Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting
Part 1 (held in Public)

Wednesday 6 December 2023
10.00am -12.30pm
Trust Conference Room Warrington/Via MS Teams



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 6 December 2023, 10.00am – 12.30pm
Trust Conference Room, Warrington/Via MS Teams

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/23/12/133	**10:00**	Engagement Story **–** Maternity	***To Note***	**Presentation**	Ali Kennah, Deputy Chief Nurse
BM/23/12/134	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Steve McGuirk Chair
BM/23/12/135	**10:17**	Minutes and Action Log of the previous meeting held on **4th October 2023**	***For decision***	***Minutes***	Steve McGuirk Chair
BM/23/12/136	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Steve McGuirk Chair
BM/23/12/137	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/23/12/138	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Steve McGuirk Chair
BM/23/12/139	**10:40**	Board Assurance Framework	***For approval***	***Report***	John Culshaw, Company Secretary
Strategic aim:		  			
BM/23/12/140	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports Quality and Assurance Committee (QAC) 10.10.23, 14.11.23	***For assurance***	***Report & Presentation***	Ali Kennah Deputy Chief Nurse; Dan Moore Chief Operating Officer; Paul Fitzsimmons, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee (SPC) 18.10.23, 15.11.23	***For assurance***	***Report & Presentation***	Michelle Cloney, Chief People Officer Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard** **Including**	***For assurance***	***Report & Presentation***	Jane Hurst, Chief Finance Officer John Somers, Committee Chair
(d)					

(e)		Assurance Reports Finance and Sustainability Committee (FSC) 25.10.23, 19.11.23			
		Assurance Report Audit Committee (AC) 16.11.23	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair
Strategic aim:					
BM/23/12/141	**11:30**	Maternity Update including: **i.** Ockenden Review Update **ii.** Maternity Incentive Scheme (MIS) including Saving Babies Lives Care Bundle (SBLCB) **iii.** Quarter 2 2023-24 Perinatal Mortality Review/Audit **iv.** Maternity & Neonatal Quality Review – September 2023 **v.** Maternity Training Plan 2024 **vi.** Maternity Self-Assessment Tool Biannual report **vii.** Midwifery staffing biannual review Jan-June 2023 **Viii.** Q1 ATAIN	***To note for assurance***	***Report***	Ailsa Gaskill-Jones, Director of Midwifery
BM/23/12/142	**11:45**	Moving 2 Outstanding Q2 Report	***To note for assurance***	***Presentation***	Ali Kennah Deputy Chief Nurse
BM/23/12/143	**11:55**	Fragile Clinical Services Update	***To note for assurance***	**Paper**	Ali Kennah Deputy Chief Nurse /Paul Fitzsimmons Executive Medical Director/Dan Moore Chief Operating Officer
Strategic aim:					
BM/23/12/144	**12:00**	Communications & Engagement Dashboard Quarterly Report Q2	***To note for assurance***	**Paper**	Kate Henry, Director of Communications & Engagement

Strategic aim:	

BM/23/12/145	**12:05**	Bi-monthly Strategy Programme Highlight Report	***To note for assurance***	**Paper**	Lucy Gardner Director of Strategy & Partnerships
BM/23/12/146	**12:10**	Emergency Preparedness Resilience Response	***To note***	**Paper**	Dan Moore Chief Operating Officer

Governance					
BM/23/12/147	**12:15**	Fit & Proper Persons Policy	***To note***	**Paper**	John Culshaw, Company Secretary
BM/23/12/148	**12:20**	WHH Membership Strategy 2023-25	***For approval***	**Paper**	John Culshaw, Company Secretary
BM/23/12/149	**12:25**	Review of Scheme of Reservation & Delegation and Standing Financial Instructions	***For approval***	**Paper**	Jane Hurst, Chief Finance Officer/ John Culshaw, Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/23/12/150	Learning from Experience Summary Report – Q2	Quality Assurance Committee Date: 14.11.23 Ref: QAC/23/11/239 Outcome: Noted	***To note for assurance***	**Paper**	Ali Kennah Deputy Chief Nurse
BM/23/12/151	Director of Infection Prevention & Control Quarterly Report	Quality Assurance Committee Date: 14.11.23 Ref: QAC/23/11/240 Outcome: Noted	***To note for assurance***	**Paper**	Ali Kennah Deputy Chief Nurse
BM/23/12/152	Violence Reduction Strategy (bi-annually)	Quality Assurance Committee Date: 14.11.23 Ref: QAC/23/11/241 Outcome: Noted	***To note for assurance***	**Paper**	Dan Moore, Chief Operating Officer
BM/23/12/153	Digital Strategy Group Update Report	Finance & Sustainability Committee Date: 29.11.2023 Ref: FSC/23/11/163 Outcome: Noted	***To note for assurance***	**Paper**	Paul Fitzsimmons Executive Medical Director
BM/23/12/154	WHH Influenza Vaccination Approach 2023-24	Strategic People Committee Date: 15.11.2023 Ref: SPC/23/09/125 CPO Report Outcome: Noted	***To note for assurance***	**Paper**	Michelle Cloney, Chief People Officer
Closing					
BM/23/12/155	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/23/12/156		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting - 7 February 2024, Trust Conference Room , Burtonwood Wing, WHH					

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Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 4 October 2023 Trust Conference Room – Warrington & MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Jayne Downey (JD)	Non-Executive Director
Jan O'Driscoll (JO'D)	Partner Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
Simon Constable (SC)	Chief Executive
Jane Hurst (JH)	Chief Finance Officer & Freedom to Speak Up Guardian
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Dan Moore (DM)	Chief Operating Officer
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
Ailsa Gaskill-Jones	Director of Midwifery
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Zoe Harris (ZH)	Director of Operations and Performance, Deputy Chief Operating officer
Jill Tomlinson (JT)	Matron Child Health
Ali Kennah (AK)	Deputy Chief Nurse
Emily Kelso	Corporate Governance & Membership Manager **(minute taking)**
Observing	
Janet Parker	Associate Director of Finance - Strategy
Hayley Smith	Associate Director, Strategic Communications Projects

Agenda Ref	Agenda Item
BM/23/10/109	**Engagement Story – A Child's Healing Journey**

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JT, Matron of Child Health presented the story of a young child who was admitted to the WHH paediatric ward in June 2023. The admission followed a Child and Adolescent Mental Health Service (CAMHS) assessment, where concerns were raised for the physical and mental health of the child concerned.

JT explained the severe neglect the child had suffered, following which details were provided on the efforts of staff to build the trust of the patient during her 9-week stay at WHH.

JT explained that the kind actions of staff were in addition to their professional duties and sought to ensure the patient was made to feel safe and supported. JT further explained the different therapies facilitated including play therapy and sessions with a therapy dog.

Details of multi-agency working were explained which ensured a robust transition from hospital to an appropriate community setting placement to provide ongoing support. Feedback from the local authority was also shared, specifically thanking WHH staff for the significant difference the child's care at WHH had made.

The Chair responded by indicating that this was the most powerful patient story he had received at the Board in all his time as Chair and, on behalf of the Board, commended the extraordinary and outstanding effort of all the teams of people involved in this extremely complex and sad case. The Board then discussed the care of the patient in more detail and sought, and received, assurance on the child's ongoing care in the community including education plans, communication with their sibling, intervention therapy and a dedicated psychiatrist.

The board discussed the issues around the service not being formally commissioned at WHH, noting that the patient was admitted to WHH as the social worker had confidence that this trust could offer the level of support required in this extreme case. JT informed the board that a complex needs community facility was an option being explored,

The board sought clarity on the length of stay, JT confirmed that this was a conscious decision not to discharge until the most appropriate long term community placement setting was found.

Finally, the Board observed that while many of the actions taken by staff were clearly and evidentially in the patient's best interests, they

DRAFT

	undoubtedly also involved courage and calculated risk taking, as a more structured view of regulatory compliance 'might' have viewed some of the actions to be at the limits of the approach currently taken to compliance. And this illustrated the potential for risk aversion that could jeopardise the best 'possible' care in favour of the most 'compliant care'. **The Trust Board discussed and noted the Engagement story.**
BM/23/10/110	**Welcome, apologies and declarations of interest.** The Chair welcomed the Trust Board, guests, and observers to the meeting, and noted the apologies received (as detailed above). There were no Declarations of Interest. **The Trust Board noted the welcome, apologies and declarations.**
BM/23/10/111	**Minutes and action log from the previous meeting held on 2 August 2023.** The minutes of the meeting held on 2 August 2023 were agreed as an accurate record. With one minor amendment to page 10, initials corrected to LG. 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 2 August 2023 and noted the Action Log.**
BM/23/10/112	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/23/10/113	**Chief Executive's Report** SC introduced the paper, which was taken as read. The following key points were taken from the report and board discussions: • Maternity Services CQC Inspection – the inspection had taken place in September and to date very high-level feedback had been received which had been largely positive – though three areas of concern had been drawn to the attention of the Trust (Note: these were discussed more extensively later in the agenda.) . It was noted there had been subsequent data requests that the trust was providing. KSJ confirmed that the draft report would be received within 6 weeks of the inspection date, which would be checked for factual accuracy by the trust, before it would be available in the public domain. SMcG added his praise for staff in regard to managing and coordinating the inspection. • Industrial Action – it was highlighted that today was the last day of the combined 3-day strike action by junior doctors and consultants, and

DRAFT

	that the long-term effects of this strike action were yet to be quantified. It was also noted that there had been industrial action by HCAs and that this dispute was also not resolved and would be discussed in Part 2 later in the day. **The Trust Board noted the Chief Executive's Report.**
BM/23/10/114	**Chair's Report** SMcG introduced the report, which was taken as read, though the following key points were highlighted: • Governor Video – had been developed by the Comms team to provide some insight into the role of and NHS Governor. The video link was shared in the report all Board members were encouraged to view. • The Annual Members meeting was to take place following the Board meeting at 3:30pm in the Post Graduate Centre • Governor Elections were currently taking place – the nominations deadline was the 11th October, 5pm. • The annual Warrington Mela event - the town's largest multi-cultural celebration event, hosted and organised by Warrington Ethnic Communities Association (WECA), had been attended by several departments within the Trust as well as a good turnout of governors, each hosting stands to promote the trust as an inclusive and welcoming organisation. **The Trust Board noted the Chair's Report.**
BM/23/10/115	**Board Assurance Framework (BAF)** JC presented the BAF update and highlighted the following proposed updates since the last Board meeting: • No new risks had been added; however, it was proposed that one new risk was added. This followed discussion at the Patient Safety & Clinical Effectiveness Sub-Committee, Quality Assurance Committee and the Risk Review Group. The proposal was to add a new risk (with a risk rating of 20) in relation to services within the Trust that are defined as being fragile. *"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"* • no changes to the ratings of any of the risks; • no changes to the descriptions of any of the risks; • No risks had been closed or de-escalated;

DRAFT

	JD sought assurance on the appropriateness of the rating (20) of risk 115 around minimal staffing levels in clinical areas given the recent successes in recruitment to establishment, notably the success of international recruitment campaigns. KSJ responded that the risk rating was still appropriate given retention levels in some specialties and risks associated with spikes in covid, some gaps remained. **The Trust Board discussed and noted the report and supported the addition of the new risk around fragile services with rating of 20 (5Lx4I).**
BM/23/10/116	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance, it was highlighted that the report would be taken as read with key highlights by Executive Leads and any questions on the report content from Non-Executive Directors. ***Access & Performance (ZH)*** ZH highlighted the following from the report: • There were 2 main referral to treatment pathways where operating difficulties were being experienced. • A&E had continued to be challenging and the trust had been placed into tier 1 nationally, largely due to time patients spent in ED (12 hours) before being admitted to a ward or going home. It was noted that 4-hour performance was comparable with peers. The continuous flow new initiative was explained which would help to support earlier discharge. It was noted that improvements should be seen within the next 2 – 3 months. It was further explained that continuous flow was not being done in isolation, but in collaboration with several recommendations which had been agreed following the ECIST review. • ZH explained that the continuous flow initiative was being rolled out one ward at a time, to incorporate lessons learned and ensure sustainability. SC further explained the methodology behind the initiative to spread the load of pressures across the organisation and not just the ED. It was noted that the trust was performing well in ambulance handovers, which meant congestion was often felt in ED, the initiative would help to support decongestion. • It was noted that discharge metrics had shown improvements, the sustainability of these improvements were not yet certain. ***Elective care*** ZH explained that the trust had been placed into tier 2 for elective recovery

DRAFT

at this point it was unclear as to what the parameters would be, details were expected in the coming weeks.
78-week performance had improved in September compared to August. A couple of specialities struggling in regard to 65-week position, the board were reassured of the interventions in place to support recovery, including work with independent sector.

SMcG commented on the impact of Industrial Action(IA) on elective recovery. SC added that whist the backlog was not caused by IA, rather the pauses experienced during the Covid-19 pandemic, recovery was certainly being impacted by IA.

Quality of Care (KSJ)
CR drew the boards attention to the High-Level Enquiries agenda item from the Quality Assurance Committee, September assurance report. Two high level enquiries had been noted, both in relation to letters from the HSE.

- Letter received 8 August 2023 in relation to maintenance of two autoclaves.
- Letter received 8 September in relation to streamlining processes in Pathology.

It was explained that both areas of concern were being addressed and response letters would be sent within the required timeframe. Updates would be provided through the committee.

CR also noted the committee discussions around fragile services which would be picked up under agenda item BM/23/10/119.

JD commented on the improved performance around falls and sepsis (administration of antibiotics within the required times), and the importance of using language that focused on the improved metrics and celebrated success to positively reinforce staff.

SC commented that the infrastructure put in place by the trust around patient safety was starting to show improvements in the IPR reporting metrics.

People (Workforce) (MC)
MC highlighted the following from the Workforce section of the report:

- Bank and Agency reliance in August 2023 was 15.9%, a decrease from 16.59% in June 2023. It was note that this was a combined bank and agency figure and that the Cheshire and Merseyside cap had been

DRAFT

achieved in the first quarter. It was noted that there was significant work taking place with NHS Professionals to drive efficiencies.

- It was noted that the Resourcing Task and Finish group had been established to develop a system/process to report on factors influencing temporary staffing spend.
- MC explained the conversion of agency staff to bank staff, which was having a positive impact on reducing costs, as evidenced in the finance reports.
- The board discussed the potential for a regional/system bank to share temporary staffing resource staffing, it was noted that this option was being explored and once more detail was available information could be shared with the Board.

The board discussed some issues around comparing data, it was noted that organisations were not always submitting like for like data which made comparisons difficult. It was explained that the trust had confidence in model hospital data, whereas Cheshire and Merseyside data was less reliable. MC confirmed that the Associate Chief People Officer was currently undertaking a piece of work to look at the data being submitted.

KSJ noted that mandatory training was showing an improvement and that the had been a targeting programme of work to drive improvements in CBUs and Care Groups. The Board discussed the difficulties in mandatory training given the work pressures of staff. MC briefly explained the Future NHS collaboration national programme which would enable shared learning resources and would be a valuable tool to share good practice around mandatory training. It was confirmed that further details would be shared through Committees.

Finance & Sustainability (JH)

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

- Capital Programme
- Cost Improvement Programme (recurrent forecast)

At Month 5 the plan is a £9.2m deficit, however the actual deficit was £11.6m with the overspend being due in the main to Industrial Action (IA) costs, activity delivered under plan and additional capacity in A&E. The position includes an additional £0.5m income relating to April to August 2023 following a reduction in the ERF target of 2% to support the impact of IA in April 2023. A further £0.7m has been assumed in anticipation of further ERF adjustments relating to IA in June to August 2023 (as per discussion with ICS but not yet confirmed). A coding catch up of £0.6m has

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	also been assumed for month 5. This presented risk to the reported position of £1.3m The Board discussed the estimated costs of consultants and junior doctors IA, it was noted that this was approximately 300 – 400k per month and 1.2m to date, it was further noted that the costs of cancelled appointments was still not quantified. The board discussed the additional cost of Heath Care Assistants IA it was estimated that in total by year end the cost would likely be 5m. The Board discussed the Freedom of Information requests received in relation to consultant rates of pay to cover shifts during periods of IA. KH confirmed that the trust had responded within time to all FOI request and whist open an honest data was always provided, interpretation of this data could not be managed by the trust. It was noted that the topic was receiving a lot of media scrutiny. PF confirmed that the trust had not deviated from ICS agreed levels of pay throughout periods of IA. The trust board noted the committee assurance report from: • Audit Committee – 17 August 2023 • Charitable Funds Committee – 7 September 2023 **The Trust Board discussed and noted the report**
BM/23/10/117	**Maternity Update** AGJ highlighted the following key points from each of the maternity papers. **i. Ockenden Review Updates** The WHH Ockenden update as of 31st July 2023: • **Ockenden Part 1a**: 100% compliant. • **Ockenden 1b**: 95.76% compliant and was on trajectory to be 100% compliant by 31st December 2023. • **Ockenden 2**: 75.34% compliant Ockenden 2 did not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023. AGJ explained that an updated position would be presented to the Quality Assurance Committee in October. It was noted that whilst some metrics had slipped, they did not pose an overall risk to the compliance deadline achievement. **ii. Maternity Incentive scheme – 5- year update including Saving Babies Lives Care Bundle (SBLCB)** AGJ introduced the report explaining that NHS Resolution (NHSR) were

DRAFT

operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards.

Revised specifications and timelines had been released in July 2023 and advised that Trusts must submit the completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024.

The paper provided an update of the current position and trajectory of the 10 safety actions as recommended by NHSR. Two actions were highlighted, from the report:

- **Safety Action 3** WHH is on track to demonstrate 100% compliance with transitional care services in place to minimise separation of mothers and their babies. It was noted that this was a recognised piece of work formal task and finish group had been set up to take forward the action.
- **Safety Action 6** WHH is on track to deliver all elements of Saving Babies Lives Version 3 (SBLV3). It was noted that there had been an increase in data to be added to Badgernet, which the Trust had been notified of on the 30th September, the digital and maternity teams were working together to resolve within the required timescales.

AGJ informed the Board of the additional posts required to support SBLV3, however no national funding was attached, the trust would be looking at options to fund at a meeting scheduled for later that day. KSJ and SC commented that the trust agreed SBLV3 was a valuable scheme to be implemented nationally but that the costs per trust had not been quantified in the planning. JH added that this had been raised at the regional Director of Finance meeting earlier in the week.

AGJ informed the Board that the Board would be required to sign off the board declaration so that it could be submitted to NHS resolution by 12 noon Thursday 1st February 2024, this would mean that an extraordinary Board would likely be held in late January 2024.

iii. Perinatal Mortality

AGJ introduced the report which was presented to the Board to ensure receipt of the quarterly perinatal mortality review reports as per safety action 1 of the One of the Maternity Incentive Scheme (Year 5)

The report provided details for Quarter 1 (Q1.). It was noted that the Trust was performing well.

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The key highlights from the report were:

- The WHH stillbirth rate for Q1 2023/24 was 1.65 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.04 per 1000 births. The MBRRACE-UK national stillbirth rate for 2021 is 4.2/1000 births.
- There had been one Early Neonatal Death in Q1 a baby born at 38+5 weeks (SB). The key findings, learning, good practice, and action plan for this case would be reported following a PMRT review panel which will be scheduled once the coroner report is received.
- During Q1, the trust undertook four PMRT review panels. Parental perspective of the care they received were sought in all cases.

iv. Monthly Maternity & Neonatal Quality Update

AGJ introduced the paper informing the Trust Board that inline with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5. The paper provided an update in relation to maternity and neonatal quality was reported monthy into QAC and bimonthly into Board. The following key ponts were highlighted from the report:

- Workforce measures related to retention and vacancy rate remain much improved.
- Compliance with Prompt training was underperforming, the reduction in compliance was as a result of the cancellation of the July Prompt day due to unavailability of trainers and inability to support MDT training due to medical industrial action. To support compliance an additional virtual PROMPT took place in August. Prompt will resume face to face from 4th September with increased allocation to improve compliance.
- A project to relocate maternity triage commenced in early 2023. The relocation took place on 16th August 2023. The Triage Task & Finish group continues to provide oversight of the relocation project and will work with the wider team to optimise the service. Service user feedback was being collated following the relocation. This will be shared to Quality Assurance Committee in October.
- Following an increase in complaints within maternity in the last 12 months a deep dive of complaints has been completed. The top three themes identifed as part of the deep dive were clinical care, consent/communication and staff behaviour

SMcG queried whether the CQC inspectors had viewed board papers in this respect, seeking assurance that there was seen to be value added by the board's consideration of this wide range of maternity services matters as opposed to it being a bureaucratic exercise. KSJ confirmed that a

DRAFT

	number of Board papers had been requested and shared with the inspection team, and this provided important evidence of Board assurance around maternity services which was not only important of itself but was also in line with national guidelines. **The Trust Board noted the updates in relation to Maternity.**
BM/23/10/118	**Moving to Outstanding (M2O) Update Report - Q1** KSJ introduced the presentation, it was noted that the presentation was also received by the Quality Assurance Committee, hence some of the dates were historical i.e. the CQC Maternity inspection had since taken place. It was noted that a CQC inspection of ED would likely take place in the coming months. KSJ explained that purpose of the moving to Outstanding meetings were to align with the new single assessment framework. Details were provided on the current CQC position along with the number of whistleblowing enquiries received and closed supported by Freedom to Speak Up walk rounds. It was noted that Urgent and Emergency care had received a higher number of whistleblowing than other areas of the Trust. Further details on the mock inspection programme per core service were provided. KSJ confirmed that Governors were involved in mock inspections, along with the chair and that all NEDs were welcome to participate. Details of Maternity CQC inspection were shared, areas highlighted for awareness were: • Pregnancy Booking completed – it was note that trajectory for improvement in was place and on track. • Post-Partum Haemorrhage (PPH) >1500mls – had been a blip and deep dives were being carried out to understand the cause data for 6 months was to be analysed. KSJ explained that a formal Maternity inspection had taken place at the Trust in September and that no issues had been escalated on the day, however a letter had been received detailing some significant concerns around transitional care and PPH, the trust had responded with additional evidence and the final inspection report was awaited. KSJ informed the board that another meeting had taken place with the CQC w/c 25th September, to discuss the whistleblowing concerns raised some of which related to maternity.

DRAFT

	SC explained that the moving to outstanding programme was not purely for the CQC, but an initiative to drive improvement in safety and patient experience wherever possible. KH commented that internal comms would focus on relaying this message to staff with a particular focus on driving positive culture by sharing and celebrating outstanding practice. KSJ confirmed that the trust was preparing for a well led inspection and that details of the preparation work would be shared at the 1 November Board Development Day. **The Trust Board noted the annual report for assurance.**
BM/23/10/119	**Fragile Clinical Services Update** PF introduced the report which provided the Board with a high-level overview of services currently identified as being Fragile. The following key points were highlighted from the report: • no new services had entered fragile services oversight since the last report and all services had made progress. • Urology remained the highest risk and there was some potential for further incidents of harm to be uncovered, measures were in place to improve capacity. • Gynaecology – workforce issues continued, consultant interviews were to take place early w/c 9th October, • Ophthalmology - Paediatric Ophthalmology - significant staffing pressures were ongoing; no harm had been identified to date current mitigations and ongoing improvement plans were detailed within the report. • Fractured NoF – would be going to QAC 10th October as a deep dive with a focus on demand and capacity issues – driven predominantly by increased demand, increased pressures on bed base and insufficient theatre capacity for trauma workload. It was noted that Ophthalmology – ARMD had been deescalated from fragile service oversight. PF explained that current mitigations had allowed the service to provide assurance that there has been no shortfall in capacity for the last quarter. Praise was noted in regard to the hard work of the nursing and medical team. **The Trust Board noted:** • **The current list of Fragile Services and associated high level progress updates.**

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	• **The progress made in Ophthalmology AMD/Medical Retina allowing de-escalation from Fragile Services Oversight.**
BM/23/10/120	**GMC Appraisal and Revalidation and Medical Governance** PF introduced the paper and highlighted the following key points: • Of the 18 doctors who had missed an appraisal in the 2022/23 financial year only one was at risk for non-engagement • The trust benchmarked well with peers. • The report evidenced that the new appraisal system was working well, not only were appraisals being completed they were robust and valued by staff. • Appraisals at WHH were reviewed by system partner LUHFT. • Appraisees were able to feedback on their appraisals, enabling improvements to be made. • Triangulation meetings were taking place each month with nursing colleges and the revalidation team. A list of doctors who required addition support had been developed. The board discussed recent reports in the media stating that one in three female consultants had encountered sexual or physical harassment in the workplace. It was noted that appraisals would typically not be the method by which these concerns would be raised, they would likely be picked up earlier though line management, or freedom to speak up. PF went on to explain the newly published Good Medical Practice Professional Standards 2024, which had a large section on behaviour. The trust would be working with GMC to incorporate into the appraisal process, and particularly asking individuals to reflect on their own behaviours. It was noted that there was already 360-degree feedback included in the appraisal process. DT queried whether doctors/consultants completed the NHS staff survey, MC confirmed that medical staff complete the staff survey and trends per speciality could be drawn out from responses. MC added that NHSE had launched a sexual safety charter and a paper around the charter was to be presented to the Executive Team week commencing 9 October 2023. **The Trust Board noted the paper.**
BM/23/10/121	**Freedom To Speak Up (FTSU) – Guardian Bi-annual Report** JH introduced the report which detailed that during 2022/23 the FTSU team had managed 42 disclosures (compared to 20 in 2021/22). The majority related to culture, allegations of bullying and relationship issues within teams.

