based learning from incidents with more time spent on the quality improvement work. One would expect this change to slowly be reflected in the appraisal documentation. • Scheduled review of the MHPS policy and procedure, this will include review of the associated equality impact assessment. • Introduction of new Internal Professional Standards • The Trust has a robust process for undertaking equality impact assessments for all policy developments these are subject to scrutiny by the ratification committee and reviewed on a cycle of at least every three years. This process includes a review of protected characteristics, socioeconomic factors, health inequalities and the Armed Forces and Military Veterans community. This ensures that there is no negative / adverse impact on the grounds of a protected characteristics. In addition, this highlights opportunities for positive impact to ensure processes are free from bias and discrimination. • The Trust appointed a substantive Freedom to Speak Up Guardian and Deputy Guardian, both working part time to support the FTSU work. • Staff survey • Maintaining quality review of formal and informal disciplinary processes aligned to the workforce equality standards. • Attendance NWHLRO forums supported by the Revalidation Lead to keep up-to-date and discuss topical issues, comparing regional practises, and ensuring standard practices are observed.
Actions still outstanding

- Peer review 2023/24 – Scheduled 3rd October 2024 onsite
- Revalidation policy review in line with schedule – Due Aug 2024
- Annual Appraiser refresher training and new appraiser training scheduled for Oct 2024
- Scheduled review of the MHPS policy and procedure, this will include review of the associated equality impact assessment. – Extended till March 2025

Current issues

- Peer review delayed whilst agreeing with 2 other organisations – Scheduled and confirmed for 3/10/2024

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings
- Appointing either Deputy AMD for Appraisal and Revalidation or Senior Appraiser. We hope this will eliminate any single points of failure, allow training of an experienced colleague to support with the review of appraisals and support the team with the workstream to add clarity and structure to the development opportunities for all grades of medical staff
- Initiation of new processes surrounding cohesive SARD accounts and GMC registrations. We have initially completed a full review of both lists to ensure this matches and appropriate people on both lists. This is now a monthly review completed by the relevant team members together to ensure we have a complete picture and full clarity.
- Revalidation policy currently under review and pending ratification in line with the August deadline.
- Maintain policy framework and undertaken policy consultation and reviews.
- Peer review scheduled 3/10/24. Complete by the end of 2024
- Doctors' development portfolio- The RO, AMD for A&R are working with the Trust's organisational development team to summarise the development opportunities that are available to doctors on joining the Trust. This is an ongoing workstream and will be supported further with the introduction of the Deputy AMD for Appraisal and Revalidation or Senior Appraiser
- Ongoing actions/workstreams of the SAS Task and Finish Group
- GMP 2024 – Following the soft launch in April 2024 the future objective will be embedding into this SARD appraisal documentation in order to provide formality, structure and assurances and cascading the changes our to appraisees and appraisers by the end of 2024
- Continue operational usage of Appraisal policy
- Appraiser training day – booked 2nd October 2024
- Aim to reduce overdue appraisals and to complete within the designated appraisal year.
- Appraiser QA reports are to be included in the quarterly Chairs log report to OPC
- Options appraisal to decide most effective presentation of information for revalidation decision making panels
- Use of SARD for documentation to support triangulation - Consider use of NCIS data as part of governance reports relevant surgeons appraisals
- MHPS process review in line with the Trusts new Disciplinary Policy.

- Continue operational use of values framework, disciplinary rule standards and internal professional standards documents.
- Continue publication of and communication of the Trust professional standards.
- Continue to develop the role of the FTSU champions and the links to the culture work at WHH. Build further on the worker wellbeing offer to staff who speak up and ensuring their wellbeing and safety.
- Further engagement with Medical and Dental staff to increase representation for the staff survey and therefore the utilisation of the data to inform staff voice
- Benchmark reporting data against similar Trusts in relation to doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification protected characteristics as defined by the Equality Act.
- Include outcome of peer review in next year's report

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Significant ongoing progress in Appraisal and Revalidation across the orgainisation which have been achieved in a context of very significant operational financial pressures in the orgainisation and wider ICS. This coming year's challenges and aspirations will continue to focus on maintaining high appraisal and recommendation for revalidation rates, developing a succession plan for the medical leadership of appraisal and revalidation, peer review with neighboring Trusts and building on the Trust's culture plan, particularly around the use of Internal Professional Standards, well-being offer and equality and diversity agendas.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	

Name:	
Role:	
Signed:	
Date:	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/103**			
SUBJECT:	**Freedom To Speak Up Bi-annual Report**			
DATE OF MEETING:	02/10/2024			
AUTHOR(S):	Deborah Carter, Freedom To Speak Up Guardian			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In 2023/24 the Freedom to Speak Up (FTSU) team managed thirty-one cases of disclosure. During 2022/23 the number of cases was forty-one (compared to twenty in 2021/22). The majority of issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that are highlighted.			

	The FTSU team are currently benchmarking the existing FTSU policy with others from across the NHS as part of the process to update and refresh the WHH policy. The FTSU team continues to engage with colleagues across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to raise awareness of FTSU. In February 2024, a substantive FTSU Guardian and Deputy Guardian commenced in post working two and one day each per week, respectively. The results of the staff survey linked to the 4 questions which relate to FTSU are shared in this document. An update from the National Guardians Office and the work therein is provided.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the progress of Freedom To Speak Up.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	SPC/24/09/99	
	Date of meeting	18 September 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO TRUST BOARD

SUBJECT	Freedom To Speak Up	AGENDA REF:	BM/24/10/103

1. BACKGROUND/CONTEXT

During 2023/24 the FTSU team supported thirty-one disclosures from colleagues across the organisation. Whilst in 2022/23 the FTSU team had forty-two disclosures (compared to 20 in 2021/22). The majority of the issues raised relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that they highlight.

The FTSU team continues to engage with colleagues from across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU.

On the 1st February 2024 the new FTSU Guardian commenced in post working substantively two days per week, the Guardian is supported by a Deputy Guardian working one day per week. This represents a commitment by the organisation to the FTSU process undertaken to support colleagues in the organisation to raise awareness of any concerns in relation to work. The Guardian and Deputy Guardian have been working to build the champion network of whom there are now fifty champions, and a further eighteen staff have expressed an interest in becoming Champions, work is underway to increase engagement with the champions and build the network to cover all areas of the organisation.

2. KEY ELEMENTS

The following information is provided to give an overview of the work the Guardian and team have undertaken and in particular to share the results from the last National Staff Survey, focusing on the 4 questions that relate to speaking up.

The following is a summary of FTSU disclosures from colleagues over the previous three years and in the previous quarter of 24/25.

Table 1: sets out the number of disclosures for the last 3 years and up to Q1 of 2024/25:

Table 1 Number of disclosures

	2021/22	2022/23	2023/24	2024/25
Quarter 1	4	17	6	15
Quarter 2	8	5	6	
Quarter 3	6	13	9	
Quarter 4	2	7	10	
Total	**20**	**42**	**31**	

Table 2: sets out how cases are grouped by disclosure type:

Table 2 Types of disclosures

	2021/22 Q1 – Q4	2022/23 Q1 – Q4	2023/24* Q1 - Q4
Behaviour, culture and relationships	15	31	26
Process	2	3	1
Patient safety/Quality	1	5	7
Staff levels / patient care	2	2	1
Communication		1	
Worker Safety*			6

*In Q4 national reporting changes were made to allow for more than one area of disclosure to be reported per case, and worker safety was also included.

New reporting groupings have been introduced into the data collection for 24/25 and these will be fully reflected in the next report. The Freedom to Speak up Guardian (FTSUG), Deputy and Champions continue to present at events across the Trust, in particular to the medical students, rotational doctors, preceptorship staff and international nurses. The guardian has also commenced a series of walk arounds to speak directly to staff and raise awareness of FTSU and the value that the organisation places upon this.

In February 2024, the Trust Board received an update on FTSU as well as the results from the review of the FTSU reflection and planning tool which incorporated the Trust Board's views. This is being used by the new guardian to develop the FTSU development plan.

The FTSU guardian has undertaken the national training and both existing and new champions have been requested to complete the Electronic Staff Record (ESR) FTSU training. During 2024/25 the FTSU Guardian and Deputy will start to receive reports regarding the uptake of training and will use this information to target areas to promote training in order in increase the numbers of staff who access it.