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	It was explained that the FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD to support individuals and teams to resolve the issues that are highlighted. In the first quarter of 2023/24 there had been 6 disclosures (compared to 17 in 2021/22). JH explained that the trust was currently in the process of recruiting a new freedom to speak up guardian. The Board discussed the interventions in place to understand the cause of cultural issues within teams, it was note that HR Business partners would visit areas of concern to speak with colleagues a gain softer intel in an attempt to gain a better understanding of the caused and develop action plans to improve. Executive directors reassured non-executive colleagues that they were kept well informed of the pocket areas of concern within the Trust. JH confirmed that FTSU disclosures were rarely a surprise and often linked with other grievances. **The Trust Board noted the update.**
BM/23/10/122	**EPRR Assurance Letter/Statement of Compliance** ZH introduced the report and explained the changes to this years' process, it was noted that the self-assessment would be certified following a peer review of the Trust submitted evidence by the national EPR team. It was noted that the trust was 92% compliant 8% partially complaint. **The Trust Board** • **noted the forecast EPRR Annual Assurance self-assessment rating at 'Substantial Compliance'** • **noted the changes to this year's process** • **supported the workplan in moving towards full compliance with all 62 standards.**
BM/23/10/123	**Bi-monthly 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. It was noted that this was a revised version of the report, which was aimed at being high level and available in the public domain. LG highlighted that the report now included updates on how the trust was working with PLACE and from a Cheshire and Merseyside System perspective.

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	SMcG commented that the report had been presented in the Shadow Board meeting, and that participants agreed the report could be strengthened by the addition information around how each project aligned to specific care groups. LG agreed this feedback would be taken on board for future reports. SMcG further commented that more information on project risks may also be a useful addition to future reports. LG confirmed that this would be taken into consideration, it was noted that monitoring/reporting routes such as the BAF and strategy reports through bord committees included details of project risk in more detail. **The Trust Board noted the report for information and assurance.**
BM/23/10/124	**Audit Committee Annual Report** MOC introduced the report which provided the Trust Board with assurance that the Committee had met their Terms of Reference and had gained assurance of the Trust's performance, throughout the reporting period. MOC highlighted the following: • Audit committee chairs from Cheshire and Merseyside had met, a key topic of discussion was the difficulty in appointing auditors. A number of options had been discussed including the potential for a system wide external auditor being procured. JH confirmed this was also the case for internal auditors and MIAA had been appointed for the System and that the process to appoint an external auditor would be started early to ensure a timely contract was awarded. • Risk appetite had been discussed and was currently under development for individual BAF risks, a session would take place at a future Board development day to provide detail on the work around and to gain board approval. **The Trust Board noted and approved the Audit Committee Annual Report**
FOR APPROVAL	
SUPPLEMENTARY PAPERS	
BM/23/10/125	Learning from Experience Summary Report – Q1
BM/23/10/126	Nurse Staffing Bi-annual Report
BM/23/10/127	Learning from Deaths Quarterly Report – Q1
BM/23/10/128	Director of Infection Prevention & Control Quarterly Report – Q1
BM/23/10/129	Digital Strategy Group Update Report
BM/23/10/130	RTT Validation Assurance Report

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BM/23/10/131	**Review of the Meeting** The Trust Board agreed the meeting had been effective meeting with good discussions and challenge on items.
BM/23/10/132	**Any Other Business** **Meeting ended at 12:30**
The Date and Time of the next Trust Board Meeting is Wednesday 6 December 2023 Trust Conference Room, Warrington	

Approved ……

Dated ……

Chair, Steve McGuirk

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/23/12/135 (i)	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	6 December 2023

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/137**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/23/12/137

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 4 October 2023, 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 7 - October 2023. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

We continue to focus on length-of-stay and discharge delays. Our total number of super-stranded patients with a length of stay greater than 21 days remains high at 122. However, the number of patients that do not meet the criteria to reside (NCTR) is also high at 138. For Warrington Borough Council residents in hospital, this latter number is currently 71 (21.9%, above the national average of 15%); for Halton Borough Council residents in hospital, it is 36 (29.3%). We continue to work with partners on improving these figures, as well as working on own processes with regards to length of stay more generally. We are also in receipt of national support to do so, and this is very welcome. This national support, as part of the Tier 1 Urgent & Emergency Care Programme, is also looking at the broader issues of this particular pathway.

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 March 2024. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees.

2.2 Senior Leadership Changes

After seven years at the Trust, where Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive, has been instrumental in helping us achieve so much, she will sadly be leaving WHH at the end of March 2024. Kimberley will be joining Manchester University NHS Foundation Trust as their Executive Group Chief Nurse.

I know that this has been an incredibly tough decision for Kimberley, as she remains so very dedicated to WHH and passionate about her work here. However, this is a fantastic opportunity for her and so, of course, I would like to wish her all the very best for her next career step.

The process to appoint her successor has already begun and I will share further updates in due course.

2.3 Cheshire & Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative Update

The CMAST Leadership Board met on 3 November 2023 and received two presentations related to the available data, emerging priorities and activities being coalesced within C&M on the digital agenda as well as workforce.

The need to prioritise and to target activity was discussed as was the opportunity for trusts to consider the best way to maximise effort, secure improvements and, if possible, to achieve efficiency. The Board welcomed the presentations and identified the need for a facilitated exploratory and prioritisation discussion on these subjects at its next meeting.

2.4 The David Fuller Case

Like many I am sure, I read with feelings of shock and disgust the findings of the independent inquiry into the actions of convicted murderer David Fuller.

Fuller was a maintenance supervisor who was able to sexually violate more than 100 bodies in hospital mortuaries over a period of at least 15 years. The incidents took place at Kent and Sussex Hospital and at Tunbridge Wells Hospital, both part of Maidstone and Tunbridge Wells NHS Trust (MTW).

The inquiry has published its first phase report, with a further report due next year and is expected to include recommendations for wider NHS organisations. The publication of this report has been widely covered in the media.

The inquiry, chaired by Sir Jonathan Michael, former chief executive of Guy's and St Thomas' NHS Foundation Trust, has made a number of recommendations to MTW. Had these recommendations been in place, the inquiry believes these horrific offences could have been prevented. Their Trust Board is heavily criticised in the report, as are NHS England and the Human Tissue Authority for their lack of oversight.

Like the tragic Lucy Letby case, this is another instance where I, alongside the rest of the Trust Board, need to ask the justifiable question of whether such a thing could ever happen here. It would be entirely wrong of us not to consider such a thing. Indeed, we have, unfortunately, a well-used process of "*Could it happen here?*" agenda items whenever national issues emerge and need us to be suitably reflective as an organisation. We will do this early in the new year.

There are many assurances to which I can immediately point. When this case first came to light back in 2021, we took action straight away to review security and access arrangements, not just for the mortuary but for other areas too. However, with the further insight now available following the publication of this report, we will spend time reflecting upon the learning and exploring what other actions may be appropriate to take.

We do have a multitude of ways for raising any concerns, including Freedom to Speak Up. We are strengthening this particular tool - making it easy to raise a flag - all the time.

2.5 NHS Staff Survey

This annual NHS staff survey closed on 24 November 2023.

The total number of responses was 2057 out of a possible 4561, that is 45%. This is compared to 47% in other acute trusts that use Quality Health as the staff survey provider. Last year our final figures were a total number of 1520 responses out of 4379, 35%. We sent the survey to 182 additional members of staff this year with an increase in return of 537.

This is just short of the self-imposed target of a 50% response rate that I wanted us to achieve. Although 100% participation isn't necessary (and is actually sometimes a bad sign in surveys of this nature), a high participation rate is vital to ensure that results really do represent any given team, department or indeed, organisation as a whole. We've clearly got a bit of work to do in making sure this survey is seen as relevant and that we are seen to make improvements - we take action - on the back of it, at every level.

The first set of results should be with us in December 2023 and the final set in March 2024. They will be shared as soon as they are available.

2.6 EPCMS Procurement launch

Our main Electronic Patient Record (EPR) system, Lorenzo, is approaching retirement as a clinical system.

The procurement process has started to source a new Electronic Patient Care Management System (EPCMS) which will not only replace Lorenzo, but also Fraxinus (eOutcome, NEWS2, eWhiteboards etc), ORMIS (Theatres) and ICE.

The Trust is part of the NHS England Frontline Digitisation Programme, and our outline business case was approved by the Integrated Care Board and NHS England. This has allowed us to start the procurement in November. The process will take six months and we expect to have a supplier appointed in July 2024.

NHS England has initiated a Frontline Digitisation Programme as there is an acknowledgement that the levels of digitisation across health and social care is mixed. The NHS is investing £1.9bn to ensure the right digital foundations are in place and part of this funding is being provided to trusts to 'level up' the digital capabilities. WHH is part of this Frontline Digitisation Levelling Up Programme receiving funding from NHS England to support the roll out of a new EPR.

It is vital that the end users of the clinical systems are involved in the upcoming evaluations and demonstrations of potential new systems which are planned for January 2024. This system will need to meet the needs of all end users.

Earlier this year, there was great engagement during Digital Week and interest shown during Q&A in my Team Brief by staff that are eager to be involved in the procurement of our new EPCMS. We welcome our colleagues from all departments and roles to volunteer to participate in this opportunity.

The project is currently referred to as ‘EPCMS’, which clearly needs simplification for clinical deployment. We know how creative our colleagues are across the organisation and we need help with creating a new name for the project - something which is meaningful to the Trust, our end-users and our patients.

2.7 Developments in the haematology laboratory

We have been live with our new haematology analysers and equipment for a few weeks now.

The old equipment was coming to the end of its life so needed replacement. We also needed to horizon scan to ensure we were future-proofing the laboratory and utilising the most up-to-date technology. The old equipment was moved in August, which involved separating the analysers and introducing more manual steps, meaning extra work for the staff.

The new track including three full blood count analysers, ESR analyser, smear maker/stainer and archiving area was built over the following few weeks. The laboratory at Halton has also got a new full blood count analyser, which will improve workflow as it is more flexible when prioritising urgent samples and uses more of the same reagents as the Warrington analysers. Each new piece of equipment has then been through a verification process to ensure our results are consistent and of high quality.

Looking ahead over the next few months we will be verifying a new technology that we have invested in – digital morphology. We can start to move away from microscopes and see blood cells on a big screen. This will help enormously with training, flexible working – blood film reporting on both sites, and queries out of hours to the on-call consultants.

2.8 Continuous Flow

Early discharges across wards and subsequent movement out of the Emergency Department (ED) has a huge positive impact on hospital wide flow and supports a reduction in time spent in ED for our patients. We know that elongated time in ED has a direct relationship with poorer outcomes, including harm. Therefore, to support earlier flow and reduced time spent in ED, we have begun to introduce a ‘continuous flow’ process across the Trust.

The ‘continuous flow model’ of care sets times for transfer of patients from the Emergency Department to the admission unit and from the admission unit to wards in advance each day. This means wards will know when to expect new patients to arrive for admission and allows for improved planning so patients can be admitted to the most suitable ward to care for their needs earlier in the day.

Because patients are transferred at set times agreed in advance this can mean that patients arrive on a ward or admission unit before a bed is available. This may mean patients having to wait in a ward area, whilst a ward bed is made ready, or for a patient who is waiting to go to the discharge lounge/home to wait in an alternative ward area. During this time, patients will be cared for by nursing and medical staff for an identified ward. Continuous flow has been rolled out at other trusts including those in Bristol and Oldham with positive impacts being reported. We have learnt from these organisations.

We decided to do a phased implementation of continuous flow across our wards from Monday 9 October.

The benefits of this model include:

- Facilitates earlier discharge and supports better forward planning of discharges for wards.
- Increased utilisation of the discharge lounge.
- Reduced ED crowding including care on corridors.
- Quicker Ambulance Handovers.
- Increased utilisation of virtual wards or Hot clinics.
- Reduction in overnight bed moves.
- Reduction in average number of patients in the Emergency Department.
- Reduction of average time in Emergency Department.
- Supports reduction in 12-hour breaches - although this is not a direct result of continuous flow, the process, alongside other measures do support this reduction.

Like all new processes, there are always risks and no guarantee that this will have the desired impact to the extent that we need. This is why we decided to roll the process out gradually in a phased approach so that we can track progress and pick up any issues immediately. There has been lots of learning from our early weeks but overall, the feedback from all our key stakeholders has been overwhelmingly positive.

2.9 Special Days/Weeks for professional groups

Since our last Board meeting in October 2023, several topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. These have included:

Black History Month: October 2023
National Freedom to Speak Up Month: October 2023
Physician Associate Week: 6 – 12 October 2023
Specialty, Associate Specialist and Specialist (SAS) doctors Week: 9 – 13 October 2023
Allied Health Professionals Day: 14 October 2023
International Infection Prevention Week: 15 – 21 October 2023
Advanced Practice Week: 6 - 11 November 2023
World Quality Week: 6 – 9 November 2023
Occupational Therapy (OT) Week: 6 - 12 November 2023
World Radiography Day: 8 November 2023

2.10 Local political leadership engagement

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

2.11 Employee Recognition

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

You Made A Difference Award (September 2023): Michael Ryder

This award was made to Michael Ryder from our chaplaincy team for all that he has done in supporting staff, specifically those needing additional help through the current cost-of-living crisis. He became an emergency contact for the staff engagement and wellbeing team to get in touch if necessary. Mike also proceeded to run free canoe days for WHH staff members and their family over the summer, as he is a qualified canoe instructor. Mike gave up his own time to provide two full days of canoeing for staff and their families over the summer holidays, when often finding family friendly activities to take part in can be very expensive.

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

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

- Steve Bennett, Head of Strategy & Partnerships
- Caroline Lane, Project Manager - Strategy & Partnerships
- Anne Wainwright, Specialist Nurse Practitioner - Paediatrics
- Mr Dave Atkinson - Consultant Orthopaedic Surgeon, Surgical Specialities
- Mr Ashtin Doorgakant - Consultant Orthopaedic Surgeon, Surgical Specialities
- Louise Foley - Cancer Nurse Specialist, Digestive Diseases
- Clara Dennis - Cancer Nurse Specialist, Digestive Diseases
- Frailty Assessment Unit Team, Integrated Medicine & Community
- Tracey Roberts - Specialist Nurse, Surgical Specialities
- Louise Robinson - Specialist Advanced Practitioner, Digestive Diseases
- Belinda Hill - Staff Nurse, Endoscopy
- Catherine Conneely - Staff Nurse, B4
- Tina Reynolds - Nurse Manager, ITU
- Denise Edwards - Waiting List Clerical Officer, Endoscopy

- Allison Wilson - Sister, Orthopaedic Outpatients
- Nicola Clarke - Staff Nurse, Ward B11
- Maria Palmer - Assistant Practitioner, Ward A1/Acute Medical Unit
- Nicola Burns and Team - Acute Medical Unit, Urgent & Emergency Care
- Katie Nixon and Team – Forget-me-not Unit (B12), Integrated Medicine & Community

2.12 Signed under Seal

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

- Schedule of Works – Daresbury Ophthalmology Scheme (phases 2-3)

3 MEETINGS ATTENDED

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

- NHS England National Leadership Event, London – 8 November 2023
- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)
- CMAST Clinical Pathways Programme (Various)
- Steven Broomhead, Chief Executive, Warrington Borough Council
- Stephen Young, Chief Executive, Halton Borough Council
- Carl Marsh, ICB Place Director (Warrington)
- Anthony Leo, ICB Place Director (Halton)
- Warrington Wider System Sustainability Group (Monthly)
- Clinical Research Network Northwest Coast Partnership Group Meeting (Quarterly)

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 7 (October 2023)

Appendix 1 - CEO Dashboard Month 7 – October 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	79.60%	F
RTT 18 Weeks	92.00%	51.30%	F
RTT 65+ Weeks	0	1324	F
A&E % patients seen within 4 hours	> 75.00%	67.13%	F
A&E % waiting longer than 12 hours	< 2.00%	19.73%	F
Cancer 14 Days	93.00%	65.55%	F
Breast Symptomatic 14 days	93.00%	96.00%	?
Cancer 28 Day Faster Diagnostic Standard	75.00%	75.86%	?
Cancer 62 Days Urgent	85.00%	64.29%	F
Ambulance Handovers within 60 mins	100%	79.94%	F
Discharge Summaries 24 hours	95.00%	88.50%	F
Cancelled Operations – 28 days	0	2	?
Super Stranded Patients	Trajectory	126	No SPC
Theatre Utilisation	85.00%	85.80%	?
Day cases	85.00%	89.64%	P

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	P
Sepsis Screening Emergency	90.00%	68.00%	F
Sepsis Screening Inpatients	90.00%	88.00%	F
Sepsis Antibiotics Emergency	90.00%	68.00%	F
Sepsis Antibiotics Inpatient	90.00%	68.00%	F
Inpatient Falls	20.00% reduction	30	P
VTE	95.49%	94.74%	?
Pressure Ulcers	10.00% reduction	16	?
Medication Reconciliation (24 hrs)	80.00%	44.00%	F
Complaints over 6 months	0	0	P
Healthcare Infections - MRSA	N/A	0 YTD	P
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	23 YTD	?
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	48 YTD	?
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	9 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	4 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	4.06%	No SPC
Maternity 3rd and 4th Degree tears	Less than 1.85%	2.54%	No SPC
Maternity Pregnancy Bookings before 10 weeks	75%	54.10%	F
Maternity Pregnancy Bookings before 13 weeks	90%	83.10%	F
MUST nutritional assessment completion	85%	63.55%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (culm) (£m)	-£1.12	-£2.12	No SPC
Capital Spend (£m)	£14.47	£7.26	F
Cash Balance (£m)	£16.95	£17.27	No SPC
Better Practice Payment Code (culm) (£m)	95%	92%	F
CIP In Year Delivered (culm) (£m)	£7.20	£7.20	P
CIP Forecast (Recurrent) (£m)	£7.20	£2.40	F
Agency Ceiling	Less than 3.7%	3.80%	?

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.67%	F
Retention	85.00%	86.14%	F
Core/Mandatory Training	85.00%	90.01%	P
PDR Compliance	79.00%	74.93%	F

Strategy

Strategy

- **Estates Strategy** - A draft of the Trust's refreshed Estates Strategy was reviewed by Trust Board on 1st November. The Estates Strategy will incorporate a refreshed new hospitals plan, as well as key strategic estates priorities for the next 5 years.

- **Endoscopy Hub** - The Trust's bid to be one of two endoscopy hubs within Cheshire and Merseyside was successful. Plans will now be developed and delivered at pace to provide additional endoscopy capacity on our Halton hospital site.

- **Halton Health Hub** - An Active Travel Wellbeing Worker will be based in the Halton Health Hub at Runcorn Shopping City from November. Working from the hub on a Wednesday and a Thursday, this role is designed to encourage Runcorn residents to better engage with their own ways to wellbeing, with specific focus on access to active travel opportunities across the Halton Borough. This project is being delivered in partnership with Liverpool City Region and Wellbeing Enterprises, a community interest company.

- **Warrington Living Well Hub** - All major structural works have now been completed at the Warrington Living Well Hub. The hub is due to open to residents early in the new year. A general manager of the hub has been recruited. The planned service offers include families and children, pre-frailty, falls, dementia, women's health, care leavers and healthy lifestyles. WHH services will include maternity, cardiac rehab and physiotherapy.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/12/138**	
SUBJECT:	**Chair's Report**	
DATE OF MEETING:	6 December 2023	
AUTHOR(S):	Steve McGuirk, Chair	
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will... Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓
	SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*

This report seeks to draw attention to matters that the Chair believes are of particular significance to the Board of Directors and not covered elsewhere on the Board agenda.

This update draws attention to:

- General Trust Update
  - Chief Nurse & Deputy Chief Executive - Kimberley Salmon-Jamieson
  - Supporting financial recovery
  - Trust achieves Bronze Award as part of NHS Rainbow Badge Programme
- WHH Meetings and Events Attended
  - Board Development Day
  - Council of Governors Meeting

	• Industrial Action
	• System Working & National Updates/Events
	  ○ Cheshire & Mersey Chairs Bi-Monthly Meeting
	  ○ PLACE Meeting
	  ○ NHS Providers NW Regional Meeting
	  ○ Cheshire and Merseyside Health & Care Partnership
	  ○ CMAST Chairs Meeting
	• Council of Governors & Members
	  ○ Annual Members Meeting
	  ○ Governor Elections
	  ○ Governor Observation Visits		

PURPOSE: ***(please select as appropriate)***	**To note** ✓	**Approval**	**Decision**
RECOMMENDATION:	The Trust Board is asked to: I. Note the matters being brough to the attention of the Board. II. Make any comments or ask any questions arising from the report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chair's Report	AGENDA REF:	BM/23/12/138

BACKGROUND/CONTEXT

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

MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

Date	Location	Meeting
11 October	Warrington CCG	C&M Trust Chairs Bi-Monthly Meeting
12 October	MS Teams	Chair's Briefing for Governors
25 October	Bridgewater, Spencer House	PLACE Meeting
1 November	Warrington Hospital	Board Development Day
7 November	Wrightington Hotel & Spa	NHS Providers NW Regional Meeting
9 November	Halton Hospital	Council of Governors Meeting
14 November	Boardroom, The Department, Lewis's, Renshaw Street	C&M Health & Care Partnership
15 November	MS Teams	CMAST Chair's Meeting

KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

3.1 General Update

Chief Nurse & Deputy Chief Executive - Kimberley Salmon-Jamieson
After seven years at the Trust, our chief nurse, Kimberley, will sadly be leaving WHH (the end of March 2024). She will be joining Manchester University NHS Foundation Trust (MFT) as their Executive Group Chief Nurse.

This has been a tough decision for Kimberley, as she remains dedicated to WHH and passionate about her work here. It is difficult to overstate the positive impact Kimberley has had and she leaves behind a legacy that she can be truly proud of. But, MFT is one of the largest trusts in the country and this is therefore a fantastic opportunity for her. On behalf of the Trust Board, and indeed the people of Warrington and Halton, I would like to wish her all the very best for her next career step.

The process to appoint her successor has already begun, with interviews scheduled for Monday 18 December. Internal and external stakeholders, including Governors, ICB and Place representatives, will be involved in the interview process.

Supporting Financial Recovery
Based on our current position (as described in detail elsewhere on this agenda), the Trust is not predicted to hit our previously forecast financial position by the end of the financial year. Other hospital trusts across the country are facing similar challenges which illustrates they develop from a combination of national aspects (such as industrial action by several cohorts of staff) as well elective recovery challenges, alongside local operational challenges; including the difficulties of discharging patients to the community. But in stark terms, our deficit will be at least £15.7m and almost certainly higher.

A communication was therefore posted to all staff on Thursday 23rd November, detailing steps on how each individual can play their part in supporting the financial recovery plan for WHH.
Patient care and safety will always come first, and the quality of our care matters to us and our patients, but it is a fact of public life that there are financial limits to everything, and we must therefore do everything we can to ensure we are in the strongest possible financial position.
Linked to this, consequently, we need to redouble our efforts to scrutinise all areas of expenditure, and look again at more radical change, in order to improve our position with our goal being to become financially sustainable within three years.

Trust achieves Bronze Award as part of NHS Rainbow Badge Programme
The Rainbow Badge initiative was created as a way for NHS staff to demonstrate that they are aware of the issues LGBTQ+ people can face when accessing healthcare.
Pleasingly, WHH has recently been recognised for its commitment and dedication to reducing barriers to healthcare for the LGBTQ+ community. We have been awarded a Bronze Award as part of the Rainbow Badge Programme, after demonstrating the good work undertaken at WHH in several areas including policies, workforce inclusion, clinical service provision, and leadership; evidenced by the findings from staff and patient surveys.

3.2 WHH Meetings and Events Attended

Board Development Day – 5th November 2023
Members of the Board took part in a learning and development day. The first item on the agenda was presented by David Lewis, Senior Partner, Stewart Duffy, Legal Director, Saira Ali, all from Weightmans solicitors and the items covered included:

- **Regulatory Updates** - The law of Corporate Manslaughter, and criminal liability generally at Board level.
- **Governance Updates - The Fit and Proper Persons Regime & Risks of GMC/NMC referral**
- **Employment law Updates - Employment law and HR issues arising from a criminal investigation.**

Other agenda items included claim process updates, Estates Strategy 2024-29 and the forecast financial position.

Council of Governors Meeting – 9 November 2023
The Council of Governors meeting took place on the 9th of November 2023, which was a hybrid meeting that physically took place in the Education Centre at Halton Hospital and via MS Teams. The meeting was well attended by Governors and board members.

The key agenda items discussed were PLACE 2022 Results, Patient Engagement Portal, Governor Elections Results, Associate Non-Executive Director Terms of Office, Working with

People and Communities Strategy, Communications, Engagement & Involvement Dashboard Q2.

The Council of Governors also approved the Membership Strategy 2023-25.

Papers for Council of Governors meeting are made available to the public prior to meetings on the Trust Website. The meetings are open to members of the public to observe. The next Council of Governors meeting will take place on: 15 February 2023, 4pm to 6pm in the Trust Conference Room, Warrington site.

If anyone would like to find out more about the role of Governors at WHH please see our Governor Handbook which was showcased as an example of good practice at the 2023 NHS Providers Governor Conference.

3.3 Industrial Action

Industrial action by UNISON healthcare support worker members took place during week commencing 30 October and 6 November 2023.

- 7am on Thursday 2 November to 8.15am on Saturday 4 November 2023
- 7am on Monday 6 November to 8.15am on Wednesday 8 November 2023

This strike action involved band 3 healthcare assistants, midwifery support workers and theatre support workers and related to a dispute about a re-banding claim and associated backdating arrangements. Discussions with Unions are ongoing and further updates will be provided as and when available.

Doctors began their strike action on Monday 2 October at 7am and finished at 7am on Thursday 5 October. This was combined action by Junior doctors and consultants.

Industrial action is, of course, disappointing as it is inevitable that it has an impact on patients. At the peak of the industrial action, outlined, there were 154 WHH staff absent from work.

In terms of planned care, this resulted in the postponement of patient appointments, though, it should also be recognised that the impact goes beyond planned care. This is because the focus on patient safety and emergency care means missing staff have an impact on other areas, which, in turn, can slow down discharge and take clinicians away from their usual work. The true impact of industrial Action on WHH, therefore, is yet to be quantified.

3.4 System Working and National Updates

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

NHS Providers NW Regional Meeting – 7 November 2023
The CEO of the NHS Providers - Sir Julian Hartley- attended the NW Chairs meeting and provided an extensive overview of the political, financial and operational challenges facing the NHS and Providers in particular. The word unprecedented gets frequently used but this rather gloomy – but accurate - account of, for example, the interplay between the politics of an aging population and a social care and mental health crisis, the impact of the Covid-19 Pandemic (and ongoing Public Inquiry); the financial challenges facing the government; and other major inquiries/ reviews such as the Letby case and the Ockenden Review (to mention but a couple) - all illustrate just

some of the issues that are collectively bringing to bear challenges for Providers not previously been experienced. There is little action to take beyond an acknowledgment of the immensely challenging backdrop being faced by all trusts and WHH is no exception. What was also emphasised, however, was the renewed focus on the costs and financial impact of the demand for the services of the NHS which underlines the way the NHS will be a central feature of the general election campaigning in the coming months.

Cheshire & Mersey Health & Care Partnership – 14 November 2023
The meeting was chaired by Cllr Louise Gittins. The agenda items covered were;

An introduction to Children's Services including role of Director of Childrens' Services / lead member, statutory legislation/guidance (Role of Corporate Parent).

An overview of the beyond programme was provided along with an update on the new Children and Young People (CYP) ICB committee. It was explained that the Committee's main purpose was to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (children and young people), including looked after children.

The second item discussed was addressing Gaps in Care and supporting children who "fall between the gaps", in response to the identified issue around gaps in cross-system commissioning for appropriate models / services to meet the needs of these young people. A progress update was provided on work to date and forward plans. Those in attendance took part in focused break out group discussions.

CMAST Chairs Meeting – 15 November 2023
The CMAST Chairs Meeting was facilitated MS Teams, and predominantly focused on discussions around addressing the significant financial challenges created by industrial action in 2023/24, including actions to be taken and Cheshire and Merseyside implications and opportunities.

Also discussed was NED appointments and NHSE policy for Associate NEDS. The next meeting is scheduled for the 17 January 2023.

3.5 Council of Governors & Members Update

Annual Members Meeting – 4 October 2023
The Annual members meeting took place in the Post Graduate Centre at Warrington Hospital, following the Trust Board meeting. The meeting took a different format this year with concise presentations by the Chair and Chief Executive on behalf of the Board, and by the Lead Governor on behalf of the Council of Governors.

In addition, guest speaker Paul Wood, Rugby League Cares (former Super League, Warrington Wolves and England player) presented on the work being undertaken at the Trust around mental health and wellbeing for staff.

All presentations were well received by Trust Members and attendees, with some thought-provoking questions being put forward; these were answered thoroughly by Trust Board members and Governors.

Governor Elections 2023
The Trust holds Governor Elections each year to fill any vacant seats on our Council of Governors and/or to open up seats in relation to those Governors whose term of office is ending. This year none of the seats were contested and the successful candidates were informed on the 17 October 2023.

The results were:

Public Governors

- 1 in Warrington North - **Colin Jenkins** (3rd term)
- 2 in Warrington South - **Sue Fitzpatrick** (2nd term)
  - **Carol Ann Kelly** (1st term)
- 2 in Rest of England - **Kevin Keith** (2nd term)
  - One seat remains vacant – as only one nomination for this constituency was received.

Staff Governors

- 1 in Support Staff – seat remains vacant – no nominations were received.
- 1 in Clinical Scientists or Allied Health Professionals – Rachel Bold (therapy manager) (1st term)

Newly elected Governors started their term on 1 December 2023. A new Governor induction and training session has been scheduled for the 11 December 2023, at which Governors will be trained on the statutory duties and responsibilities.

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

- Ward A6 – 17 October 2023
- Pharmacy Department - 13 November 2023

RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/23/12/139</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Board Assurance Framework</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">6th December 2023</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">John Culshaw, Company Secretary</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Simon Constable, Chief Executive</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.
SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future
SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.</td><td>✓
✓
✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</td><td colspan="5">All</td></tr>
<tr><td rowspan="6">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td>✓</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="5">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 colspan="2">N/A</td></tr>
<tr><td>✓</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td rowspan="3">3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td>✓</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="5">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 have been no changes to the ratings of any of the risks;</td></tr>
</table>

	• There have been no changes to the descriptions of any of the risks; • No risks have been closed or de-escalated; Notable updates to existing risks are also included in the paper.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, 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	BM/23/10/115	AGENDA REF:	BM/23/12/139

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

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

2.2 Amendment to Risk Ratings

Since the last meeting, there have been no changes to the ratings of any of the risks.

2.3 Amendments to descriptions

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

2.4 De-escalation of Risks

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

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have	<u>Controls</u> • Executive led ED Improvement Group established chaired by the Chief Operating Officer with Chief Nurse & Medical Director as co-chairs • Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	areas to be submitted to the Trust Board in December 2023 <u>Assurances</u> • Continuous flow commenced on 8th October 2023 and is planned for a full roll out in medicine by the end of November 2023 • Triage and streaming test of change to commence in November 2023 – This is to improve productivity and utilisation of assessment areas to support lowering ED occupancy. • Transition to type 5 SDEC reporting to go live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. • Reconfiguration of the ED footprint due to take place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12 hour time in department as referenced in the Tier 1 urgent care metrics. • Funding agreed to progress with the co-location of Minors with SDEC capital works. 12 week programme of work will commence in October 2023 to complete in January 2024. This will improve utilisation and flows away from the main ED in to Minors assessment areas. • As part of being in tier 1 urgent care, the Trust and wider system are being supported by Newton to undertake a place diagnostic on capacity and demand. The outcome will help improve flow, reduce attendances and thus lower bed occupancy.		
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm, failure to achieve constitutional standards and financial plans.	<u>Assurances</u> • The Trust has been confirmed as the regional diagnostic hub to support the reduction of local and system waiting lists. • Additional ENT Locum supported to help target ENT specialty long waiters. Thie will specifically help treat 78 and 65 week waiters before the end of March 2024 • Regional funding secured to support reduction in the echocardiogram	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		waiting list. This is with third party providers and is due to start on 1st November 2023. • The Trust Board supported (1st Nov 2023) an additional £400k for third party providers to help treat all 78 week waiters before the end of March 2024 and significantly reduce 65 week waiters. Further support to be considered by the Trust Board in December 2023. <u>Gaps in Controls</u> • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants.		
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	<u>Controls</u> • Phase 3 of the agency reduction action plan put in place on the 13.11.2023 to cease agency usage on general wards. Associate Chief Nurse, Trust Workforce Lead and Deputy Chief Nurse approval only. <u>Assurances</u> • Nursing: 8 newly qualified staff nurses commenced in ED in October 2023 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 12.47% in October 2023. Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.99% in October 2023 • Maternity: Retention rates continuing to follow a positive trajectory. Turnover for all permanent staff has decreased from 28.36% in September 2022 to 13.661% in September 2023 (Reduction of 14.7%) for registered staff this figure has reduced from 27.72% in September 2022 to 14.91% in September 2023 (reduction of 12.81%) • Maternity: Vacancy rate for registered staff is 13.31%. 8.8 FTE registered staff in the recruitment pipeline. All vacant roles are out to advert • Cost avoidance from agency managed service of 1,398,697 since April 2022 • Reduction in agency spend of 218K since April 2023.	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Reduction in agency hourly rate from £43.20 in April 2022 to £38.32 in October 2023 • International Nurse recruitment: The final cohort (14) of international nurses are now on their allocated wards focus on pastoral support and retention • Roster approval for Christmas and New Year periods has been brought forward and fully approved Gaps • 40% vacancy rate for Band 6 Pharmacists October 2023; 80% Band 7		
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	<u>Controls</u> • Weekly CEO led recovery meeting (inc finance & operations) in place • Tightening controls of non-pay expenditure • Appointment of Director of Recovery on short term contract • The Director of Recovery is reviewing CIP, Cost Pressures and Benefit realisations. • Trust ensuring that activity provided externally does not exceed tariff cost <u>Assurances</u> • Working with the ICS on the forecast position. Letter received confirming additional £4.8m non-recurrent funding, including £1m tier 1 urgent care.	20	No impact on risk rating
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.7% as at August 2023 and is showing an improving variation. The lowest annual absence rate since April 2020. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. <u>Controls</u> • Following an MIAA Audit, the HR team are working with CBUs to develop an audit framework to provide greater assurance regarding compliance with	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		the Supporting Attendance policy by managers. <u>Assurances</u> • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.5% in August 2023. • Current annual welcome back conversation compliance is 91.2% in August 2023. **Turnover and Attraction** Turnover in August 2023 was 13.4% and is showing an improving trend. Turnover of permanent staff in August 2023 was 12.34% which was below Trust target. **Temporary Staffing & Agency Spend** Bank and Agency reliance in August 2023 was 15.9%. Reasons for the variation can be attributed to industrial action and continuing sickness absence, turnover and additional capacity.		

1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	<u>Controls</u>
		
		• IA Task and Finish group completed organisational preparedness for Industrial Action policies and procedures ratified and FAQ documents created and published and updated regularly.
		• B2 HCAs industrial action took place 28th – 29th September 2023 - 5 derogations approved.
		  ○ emergency, trauma and maternity theatres
		  ○ x2 theatre cancer fast track lists
		• Derogation requests to be made for planned B2 HCSW Industrial Action from 16/10/23 – 21/10/23.
		• Executive Medical Director led check and challenge meetings for periods of Industrial Action to prepare and mitigate risk.
		• Chief Nurse led meetings re: Industrial Action preparedness for periods of B2 HCSW Industrial Action to prepare and mitigate risk.
			20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating

		<u>Assurance:</u>
		
		• Mandate met for Junior Doctors Industrial Action mandate will run until 28/02/2024
		• National guidance available for Consultant IA
		• 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.
		
		<u>Gaps in Assurances & Controls</u>
		
		• Unison notification of intention to ballot B2 HCSW opens 07/08/23 and closes 03/09/23
		• Unison ballot met 50% threshold potential period of Industrial Action from 18/09/23 – 03/03/23
		• B2 HCAs industrial action took place 28th – 29th September 2023
		  ○ HCA staff on strike = 169 people, at a total of 2,036 hours lost
		• B2 HCAs industrial action planned for:
		  ○ 7am Mon 16th – 8am Tues 17th October 2023
		  ○ 7am Wed 18th – 8am Thurs 19th October 2023
		  ○ 7am Fri 20th – 8am Sat 21st October 2023
		• Ongoing discussions with Unison re B2 HCSW IA and without prejudice offer made on 09/10/23 with a view to calling off the planned strikes Unison to respond by 1pm 13/10/23.
		• BMA SAS ballot for IA closes 16th October 2023
		• Trust has received notice from HCSA that ballot for IA will open 18/10/23 and close on 15/11/23 - 6 members will be balloted.
		• BMA Consultants industrial action 19th – 20th September 2023
		• BMA Junior Doctor industrial action 20th – 22nd September 2023
		• BMA joint industrial action Consultants and Junior Doctors 2nd October – 4th October 2023		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		○ Average number of JD participating in IA – 101 JD = 69% • Average number of Consultants participating in IA – 38 Consultants = 28%		
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 patient harm and a failure to achieve constitutional standards.	ENT Surgery added to the Fragile Services Oversight Program	20	No impact 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.	<u>Controls</u> • Active core member C&M Cyber Core Group and the C&M Health and Care Partnership Cyber Security Group. • Outcome of the third Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness. <u>Gaps in controls</u> • No funding for MUSE system migration • Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning	16	No impact on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	<u>Assurance</u> • 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)	16	No impact on risk rating
1898	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all	<u>Gaps</u> • Confirmation received that the Trust was unsuccessful in securing funding via HIP phase 3. Future rolling programme of funding has been	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	indicated; however, the details are currently unclear. • Estates strategy incorporating options and enablers for new hospitals plans complete. <u>Assurances</u> • Funding secured to deliver: ○ Community Diagnostics Centre, ○ Additional theatre ward and endoscopy capacity at Halton ○ Community Hubs in Runcorn and Warrington.		
125	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	<u>Assurances</u> • Approval received to replace Computer Aided Facilities Management System with a plan to go live on 1st December 2023 • Capital programme of works to be upgrade the Trust's patient catering facilities commenced in October 2023 and due to complete in June 2024. • Full site survey for RAAC commissioned in October 2023 and due to complete at end of November 2023	15	No impact on risk rating
145	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	<u>Assurances</u> • Capital bid for strategic capital project resource submitted as part of the 2024/25 capital planning process. • National funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case in development to be presented to the Trust Board in February 2024.	12	No impact on risk rating

3. RECOMMENDATIONS

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

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	1	20 (5x4)	8 (2x4)	TBC	Quality Assurance Committee
1215	Daniel Moore	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (4x5)	6 (3x2)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
134	Jane Hurst	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1757	Michelle Cloney/Paul Fitzsimmons	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	20 (5x4)	8 (4x2)	TBC	Strategic People Committee
2001	Paul Fitzsimmons	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to	1	20 (5x4)	6 (2 x 3)	TBC	Quality Assurance Committee

		the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.					
1114	Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1372	Paul Fitzsimmons	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1898	Lucy Gardner	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	3	16 (4x4)	4 (1x4)	TBC	Finance & Sustainability Committee
125	Daniel Moore	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	1	15 (3x5)	10 (2 x 5)	TBC	Executive Management Team
145	Simon Constable	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (3x4)	8 (4x2)	TBC	Executive Management Team
1846	Kimberley Salmon-Jamieson	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage	1	12 (4x3)	4 (1x4)	TBC	Quality Assurance Committee

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

Risk Appetite Statement

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

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

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

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

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

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

<u>Quality</u>

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

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

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

Board Assurance Framework

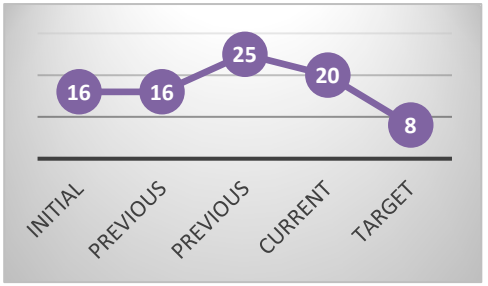
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety			**Initial:**	16(4x4)
				Current:	20(5x4)
				Target:	8 (2 x 4)

Assurance Details:

Controls

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



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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/10/2023 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report	Ongoing monitoring of risk via daily report SITREP,	Field-Delaney, Sheila	31/10/2023 (ongoing)	

	National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG			

Board Assurance Framework

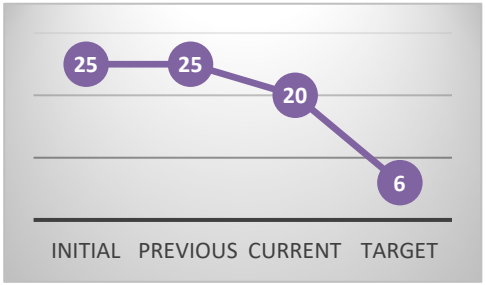
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial:**	25 (5x5)
				Current:	20 (4x5)
				Target:	6 (3x2)

Assurance Details:

Controls

- Clinical Services Oversight Group (CSOG) established
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance.
- Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23.
- Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted.
- Waiting lists are reviewed through the Performance Review Group Weekly
- Workforce is continually reviewed to ensure that all wards and teams are staffed safely.
- Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery
- The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures.
- Capacity identified and being utilised with appropriate independent sector providers
- To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reservice programme of work.
- Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity
- Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward A5 on the Warrington site.
- Weekly theatre scheduling to ensure listing of patients in line with national guidance.
- Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
- Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks
- Continue to ensure urgent cancers are prioritised in line with national guidance
- Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends.
- Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients
- Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae by the end of Q4 2022/23.
- Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24
- Digital Validation commencing in May 2023 to improve data quality of the Trust waiting lists



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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/10/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)

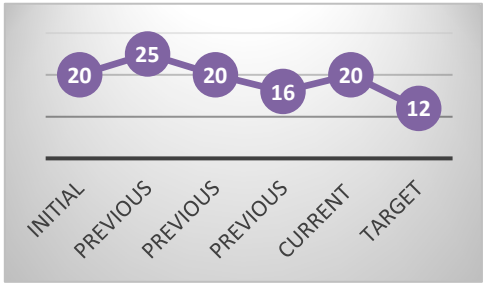
Assurance Details:

Controls

- 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG)
- Progress against recruitment to fill Trust vacancies monitored by Associate Chief nurses and Deputy Chief Nurse at WRG, areas of concern escalated to Chief Nurse, Deputy Chief Executive and local actions plans in place with additional support from Executive Team
- Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity
- Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels
- Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service
- Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making
- Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust
- Workforce plan in place, includes agency reduction plan with phase 1 and phase 2 completed
- Phase 3 of the agency reduction action plan put in place on the 13.11.2023 to cease agency usage on general wards. Associate Chief Nurse, Trust Workforce Lead and Deputy Chief Nurse approval only
- Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team

Assurances

- Nursing: 8 newly qualified staff nurses commenced in ED in October 2023
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 12.47% in October 2023. Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.99% in October 2023
- Maternity: Retention rates continuing to follow a positive trajectory. Turnover for all permanent staff has decreased from 28.36% in September 2022 to 13.661% in September 2023 (Reduction of 14.7%) for registered staff this figure has reduced from 27.72% in September 2022 to 14.91% in September 2023 (reduction of 12.81%)
- Maternity: Vacancy rate for registered staff is 13.31%. 8.8 FTE registered staff in the recruitment pipeline. All vacant roles are out to advert
- Cost avoidance from agency managed service of 1,398,697 since April 2022
- Reduction in agency spend of 218K since April 2023.
- Reduction in agency hourly rate from £43.20 in April 2022 to £38.32 in October 2023
- Revenue requests for ED have been approved which supports increased staffing establishment to provide corridor care 24/7
- International Nurse recruitment: The final cohort (14) of international nurses are now on their allocated wards focus on pastoral support and retention
- Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead
- Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly



	• Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift • Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews • Leaver data is closely monitored and Trust Executive Team supported a position of over recruitment to enable replacement of leavers in a timely manner • Retention – Internal Transfer process in place for staff • A7, A8 and A9 uplift in healthcare support workers for night shifts approved to support the provision of enhanced care • Roster approval for Christmas and New Year periods has been brought forward and fully approved • Re-launch of what was the Safe Staffing Group, now the Nurse Staffing and Clinical Outcomes Group to provide a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk	
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B18 and A4 accelerated transfers and boarding out of hours • Winter pressures planning and early escalation of A10 with B4 plannedB4 and potential to open Cardiac Catheter Lab • Partially funded revenue requests • 40% vacancy rate for Band 6 Pharmacists October 2023; 80% Band 7 • Time to post when recruiting new staff • Ensuring safe staffing in response to doctor and healthcare support worker strikes	

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

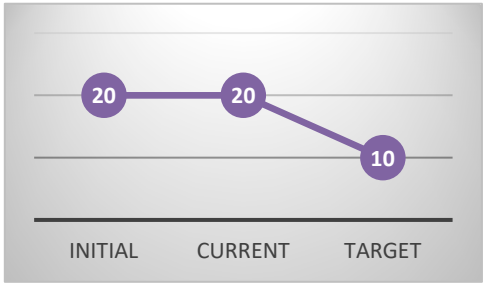
Assurance Details:

Controls

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

Assurances

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



	• Capital is reported monthly to F&SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Overall, no change in WTE plan, however there is a plan to reduce agency and bank and increase substantive staffing. • HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • We have allocated CIP targets under an approved new methodology for 2023/24 • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • ICS Expenditure Control Group established. Terms of Reference drafted and the initial meeting will take place on 1st October 2023 • Working with the ICS on the forecast position. Letter received confirming additional £4.8m non-recurrent funding, including £1m tier 1 urgent care.	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Risk of unforeseen costs and under delivery of activity and income due to further COVID-19 / Flu surge / Industrial action • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Introduction of protocol for changing forecast outturn with the potential impact of restricting financial freedoms and access to capital. • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Not all cost pressures have been funded in plan for 2023/24 • Risk to financial freedoms as the Trust has a deficit plan • Sufficient cash available based on operational plan however, deterioration from plan represents a risk to cash • Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted • New 65 week target will require investment of circa £1m	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Undertake review of CIP, Cost Pressures and Benefits Realisation	Report outcome of review to Finance & Sustainability Committee	Named Executive Leads to deliver plans	Powls, Matt	20.12.2023	
Review ERF activity	Review ERF activity with Place Lead	Complete Review	Hurst, Jane	30.11.2023	

Board Assurance Framework

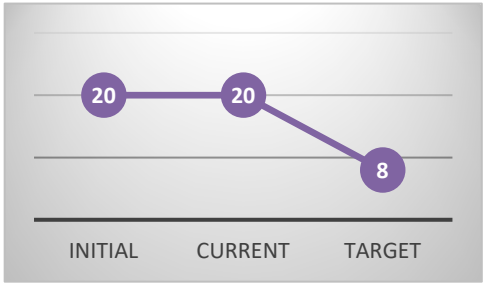
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial:**	20 (4x5)
				Current:	20 (4x5)
				Target:	8 (4x2)

Control & Assurance Details:

Sickness Absence

The rolling 12-month sickness absence rate is 5.7% as at August 2023 and is showing an improving variation. The lowest annual absence rate since April 2020. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.