The guardian team has reviewed the results of the last staff survey and has been considering the issues raised in the four questions that link to Speaking Up and are keen to target work to improve response scores:

- I would feel secure raising concerns about unsafe clinical practice – positivity with this question have increased from the previous year but are a deterioration on the 2 years prior and remain lower than the best performing Trusts.
- I am confident that my organisation would address my concerns – positivity with this question has increased from the previous year but is lower than the 4 years prior and lightly lower than with the best performing Trusts.
- I feel safe to speak up about anything that concerns me in this organisation – positivity towards this question has increased and is higher than the previous 2 years but is still lower than the best performing Trusts.
- If I spoke up about something that concerns me, I am confident my organisation would address my concerns – there was marked in positive increase with responses to this question from the previous year but still lower than the best performing Trusts.

I would feel secure raising concerns about unsafe clinical practice

	2019	2020	2021	2022	2023
Your org	72.61%	74.66%	77.69%	71.28%	73.75%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	2092	1467	1732	1511	2042

I am confident that my organisation would address my concerns

	2019	2020	2021	2022	2023
Your org	63.49%	64.26%	63.09%	59.17%	61.26%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	2093	1468	1727	1509	2030

I feel safe to speak up about anything that concerns me in this organisation

	2020	2021	2022	2023
Your org	69.37%	63.73%	60.66%	64.59%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	1480	1732	1501	2042

If I spoke up about something that concerns me I am confident my organisation would address my concerns

	2021	2022	2023
Your org	53.79%	48.62%	54.39%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	1730	1499	2039

The Guardian team are developing a new FTSU strategy and will seek to target some of these areas in the objectives. Particularly to try to reduce the inhibitors to Speaking Up which are understood to be often reported as fear of detriment and reprisal and a sense of futility.

October is national Freedom To Speak Up month and the team have a range of plans to promote the topic of the month which is “Listen Up.”

The Trust has responded to the Thirlwall Public Enquiry first call for information in which there were questions relating to the role of FTSU. We will continue to engage with the Enquiry team and respond accordingly. The new CQC single assessment framework contains areas which covers the FTSU process within organisations.

National Update

In 2022/23 NHS FTSU guardians nationally handled over 25,000 cases, this number increased to 32,167 in 2023/24. From the cases raised in 2023/24:

- Two in every five cases raised (38.5%) involved an element of **inappropriate behaviours and attitudes**. The most reported theme in 2023/24.
- 18.7% of cases raised included an element of **patient safety/quality**, a marginal drop compared to 2022/23 (19.4%).
- **Detriment** for speaking up was indicated in 4.0% of cases, the same as in 2022/23.
- The percentage of cases which were raised **anonymously** was 9.5%. This was similar to the percentage raised anonymously in 2022/23 (9.4%).
- Four-fifths (79.8%) of those who gave feedback said **they would speak up again.**

The national team has published its survey of FTSU guardians. The survey highlighting 84% of guardians who responded said that their organisation is working to tackle the barriers to speaking up. However, there is a sharp decline in their perceptions overall that the speaking up culture is improving.

Just over half (54%) said they had enough time to carry out their FTSU guardian role. In addition to supporting workers who speak up, guardians also need time for the proactive part of their role, identifying and tackling barriers to speaking up; yet 48% spent the majority of their time responding to workers, a reflection on the increased number of cases being raised to guardians.

Almost 1 in every 25 cases reported to guardians Nationally are from workers indicating that they have suffered detriment after speaking up**.** In 23/24 there was one case of detriment reported by WHH.

The Speak Up data from 2023/24 is now available to view on the National Guardians Office - NGO website.

The National Guardians Office (NGO) has recently commissioned a speak up review into the experiences of overseas trained workers, the questionnaire for this has been widely circulated to colleagues in WHH.

The National Guardian's Office has recently published responses to the following publications:

- Response to the Health Services Safety Investigation's Body (HSSIB) Investigation into temporary staff

"And identifies that this report underlines why it is so important that everyone – no matter what their contract terms – can speak up and their concerns and suggestions are heard and acted upon.
Freedom to Speak Up guardians are available to all workers – this includes temporary, agency and bank staff. They can offer fresh insights into practices and quality of care. For the safety of all our patients, it is essential that their voices are encouraged and listened to, to stop harm before the investigation stage."

- Independent Culture Review of the Nursing and Midwifery Council

“I welcome the response of the board and executive and their immediate actions. Where people are fearful of speaking up, it is essential to offer them an alternative route to raise concerns, so I am pleased to see that the NMC is putting that support in place with a Freedom to Speak Up Guardian.

Regulators must set the tone and model the behaviour they expect of those they regulate. That begins by listening to colleagues and welcoming their voices as opportunities for learning and improvement.”

The NGO has recently produced a **New information film for Freedom to Speak Up Non-Executive Directors and Trustees**

The NGO has p++-ublished a new strategy, below is a summary of the strategy on a page. Alongside the strategy is published a vision statement “Building a Culture of Confidence: turning up the dial on Freedom to Speak Up”

The Guardian team will consider this as they build on the strategy for WHH.

In addition, Dr Henrietta Hughes OBE, Patient Safety Commissioner, has shared information about the critical role Freedom to Speak Up guardians play in supporting Martha's Rule.

All resources and information are available via the NGO’s website News - National Guardian's Office.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

In response to the local and national disclosures and the publication of a number of reports which recommend the FTSU route to support organisations to influence culture change, investment has been made into the FTSU team. This will enable more engagement with staff across the Trust and provide opportunities bring about improvement and culture change.

The new Guardian and team are cognisant of the various documents and their recommendations and will seek to build these into the new FTSU Policy and Strategy.

4. RECOMMENDATIONS

The Trust Board is asked to note the report, and the information provided regarding the developments and progress of Freedom To Speak Up within the organisation.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/104**			
SUBJECT:	**Integration Warrington and Halton Teaching Hospitals NHSFT and Bridgewater Community Healthcare NHSFT**			
DATE OF MEETING:	2 October 2024			
AUTHOR(S):	Lucy Gardner, Chief Strategy & Partnerships Officer Kate Henry, Director of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer Kate Henry, Director of Communications and Engagement			
LINK TO STRATEGIC OBJECTIVE:	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**all**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	We continue to progress our collaboration with Bridgewater and, following a productive first Joint Board development session on 4th September, present the following items to both Trust Boards for approval: 1. Joint Branding 2. Initial Strategic Case for Change			
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**	
RECOMMENDATION:	The Trust Board is asked to approve the Joint branding and the initial Strategic case for Change.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Joint Executive Team meetings and Joint Board Development session
	Agenda Ref.	
	Date of meeting	4 September 2024
	Summary of Outcome	Supported with some amends suggested, amends now incorporated.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

Integration branding proposal v2

For approval at Board meetings
taking place on 2/3 October 2024

Integrating hospital and community services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

The ask

- After exploring partnership branding options, it was agreed at the Board to Board meeting held in September that we need to undertake further engagement work with staff, patients and the public about future partnership (and ultimately organisation) names.
- This work is ongoing and will take some time to engage and seek a wide range of views.
- In the meantime, and as we are progressing with integration plans, a proposal to brand the integration programme as ‘Better Care Together’ is being put forward for approval.
- As previously, any branding developments must:
  - Meet NHS Identity Guidelines, which help to ensure clarity for the public and staff
  - Be developed internally – no external design / agency spend
  - Be approved through the governance processes being established (at this point in time, both Boards)
  - Be implemented in a cost effective way

The proposal

- To brand the integration programme ‘Better Care Together’, using the graphic below:

- As per NHS identity guidelines, two NHS logos must not appear on the same page – this is confusing for the public and dilutes the strength of the NHS identity.
- For all materials relating to the integration programme, a single NHS lozenge will be used, accompanied with the Better Care Together graphic, and the following descriptor text:

Integrating community and hospital services provided by
Bridgewater Community Healthcare NHS Foundation Trust and
Warrington and Halton Teaching Hospitals NHS Foundation Trust

An example


DRAFT v3
NHS
Better Care Together
Home · Community · Hospital
Integrating community and hospital services provided by
Bridgewater Community Healthcare NHS Foundation Trust and
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Potential sensitivities

- As we increasingly work and behave as one single organisation, we will need a branding solution for very practical matters which will need to be managed sensitively
- Examples include:
  - Email signatures / lanyards for joint postholders e.g. CEO and potentially some exec directors – can't be seen to align to one organisation more than the other
  - Templates for joint BAU communications channels e.g. one CEO-led Team Brief across both organisations rather than two
- Additionally, and as we plan to become a single organisation (subject to options appraisal and approval etc), we will need to demonstrate engagement activity being undertaken and feedback being considered about the organisation's name
- This work will also require us to find a solution for services provided outside of Warrington and Halton, e.g. Bridgewater's dental services and WHH's breast screening service

Progress and next steps

- Discussed at Exec to Exec Meeting - 16 July 2024
- Discussed at Board to Board – 4 September
- Revised following feedback and discussed at Exec to Exec meeting – 17 September
- For approval at Bridgewater and WHH Board meetings – 2 and 3 October
- Implement alongside communication of key messages for the programme
- Seek views on partnership name / future organisation name via both organisations' channels, including from staff, stakeholders, governors, patients and the public, e.g. WHH's Experts by Experience and Bridgewater's equivalent
- Share findings at future Exec to Exec and Board to Board meetings for decision









Better Care Together

Home · Community · Hospital

Integrating community and hospital services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

A case for change

We want to provide better care together.

Bridgewater Community Healthcare NHS Foundation Trust (BCH) and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) are joining forces and working as one to improve healthcare services for our communities.

This document, produced for commissioners and system partners, provides an update on our strategic intentions around integration.

Warrington and Halton need strong and resilient clinical services, and our healthcare system must be sustainable for the future. We know that we can achieve more together for both our patients and staff.

By coming together, we will deliver new models of care, with the continued involvement of a wide range of partners and voices, including primary care, local authorities and people with lived experience. We want to provide care as close to home as feasibly possible and focus significantly on improving population health and reducing health inequalities.

This is an exciting opportunity to really make things better for our patients and our staff, while also making our services stronger and more resilient.

With shared leadership, we will co-design our clinical strategy and integrate our services. We will make greater use of technology, enabling us to deliver care differently. Healthcare needs have changed, and so we must continue to change and evolve in providing the best care possible to meet people's needs.

Subject to all necessary approvals, we plan to eventually become a single organisation. This will help us to create the environment, leadership and governance for high-quality clinical and corporate services to thrive.

Our organisations have much in common, and we are looking forward to a bright future for our healthcare services in Warrington and Halton, and those we provide further afield.

The benefits

Benefits for patients

By working together as one, we will improve patient outcomes and service delivery. We will see shorter waiting times, with a more streamlined patient journey through the joining up of services. Importantly, patients will have a better experience when accessing community and hospital healthcare services.

We will bring together the best of both organisations, resulting in the increased use of digital solutions wherever appropriate to enable the right care to be provided in the right place.

Services will be delivered as close to home as feasibly possible and only centralised when necessary. Where services are complex, specialised or small volume, they will be stronger and more resilient as a result of consolidation, making the services more sustainable for future patients who may need them.

In all that we do, we will work to reduce health inequalities and improve access to services, and we are committed to co-producing changes to clinical services wherever possible.

Benefits for staff

We understand that our staff want to deliver the highest standard of compassionate care. Therefore, any enhancements in patient and service user care will also improve the work environment, making it more fulfilling and meaningful for our teams.

Through integration, we will open up better opportunities for career development. By providing shared training and educational resources, we aim to support, develop, and retain our workforce. This will create new roles for those looking to advance their careers, take on new challenges, or transition into different positions within our organisation.

These changes will help us fill gaps by sharing resources and becoming more appealing to new talent. This includes not only patient-facing roles but also support teams such as safeguarding, digital design, medical engineering, recruitment, and patient experience.

These enhancements will ensure our staff have access to the support and services they need to deliver the best possible care.

Financial benefits

We will make significant financial savings, first by working together as one, before eventually becoming a single organisation, subject to all necessary approvals. We will leverage economies of scale, benefitting from the efficiencies of being a larger organisation. This includes, for example, the reduced cost of borrowing through internal cash support and increased buying power when procuring goods and services together.

We will continue our work to reduce spend on agency staffing, and we will think differently about our vacant posts. We may also see a reduction in premium rates through the use of integrated teams, particularly in support of our fragile services.

By bringing together our corporate functions, we will be able to improve the quality of our services at a reduced cost. This may also enable us to cease contracts for externally provided services where it can be delivered at a minimal cost by one of our respective organisations.

Overview of our organisations

BCH

Bridgewater Community Healthcare NHS Foundation Trust

1,550 staff

£97m annual turnover

66 community sites in Warrington, Halton, Cheshire, Merseyside and Greater Manchester

Community adult and children's nursing and therapy services in Halton, Warrington and St Helens. Community dental services across Cheshire, Merseyside and Greater Manchester

WHH

Warrington and Halton Teaching Hospitals NHS Foundation Trust

5,000 staff

£347m annual turnover

2 acute hospitals and more than 30 community sites in Warrington and Halton

Full range of acute general hospital services, across unplanned care, planned care and clinical support services, predominantly covering Warrington and Halton

Warrington and Halton Teaching Hospitals NHS Foundation Trust

MISSION

We will be outstanding for our patients, our communities and each other

VISION

We will be a great place to receive healthcare, work and learn

VALUES

Working Together

Listening and understanding to be able to work well with others

Excellence

Being the best that we can be, with patients and families at the heart of all we do

Inclusive

Supporting and valuing everyone to be their true and authentic selves

Kind

Acting consistently with compassion, empathy, civility and respect

Embracing Change

Reflecting, learning and improving, seeking feedback and new ideas

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

Bridgewater Community Healthcare NHS Foundation Trust

MISSION

We will improve health, health equity, wellbeing and prosperity across local communities by providing person centred care in collaboration with our partners

VISION

We will create stronger, healthier, happier communities

VALUES

P — Person Centred

We are passionate about individual needs and promote independence in the healthcare that we provide

E — Empowered

We empower our people and encourage new ideas to deliver and create improvements in community care

O — Open & Honest

We behave in a way that develops relationships based on trust, openness, honesty and respect

P — Professional

We support our people, so everyone has the right skills and training to deliver outstanding patient care

L — Local

We are always learning about our communities and show great pride in being a local provider of health and care

E — Efficient

We use our resources wisely to provide sustainable and value for money healthcare for our patients

AIMS

COMMUNITY

Improve the health and wellbeing of local people and communities

PEOPLE

Improve the health and wellbeing of our staff

QUALITY

Improve the quality of services provided

SUSTAINABILITY

Improve the sustainable and efficient use of resources

The wider context

National context

- The NHS Long Term Plan recognises that as medicine advances, health needs change, and society develops, the NHS must continually move forward so that in 10 years' time we have services that are fit for the future.

- The current delivery model of health and care services is unsustainable in the medium-term, with overall healthcare demand and complexity of demand increasing, almost universally.

- The NHS White Paper 2021, Integration and Innovation: working together to improve health and social care for all, builds on the NHS Long Term Plan and is focused on the recovery from the COVID-19 pandemic by removing unnecessary bureaucracy, empowering local leaders and services and tackling health inequalities.

- NHS England's Priorities and operational planning guidance 2024/25 focuses on the recovery of services through continuous improvement in access, quality, and productivity, whilst transforming the way we deliver care and creating stronger foundations for delivery in the future.

Regional context

- The needs of the local population are changing, and services need to be more responsive to long-term conditions as well as the necessary acute interventions.

- The population is ageing and growing, inevitably adding pressure to local hospitals, emergency care, and community services.

- Recruiting and retaining staff is challenging in a competitive market. Being able to find and keep the best staff will be supported by better patient flows and more flexible ways of working.

- We must maintain high quality care and levels of performance. Integrated working will enable this as our environment becomes ever more challenging.