Controls

•New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023.
•Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers.
•Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported.
•Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management.
•People Health and Wellbeing Group. The group have focused on understanding the Trust's absence reasons and reducing the volume of absences recorded as 'unknown'.
•Supporting Attendance Month - roadshows, drop-in sessions, comms and events to showcase the Trust's commitment to Supporting Attendance
•Focused welcome back conversation recording and internal audit
•Following an MIAA Audit, the HR team are working with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers.

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 3.5% in August 2023.
•Pilot took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE
•Pro-active health interventions being 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
•Current annual welcome back conversation compliance is 91.2% in August 2023.
•Sickness absence, turnover and attraction workstreams have been reviewed inline with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been

Turnover and Attraction

Turnover in August 2023 was 13.4% and is showing an improving trend. Turnover of permanent staff in August 2023 was 12.34% which was below Trust target.
Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving.

	Controls •Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted action. This information is available on the Trust Workforce Information Dashboard. •Rugby League Cares have been supporting WHH since July 2021 •Grief and Menopause cafes •Social media accounts have been created to support recruitment attraction across a number of social media platforms •Financial wellbeing resources have been implmented to support the workforce and retention including Wagestream • 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. **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 16% of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions. **Temporary Staffing & Agency spend** Bank and Agency reliance in August 2023 was 15.9%. Reasons for the variation can be attributed to industrial action and continuing sickness absence, turnover and additional capacity. **Controls** •The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies approval o ECF process for bank and agency temporary staffing pay spend approval o Medical Rate Escalations approved by Medical Director • The Resourcing Task and Finish group are developing robust processes to support compliance with national guidelines/standards for using temporary workers. All staff groups/CBUs will be monitored against these standards. Compliance is to be reported within the Medical and Nursing/AHP Workforce Groups and to FSC. A dashboard is being developed that will summarise workforce related intelligence to inform decision making regarding vacancies and temporary staffing. This will evolve to support the CBUs/staff groups to understand compliance gaps with national standards. **Assurances** •Compliance against our processes and rate cards monitored through the Finance and Sustainability Committee •To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace the ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group.	
Assurance Gaps:	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Turnover continuing to be above target but is showing an improving variance to meet target. • Agency spend above the 3.4% target, factors influencing this will be monitored within the new approach developed by the Resourcing working group • Compliance with NHSE Agency Rate card very low, to be measured within the new approach developed by the Resourcing working group • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an approach to measuring and monitoring factors influencing temporary staffing spend	Through the Resourcing working group establish a process of developing an approach to measuring and monitoring factors influencing temporary staffing spend	The Resourcing working group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: • Agency controls best practice • Rostering compliance • Rate card compliance • Establishment Control compliance (or an alternative approach) • Unplanned absences • Recruitment activity System will ensure the factors are reported to FSC and Workforce Review Groups	Carl Roberts	31.10.2023	
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	31.03.2024	
Embed an agile and flexible working culture within all WHH Teams	Through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1757	**Executive Lead:**	Cloney, Michelle/Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future. Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety			**Initial:**	16 (4 x 4)
				Current:	20 (5 x 4)
				Target:	8 (4 x 2)

Control & Assurance Details:

Controls

•Weekly IA Task and Finish group established from 28th October 2022 requiring representatives from across all departments to attend to plan for IA.

• Derogation list for required services drafted for review as required with Staff Side once notification of strike received.

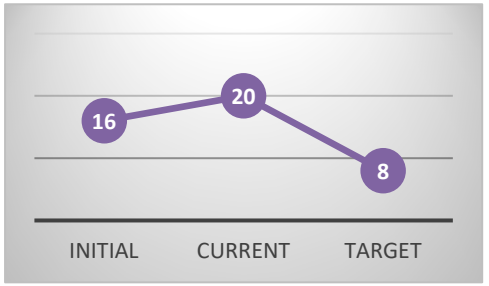
•Weekly meetings with Staff Side established to manage partner relationships.

•Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible.

- 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
- IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH.
- 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.
- B2 HCAs industrial action took place 28th – 29th September 2023 - 5 derogations approved.
  - emergency, trauma and maternity theatres
  - x2 theatre cancer fast track lists
- Derogation requests to be made for planned B2 HCSW Industrial Action from 16/10/23 – 21/10/23.
- Executive Medical Director led check and challenge meetings for periods of Industrial Action to prepare and mitigate risk.
- Chief Nurse led meetings re: Industrial Action preparedness for periods of B2 HCSW Industrial Action to prepare and mitigate risk.



Assurance

- Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.
- Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
- Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. Planning meetings commenced and will continue. Rest facilities available throughout strike action period. Control room to be set up. Additional skills training to be set up. Junior Doctors who choose to work will report to the control room.
- Controlled and calm response for Junior Doctors 5-day walkout in July and the 48-hour consultant strike action on 20 - 21 July 2023
- AfC pay agreement implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24
- RCN ballot that closed on the 23/06/23 did not meet the mandate therefore no further planned RCN IA at present time. Society of Radiographers did not meet their mandate at WHH.
- BMA Junior Doctors re-ballot to commence 19/06/23 - 31/08/23 as current ballot mandate runs out at the end of August.
- Mandate met for Junior Doctors Industrial Action mandate will run until 28/02/2024

	• National guidance available for Consultant IA • BMA have published letter 13/07/23 r.e. the process for requesting derogations. • 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. • Trust mitigated the need for derogations to services for Consultant IA held in July 2023 • Recruiting Junior Doctors to WHH bank • 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.	

Assurance Gaps:	• Currently 2 ballots in progress, Junior Doctors BMA and Unison Band 2 Health Care Support workers.
	• 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
	• Consultant IA likely to have significant operational and financial impact on the Trust.
	• 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. The Secretary of State for Business and Trade has 7 days to appeal this high court decision. Also, Collaborative banks cannot be utilised.
	• Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extracontractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods.
	• The above is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics
	• Unison notification of intention to ballot B2 HCSW opens 07/08/23 and closes 03/09/23
	• Unison ballot met 50% threshold potential period of Industrial Action from 18/09/23 – 03/03/23
	• B2 HCAs industrial action took place 28th – 29th September 2023
	  ○ HCA staff on strike = 169 people, at a total of 2,036 hours lost
	• B2 HCAs industrial action planned for:
	  ○ 7am Mon 16th – 8am Tues 17th October 2023
	  ○ 7am Wed 18th – 8am Thurs 19th October 2023
	  ○ 7am Fri 20th – 8am Sat 21st October 2023
	• Ongoing discussions with Unison re B2 HCSW IA and without prejudice offer made on 09/10/23 with a view to calling off the planned strikes Unison to respond by 1pm 13/10/23.
	• BMA SAS ballot for IA closes 16th October 2023
	• Trust has received notice from HCSA that ballot for IA will open 18/10/23 and close on 15/11/23 - 6 members will be balloted.
	• BMA Consultants industrial action 19th – 20th September 2023
	• BMA Junior Doctor industrial action 20th – 22nd September 2023
	• BMA joint industrial action Consultants and Junior Doctors 2nd October – 4th October 2023
	  ○ Average number of JD participating in IA – 101 JD = 69%
	  ○ Average number of Consultants participating in IA – 38 Consultants = 28%	

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	30/11/2023 (ongoing)	
Check and challenge meetings to commence for Consultant Industrial Action	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Fitzsimmons, Paul	30/11/2023 (ongoing)	

Weekly Industrial Action Update to Execs	Executive Management Team to receive weekly updates on Industrial Action	Executive Management Team to receive weekly updates on Industrial Action	Hilton, Laura	30/11/2023 (ongoing)	
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	30/11/2023 (ongoing)	
Nursing led Industrial Action Preparation meetings for HCSW B2 Industrial Action	Nursing led Industrial Action Preparation meetings for HCSW B2 Industrial Action	Nursing led Industrial Action Preparation meetings for HCSW B2 Industrial Action	Kennah, Ali	30/11/2023 (ongoing)	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	2001	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.			**Initial:**	20 (5 x 4)
				Current:	20 (5 x 4)
				Target:	6 (2 x 3)

Assurance Details:

The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'.

Current services included in the Fragile Services Oversight program are:

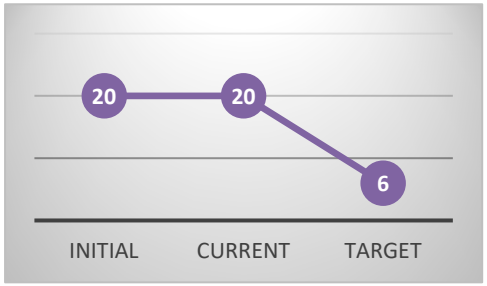
- Gynaecology
- Urology
- Orthopaedics – Fractured Neck of Femur
- Ophthalmology – Paediatric Ophthalmology
- ENT Surgery

Controls

- Formal process in place for identification and designation of Fragile Services
- Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams
- Appropriate prioritisation of Fragile Service Revenue and Capital Requests

Assurances

- Monthly oversight through standardised Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC)
- Escalation to Quality Assurance Committee via PSCESC escalation reports
- Bi-monthly Fragile Services report to Trust Board



Assurance Gaps:

- Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bedbase)
- Ongoing industrial action
- Increasing demand

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

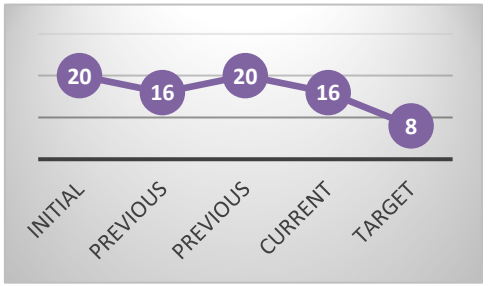
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	8 (2x4)

Assurance Details:

Assurance:

- Risks for Cyber on risk register in line of national requirements of the DSPT & NHS England
- **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures).
- **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.
- **Trust benchmarking** activities including Use of Resources reviews (Model Hospital).
- New updated ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.
- Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee.
- Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital
- WHHT return for assurance re cyber security to NHS England



Controls:

- **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.
- Active core member C&M Cyber Core Group and the C&M Health and Care Partnership Cyber Security Group.
- **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
- **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training.
- External NHS England approved Cyber Training for the Trust Exec Board
- 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.
- Secondary secure backup at Halton Data Centre
- Remote devices no longer bypassing the web proxy
- Active Directory password set to expire again (covid working from home-related).
- Fully recruit to the Digital Service restructure Phase 1 restructure
- Outcome of the third Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness.

	• Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched	
Assurance Gaps:	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) • Using unsupported software SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. Would be difficult to implement. • Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Version 7 of Clinisys Ice is end of life • No funding for MUSE system migration • Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning	

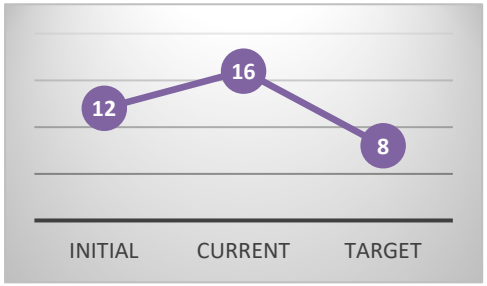
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).	Migrate all 2003 and 2008 servers to 2016.	The data from SharePoint to be migrated has been delayed until Jan 24, this is due to Governance still testing the system and updating materials. Once completed the last 2 2008 Windows Servers will be decommissioned.	Deacon, Stephen	31/01/2024	
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating	Migrate/decommsion Server 2012 servers	Update to the 2012 EOL project: WHHUSOFTV1	Waterfield, Tracie	31/03/2024	

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.		IT elements complete. Working with Operations and Digital Analytics to complete work target decommission the server in Q4 WHHNBSSV1 The third-party informed us that due to a software issue the 21st migration date has been postponed. New date TBC target January 2024. NCHVPRISM01 Work scheduled with the third-party. Team leaders of users have been informed of maintenance work. Tuesday 28th November 12pm – 2pm. WHHMUSEV1 Awaiting on funding decision emergency capital prioritisation submitted awaiting CPG support in December 2023 WHHMUSEV2 Awaiting on funding decision emergency capital prioritisation submitted awaiting CPG support in December 2023 WHHDWH1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in February 2024 WHHDWW1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in February 2024 WHHLEV1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in February 2024 WHHCONWRXV1 PO raised works will be scheduled in Q4.			

		WHHCONWRXV2 PO raised works will be scheduled in Q4. WHHTEMPOV1 Data migration to new server arranged 23/22/23. Decommissioned will be arranged end November providing there are no issues with the data migration.			
Upgrade and enable DLP to enable USB read-only. Disabled as its is crashing desktops, needs the ePO agent on the server to be upgraded.	Upgrade and enable DLP	Order has been submitted and is with Procurement. Once order complete the software can be rolled out to the desktops and laptops.	Waterfield, Tracie	31/12/2023	
Seek funding for Cynerio Medical Devices Module	Seek funding for Cynerio Medical Devices Module	Applied for capital funding 24/25 to purchase the Medical Devices module, waiting on outcome.	Deacon, Stephen	29/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

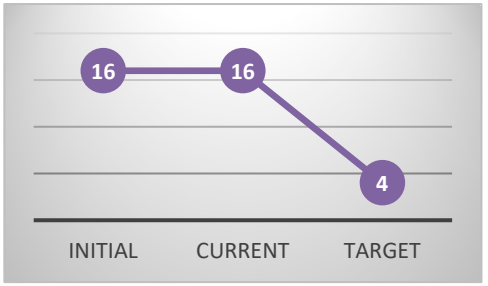
Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety			**Initial:**	12 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
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) **Controls:** • Business case approved and contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling in OBC includes 5-year Lorenzo costs • ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance. • Senior Programme Manager assigned • Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits				
Assurance Gaps:	**Gaps In Assurance:** • ICS strategic approach to delivering managed convergence through open procurement remains unclear **Gaps In Controls:** • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Phasing of frontline Digitisation Funding with funding availability not matching the timing of forecast expenditure • Deficit in programme year 3				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE Digital leadership fully sighted and remain supportive of procurement approach following departure from partnership procurement model	Ongoing engagement with ICS and NHSE Digital leadership	Fitzsimmons, Paul	11/10/23	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1898	**Executive Lead:**	Gardner, Lucy	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communit				
Risk Description:	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.			**Initial:**	16 (4x4)
				Current:	16 (4x4)
				Target:	4 (1 x 4)

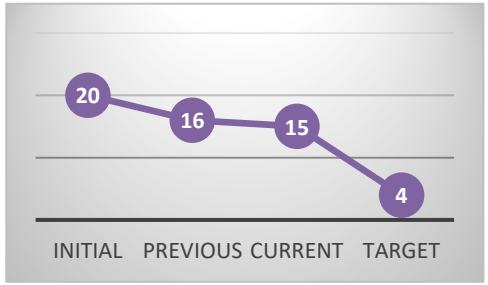
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have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

Assurance Gaps:	• Confirmation received that the Trust was unsuccessful in securing funding via HIP phase 3. Future rolling programme of funding has been indicated; however, the details are currently unclear.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
New Hospitals Strategy Refresh	Produce updated estates strategy outlining steps required to create new hospital estate for Trust.	Complete and sign off Estates Strategy.	Moore, Dan	10/01/2024	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Gardner, Lucy	31/03/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	125	**Executive Lead:**	Moore, Dan	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns			**Initial:**	20 (5x4)
				Current:	15 (3x5)
				Target:	10 (2 x 5)
Assurance Details:	**Controls:** Annual capital funding is allocated to business critical, mandated and statutory estates projects Planned Maintenance Program Reactive maintenance process Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments **Assurance:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills In September 2022 it has been confirmed that phase 1 of the CDC & the Targeted Investment Fund (TIF) for delivery of elective recovery at the Halton site have both been approved. The capital builds in these cases will substantially increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity New CT and MR scanner replacement to be undertaken in 2023/24 Approval received to replace Computer Aided Facilities Management System with a plan to go live on 1st December 2023 Updated Estates Strategy in development and draft to be prsented to the Trust Board in November 2023 Second stage of digital fire alarm upgrade (Kendrick Wing) planned for 2024/25 Capital plan Capital programme of works to be upgrade the the Trust's patient catering facilities commenced in October 2023 and due to complete in June 2024. Full site survey for RAAC commissioned in October 2023 and due to complete at end of November 2023				
Assurance Gaps:	Limited capital funding to address backlog Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM) Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome				

	Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market.

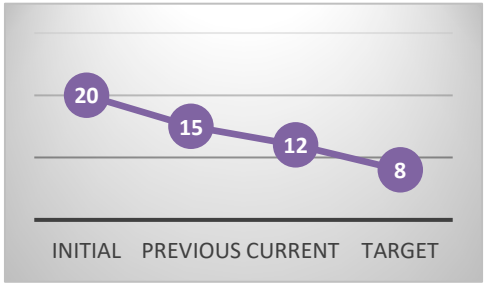
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	30/06/2024	
Develop estates maintenance compliance monitoring tools	Integrate performance and compliance into0 routing estates maintenance operations	Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance and in turn improve compliance against recommended guidelines and internal KPIs	Ian Wright	01/12/2023	
Develop new estates strategy	Update Estates Strategy	Complete strategy update for approval	Ian Wright	01/11/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	145	**Executive Lead:**	Constable, Simon
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.		
Risk Description:	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.		
Assurance Details:	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. • Council and Place Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level have been refreshed • Breast Centre of Excellence opened. Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Revised plans for CDC approved by Trust Board and national diagnostics team. • Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. - Full Business Case for the Health & Wellbeing Hub approved by the Government. Contractors appointed to commence the capital works for Health & Wellbeing Hub. • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. • Consistent Trust representation within Cheshire & Merseyside ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative.		

Rating	
Initial	20 (5x4)
Current	12 (3x4)
Target	8 (4x2)

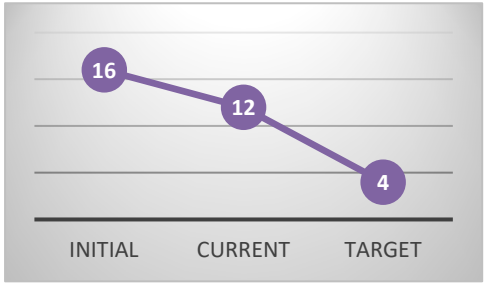


	• Trust representation on place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • Director of Strategy & Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Adaptive Reserve Fund created with Warrington Place partners • Discussions with neighbouring Trusts to accelerate collaboration taking place **Assurances** • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • Full refresh of the Trust 5-year strategy complete • In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. • Pace of pathology collaboration no longer poses a such significant risk to service delivery for WHH as challenges within histopathology are being addressed via mutual aid and recruitment. • Capital bid for strategic capital project resource submitted as part of the 2024/25 capital planning process • Nationanal funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case in development to be presented to the Trust Board in February 2024.	
Assurance Gaps:	• Self assessments of both Warrington & Halton place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy. • Trust's capacity to deliver significant number of capital projects	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/04/2024	
Ensure sufficient capacity to deliver increased number of capital projects	Undertake Gap Analysis of requirements vs resource	Address any gaps identified	Lucy Gardner & Dan Moore	31/12/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1846	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage			**Initial:**	16 (4x4)
				Current:	12 (3x4)
				Target:	4 (1 x 4)
Assurance Details:	**Controls** • Allocation of the Patient Safety Project Director to lead the incident response. • Appointment of an audiology Patient Safety Project Review Manager to prepare a comprehensive service review document and a whole project timeline. • The Trust is ensuring that for any babies who require testing, that this is carried out safely and in line with national best practice. This includes on site oversight provided by audiologists from an IQIPS accredited audiology service, for each ABR undertaken. • Allocation of technical support to maintain and effective waiting list and ongoing patient management tracking functionally. • Operational support to action service change requirements. • Audiology services to participate in Cheshire and Mersey Peer Review process to ensure oversight and consistency of ABR results • Auditory brain stem testing is carried out with commissioner support, with a contract variation in place. • Work to achieve UKAS IQIPS accreditation has commenced. **Assurances** • WHH has been working with Rochdale (Northern Care Alliance NHS Group) on the continuation of the ABR pathway and WHH staff training. • Two audiology staff members have undertaken full competency assessments in order to undertake unsupervised ABR testing. • Peer review is in place to assess every ABR test result undertaken				
Assurance Gaps:	**Gaps in Controls** Until all the children requiring review have been assessed full harm determination cannot be made.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Full investigation to be carried out.	A programme of works to be set out to enable the Trust to carry out a complete and concise investigation of ABR testing since 2018.	An incident cell has been formed to oversee the actions required identified as part of the review. This requires the management of multiple stakeholders across local, regional and national bodies. In addition, there is the requirement to undertake a due diligence exercise for each baby who has had an ABR review since the beginning of 2018 up until 2/02/23.	Deborah Carter	31/01/2024	
Service review to be undertaken	A full service review to be undertaken of the audiology service.	A full service review to be undertaken of the audiology service.	Deborah Carter	31/01/2024	
To establish if any harm has been caused as a result of the issues identified in the incident	To undertake a full review of each individual identified	Clinical MDT established to review all cases	Deborah Carter	31/01/2024	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/12/140**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	6th December 2023	
AUTHOR(S):	Marie Garnett – Head of Contracts, Performance and Commercial Development Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Acting Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Kimberley Salmon-Jamieson – Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk	

<table>
<tr><td></td><td>delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff</td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
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</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>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>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td>
The Trust has 81 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance over the last 7 months. Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>8 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality
• Medication Safety Reconciliation within 24 hours
Access and Performance
• Diagnostic Waiting Times 6 Weeks
• Referral to treatment – Open Pathways
• A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge
• Discharge Summaries – Number not sent in 7 days
• RTT – Number of patients waiting 65+ weeks
Workforce
• Bank and Agency Reliance
Finance
• Capital Programme
</td></tr>
</table>

	At Month 7 the plan is a £11.96m deficit, however, the actual deficit was £15.82m with the overspend being due in the main to Industrial Action (IA) costs, activity delivered under plan and additional capacity in A&E. The position includes an additional £0.7m income relating to April to August 2023 following a reduction in the ERF target of 2% to support the impact of IA in April 2023. A further £0.5m has been assumed in anticipation of further ERF adjustments relating to IA in June to October 2023 (as per discussion with ICS). A coding catch up of £0.4m has also been assumed for month 7 which is a risk in the reported position.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the reduction in the oversubscribed capital programme and the associated deferral of part of one scheme to 2024/25 as supported and approved by the Finance and Sustainability Committee. 2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 3. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/23/10/145; FSC/23/11/162	
	Date of meeting	25/10/2023; 29/11/2023	
	Summary of Outcome	Reduction in oversubscription of capital programme and associated deferral of schemes to 2024/25. Changes to the capital contingency supported and approved.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/23/12/140

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 81 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** 13. Medication Safety - Reconciliation within 24 hours ***(39% - 80% target)*** **A&P** 34. Diagnostic Waiting Times 6 Weeks ***(79.6% - 95% target)*** 35. Referral to treatment Open Pathways - ***(51.3% - 92% target)*** 37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge ***(19.7% - 2% target)*** 51. Discharge Summaries - Number NOT sent in 7 days ***(356 - 0 target)*** 67. RTT - Number of patients waiting 65+ weeks ***(1324 - 0 target)*** **Workforce** 71. Bank and Agency Reliance ***(15.9% - 9% target)*** **Finance** 77. Capital Programme ***(£7.26m – £14.47m target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 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 – 33. MUST nutritional assessment completion **A&P** 36. A&E Wait Times - % patients waiting under 4 hours 39. Cancer 14 Days 45. Cancer 62 Days Urgent 47. Ambulance Handovers within 15 minutes 50. Discharge Summaries - % sent within 24hrs 53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation 58. Elective Outpatient Activity **Finance** 80. Cost Improvement Programme (recurrent forecast) – In year performance to date	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 21. Friends and Family (ED and UCC) 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis 31a. Maternity Pregnancy Bookings before 10 weeks 31b. Maternity Pregnancy Bookings before 13 weeks **A&P** 48. Ambulance Handovers within 30 minutes 49. Ambulance Handovers within 60 minutes **Workforce** 68. Supporting Attendance 69. Retention 73. Safeguarding Training 74. PDR **Finance** 78. Better Payment Practice Code	**CONSISTENTLY FAILING TARGET & NO SPC**
Inconsistently Passes/Fails the Target	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **Quality** 6. Healthcare Acquired Infections (Ecoli) 10. VTE Assessment **A&P** 43. Cancer 31 Days Subsequent Surgery	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 12. Pressure Ulcers 28. Acute Kidney Injury **A&P** 40. Breast Symptoms 14 Days 41. 28 Day Faster Cancer Diagnosis Standard 42. Cancer 31 Days First Treatment 59. Patients seen in the Fracture Clinic within 72 hours	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 15. Staffing Care Hours per patient day (CHPPD) **A&P** 65. Theatre Utilisation (measured as productive operating time only) **Workforce** 70. Turnover **Finance** 81. Agency Ceiling	**INCONSISTENTLY PASSING TARGET & NO SPC**

	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE	CONSISTENTLY PASSING TARGET & NO SPC
Consistently Passes the Target (based on the last 7 months)		**Quality** 1.Incidents 2. Duty of Candour (serious incidents) 19. Complaints 20. Friends and Family (Inpatients & Day cases) 22. Mixed Sex Accommodation Breaches (Non ITU Only) **A&P** 44. Cancer 31 Days Subsequent Drug 46. Cancer 62 Days Screening 52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 54. Urgent Operations Cancelled for 2nd Time 66. Day case (measured as an aggregate of total cases)	**Quality** 3.Healthcare Acquired Infections (MRSA) 11. Inpatient Falls & harm levels 14. Staffing - Average Fill Rate 18. NICE Compliance **Workforce** 72.Core/Mandatory Training **Finance** 79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	
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 16. Mortality ratio – HSMR	**Quality** 4. Healthcare Acquired Infections (MSSA) 17. Mortality ratio - SHMI 32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 38. Average time in department ED 55. Super Stranded Patients 62. Reduction in Outpatient Follow Ups 64. % Patients discharged to their usual place of residence	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks **A&P** 61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	**Quality** 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage 30. Maternity 3rd and 4th Degree tears **A&P** 56. Elective Recovery Activity (Grouped SPCs) 57. Elective Recovery Diagnostic Activity 60. % patients referred to long COVID service not assessed within 15 weeks **Finance** 75. Trust Financial Position (£m) 76. Cash Balance (£m)

Key:

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**

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

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

The Income Statement for October 2023 is attached in **Appendix 5**.

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

- CIP delivery.
- Cost pressures – the Trust was unable to fund circa £8m cost pressures and has put in a process to oversee mitigation plans and risk management.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR) - An additional £1.2m income is included in the position following a reduction in the ERF target of 2% to support the impact of IA in April 2023. Correspondence has been received from the ICS that there will be a further reduction of the ERF target of 2% to account for the impact of industrial action between June and October 2023. A further adjustment of £1.2m will be included from Month 8.
- A&E staffing pressures.
- Additional capacity open due to the levels of no criteria to reside patients.
- Cost of Industrial Action.
- Activity delivered is under plan resulting in loss of income.

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

Cash

The cash balance at the end of October is £17.3m. The cash flow forecast demonstrates sufficient cash levels for the year based on the latest forecast position.

CIP

At 31 October 2023, the Trust has delivered a CIP of £7.2m against a target of £7.2m. The full year CIP target is £17.9m of which £15.3m has been identified (85%). The current level of recurrent CIP is £9.9m which is an increase of £0.3m from last month, however, further work is required to increase recurrent CIP levels.

Capital Programme

The Trust's capital programme was oversubscribed by £1.5m at the beginning of the financial year which reduced to £0.7m in month 5. A further review has been undertaken and an additional scheme can be deferred to 2024/25 (£0.3m) therefore reducing the amount oversubscribed to £0.4m. This movement was supported by FSC. The scheme to be deferred is part of the Catering Upgrade based on the profile of works with no change to the expected completion date.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 7		**135**
Proposed changes in month		
2022/23 Year End Accruals Released		
Various - reversed release in error	- 10	
Sub Total		**- 10**
Vat Rebate		**24**
Contingency as at end of month 7		**149**

The Trust Board is asked to:

- Note the reduction in the oversubscribed capital programme and the associated deferral of part of one scheme to 2024/25 as supported and approved by the Finance and Sustainability Committee.
- Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

Financial Forecast

A best, worst, and likely scenario forecast financial position has been produced (**Table 4**) following receipt of a letter from NHS England which provided clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government. The Trust's allocation of the additional income made available to the C&M ICS is £4.8m.

Table 4: Best, likely worse scenario

	Best	Likely	Worse
	£m	£m	£m
Plan	(15.75)	(15.75)	(15.75)
CIP	0.0	(2.5)	(5.1)
Pressures	0.0	(3.4)	(7.9)
Income	(1.2)	(3.5)	(6.0)
Band 2 to 3	0.0	(1.6)	(2.4)
IA costs not funded	(2.6)	(2.6)	(2.6)
Pay award gap not funded	0.0	(2.0)	(2.0)
Forecast	**(19.55)**	**(31.35)**	**(41.75)**
ICS Support	4.8	4.8	4.8
Trust further stretch target	0.0	5.3	0.0
Revised forecast	**(14.75)**	**(21.25)**	**(36.95)**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the reduction in the oversubscribed capital programme and the associated deferral of part of one scheme to 2024/25 as supported and approved by the Finance and Sustainability Committee.
2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
3. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target*
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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	QUALITY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
1	1. Incidents	0	0	Oct-23		0	Sep-23	P
2	2. Duty of Candour (serious incidents)	100.00%	100.00%	Oct-23		100.00%	Sep-23	P
3	3. Healthcare Acquired Infections (MRSA)	0	0	Oct-23	L	0	Sep-23	P
4	4. Healthcare Acquired Infections (MSSA)	No target set	5	Oct-23		5	Sep-23	No SPC
5	5. Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	4	Oct-23		6	Sep-23	?
6	6. Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	6	Oct-23	H	7	Sep-23	?
7	7. Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	2	Oct-23		2	Sep-23	?
8	8. Healthcare Acquired Infections (PA)	Less than 2 - annual	1	Oct-23		1	Sep-23	?
9	9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	2	Oct-23	L	2	Sep-23	No SPC
10	10. VTE Assessment	95.00% (quarterly position)	94.74%	Oct-23	L	93.98%	Sep-23	?

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11	11. Inpatient Falls & harm levels	20% or more decrease from previous year	30	Oct-23	L	30	Sep-23	P
12	12. Pressure Ulcers	10% reduction	16	Oct-23		10	Sep-23	?
13	13. Medication Safety Reconciliation within 24 hours	80.00%	44.00%	Oct-23	L	39.00%	Sep-23	F
14	14. Staffing - Average Fill Rate	90.00%	97.77%	Oct-23	H	90.43%	Sep-23	P
15	15. Staffing - Care Hours Per Patient Day (CHPPD)	7.9	8	Oct-23	H	8	Sep-23	?
16	16. Mortality ratio - HSMR	No target set	91.85	Oct-23	H	91.85	Sep-23	No SPC
17	17. Mortality ratio - SHMI	No target set	97.81	Oct-23		97.61	Sep-23	No SPC
18	18. NICE Compliance	90.00%	93.12%	Oct-23	H	92.73%	Sep-23	P
19	19. Complaints	Zero complaints open over 6 months old/in the backlog	0	Oct-23		0	Sep-23	P
20	20. Friends and Family (Inpatients & Day cases)	95.00%	98.00%	Oct-23		96.00%	Sep-23	P
21	21. Friends and Family (ED and UCC)	87.00%	77.00%	Oct-23	H	78.00%	Sep-23	F
22	22. Mixed Sex Accommodation Breaches (Non ITU Only)	0	0	Oct-23		0	Sep-23	P

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23	23. Sepsis - % screening for all emergency patients.	90.00%	68.00%	Oct-23		70.00%	Sep-23	F
24	24. Sepsis - % screening for all inpatients	90.00%	88.00%	Oct-23		52.00%	Sep-23	F
25	25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	68.00%	Oct-23		72.00%	Sep-23	F
26	26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90%	68.00%	Oct-23	H	88.00%	Sep-23	F
27	27. Ward Moves between 10:00pm and 06:00am	0	54	Oct-23	No SPC	54	Sep-23	No SPC
28	28. Acute Kidney Injury	Less than previous month	192	Oct-23		144	Sep-23	?
29	29. Maternity Postpartum Haemorrhage	3.70%	4.06%	Oct-23	No SPC	4.90%	Sep-23	No SPC
30	30. Maternity 3rd and 4th Degree tears	<1.85%	2.54%	Oct-23	No SPC	5.26%	Sep-23	No SPC
31a	31a. Maternity Pregnancy Bookings before 10 weeks	10-week Target: >75%	54%	Oct-23	H	53%	Sep-23	F
32b	31b. Maternity Pregnancy Bookings before 13 weeks	13-week Target: >90%	83%	Oct-23	H	79%	Sep-23	F
32	32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	37%	Aug-23		10%	Jun-23	No SPC
33	33. MUST nutritional assessment completion	above > 85%	63.55%	Oct-23		65%	Sep-23	F

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
34	34. Diagnostic Waiting Times 6 Weeks	95.00%	79.60%	Oct-23	L	79.60%	Oct-23	F
35	35. Referral to treatment Open Pathways	92.00%	51.30%	Oct-23	L	51.30%	Oct-23	F
36	36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	67.13%	Oct-23		67%	Oct-23	F
37	37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	19.73%	Oct-23	H	19.7%	Oct-23	F
38	38. Average time in department ED	No Target	376	Oct-23		376	Oct-23	No SPC
39	39. Cancer 14 Days	93%	65.55%	Sep-23		65.55%	Sep-23	F
40	40. Breast Symptoms 14 Days	93%	96.00%	Sep-23		96.00%	Sep-23	?
41	41. 28 Day Faster Cancer Diagnosis Standard	75%	75.86%	Sep-23		75.86%	Sep-23	?
42	42. Cancer 31 Days First Treatment	96%	98.59%	Sep-23		98.59%	Sep-23	?
43	43. Cancer 31 Days Subsequent Surgery	94%	88.24%	Sep-23	L	88.24%	Sep-23	?

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44	44. Cancer 31 Days Subsequent Drug	98%	100.00%	Sep-23		100.00%	Sep-23	P
45	45. Cancer 62 Days Urgent	85%	64.29%	Sep-23		64.29%	Sep-23	F
46	46. Cancer 62 Days Screening	90%	84.62%	Sep-23		84.62%	Sep-23	P
47	47. Ambulance Handovers within 15 minutes	65%	42.23%	Oct-23		42.23%	Sep-23	F
48	48. Ambulance Handovers within 30 minutes	95%	72.72%	Oct-23	H	72.72%	Sep-23	F
49	49. Ambulance Handovers within 60 minutes	100%	79.94%	Oct-23	H	79.94%	Oct-23	F
50	50. Discharge Summaries - % sent within 24hrs	95%	88.50%	Oct-23		88.50%	Oct-23	F
51	51. Discharge Summaries - Number NOT sent within 7 days	0	356	Oct-23	H	356	Oct-23	F
52	52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.08%	Oct-23		0.08%	Oct-23	P
53	53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	2	Oct-23		2	Oct-23	F
54	54. Urgent Operations Cancelled for 2nd Time	0	0	Oct-23		0	Oct-23	P

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55	55. Super Stranded Patients	Trajectory	126	Oct-23		126	Oct-23	No SPC
56	56. Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
57	57. Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
58	58. Elective Outpatient Activity	0%	91%	Oct-23		91%	Oct-23	F
59	59. Patients seen in the Fracture Clinic within 72 hours	95%	95.10%	Oct-23		95%	Oct-23	?
60	60. % patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Oct-23	No SPC	0	Oct-23	No SPC
61	61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	No Target set	91%	Oct-23	H	91%	Oct-23	No SPC
62	62. Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	91%	Oct-23		91%	Jan-00	No SPC
64	64. % Patients discharged to their usual place of residence	No Current Threshold	95%	Oct-23		95%	Oct-23	No SPC
65	65. Theatre Utilisation (measured as productive operating time only)	85%	85.80%	Oct-23	H	86%	Oct-23	?
66	66. Day case (measured as an aggregate of total cases)	85%	89.64%	Oct-23		87%	Oct-23	P
67	67. RTT - Number of patients waiting 65+ weeks	0	1324	Oct-23	H	1324	Oct-23	F

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		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
68	68. Supporting Attendance	4.20%	5.67%	Oct-23	L	5.68%	Sep-23	F
69	69. Retention	86.00%	86.14%	Oct-23	H	85.85%	Sep-23	F
70	70. Turnover	Below 13%	13%	Oct-23	L	13%	Sep-23	?
71	71. Bank and Agency Reliance	9% or Below	16.03%	Oct-23	H	16.01%	Sep-23	F
72	72.Core/Mandatory Training	85.00%	90.01%	Oct-23	H	90.06%	Sep-23	P
73	73. Safeguarding Training	Trajectory	83.80%	Oct-23	H	83.85%	Sep-23	F
74	74. PDR	85.00%	74.93%	Oct-23	H	76.05%	Sep-23	F

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		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
75	75. Trust Financial Position (£m)	-£1.12	-£2.12	Oct-23	No SPC	-2.06	Sep-23	No SPC
76	76. Cash Balance (£m)	£16.95	£17.27	Oct-23	No SPC	19.43	Sep-23	No SPC
77	77. Capital Programme (£m)	£14.47	£7.26	Oct-23	L	£5.22	Sep-23	F
78	78. Better Payment Practice Code	95%	92%	Oct-23	H	94%	Sep-23	F
79	79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£7.20	£7.20	Oct-23	H	5.40	Sep-23	P
80	80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m)	£7.20	£2.40	Oct-23		5.40	Sep-23	F
81	81. Agency Ceiling	Less than 3.7%	3.8%	Oct-23	L	3%	Sep-23	?

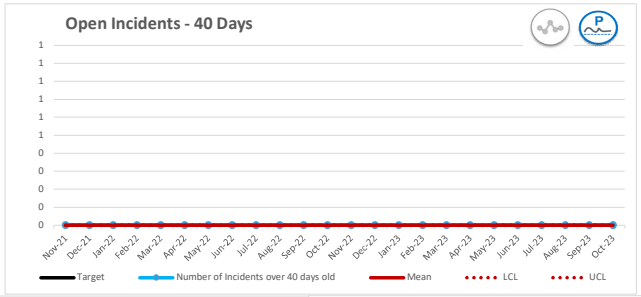
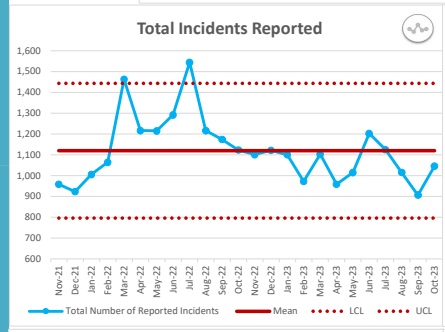
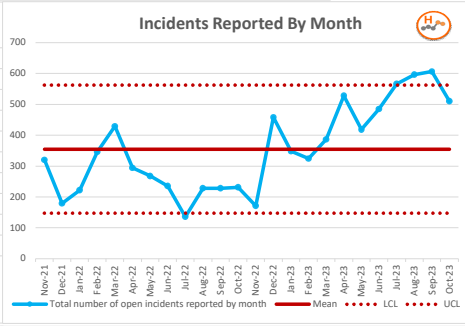
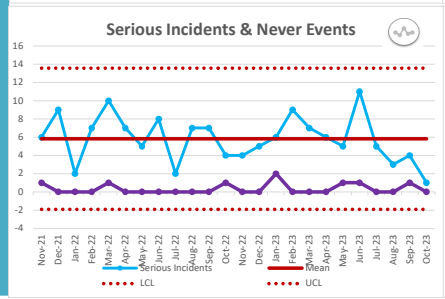
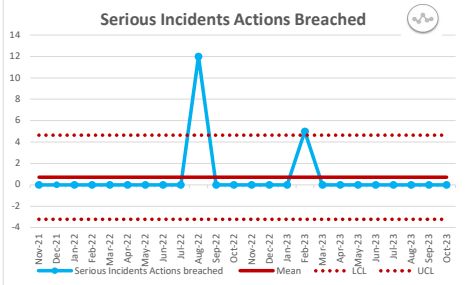
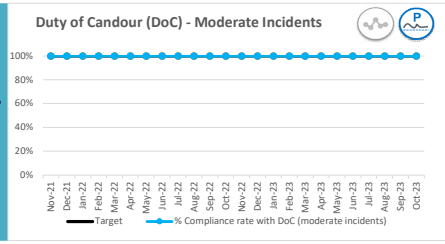
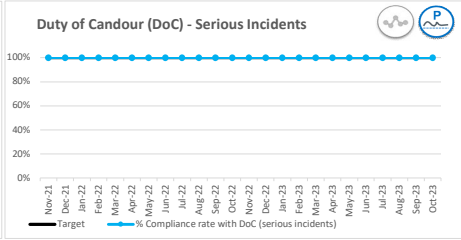
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

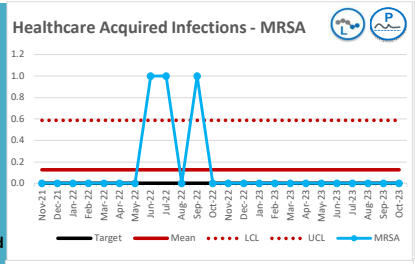
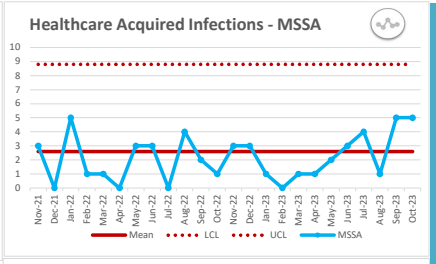
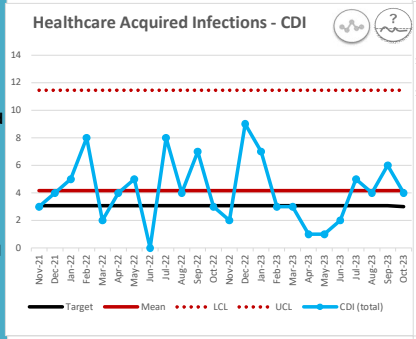
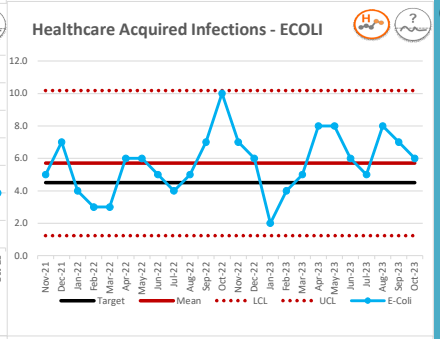
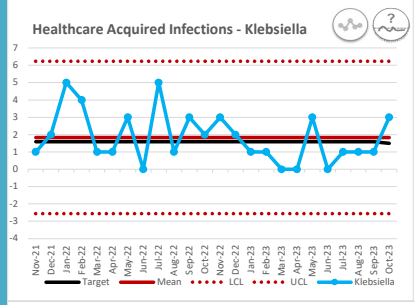
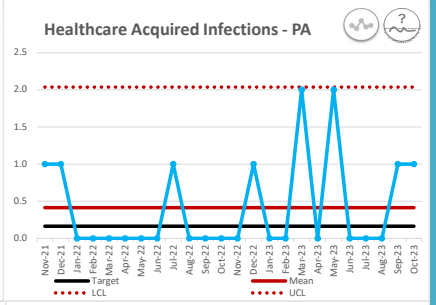
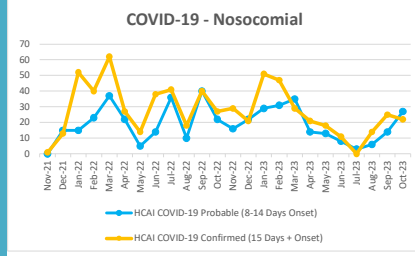
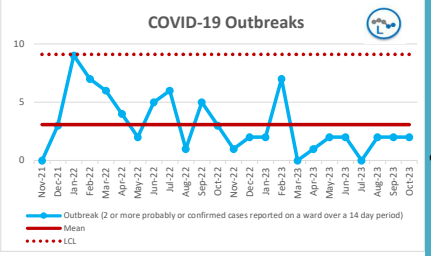
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	SOF CQC **There were 0 incidents over 40 days old.**	    	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**Incident reporting remains within range with little variance across the Trust. The number of open incidents has reduced to within normal control limits following an increase over the last four months.** **There are no overdue 40-day incidents.** **There was 1 Serious Incidents reported in October 2023. An decrease of 3 SIs when compared to September 2023.** **There were 0 breached serious incident actions in October 2023.**	**Incident Reporting** **A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each CBU is supported by a designated member of the Governance Team to ensure consistency. A systems review was undertaken to further understand the position in relation to open incidents, these have returned to within range. This was impacted by staffing deficits within the Governance Team and the introduction of PSIRF.** **Number of incidents within 40 days** **Weekly CBU monitoring supports timely escalation to the Associate Director of Governance, thus ensuring the position of zero incidents over 40 days continues to be maintained.** **Serious Incidents** **Weekly monitoring continues with appropriate escalation to the CBU leads. The Trust transitioned to PSIRF on the 1st September 2023.**
2. Duty of Candour (serious incidents) **Target: 100%**	CQC **The Trust achieved 100% for Duty of Candour in month.**	 	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**There is no variance, the Trust remains 100% compliant.**	**Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Appendix 2