The opportunities

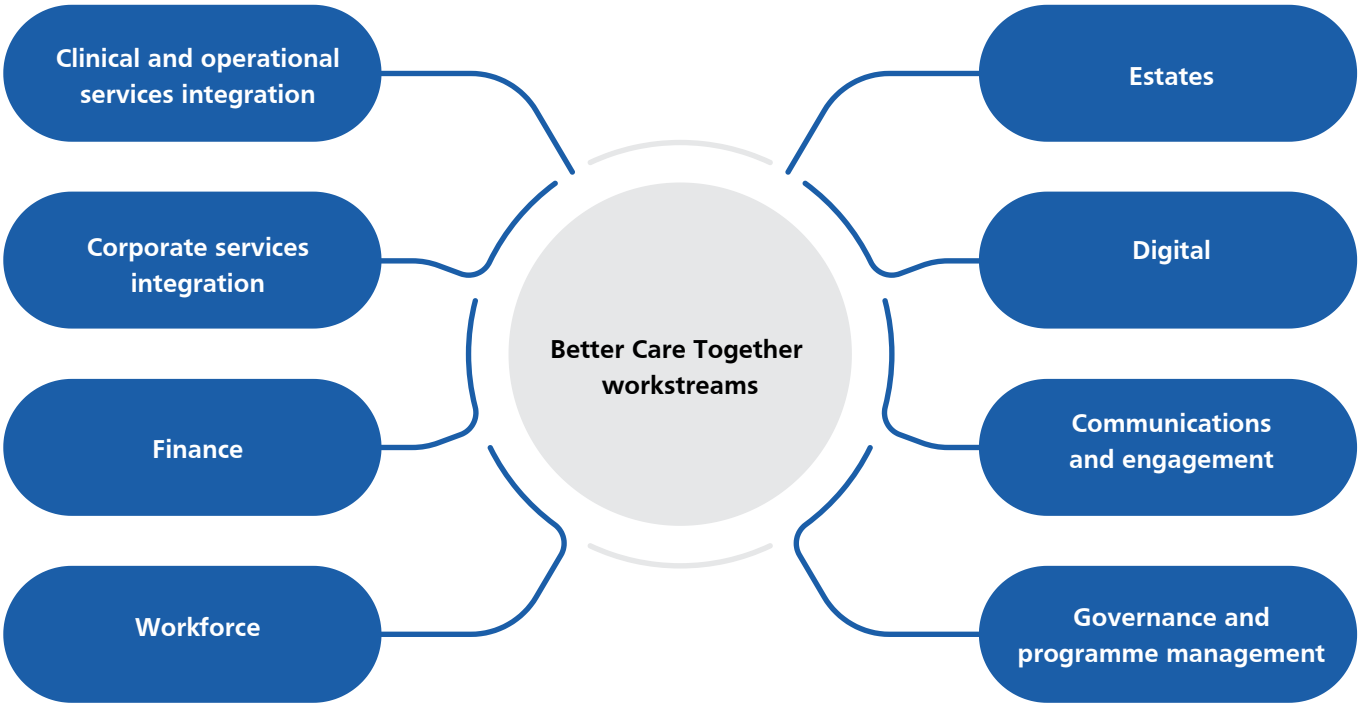
By working together as a single organisation, we believe there are vast opportunities to be gained, including:

- improved clinical sustainability
- clinical service reconfiguration - delivering optimal patient pathways and staff flow, including seamless transfer between local acute and community services
- workforce optimisation and development - doing all we can to retain staff and thinking differently about the vacancies we have, with new joint approaches to recruitment, secondments, and ways of working across clinical and support services
- economies of scale - larger shared services can leverage their scale during procurement and eradicate areas of duplication
- estates optimisation - joint estates utilisation across acute and community services
- improved digital services and integration - yielding best practice from both organisations and eradicating duplication

Progress made and next steps

Our executive teams and Trust Boards have been working together to carefully develop this proposal. A memorandum of understanding has been developed and signed by the chief executives of each organisation.

A programme has been set up, called Better Care Together, which has seen the creation of eight workstreams, listed below. Each workstream has a named responsible officer from each organisation, and all have developed initial priorities for the coming 6, 12 and 24 months.



Governance arrangements have been established, including joint exec-to-exec meetings, joint Board meetings, and the creation of a steering group made up of senior representatives from both Trusts as well as system partner organisations.

Initial communications have taken place internally and externally, with further routine communications and engagement activity being planned to ensure all parties feel informed and involved.

Over the coming months, we will be working to finalise governance arrangements, introduce a shared executive team, and align our infrastructures. Together, we will develop new and improved ways of working, starting first with services identified as an urgent priority. Subject to all necessary approvals, we hope to become a single organisation as soon as possible.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/105**	
SUBJECT:	**Strategy Programme Highlight Report**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Megan Wainwright, Strategy Project and Team support officer	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*

Key messages:

- The Living Well Hub in Warrington has seen over 4,500 visitors attend since the doors opened in mid-March 2024. Around 60% of these attendances have been people “dropping in” to the hub to access a service, and the remainder have been for pre-booked appointments.
- Almost 53,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC)

	spaces since the first phase of the development opened in the Nightingale building in May 2023. • A new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is due to be implemented this autumn. Clinical posts are currently being advertised and the project team are engaging with primary and secondary care colleagues to develop the clinical pathway. • Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. Workstream teams are developing work plans to take forward aspects of the programme and stakeholder communication is ongoing. • The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to FSC and the ICB regularly. Corridor care has reduced from an average of 10 hours to 4.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note this report for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Executive Team	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Strategy Update
July-August 2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Section 1 - Key Messages	
Slide 2	Summary of key developments this reporting period

Section 2 - Stakeholder Engagement	
Slide 3-4	Summary of key stakeholders engaged during the reporting period

Section 3 - Key Strategic Projects

Page	Project	Strategy Lead	Status
Slide 5-6	Living Well Hub in Warrington	Stephen Bennett/Caroline Lane	
Slide 7-8	Runcorn Town Deal	Carl Mackie/Viviane Risk	
Slide 9-10	Community Diagnostic Centre	Stephen Bennett/Lefteris Zabatis	
Slide 11-12	New Hospitals Programme and strategic estates	Carl Mackie/Viviane Risk	

Section 4 - Other Trust Strategic Updates	
Slide 13-15	Summary of other Trust strategy related updates

Section 5 - Place-based Strategic Updates	
Slide 16	Summary of strategic updates from local places (Warrington and Halton)

Section 6 - Cheshire and Merseyside Strategic Updates	
Slide 17	Summary of strategic updates from Cheshire and Merseyside

Key Messages

- The Living Well Hub in Warrington has seen over 4,500 visitors attend since the doors opened in mid-March 2024. Around 60% of these attendances have been people “dropping in” to the hub to access a service, and the remainder have been for pre-booked appointments.

- Almost 53,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023.

- A new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is due to be implemented this autumn. Clinical posts are currently being advertised and the project team are engaging with primary and secondary care colleagues to develop the clinical pathway.

- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. Workstream teams are developing work plans to take forward aspects of the programme and stakeholder communication is ongoing.

- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to FSC and the ICB regularly. Corridor care has reduced from an average of 10 hours to 4.

Stakeholder and engagement overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Asia Bibi	Associate Chief Operating Officer, Alder Hey	Paediatric surgical hub development
Cathy Morgan	Director of Secondary Prevention, Dept of Health and Social Care	Living Well Hub and the wider Living Well programme
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates
Naz Ghodrati	CEO, Warrington Voluntary Action	Living Well programme in Warrington and Virtual Hub
Ian Triplow	CDC Programme Director, Cheshire & Merseyside	Community Diagnostic Centre
Paula Worthington	Director of Education and SEND, Warrington Borough Council	Living Well programme and Virtual Hub
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme and Virtual Hub
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities and prevention programme in Halton
Gill O'Hare	Service Development Manager, Adult Social Care, Warrington Borough Council	Development of Community Networks across Warrington and links to Living Well programme
Rob Cooper	Managing Director, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Dr Sangeetha Steevart	General Practitioner, Clinical Director, Warrington Place	Living Well Hub and women's health
Steve Cullen	CEO, Warrington Citizen's Advice Bureau	VCFSE connections as part of Living Well programme
Wesley Rourke	Executive Director Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Tracey Cole	Diagnostic Programme Director C&M	CDC, pathology collaboration
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M clinical strategy
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy
Linda Buckley	Managing Director, CMAST Provider Collaboration	CMAST

Stakeholder and engagement overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Mike Amesbury	MP	New hospitals and strategic developments
Sarah Hall	MP	New hospitals and strategic developments
Rob Cooper	COO, Mersey and West Lancs NHS Hospitals Trust	Pathology collaboration
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
Nick Armstrong	Estates, Cheshire and Merseyside ICB	Strategic estates planning, Warrington
Paul Mullane	Director of Development and Sales, Halton Housing	Estates Planning, Runcorn Town Deal
Ian Lewis	Operations Manager, Northwest Region, Get Set for Skills, DWP	Runcorn employment project, Halton Health Hub
Leigh Thompson	Director of Strategic Partnerships, Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan
Carla McSherry	Health Engagement Officer, Halton Borough Council	Runcorn Health and Education Hub
Mike Horsley	Senior Delivery Officer, Halton Borough Council	Runcorn Health and Education Hub
Helen Goodwin	Interim Head of Support Services, Halton Borough Council	Runcorn Health and Education Hub
Adam McClure	Senior Programme Manager, Cheshire and Merseyside Diagnostic Programme	Pathology Collaboration
Neil Haslam	Clinical Lead, Cheshire and Merseyside Endoscopy Network	Intelligent Liver Function Testing
Luke Byrne	Assistant Divisional Director of Nursing: Sexual Health & HIV, Axess Sexual Health, LUFHT	Runcorn Health and Education Hub
Palak Malik	Marketing Executive, NHS Property Services	Promotional video for Living Well Hub
Sam Scott	CEO, Halton Housing	Strategic priorities and opportunities, wider determinents

Living well hub in Warrington- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH has led a major project to develop a system-wide Health and Wellbeing Hub in Warrington Town Centre. The project forms part of the Town Deal programme, which covers 7 different infrastructure projects across Warrington, funded as part of the Government's levelling up agenda. The Health & Wellbeing Hub (known as the Living Well hub) is designed to target and address health inequalities in Warrington by providing a range of services focussed on prevention and early intervention in a town centre location with proximity to the areas of the town with the highest levels of deprivation. The Hub is a space where providers from across mental and physical health, social care and the third sector can come together to deliver integrated services, support and learn from one another for the collective benefit of the local population.