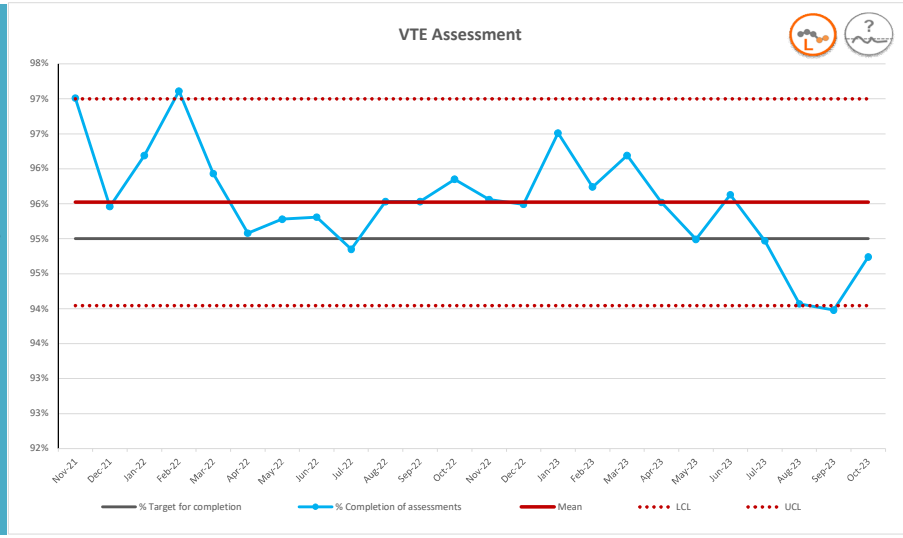
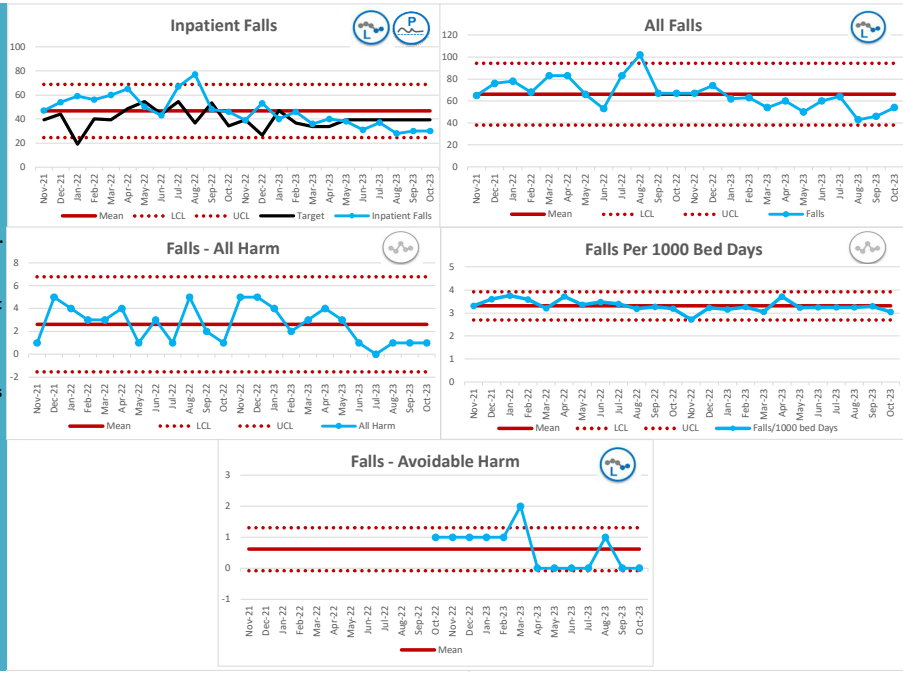
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) **Target: ZERO**		**(MRSA) Assurance: The Trust consistently passes the target.** **(MRSA) Variation: Special Cause Variation of an improving nature.**	**MRSA: Nil returns for Apr - Oct** **MSSA: 5 Trust apportioned case: different locations and likely sources.** **CDI: 4 Trust apportioned cases in Oct - remain within annual trajectory.** **ECOLI: Klebsiella: Mainly UTI associated, followed by hepatobiliary source cases for all GNBSI cases.** **Pseudomonas aeruginosa: 1 Trust apportioned case in Oct. Total 4 cases. FY threshold breached by 2 cases against threshold of 2 cases.** **Covid-19: 2 outbreaks reported in Oct.**	**MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise patient safety investigation template to align with PSIRF.** **CDI: CDI prevention action plan in place. RCA investigations & review meetings will continue, approach will be aligned to PSIRF, SIGHT mnemonic education will continue.** **ECOLI: Klebsiella: Pseudomonas aeruginosa: Audit of hepatobiliary cases has commenced, revise investigation of hospital onset GNBSI cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse led removal, focus support on wards with higher UTI associated cases. The GNBSI Prevention Group has been reconvened and Lead Nurses engaged to drive prevention activity.** **Covid-19: Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients, staff and visitors. The national requirements to report Covid-19 outbreaks remains in place.**
4. Healthcare Acquired Infections (MSSA) **Target: No set Target**				
5. Healthcare Acquired Infections (CDI) Target: Less than 36 -annual		**(CDI) Assurance: The Trust inconsistently passes/fails the target.** **(CDI) Variation: Common Cause (Normal) variation.**		
6. Healthcare Acquired Infections (Ecoli) Target: less than 54 - annual		**(ECOLI) Assurance: The Trust inconsistently passes/fails the target.** **(ECOLI) Variation: Special cause variation of a concerning nature**		
7. Healthcare Acquired Infections (Klebsiella) Target: Less than 18 - annual		**(K) Assurance: The Trust inconsistently passes/fails the target.** **(K) Variation: Common Cause (Normal) variation.**		
8. Healthcare Acquired Infections (PA) Target: Less than 2 - annual		**(PA) Assurance: The Trust inconsistently passes/fails the target.**		
9. Healthcare Acquired Infections **COVID-19 Hospital Onset & Outbreaks (No**		**Assurance: N/A - No target.** **Variation: Special cause variation of an improving nature**		
2 in month COVID-19 outbreak. **Covid-19:** **27 day 8-14 cases probable healthcare associated cases YTD** **22 day 15+ cases definite healthcare associated YTD**				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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RR116

Quality Improvement - Trust Position

Appendix 2

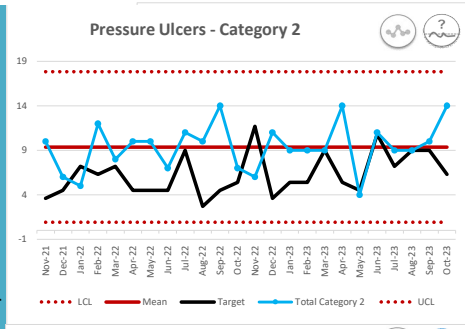
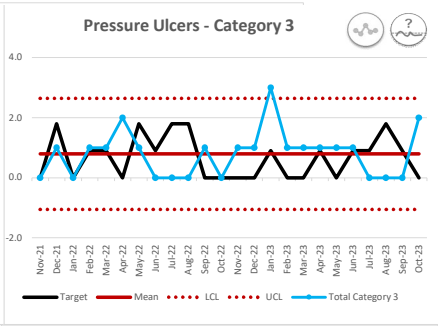
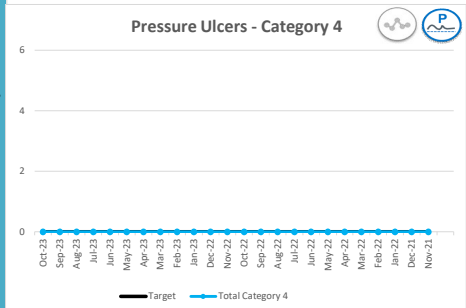
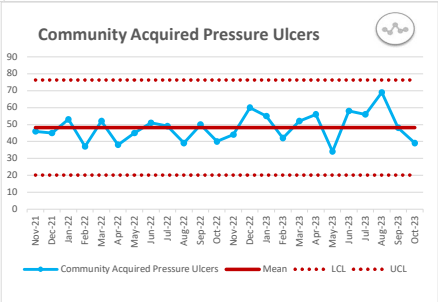
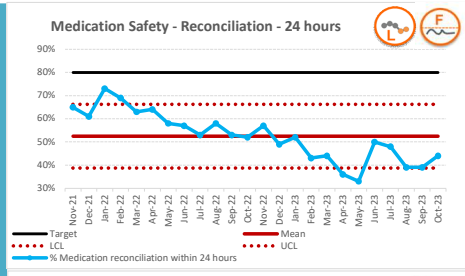
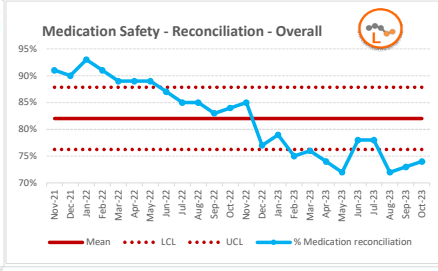
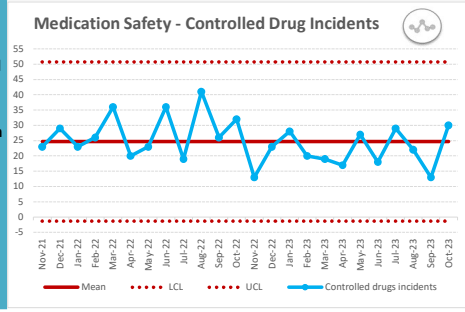
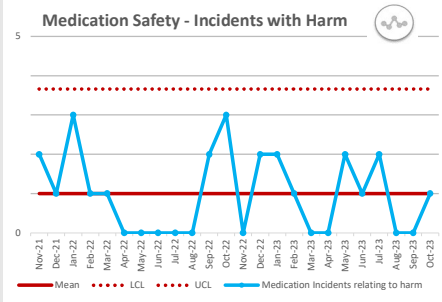
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment Target: 95% (quarterly position)	The Trust did not achieve the required target at 94.74% for VTE assessments in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special cause variation of a concerning nature	Performance improved in October to just below Trust target.	VTE Data sharing Further work with the corporate information team to develop a BI dashboard of VTE RA data at every ward level to improve overall compliance. This was endorsed by PSCESC as an one of the improvement plans based on VTE report. Education and training To continue to raise awareness of the need for VTE completion with the every changeover of junior doctors 4 months placement. Improvement plan To gather feedback from all CBUs on how to improve future CBU VTE risk assessment compliance.
11. Inpatient Falls & harm levels Target: 20% or more decrease from 22/23 (610 Inpatient Falls in	54 total falls were reported in month. 30 of these were inpatient falls. There has been a 10.74% decrease in falls from last year. There has been a 21.05% decrease in inpatient falls from last year. There was 1 fall(s) in month with harm.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	The number of in patient falls remains below the Trust mean with a reduction noted in falls per bed days. The inability to provide enhanced care is a contributory factor for falls occurring in October.	Lessons learned from weekly Harm Free Care meetings are shared with ward teams. Work with the Quality Improvement Team continues to introduce new bed side eye sight test. A new Enhanced Care Tool has been successfully piloted with a plan to introduce Trust wide as part of the updated Enhanced Care Policy.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

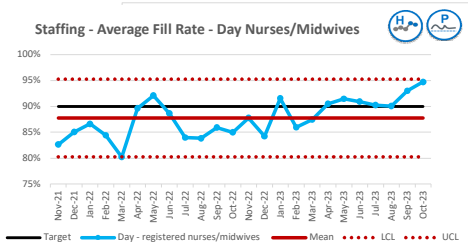
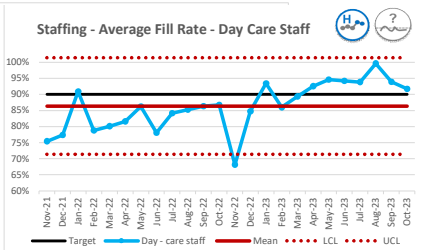
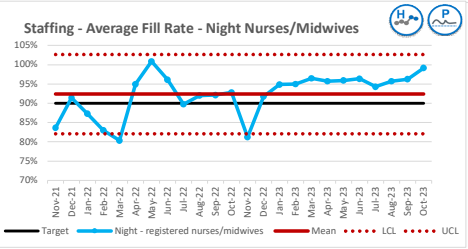
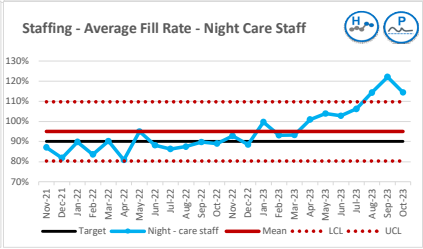
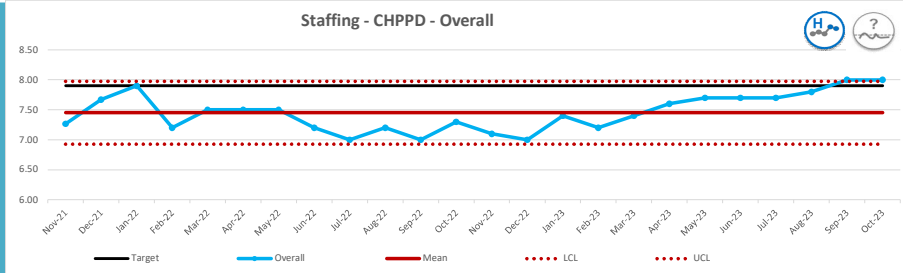
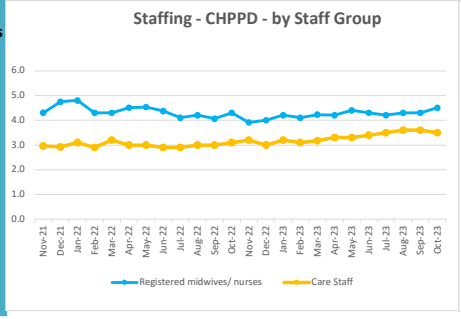
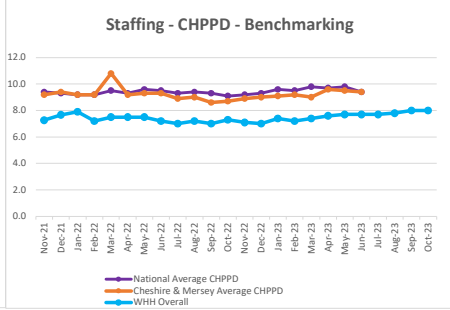
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Pressure Ulcers **Target: 10% reduction based on 91 in 2021/22** **There were 14 hospital acquired category 2 pressure ulcers and 2 Category 3 pressure ulcer in month.** **There were 39 community aquired pressure ulcers in month.**	   	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Contributory factors to the development of category 2 pressure ulcers include inconsistent repositioning, impacted by the industrial action by Health Care Support Workers in October, and the recognition of risk related to medical devices.**	**Actions to improve the position include:** **1. After Action Reviews are completed and lessons are shared with ward teams and via Operational Patient Safety Group.** **2. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.** **3. As a safety priority for the Trust, a post has been funded through Continuous Professional Development to support improvements at ward level in particular areas of higher incidence such as A9 and A6.** **5. The Tissue Viability Nursing (TVN) Team continue to have an increased presence in the Emergency Department.** **6. The QI Team are supporting Matrons to monitor the sustainability of the change package.** **7. Tissue viability training for preceptorship nurses and international nurses.** **8. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management.**
13. Medication Safety **Reconciliation within 24 hours Target: 80%** **Medicines reconciliation was completed within 24 hours of admission for 44% of patients. 74% of patients had MR completed during inpatient stay.** **There were 30 controlled drug incidents. There was 1 medication harm incident reported in month.**	   	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**Medicines reconciliation: performance continues to be adversely impacted by the current pharmacist vacancy rate.** **Controlled drug incidents: there is no target for this metric. The most common type of incident relating to controlled drugs related to administration (n=7) and unaccounted for losses (n=5), but no specific themes were identified. All unaccounted loss incidents have been fully investigated and no evidence of diversion found.** **Incidents causing harm: there is no target for this metric. One incident causing harm occurred in October 2023, relating to outpatient documentation. A thorough investigation has been undertaken and actions in place to prevent recurrence.**	**Medicines reconciliation:** **1. Ongoing recruitment - 2wte band 6 pharmacists started September 2023, 1wte starting in October 2023 and 2wte starting in January 2023. No new starters at band 7/8a level. Good recruitment to band 4/5 pharmacy technician vacancies - new starters online over the next few months.** **2. Continued use of bank and agency pharmacists to support gaps in the establishment.** **3. 2wte band 5 technicians recruited to work in ED, will support with medicines reconciliation of patients with DTA.** **Controlled drug incidents:** **Monthly self-assessments and quarterly CD audits are undertaken. Themes identified and addressed with specific action plans. Support given to areas with poor compliance.** **Incidents with harm:** **All medication incidents reviewed by pharmacy, clinical and governance teams and lessons learned shared.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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RR116

Quality Improvement - Trust Position

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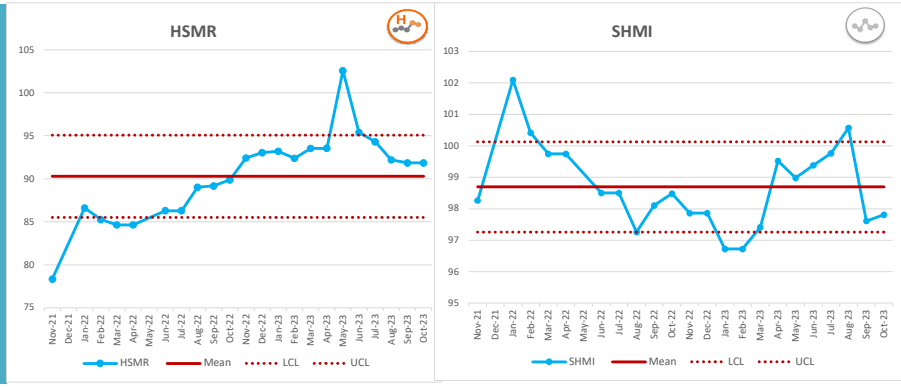
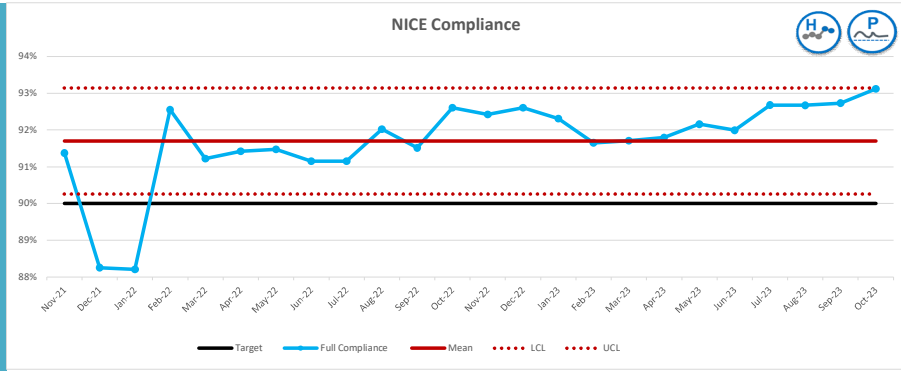
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 94.71% Day (Care Staff) 91.71% Night (Nurses/Midwife) 99.16% Night (Care Staff) 114.43% RR115 RR1108	   	Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Staffing fill rates have improved for registered nurses and midwives which is supported by the reduction in vacancies. The fill rates for care staff has reduced in month due to the impact of industrial action and escalated beds open across the Trust.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. RN vacancy is currently 98.74 with 91.89 in the recruitment pipeline at Band 5. This includes international nurse cohort 14 which equates to 11 international nurses joining their appointed areas during October. HCSW vacancy has increased to 73.95 wte due to an increased establishment on A7, A8 + A9 and international nurses moving from a Band 3 to Band 5 position, with 61.24 in the recruitment pipeline. A continuous advert for both RN and HCSW is in place with Trust recruitment events planned.
15. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In month, the average CHPPD were: Nurse/Midwife: 4.5 hours Care Staff: 3.5 hours Overall: 8 hours	  	Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause variation of an improving nature.	The CHPPD October remained at 8.0 overall which is a continued improving trajectory.	Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety and work is ongoing to reduce agency usage, recruit to posts and migrate regular agency workers to NHSP. There are clear processes for escalation to ensure safe staffing is provided based upon acuity to ensure patient safety.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 91.85. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 97.81.		(HSMR) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature. (SHMI) Assurance: NA - no target Variation: Common Cause (Normal) variation.	The SHMI relates to 12 months data up to and including April 2023. SHMI remains in Band 2 "Mortality - As expected" HSMR remains a low outlier	Mortality reviews and Medical Examiner reviews continue to be undertaken alongside the governance incident process to provide qualative assurance and learning alongside the quantative assurance provided by HSMR and SHMI
18. NICE Compliance Target: 90%	The Trust achieved 93.12% 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. Compliance position currently 93.14%	The Clinical Effectiveness Manager continues to work closely with the CBUs with focus upon partial compliance and those 'under review' to ensure timeliness of progress and completion.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

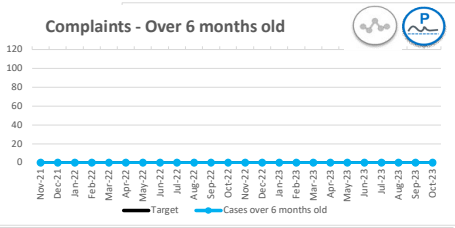
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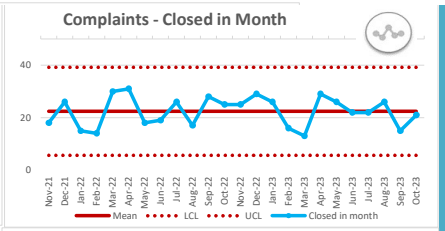
Quality Improvement - Trust Position

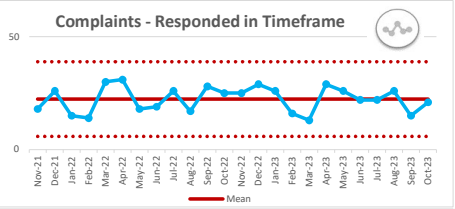
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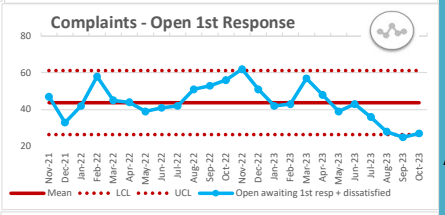
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Complaints Target: Zero complaints open over 6 months old/in the backlog.	Complaints - Over 6 months old; Complaints - Closed in Month; Complaints - Responded in Timeframe; Complaints - Open 1st Response; Complaints - Received in Month; Complaints - PHSO; Complaints - PALS concern	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues to sustain performance in the timely completion of complaints. There continues to be no complaints over 6 months old. The complaints team and wider Trust are working hard to sustain this position.	Positive complaints position of 30 open complaints. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams. All CBUs have a designated complaints case handler to ensure consistency.

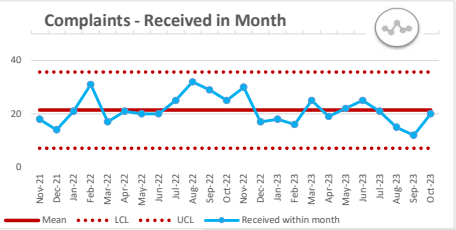
In month, 20 new complaints were received to the Trust which was an increase of 8 from the previous month. There were 0 dissatisfied complaints received in month, which is a decrease from the previous month.

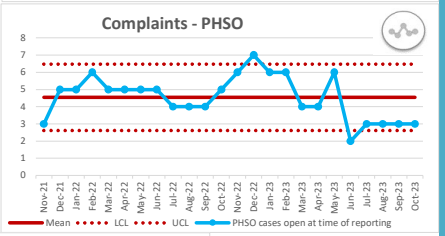


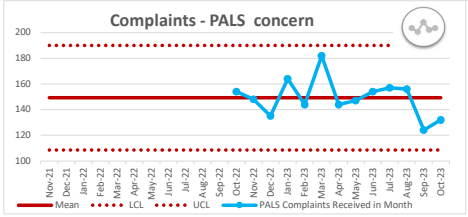










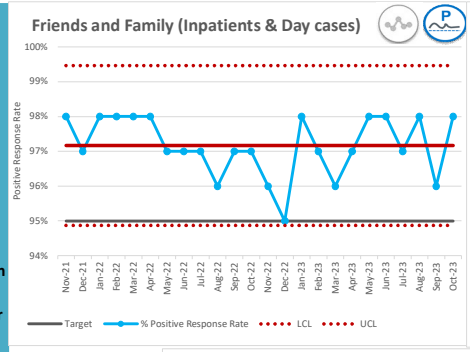
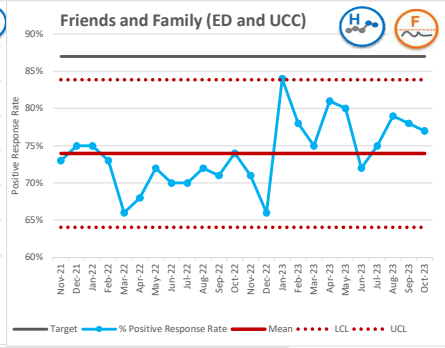
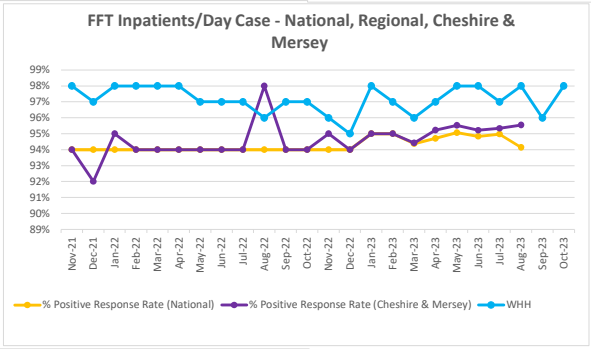
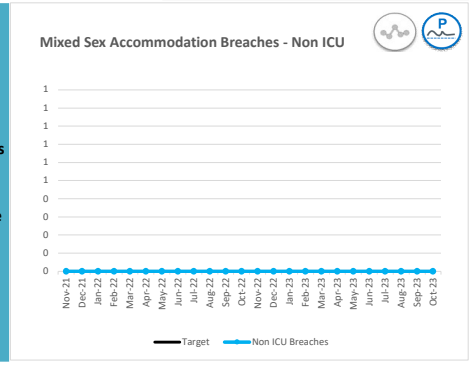
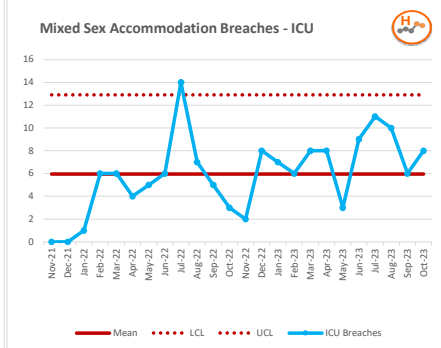


Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

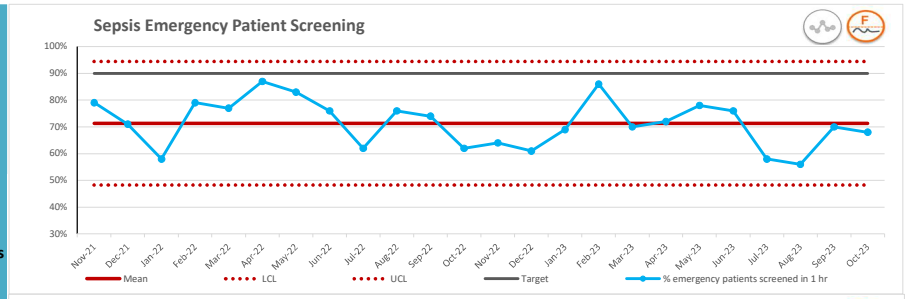
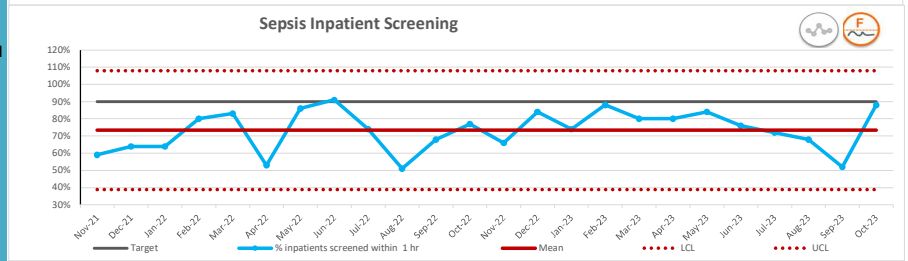
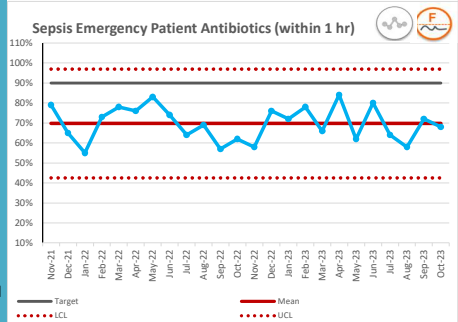
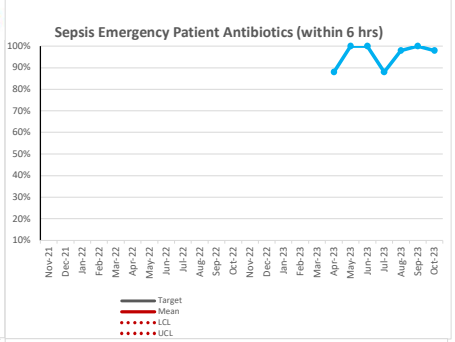
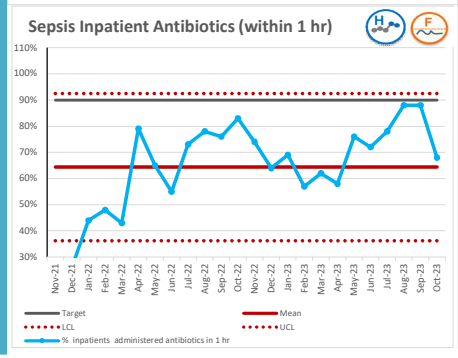
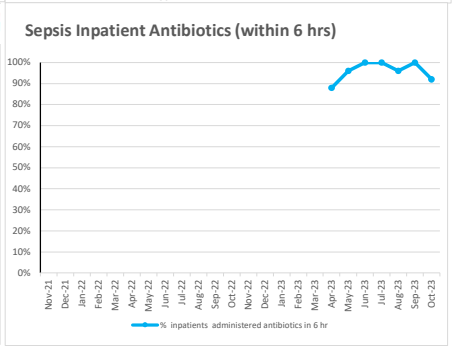
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) **Target: 95%** The Trust achieved 98% in month for Inpatient & Day case FFT and 77% for ED/UCC FFT. The most recent National average for FFT was 94.14% and for C&M was 95.55%.	  	(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 98% positive recommendation rate in October 2023. The departmental teams continue to maintain a high positive response rate by monitoring feedback regularly and are currently working on increasing response rates. ED/UCC - The Trust achieved 77% positive feedback in Friends and Family Test results in October 2023. The focus with Patient Experience & Inclusion Team and the UEC Senior Nursing Team is to improve written and verbal communications in the area with patients. The Patient Experience Team support with regularly observations and feedback to the team to support improvements.	Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis to look for improvement areas. Patient experience also to visit and audit areas, feeding back via local and Trust wide level. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients. ED/UCC - Key themes for improvement in relation to positive recommendation rates continue with communication, waiting times, pain and the environment. Patient experience also to visit and audit areas, feeding back at a local and Trust wide level. Measures taken to improve patient experience within the Emergency Department include but are not limited to: -monitoring of care and comfort rounds - visual communications to be prominent in area
22. Mixed Sex Accommodation Breaches (Non ITU Only) **Target: Zero** There were 0 mixed sex accommodation incidents outside of the ITU in month. There were 8 MSA incidents within the ITU.	 	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There were 8 mixed sex accommodation breach reported in October 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.	Work is underway in the Unplanned Care Group in relation to ongoing patient flow to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each bed meeting. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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RR116

Quality Improvement - Trust Position

Appendix 2

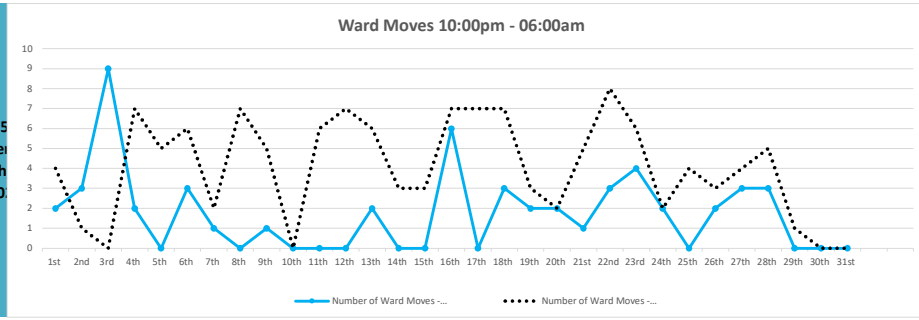
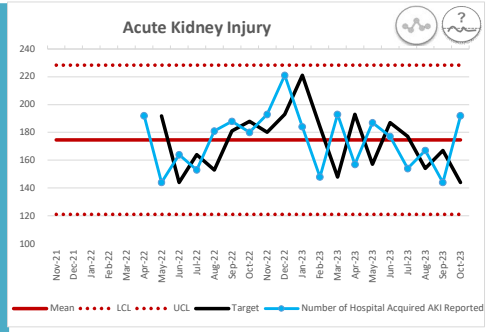
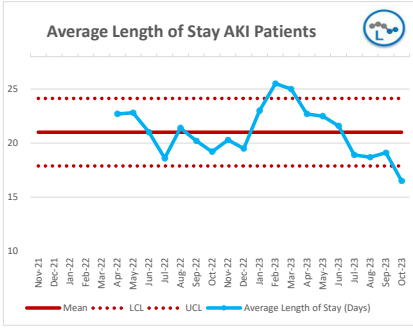
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. Target: 90% 24. Sepsis - % screening for all inpatients Target: 90%	The Trust achieved: • 68% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 88% 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.	Improvement noted in screening in inpatient areas. The contributory factor to not achieving compliance in both in patient and Emergency Department is the completion of blood cultures within the timeframe.	Quality Improvement support is in place to drive improvements across the Trust. There are four workstreams with a focus for improvement: ED, In-patient, Paediatrics and Maternity. Sepsis management remains a focus on Safety Huddles. Blood gas analysis and training for obtaining blood cultures within the Emergency Department and in patients is under review within the CBU's to ensure to ensure timely completion. Short sepsis teaching sessions are underway on the wards facilitated by the Patient Safety Nurses. No harm is recorded for patients following review of health care records.
25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag Target: 90% 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis Target: 90%	The Trust achieved: • 68% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. • 68% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.	   	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (Inpatient) Assurance: The Trust inconsistently passes/fails the target. Variation: Special cause variation of an improving nature.	The delay in prescription completion is a contributory factor for both the Emergency Department and in patient wards.	The importance of prescribing antibiotics in a timely manner continues to be a focus for improvement. Lessons learned from other organisations supports the use of Patient Group Directives (PGD) for the administration of antibiotics. A review of WHH PGD utilisation with pharmacy and senior clinical teams will be undertaken to consider this practice at WHH.

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RR116

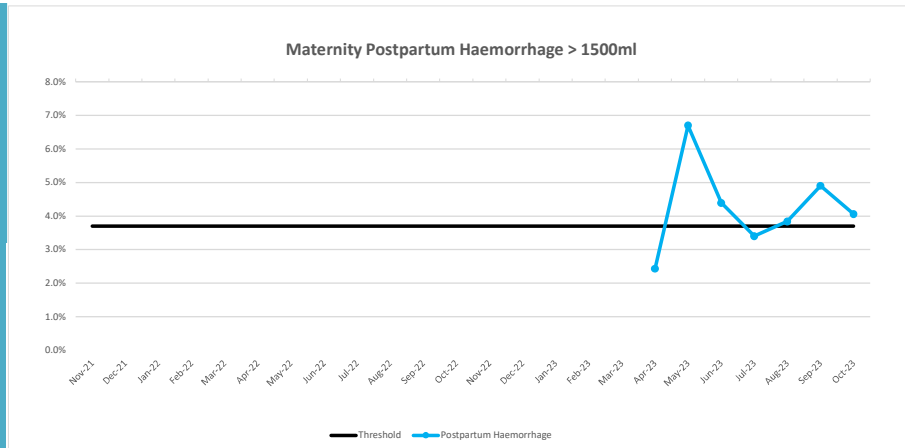
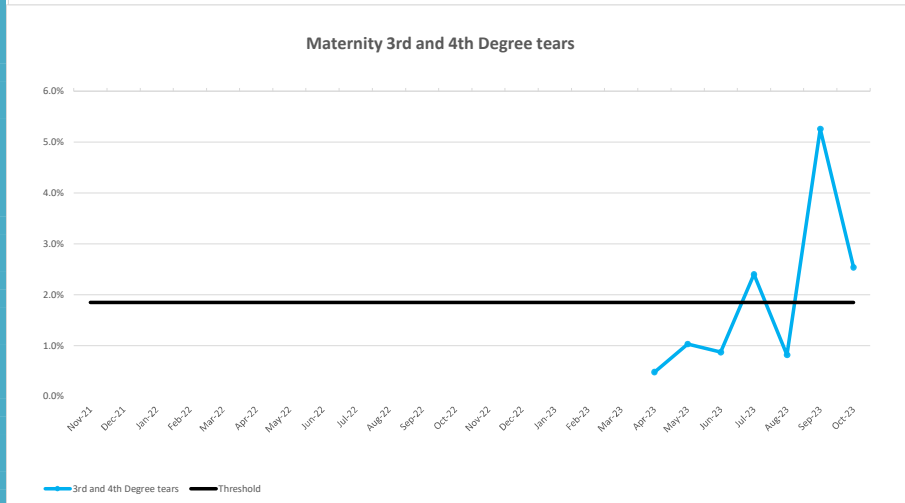
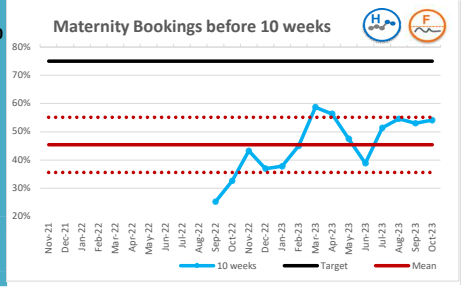
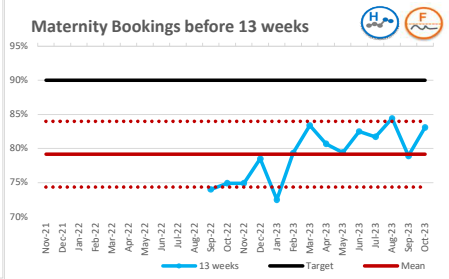
Quality Improvement - Trust Position

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)?
27. Ward Moves between 10:00pm and 06:00am **No Target**	There was a total of 5 ward moves betwee 10pm-6am in month compared to 126 in 20		N/A - Monthly/ Annual Comparison.	The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non essential clinical patient moves.	The Senior Manager on call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who undertake a welfare check.
28. Acute Kidney Injury **Target: Less than previous month**	There were 192 acute kidney injuries reported in month.	 	Variation: Common Cause (Normal) variation.	There has been a significant decrease in the length of stay for patients with AKI's. An increase of incidents of Hospital Acquired AKI's is seen in month.	Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient . Staff survey undertaken to understand 'barriers to completion' and suggested E-learning / ward-based teaching package to be developed. Ward based further AKI education as part of the AKI role. Drive to increase the AKI bundle to improve practice and utilise the AKI clinics each week to reduce the 30-day readmission rate.

Quality Improvement - Trust Position

Appendix 2

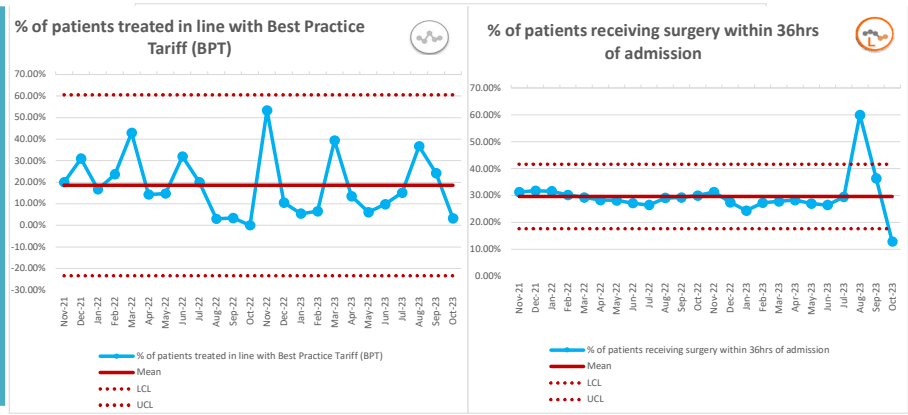
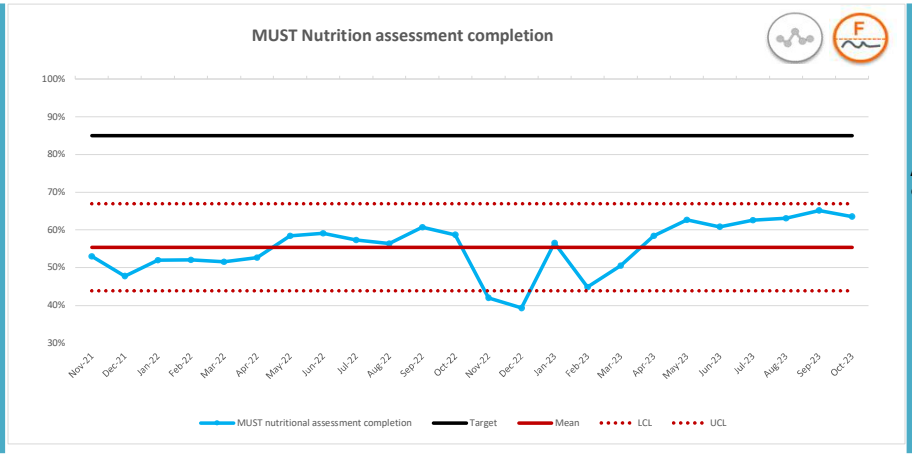
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 4.06% Postpartum Haemorrhages >1500ml in month.**		**N/A - Not enough datapoints.**	**Rates for October are above the benchmark but there is an improving position from September 2023 and a significant improvement since may 2023. A full audit of PPH >1500mls March 2023 - September 2023 is underway via Intrapartum Incident Review Group and will be reported to Quality Assurance in December 2023.**	**A retrospective audit of PPH will commence in September 2023 to assess the impact of the action plan and any additional learning since its implementation. 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 will meet regularly to review patterns and themes from incidents of PPH >1500ml. All PPH >1500mls continue to be reviewed via governance processes.**
30. Maternity 3rd and 4th Degree tears **Threshold: <1.85%**	**There were 2.54% 3rd and 4th Degree tears in month.**		**N/A - Not enough datapoints.**	**Incidence of 3rd & 4th degree tears has reduced significantly in October. There were five cases. 3rd & 4th degree tears are reviewed via governance processes and the learning from these reviews is then shared.**	**Incidence of 3rd & 4th degree tears continue to be reviewed via governance processes and the learning from these reviews is then shared. In view of the increased rates these will be reviewed as a cluster to ensure we are capturing any themes and improving practice and shared via Women's Health Governance meeting.**
31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks **10-week Target: >75%** **13-week Target: >90%**	**54.1% bookings before 10 weeks and 83.1% bookings before 13 weeks.**	 	**(10 weeks) Assurance: The Trust consistently fails the target.** **(10 weeks) Variation: Special cause variation of an improving nature.** **(13 weeks) Assurance: The Trust consistently fails the target.** **(13 weeks) Variation: Special cause variation of an improving nature.**	**An action plan is in place to improve timeliness of bookings and there had been general improvement over the last 12 months. For both booking measures performance has continued to improve and is nearing that of local provider best averages (58.9% for bookings <10 weeks and 87.9% for bookings <13 weeks). Work will continue to meet the stretch target to achieve best practice results.**	**An action plan is in place to improve timeliness of bookings and there had been significant improvement following implementation of this particularly in relation to bookings <10 weeks. This work will continue with booking performance monitored on a weekly basis .**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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RR116

Quality Improvement - Trust Position

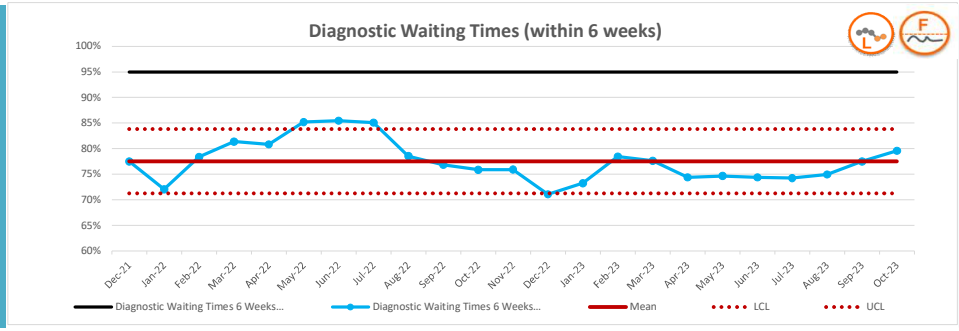
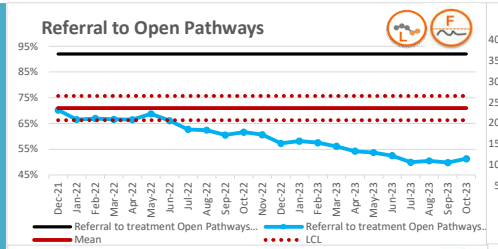
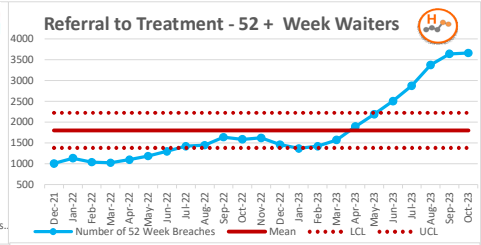
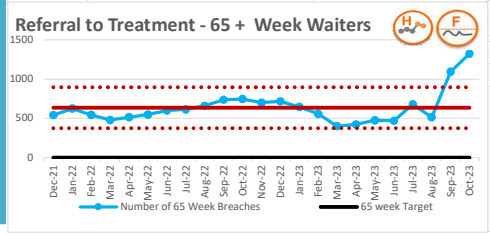
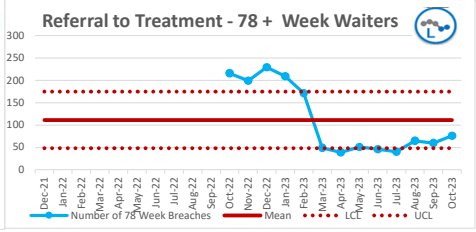
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Fractured Neck of Femur Target: Best Practice Tariff	3.2% of patients were treated in line with Best Practice Tariff (BPT) in Oct-23.		Variation: Common Cause (Normal) variation.	A reduction is noted in October for patients receiving surgery within 36hrs.	Work continues with regards to improving capacity to aid performance of 'Prompt surgery', this includes a review of theatre availability for trauma, scheduling of an additional list, as is possible, productivity monitoring and a review of the delivery of the Trauma Consultant on Call rota'.
33. MUST nutritional assessment completion Target: above 85%	MUST Nutrition assessment completion was 63.55% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The performance in completion of MUST is noted at 64% a slight reduction on last month but overall improvement.	Local QI projects and dashboards are in place. SPC charts for each ward to be added to dashboard to aid data interpretation have been made available. Ward-based interventions are to be re-launched. Collaboration with QI team to analyse audit data and formulate Trust wide Quality improvement project. Compliance is monitored by monthly Nutrition, Food & Hydration Steering Group.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

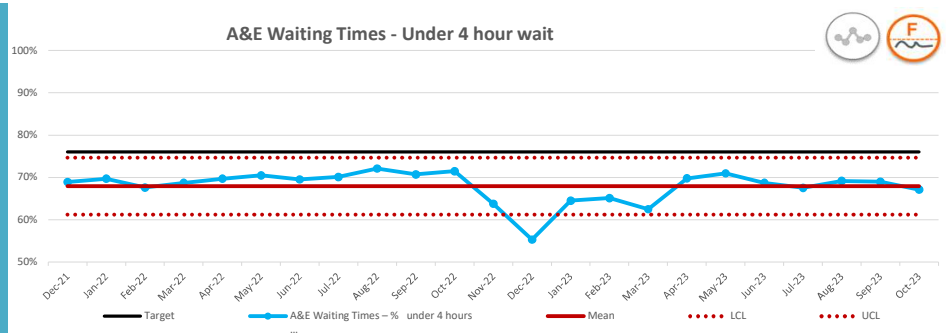
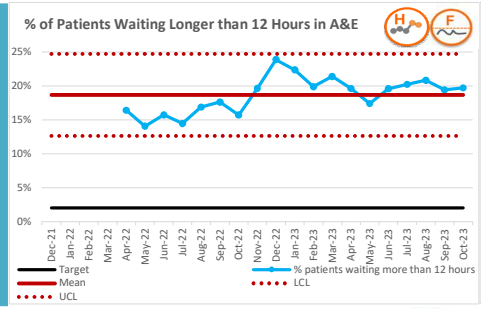
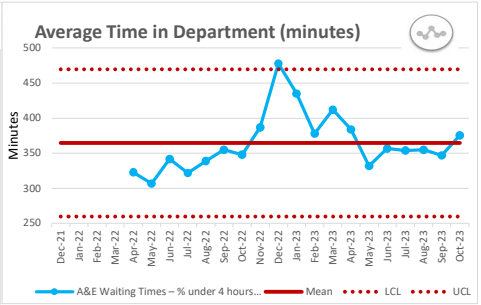
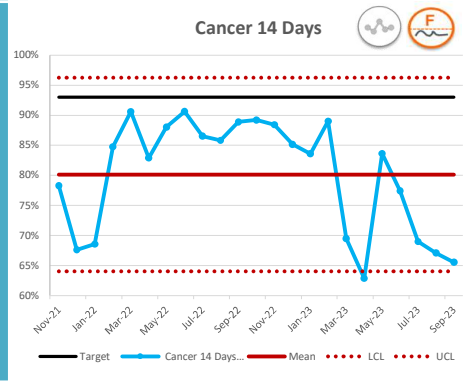
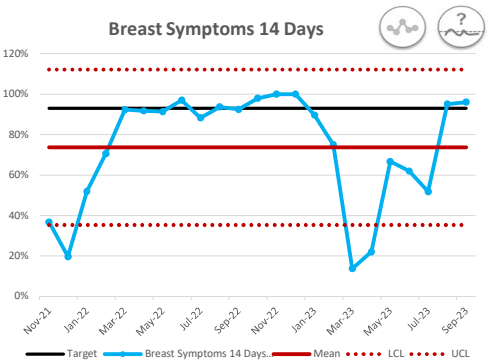
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
34. Diagnostic Waiting Times 6 Weeks Target: 95%	SOF CQC **The Trust achieved 79.6% in month.** RR1215 RR1125		**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.**	**A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies, recovery plans are in place for all modalities**
35. Referral to treatment Open Pathways Target: 92% 67. RTT - Number of patients waiting 65+ weeks Target: 0	SOF CQC **The Trust achieved 51.3% in month. There were 3661, 52 week breaches, 76, 78 week breaches and 1324, 104 week breaches in .** RR1125 RR1215	   	**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**RTT performance - 52, 65, 78 week wait performance in the reporting period was worse than the operational as a result of cancellations due to industrial action.**	**Recovery of the elective programme is taking place with:** **• Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.** **• Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.** **• Restoration and recovery plans for 2023/24 have been drawn up in line with Operational Planning Guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
36.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 75%	The Trust achieved 67.13% excluding Widnes walk ins in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • System resource investment in order to support Pathway 1 discharges. • Additional beds remain open on the Halton site to support bed capacity and flow.
37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	19.73% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 376 minutes.	 	Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature.	12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED.	The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 23/24 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 23/24 is set up to support improvement.
38. Average time in department ED No Target					
39. Cancer 14 Days Target: 93%	The Trust achieved 65.55% in November 2022 for Cancer 14 days and 96% in month for Breast Symptomatic.	 	(C14) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation. (Breast) Assurance: The Trust inconsistently fails the target. Variation: Common Cause (normal) variation.	Breast Symptoms 14 days continues to perform well. The cancer 14 day standard has been challenged for a number of months with a specific problem in gynaecology. This metric will cease to exist from the 1st October 2023 as the 28 day Faster Diagnosis standard (FDS) becomes the focus. It is important to note, that in order to achieve the 28 FDS, then there will be a requirement for patients to have their first OPD appointment in 2 weeks or less.	The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard. Performance against this standard is monitored via the Performance Review Group (PRG). Targeted capacity and demand work has been initiated for the Breast service.
40. Breast Symptoms 14 Days Target: 93%					