What does this mean for WHH?

Delivery of WHH services, including midwifery, cardiac rehabilitation, phlebotomy and physiotherapy from a convenient and accessible town centre location. Working alongside key partners including Bridgewater, Mersey Care, Warrington Borough Council and the Voluntary, Charity and Social Enterprise organisations to support the prevention agenda.

Progress since last report

- Total attendances at the Hub have now topped 4,500 since the doors opened in March 2024 with a stepped increase seen in August.
- 60:40 split in terms of drop-in attendances to booked appointments.
- A receptionist has been recruited and commenced in position on the 5th July, increasing staffing resilience and allowing senior staff to take a more strategic role.
- The remedial work to replace the flooring in the hub will take place out of hours on 28/29 Sept and 5/6 Oct.
- Unfortunately, the 2 entries submitted to the national HSJ awards about the project were unsuccessful.
- Discussions with NHS Property Services about working with them to develop some professional promotional materials to use for marketing and raising awareness of the Hub services.

Living well hub in Warrington- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Implementation of ongoing project governance arrangements	September 2024

Contact details

Caroline Lane - Strategic Project Manager
caroline.lane10@nhs.net

Runcorn town deal-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long-term conditions from a central location in Runcorn.

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

What does this mean for WHH?

- Delivery of WHH services, including maternity, respiratory, and phlebotomy, from a convenient and accessible town centre location.
- Opportunity to work with local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies.
- Opportunities to further integrate services with other providers across health, care and wellbeing.

Progress since last report

- Tender documents currently being drafted with an aim to begin the formal procurement process later in September.
- Continued technical engagement with all elements of the deigns to ensure a robust, flexible and clinically appropriate environment for partners to deliver services from is created.
- Further development of the Heads of Terms for the lease agreement for the location, the current library building on Granville Street, Runcorn.
- Continued engagement with all partners on development of the collaboration agreement which formally sets out roles and responsibilities of all parties when operating the hub.

Runcorn town deal- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people** ✓	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
RIBA Stage 4 designs approved	September 24
Procurement process for lead contractor commencement	September 24
Lead contractor procured	December 24

Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net
Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

Community diagnostic centre-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.
- The final approved CDC Programme covers three phases:
    - Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton.
    - Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City.
    - Phase 3 will see the development of a new build extension to the CSTM building on the Halton site to accommodate additional CT and MRI services.

What does this mean for WHH?

- Additional capacity to undertake diagnostic testing for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.
- New estate at Halton General Hospital and at the Halton Health Hub in Runcorn Shopping City, which supports new hospitals plans and the estates strategy.

Progress since last report

- Over 51,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023.
- Foundation & Groundworks phase complete
- Structural steel and roof completed
- Completion of the project is planned for March 2025.
- Commencement of clinical activity in phase 3 is planned for end of March 2025.
- Funding has been secured to implement a new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City).

Community diagnostic centre- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	Looking after our people	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	Working responsibly
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Completion of foundation, groundworks and structure completed	Sep 2024
Services within new build CDC (phase 3) to commence	Apr 25

Contact details

Lefteris Zabatis - Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New hospitals and strategic estates planning- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending Captain Sir Tom Moore to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

What does this mean for WHH?

- Delivery of Trust services from modern, accessible and safe environments.
- Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations.

Progress since last report

- Meetings with local MPs, including Mike Amesbury and Sarah Hall to discuss the recent estates developments and the progress of the new hospital plans in both Warrington and Halton
- Specification drafted for the next phase of work for the advancement of our plans for a new hospital for Warrington, a development control plan which would describe the steps required to redevelop our current site across a number of years to create a new hospital

New hospitals and strategic estates planning- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Commissioning of updated new hospital plan including phased opportunities for investment	October 24

Contact details

Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Other Trust strategic updates

Daycase Unit & Theatre 5 at CSTM, Halton

- Construction works complete
- All areas handed over to operational teams

C&M Endoscopy Hub at Nightingale Building, Halton

- Phase 1 Endoscopy Hub construction works complete
- Official opening took place on Friday 6th September 2024
- First patient seen in Endoscopy Hub on Monday 9th September 2024
- Phase 2 decontamination unit handover planned Monday 23rd September 2024

Theatre 3 at Nightingale Building, Halton

- Theatre teams vacated department and construction works start on Monday 23rd September 2024
- Isolations taking place across department in preparation for construction works

Upgrade to Ward B2 at Nightingale Building, Halton

- WHH Project Team working with Estates colleagues to appoint construction company

Other Trust strategic updates

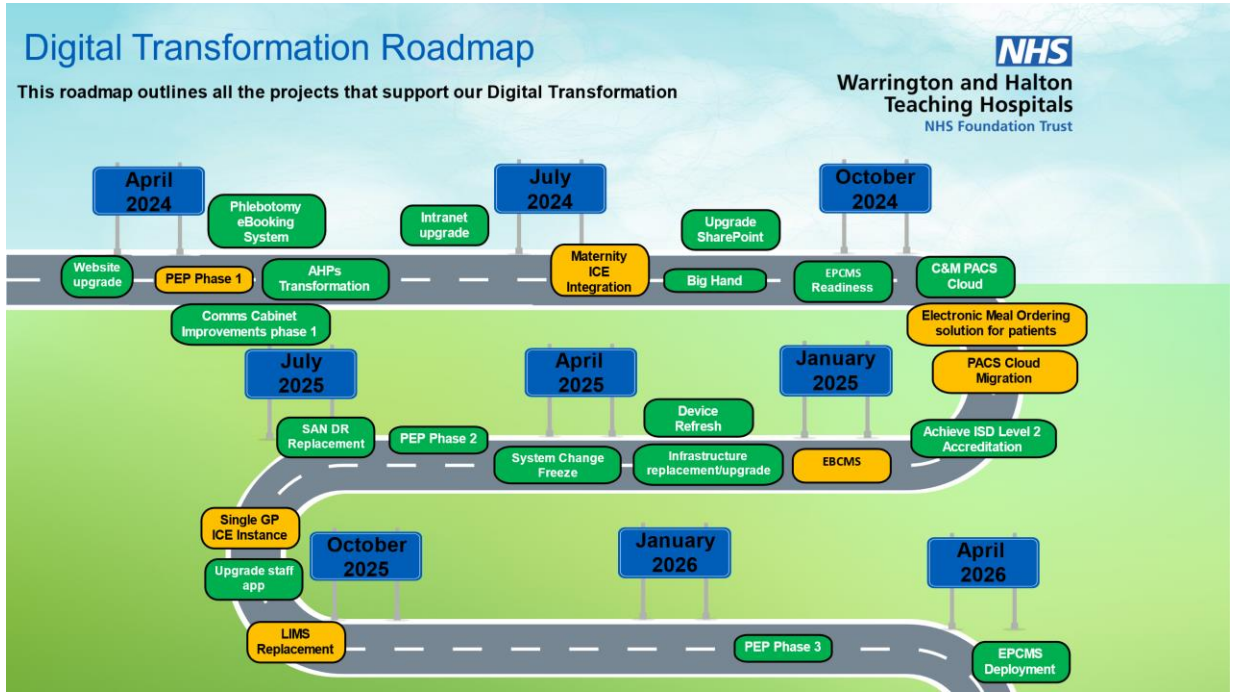
Digital Projects

Electronic Patient Care Management System (EPCMS)

- Following Trust Board approval of the EPCMS procurement outcome in June, ICB endorsement was confirmed on 27th July 2024
- The 6-week delay led to queries from the vendors and has impacted on programme timescales. Following notification of the preferred supplier, a challenge was raised by one of the unsuccessful bidders
- Procurement abandoned
- Lessons learnt review is being planned
- Options and timeline for re-procurement are being identified and assessed
- EPCMS Readiness workstream will continue at pace

Patient Engagement Portal (PEP)

- In August 176,156 notifications have been sent via the PEP.
- 56.5% of patients received notifications by SMS.
- 53% of WHH patients are registered with the NHS app.
- £658.59 approx. savings from the reduction in SMS messages being sent.
- 11.24% reduction seen in DNAs at WHH since notification go live.
- Ongoing preparations and communication with DrDoctor for a showcasing event to be held. This will include demonstrations of the video consultation functionality the PEP can offer a long with, 2-way messaging and more scheduled for the 4th of October.
- A request to pause PEP CRIS integration until January 2025 has been submitted due to workload pressures from PACS migration in Radiology - resources required for preparations for PACS go live 2nd December 2024.



Place based strategic updates

Urgent and Emergency Care System Improvement

- The Urgent and Emergency System Improvement Programme continues and all workstreams are making progress. We continue to report regularly to FSC and the ICB.

Warrington and Halton Integration

- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital NHS Trust to make best use of our resources and improve care for our patients.
- Workstream teams are developing detailed plans to support delivery of their objectives.
- Regular joint executive and Board to Board meetings are being held and both organisations will share a single Chief Executive Officer from the 1st of November.

Warrington

- Work is progressing to launch a new strategic project for Warrington that will see the development and implementation of a new digital health and wellbeing hub. The “virtual hub” will create a single point of access and/or information for residents to find out about services on offer in the borough to support health and wellbeing. The initial version of the software is planned to be live to the public before the end of the financial year.

Halton

- Delivery plans for each specialist area of the Wider Determinants of Health group are being developed and priority areas for focus have been identified. Priority areas include, employment, workforce and education, violent crime reduction, economic regenerations and living conditions and each has established a subgroup to take this work forward.

Cheshire and Merseyside strategic updates

Laboratory Information Management System (LIMS)

- The Full Business Case for a unified LIMS across 5 healthcare organisations was approved by the Trust Board in June 2024. The contract has been awarded to the preferred supplier and implementation is planned to begin in 2027.

Pathology collaboration

- The pathology hub delivery group (East) has been established and a potential Target Operating Model described. An Outline Business Case has been developed and will be considered by WHH Trust Board in November. Work continues within the workstreams to plan for implementation.

Paediatric surgery

- The pilot of Alder Hey @ Warrington continues with paediatric theatre lists being delivered by Alder Hey surgeons in Warrington. Further collaboration with Alder Hey is being discussed and a joint project team is being established in the autumn.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/106**	
SUBJECT:	**EPRR Core Assurance 2024-2025**	
DATE OF MEETING:	2 October 2024	
AUTHOR(S):	Rachel Clint, Head of EPRR, Daniel Moore, Acting Chief Executive Officer	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Acting Chief Executive Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **#1757** If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services. **#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	

	#1898 If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions. **#125** If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	This report will:- • Provide an overview of the Emergency preparedness, resilience and response (EPRR) annual assurance process for 2024-25 • Provide an overview of Warrington and Halton Teaching Hospital's compliance with the EPRR Core Standards • Provide an overview of the deep dive into Cyber Security

	• Outline a workplan to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to support and note the EPRR annual Core Assurance Submission		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/24/09/131	
	Date of meeting	Monday 23rd September	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	EPRR Core Assurance	AGENDA REF:	BM/24/01/105

1. BACKGROUND/CONTEXT

The 2024/25 EPRR NHS England core assurance process was shared on 15th July 2024. The process remained largely unchanged from last years. (Appendix 1)

All NHS funded organisations undertake a self-assessment against the relevant NHS core Standards for EPRR. The core standards cover 10 domains:
1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

Organisations, including acute trusts are asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each.
The compliance level for each standard is defined as:

- Fully compliant: fully compliant with the core standard.
- Partially compliant: not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
- Non-compliant: not compliant with the core standard. Compliance will not be reached within the next 12 months

All NHS funded organisations generate an overall EPRR assurance rating using the following:

- Fully: the organisation is fully compliant against 100% of the relevant NHS EPRR core standards
- Substantial: the organisation is fully compliant against 89-99% of the relevant NHS EPRR core standards
- Partial: the organisation is fully compliant against 77-88% of the relevant NHS EPRR core standards
- Non-compliant: the organisation is fully compliant up to 76% of the relevant NHS EPRR core standards

The outcome is expected to then be presented and discussed at a public board meeting prior to submission and published in the annual report within the Trust's own regulatory reporting requirements.

2024/25 deep dive
Each year, alongside the annual assurance process, a 'deep dive' is conducted to gain valuable additional insight into a specific area. Following recent incidents and common health risks raised as part of last year's annual assurance process, the 2024/25 EPRR annual deep dive will focus on responses to cyber security and IT related incidents. Compliance ratings against individual deep dive questions do not contribute to the overall organisational EPRR assurance rating.

2. KEY ELEMENTS

2023/24 Cycle of Core Assurance
In May 2023, a new process was announced introducing more robust governance and rigour around the assessment process. After submitting **92% substantial compliance** in September 2023, a **5% non-compliant** rating was returned, with the identification of multiple focus areas. The experience of WHH was common across other Cheshire and Merseyside providers

2024/25 Cycle of Core Assurance
Since returning from maternity leave at the end of January 2024, the Head of EPRR has been working on a plan to restore the Trust's substantial compliance, and work towards full compliance. This has involved a complete refresh of the EPRR portfolio, adapting to the feedback from the 2023/24 outcomes (Trust and ICB level) and developing plans in relation to changes in guidance, in personnel, and in the delivery of EPRR. A significant number of new policies and plans have been established, with many of these being tested through the events of the past 8 months.

As a result of the reset of the EPRR workstream, the Head of EPRR has self-assessed the current compliance status as **73% (full compliance with 45 standards)**. This rating leaves the Trust with a **non-compliant** rating, as 77% of standards need to be assessed as fully compliant to receive a partially compliant rating. There is an action plan in place to address the standards deemed to be partially compliant, there are **17 out of 62 in total that require more attention**.

All 11 areas of the deep dive into Cyber Security have been assessed as fully compliant. This however does not change the overall compliance rating as the deep dive has no bearing on the overall outcome.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	5	5	0
Hazmat/CBRN	12	2	10	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	45	17	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	11	0	0
Total	11	11	0	0

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Action Plan

The 17 Partially Compliant EPRR Core standards in 2024/25 are:

15 Duty to maintain plans – Evacuation and Shelter

In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff, and visitors.

A national update to the Evacuation and Shelter Plan is due. The last time this plan was tested at WHH was in November 2021. The plan has been reviewed in August 2024, noting changes to fire and escape routes as the Trusts footprint continues to change. A further revision and test of this plan will take place once updated national guidance has been received, updated and embedded into the local plan.

16 Duty to Maintain Plans – Mass Casualty
Following a review of the Trust Major Incident Plan, the Head of EPRR will now focus on updating the Mass Casualty Plan, with local and regional exercises due in Q3 this year. Planning will involve looking at the following:

- Trust's ability to receive casualties quickly via releasing ambulance crews promptly and creating capacity within your ED
- Check the capability of trusts to release 10% of their acute bed base to provide capacity to for admissions within 6 hours
- Check the capability of trusts to release 20% of their acute bed base to provide capacity to for admissions within 12 hours
- Check trusts capability to double their Level 3 ICU Capacity for at least 96 hours
- Provide assurance that trusts will be able to manage the operational impacts of such an incident

Collaboration with Unplanned Care and system partners will enable a successful refresh of the Trust's mass casualty plan.

Business Continuity

46 Business Impact Analysis/ Assessment (BIA)
The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es)

The BIA process has been refreshed. It is expected all care groups and services will conduct BIAs when refreshing their business continuity plans. Business Continuity Workshops will support training needs. This will be monitored through the Event Planning Group.

48 Testing and exercising
The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.

An internal audit of service level business continuity plans is in place and departments will be expected to exercise their plans, sharing reports through the Event Planning Group.

50 BCMS monitoring and evaluation
The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.

An internal audit of service level business continuity plans is in place and departments will be expected to update their plans and share in a central location on Sharepoint. In 2025, MIAA will be approached regarding the external auditing of plans.

51 BC Audit
The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.

An internal audit of service level business continuity plans is in place and departments will be expected to update their plans and share in a central location on Sharepoint. In 2025, MIAA will be approached regarding the external auditing of plans.

52 BCMS continuous improvement process
There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.

The review of all Business Continuity Plans will continue 2024/25, with workshops to support training needs.

Hazmat / CBRN

55 Governance
The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance which should be clearly documented

A draft CBRN plan has been completed. A monthly CBRN subgroup has been established to clarify roles and responsibilities.

56 Hazmat / CBRN risk assessments
Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type

A draft CBRN plan has been completed. A monthly CBRN subgroup has been established to review the risk assessment.

58 Hazmat/ CBRN planning arrangements
The organisation has up to date specific Hazmat/CBRN plans, and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders

A draft CBRN plan has been completed. A monthly CBRN subgroup has been established to review the plan and training and exercising requirements.

60 Equipment and supplies
The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients

The trust holds appropriate kit and equipment, as part of the review of the plan audits and maintenance plans require confirmation. A nominated lead from UEC will be required to manage this.

61 Equipment - Preventative Programme of Maintenance

There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks

A nominated team from UEC will be established to support this with consistency. This will be managed via the CBRN subgroup.

62 Waste disposal arrangements
The organisation has clearly defined waste management processes within their Hazmat/CBRN plans

Processes are defined in the draft CBRN plan. Training to be deployed via the CBRN subgroup.

63 Hazmat/ CBRN training resource
The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments

The trust has a number of trained CBRN and Decontamination leads. These are able trained as 'train the trainer' so can share their learning with the department. A training plan will be established through the CBRN subgroup.

64 Staff training - recognition and decontamination
The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented

The trust has a number of trained CBRN and Decontamination leads. These are able trained as 'train the trainer' so can share their learning with the department. A training plan will be established through the CBRN subgroup.

65 PPE Access
Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7

Training programme to be rolled out to wider personnel to ensure resilience in UEC.

66 Exercising
Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme

Training and exercise plan to be agreed through the CBRN subgroup.

Summary
The two key areas for priority focus are in the domains of CBRN / Hazmat and Business Continuity. With targeted interventions and the establishment of sub-working groups, it is felt the gaps in the 2024/25 cycle will be addressed within the next 6 months. All compliant plans will also be refreshed as part of the work programme for EPRR. Compared to other Trusts in Cheshire and Merseyside and beyond, WHHFT is under-resourced with only one dedicated lead. This will be reviewed as integration and partnership plans continue to be looked at.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The EPRR workplan for 2024-2025 shows a timeline for training and reviews in order to support the progress towards full compliance across all EPRR Core standards.

The workplan is attached as Appendix 2.

The workplan is monitored through the Event Planning Group who meet monthly, and updates are shared with the group as per the workplan.
Lead Officers

- Dan Moore- Acting Chief Executive Officer is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust – the Accountable Emergency Officer.
- The Accountable Officer is currently supported by Rachel Clint, Head of EPRR.

4. IMPACT ON QPS?

As identified in the outcomes of the assurance process.

5. MEASUREMENTS/EVALUATIONS

The NHS Core Assurance Process is attached and outlined in Appendix 3.

6. TRAJECTORIES/OBJECTIVES AGREED

To move towards achieving at least substantial compliance across all NHS EPRR Core Standards. To embed the refreshed policies and plans into Trust activity.

7. MONITORING/REPORTING ROUTES

EPRR updates continue through the Event Planning Group and the Finance and Sustainability Committee. Any significant incidents or events are also reported through the Strategic Executive Oversight Group. The Event Planning Group will be rebranded in the winter of 2024/5.

Future EPRR assurance

NHS England are currently reviewing the EPRR assurance process to ensure that it continues to develop and support continual improvement. The NHS core standards for EPRR will continue to be reviewed and updated every 3 years, this is due in 2025. Each new updated set of standards will be published no less than 12 months ahead of them being used for assurance purposes, it is therefore expected that the next set of standards will be received in the coming months.

The reviewed process will see changes from 2025/26 which will include:

- Ensuring ICBs are empowered and supported to take the lead with regards to local delivery of the EPRR agenda (in line with the NHS England operating framework, seeking further opportunities to embed new ways of working in all our activities) - this includes ICBs being responsible for gaining the NHS EPRR assurance compliance rating from their providers of NHS funded care, under the terms of the NHS Standard Contract
- NHS England developing its relationship with related regulatory bodies to share and secure a common understanding regarding assurance outcomes, ensuring that compliance is achieved through a single mechanism - these organisations include the Care Quality Commission and the Health and Safety Executive
- Identifying any unconditional compliance requirements of the NHS core standards for EPRR
- NHS England annually self-assessing its EPRR compliance as a single organisation, including all relevant departments and regions
- Evaluating options for a digital solution to facilitate delivery of the overall assurance process

8. TIMELINES

This report is presented annually to the Board. The EPRR workplan details the monthly priorities identified by the EPRR Manager along with Local Health and Resilience Partners.

It is anticipated that the Cheshire and Merseyside ICB will feedback on WHH compliance by 31st October 2024, prior to reporting to NHS England North West and subsequently the national team by 31st December 2024. Further updates to the compliance rating will be reported through the Event Planning Group and Finance and Sustainability Committee. There will be an additional update to Board following the outcomes of this year's process.

9. ASSURANCE COMMITTEE

Event Planning Group, held monthly.

10. RECOMMENDATIONS

The Board are asked to note the EPRR Annual Assurance self-assessment rating as non-compliant, however recognise a significant amount of work has been put in to support progress towards partial compliance. It is important to note that where there have been partially compliant ratings, the Trust does have some resilience and work continues to fulfil the requirements inline with legislation and guidance.
The Board is asked to support the workplan in moving towards full compliance with all 62 standards**.**

Appendix 1 - Letter re EPRR annual assurance process 2024-25_July 2024

PRN01335_Letter re EPRR annual assuranc

Appendix 2 – Workplan

EPRR Workplan 24_25.xlsx

Appendix 3 – Core Assurance table and statement of compliance

nhs-core-standards-for-eprr-2024-templat

150 Statement of Compliance 2024.pdf

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-2025

STATEMENT OF COMPLIANCE

Warrington and Halton Teaching Hospitals has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Warrington and Halton Teaching Hospitals will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

DANIEL MOORE

Signed by the organisation's Accountable Emergency Officer

25/4/25

Date signed

04/10/2024	04/10/2024	30/04/2025
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

EPRR Update October 2024

Zoe Harris, Acting Chief Operating Officer

EPRR Update September 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Core Standards

- WHH is on track to self-assess 45/62 Core Standards as fully compliant, and 17/62 standards as partially compliant. The Cyber Security Deep Dive will be submitted as fully compliant.
- This gives an overall predicted compliance score of **73%**, and a predicted rating of **non-compliant** (see Figure 1)
- An action plan is in place to support working towards full compliance with the partially compliant standards (Mass Casualty, Evacuation and Shelter Plan, CBRNE and Hazmat Plan and Business Continuity)
- Discussion with C&M acute providers suggest they will submit their self-assessments largely between 50-70%, with only two suggesting they will self-assess as partially compliant >77% (one trust in particular achieved approximately 40% assessment last year compared to WHH 5%)

Timescale

- Submission to ICB/ NHS England by 27th September 2024, October – ICB review and feedback by 31st October 2024 and the outcomes will then be submitted to NHS England by 31st December 2024

Figure 1

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
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Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Next steps

- Nationally, the Core Assurance framework will be reviewed prior to the next cycle (3-year cycle)
- Working towards at least substantial compliance for 2025-2026 cycle (89-99%) or full compliance 100%
- Requirements to achieve trajectories – more stakeholder involvement in areas with gaps, working groups set up and nominated leads to support, interdependencies with system plans and national guidance
- Continue to engage with Bridgewater through the lens of what integration means for the EPRR workstream
- Risks – resource is an ongoing challenge faced similarly across C&M providers, WHH is one of two C&M providers with one EPRR officer
- Further detail will be submitted to the Trust Board in October

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/10/107**			
SUBJECT:	**Committee Terms of Reference and Cycles of Business**			
DATE OF MEETING:	10 October 2024			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The proposed amended Terms of Reference and Cycle of Business for the: I. Nominations and Remuneration Committee II. Finance & Sustainability Committee Are attached for consideration and approval. Key updates include amendments to:			

<table>
<tr><td></td><td colspan="3">i. Nominations and Remuneration Committee Updates to sections:
1. Purpose
5 Attendance
7 Reporting
8 Duties and Responsibilities (nominations)
ii. Finance & Sustainability Committee - Amendments to section 4 – Membership - Addition of the Director of Communications and Engagement as a core member of the committee.

Each has been reviewed and agreed by the respective Committees and are presented to the Trust Board for ratification.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to review and approve the Committee Terms of Reference and Cycles of Business</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Finance & Sustainability Committee, Nomination and Remuneration Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">FSC/24/08/88.
NARC/24/08/11</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">28.08.24
07.08.24</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Supported</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

DRAFT TERMS OF REFERENCE

BOARD NOMINATION AND REMUNERATION COMMITTEE (NARC)

1. PURPOSE

The purpose of the Board Nomination and Remuneration Committee (the "committee") is constituted as a standing committee of the Trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors' meetings.

The committee shall be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

When appointing the Chief Executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

2. FREQUENCY OF MEETINGS

The Committee shall meet at least once a year and then as the need arises.

3. QUORUM

Quorum shall be the Chair or Deputy Chair, and at least two other Non-Executive Directors.

4. MEMBERSHIP

The membership of the committee shall consist of:

- Trust Chair
- All Non-Executive Directors of the Trust Board of Directors

5. ATTENDANCE

Only members of the Board Nomination & Remuneration Committee have the right to attend the meetings, however the following individuals will normally be in attendance:

- Chief Executive or failing him/her the Deputy Chief Executive (except for matters relating to themself)
- Chief People Officer
- Company Secretary

Other persons may be invited by the Committee to attend a meeting at the discretion of the Chair.

Any member or non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

6. AUTHORITY

The committee is authorised by the board of directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the nominations and remuneration committee.

The committee is authorised by the board of directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

7. REPORTING

The committee Chair shall report to the Trust Board of Directors on all proceedings undertaken within its duties and responsibilities.

The committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

The Committee Chair (on behalf of the Nomination & Remuneration Committee) shall make a statement in the annual report about its activities and the process used to decide remuneration.

The Committee shall make information available regarding the attendance of all members at Committee meetings.

8. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following areas:

NOMINATIONS

- Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.
- Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
- Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

- Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.
- Determine whether the nominated candidate for the role of Chief Executive or an Executive Director should be appointed.
- Consider any matter relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.
- Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

REMUNERATION

- To decide and review the terms and conditions of office of the Trust's Executive Directors (and Senior Managers on locally-determined pay) in accordance with all relevant Trust Policies, including:
  - Salary, including any performance-related pay or bonus
  - Provisions for other benefits, including pensions and cars
  - Allowances
  - Notice periods
- To monitor and evaluate the performance of individual directors.
- To adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst taking account of ensuring value for money for the organisation
- Scrutinise and approve termination payments of £50K and above taking account of such national guidance as is appropriate.
- To receive assurance that in making any ex gratia payments that value for money is being achieved, that the payments are made in the public's interest and represent best use of public funds. This should include scrutiny of the calculations to justify payments made.
- To advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.

9. ADMINISTRATIVE ARRANGEMENTS

The Committee will be supported by the Company Secretary

10. REVIEW / EFFECTIVENESS

- The ToR will be reviewed at least annually

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Nomination & Remuneration Committee
Version:	V2
Implementation Date:	xx.xx.xxxx
Review Date:	xx.xx.xxxx
Approved by:	NAME OF COMMITTEE
Approval Date:	xx.xx.xxxx

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
07.08.2024	**All**	Complete review & Re-brand	xx.xx.xxxx

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

A quorum shall be two (2) members, one of who must be a Non-Executive Director. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non-Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

4. MEMBERSHIP

The Committee shall be composed of two (2) Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Core Members

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Chief Finance Officer
- Chief Nurse
- Chief Operating Officer & Deputy CEO
- Executive Medical Director
- Chief People Officer
- Director of Communications & Engagement
- Deputy Chief Finance Officer
- Director of Strategy & Partnerships
- Company Secretary & Associate Director of Corporate Governance
- Associate Director of Estates and Facilities Management
- Chief Information Officer

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

Observers

- Governor

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting; and/or
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have; and/or
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- Financial Resources Group
- Digital Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group
- Improvement & Productivity Group

7. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the NHS Provider License
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- Overseeing the development and subsequent monitoring of an operational plan including activity, workforce, finance, annual budget, annual capital programme and cashflow for approval by the Trust board.
- To ensure that appropriate triangulation across portfolios in the medium and long term financial models is
  provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- Consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Committee Assurance Report.
- To monitor compliance with NHSE requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- Benchmark financial and operational performance within the Integrated Care System, regionally and nationally
- Approve capital expenditure up to £5m on behalf of the Trust Board
- To oversee the Trust's Emergency Preparedness and Response (EPRR) Framework

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £5m or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	V10.1 **FINAL**
Implementation Date:	03.04.24
Review Date:	12 months from final approval
Approved by:	Finance & Sustainability Committee
Approval Date:	FSC March 2024, Trust Board 03.04.24

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
22 March 2017	**3 – Reporting arrangements**	- There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.	
22nd March 2017	**4. Duties and Responsibilities**	- To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement	
22 March 2017	**6 - Attendance**	- Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy. - Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance	
22 March 2017	**9. Reporting Groups**	Two groups removed: - The Business Planning sub Committee (strategic). - Strategic & Annual Planning Steering Group. One Group added: - Pay Spend and Review Committee minutes to reporting groups.	
22 March 2017	**10 Administrative Arrangements**	- Due to change in administrative support to the Committee - Agreement with the Chair and Director of Finance to amend the timescale for circulating papers	

18 October 2017	**4. Duties and responsibilities** **6. Core attendees** **9. Reporting Groups**	- Delete items relating to Estates and IM&T - Delete Director of IM&T Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records	
22 November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21 March 2018	**Core Attendees**	Addition of Medical Director	Trust Board 29.5.2019
19 September 2018	**Core Attendees**	Remove Director of Transformation	Trust Board 29.5.2019
20 March 2019	**Section 6: Core Attendees**	Remove Medical Director Add Head of Corporate Affairs	Trust Board 29.5.2019
20 March 2019	**Section 9: Reporting**	Add Financial Resources Group Remove Out Patient Turnaround Remove ICIC	Trust Board 29.5.2019
18 March 2020	**Section 6: Core Attendees**	ADD Medical Director Amend Title of Head of Corporate Affairs to read Trust Secretary Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development ADD Director of Strategy (when required)	FSC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 9: Reporting**	Remove Urgent & Emergency Care Improvement Committee	FSC 18.03.2020 Trust Board 25.03.2020
23 September 2020	**Section 4 Duties and Responsibilities**	Addition of reports from Digital Services	FSC 23.09.2020 Trust Board 25.11.2020
23 September 2020	**Section 6: Core Attendees**	Amend the titles of three Directors Add Chief Information Officer	FSC 23.09.2020 Trust Board 25.11.2020

23 September 2020	**Section 9: Reporting**	Add Digital Board	FSC 23.09.2020 Trust Board 25.11.2020
22 September 2021	**Section 6: Core Attendees** **Section 9: Reporting**	Amend title of Deputy Director of Finance & Commercial Development and Delete post of Chief Information Officer **Add Medical Staffing Review Group and Strategy & Sustainability Review Group**	FSC 22.09.2020 Trust Board 24.11.2020
21st September 2022	**Section 4: Duties & Responsibilities**	Updated reference to Committee Assurance Report and amended NHSI to NHSE following NHS Improvement becoming part of NHS England in July 2022	
21st September 2022	**Section 9: Reporting Groups**	Addition of GIRFT/Clinical productivity Group Amend title of Digital Board to Digital Management Group	
26th April 2023	**Section 4: Duties & Responsibilities**	• Updated reference to new Provider Licence • Re-instated review of performance following dis-establishment of Clinical Recovery Oversight Committee • Addition of oversight of annual operational plan • Removal of duplicate responsibility • Updated Committee Capital Spend limit • Remove reference to MTFM and LTFM	
26th April 2023	**Section 6: Core Attendees**	• Addition of Chief Executive and Associate Director of Estates & Facilities Management	
26th April 2023	**Section 9: Reporting Groups**	• Update of Report Group titles	
27th March 2024	**Section 4 - Membership**	• Update titles of members and add Chief Information Officer	
27th March 2024	**Section 6 - Reporting**	• Addition of Improvement & Productivity Group • Confirmation that the Committee oversees EPRR arrangements	
27th March 2024	**Section 9 – Administrative Arrangements**	• Affirmation of the Committee's duty ro review the Terms of Reference and Cycle of Business annually	

28th August 2024	**Section 4: Membership Core Members**	• Addition of Director of Communications and Engagement as a core member of the committee	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
20 March 2020	**V5 to be replaced by V6**	FSC 18.03.2020
23 September 2020	**V6 to be replaced by V7**	FSC 23.09.2020
22 September 2020	**V7 to be replaced by V8**	FSC 22.09.2022
21st September 2022	**V8 to be replaced by V9**	FSC 21.09.2022
26th April 2023	**V9 to be replaced by V10**	FSC 26.04.2023 Trust Board 07.06.2023
3rd April 2024	**V10 to be replaced by V10.1**	FSC 27.03.24 Trust Board 03.10.24
XX October 2024	**V10.1 to be replaced by V10.2**	FSC XX.XX.XX Trust Board XX.XX.XX