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

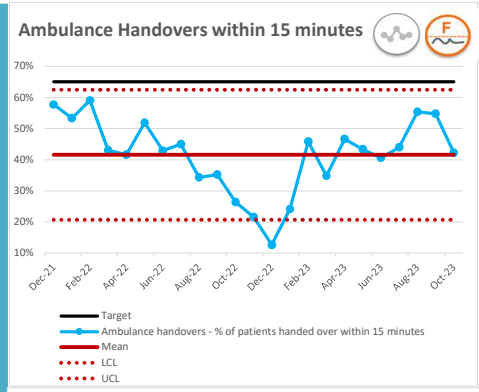
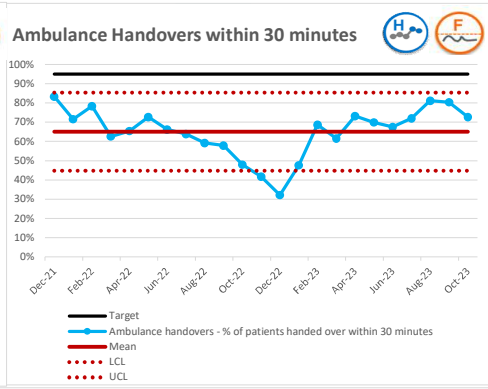
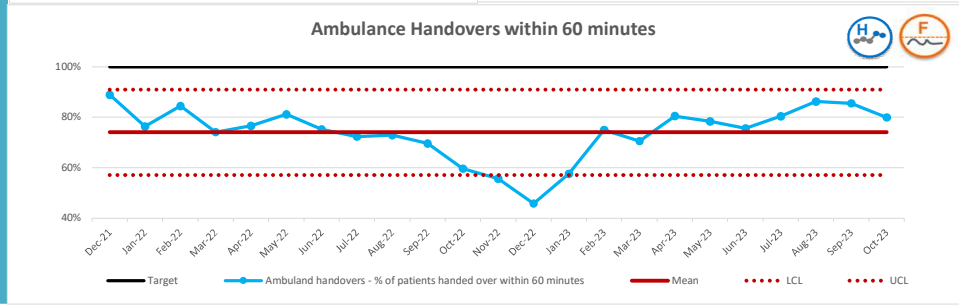
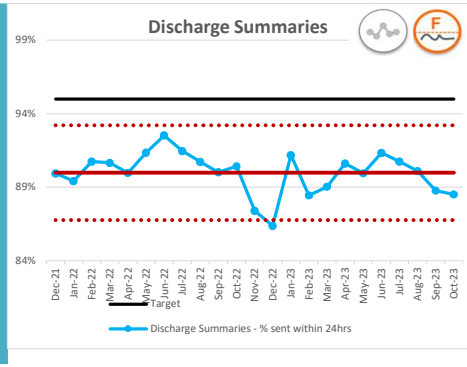
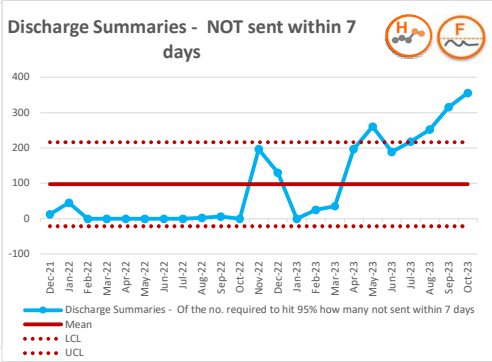
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
41. 28 Day Faster Cancer Diagnosis Standard Target: 75%	SOF The Trust achieved 75.86% in month.	Cancer 28 Day Faster Diagnostic Standard	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	The Trust is currently meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG)
42. Cancer 31 Days First Treatment Target: 96% 43. Cancer 31 Days Subsequent Surgery Target: 94% 44. Cancer 31 Days Subsequent Drug Target: 98%	SOF CQC The Trust achieved 98.59% for Cancer 30 days first treatment, 88.24% for surgery and 100% for drug treatment in month. RR1125	Cancer 31 Days First Treatment Cancer 31 Days Subsequent Surgery Cancer 31 Days Subsequent Drug	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation. (Surgery) Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of a concerning nature. (Drugs) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	Target failed in August due to a breast breach as a result of Consultant sick leave which has also affected September performance for this target due to the low numbers in this group. Performance is recovering in October but will also be reported as part of the new combined 31-day target from then on	Capacity is being reviewed in line with clinical service restoration plans.
45. Cancer 62 Days Urgent Target: 85% 46. Cancer 62 Days Screening Target: 90%	SOF CQC The Trust achieved 64.29% for Cancer 62 Day Urgent and 84.62% for Cancer 62 Day Screening in month. RR1125	Cancer 62 Days Urgent Cancer 62 Days Screening	(Urgent) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation. (Screening) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	The 62 day referral to treatment target remains a challenge with significant numbers of breaches in the Urology and gynae pathways. From 1st October 2023 this standard will be combined with the 62-day screening and 62 day consultant upgrades. Whilst the operational standards remains 85% there is a commitment to reach 70% by March 2024. Early shadow monitoring is at 73.4%.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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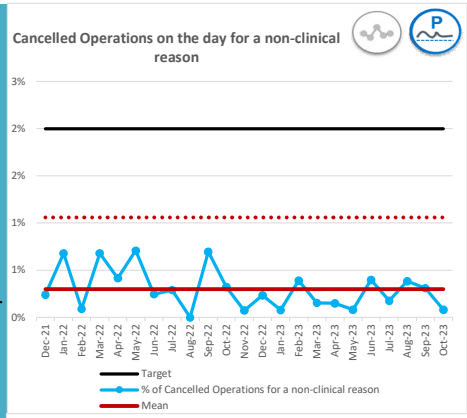
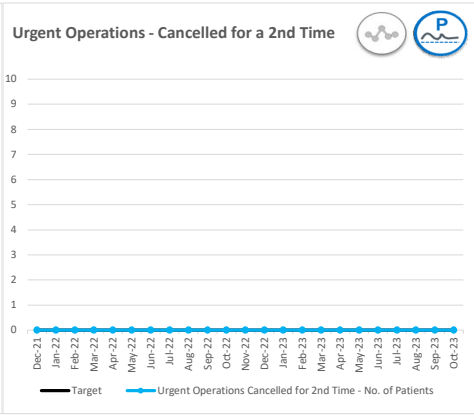
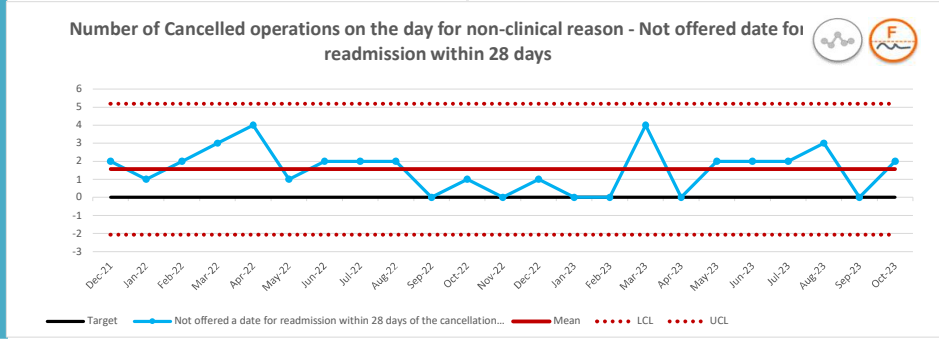
Access & Performance - Trust Position

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)?
47. Ambulance Handovers within 15 minutes Target: 65% 48. Ambulance Handovers within 30 minutes Target: 95% 49. Ambulance Handovers within 60 minutes Target: 100% **In month 42.23% of patients were handed over within 15 minutes, 72.72% were handed over within 30 minutes and 79.94% were handed over within 60 minutes.** SOF	  	**(15) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(30) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.** **(60) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**Handover performance has improved as a result of modest improvement in No Criteria to Reside patients and the reduction in the impact of winter. Additional staffing to support the offloading of Ambulances has also been used in this period.**	**The Trust will continue to work in partnership with NWAS to identify and implement improvements.**
50. Discharge Summaries - % sent within 24hrs Target: 95% 51. Discharge Summaries - Number NOT sent within 7 days Target: ZERO **The Trust achieved 89.97% in month. There was 1 discharge summary not sent within 23 days required to meet the 95.00% threshold.**	 	**(24 hrs) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(7 Days) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.** **A deep dive is underway into the increase of discharge summaries not sent within 7 days.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Access & Performance - Trust Position

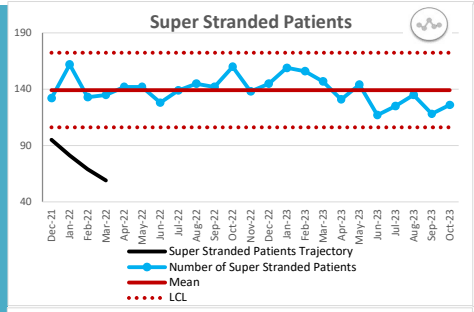
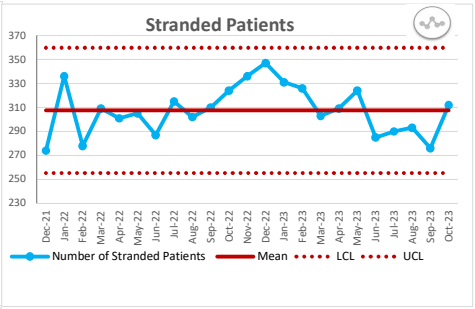
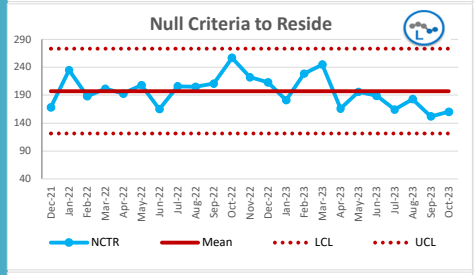
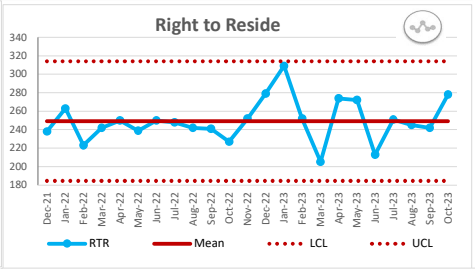
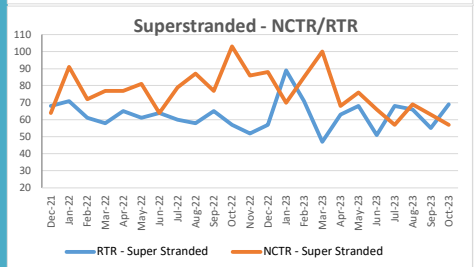
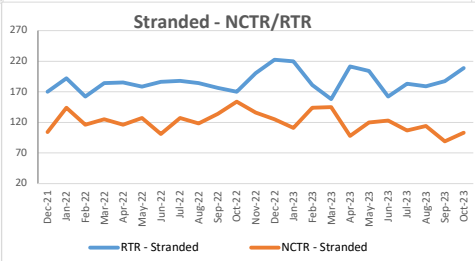
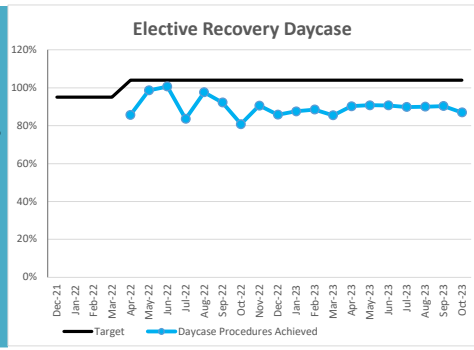
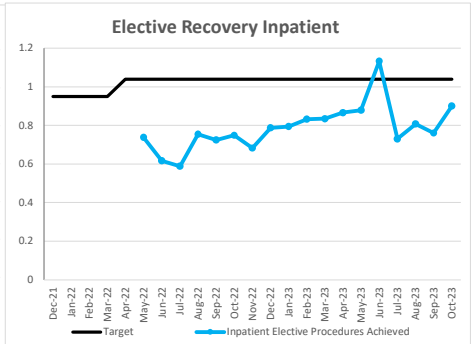
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%		(Cancelled - non-clinical reason) Assurance: The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

Cancelled operations for a non-clinical reason was 0.08 % in month. 2 cancelled operations were not offered a date for readmission within 28 days.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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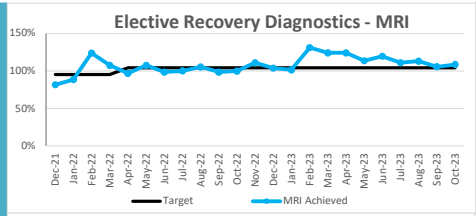
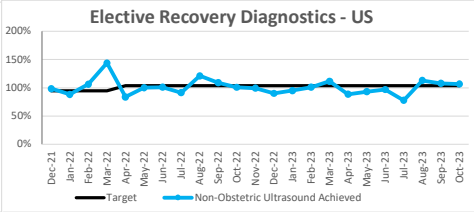
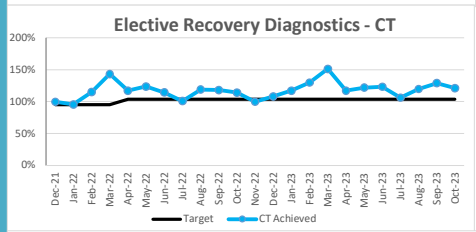
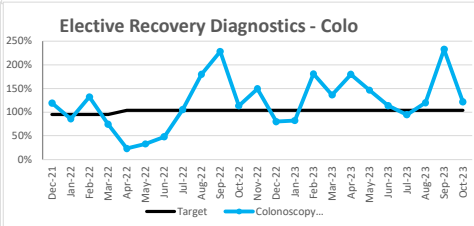
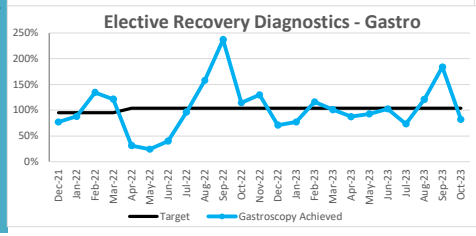
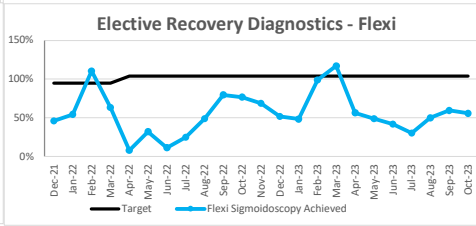
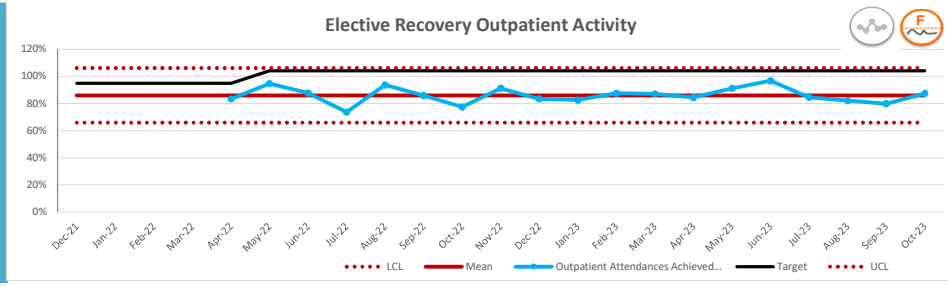
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Super Stranded Patients Target: Trajectory				
There were 312 stranded and 126 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: Special Cause Variation of an improving nature. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The number of Super Stranded patients has shown an improvement from Jan 2023.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
56. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included 90% of Daycase Procedures and 87% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient activity remains challenged although October showed the highest figures since March 2023	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

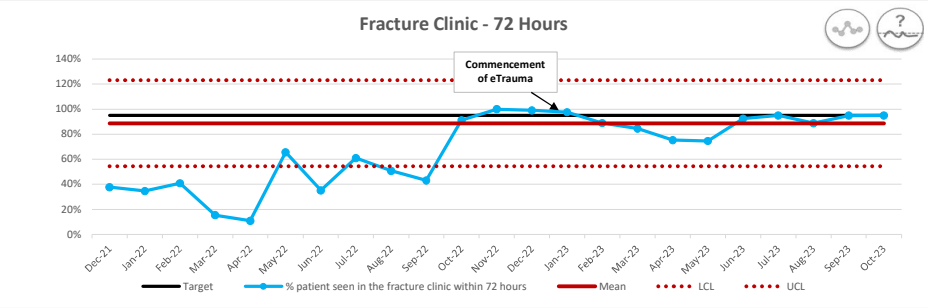
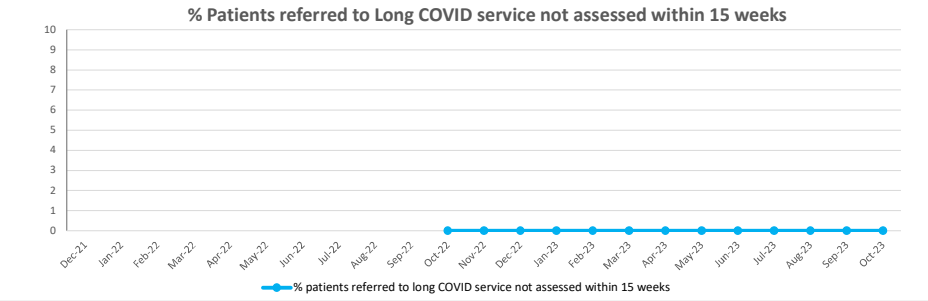
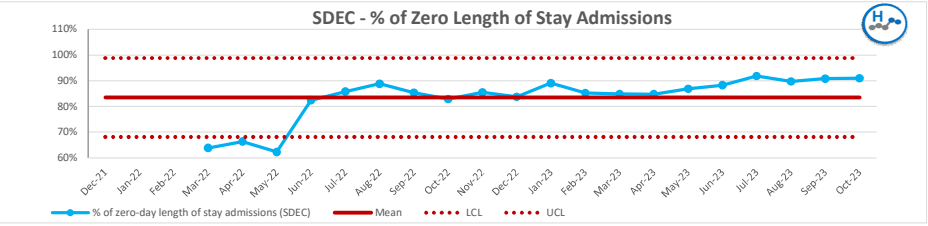
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
57. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 **In month, the Trust achieved the following % of activity against 2019. This included:** **108.6% of MRI** **121.2% of CT** **106.66% of Non-Obstetric Ultrasound** **55.95% of Flexi Sigmoidoscopy** **121.68% of Colonoscopy** **82.19% of Gastroscopy** RR1125	     	**N/A - Grouped indicator.**	**Recovery trajectories Radiological specialties and Endoscopy are in line with recovery trajectories.** **Challenges remain in Cardiorespiratory services.**	**The Trust continues to restore clinical services in line with the national operating guidance.** **Additional insourcing support for Echo is being progressed to help reduce waiting times.** **Underperformance in Flexi sig will be explored at the Performance Review Group.**
58. Elective Recovery Outpatient Activity Aggregate Target: 104%	SOF RR1125 **In month, the Trust achieved 87.37% of Outpatient activity against 2019.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) variation.**	**The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative services such as patient initiated follow. Activity is impacted by Industrial Action.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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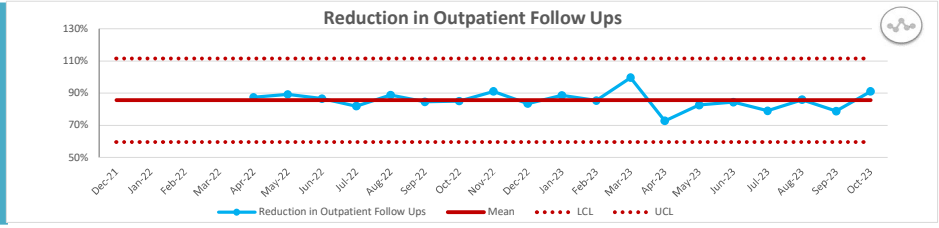
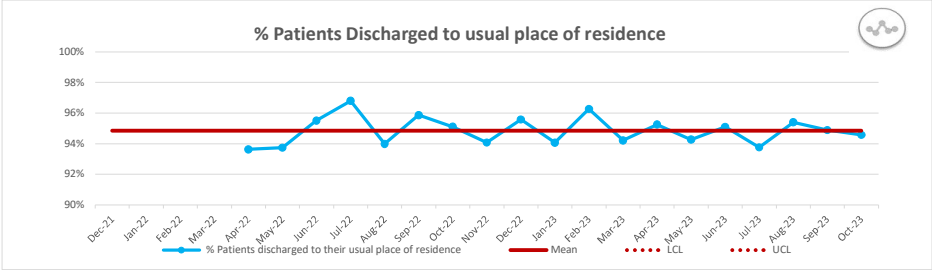
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CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
59. Patients seen in the Fracture Clinic within 72 hours Target: 95%	The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	Issue of non-compliance addressed in-month.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
60. % patients referred to long COVID service not assessed within 15 weeks	The Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks for .		N/A - Not enough datapoints.		
61. 59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	91% of SDEC Emergency Admissions had a zero day length of stay.		Variation: Special Cause Variation of an improving nature	As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

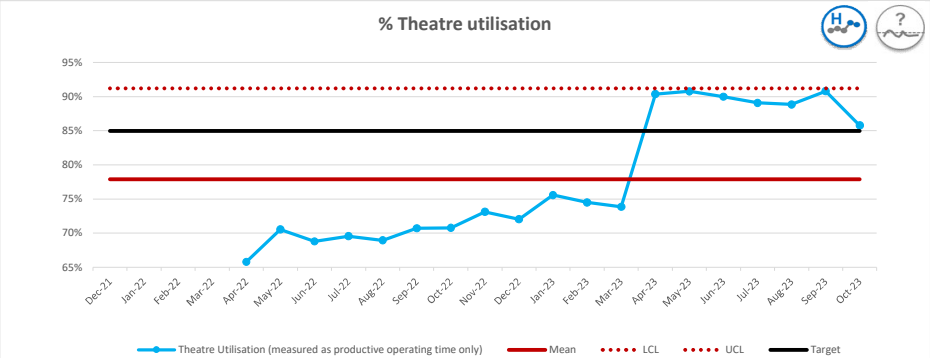
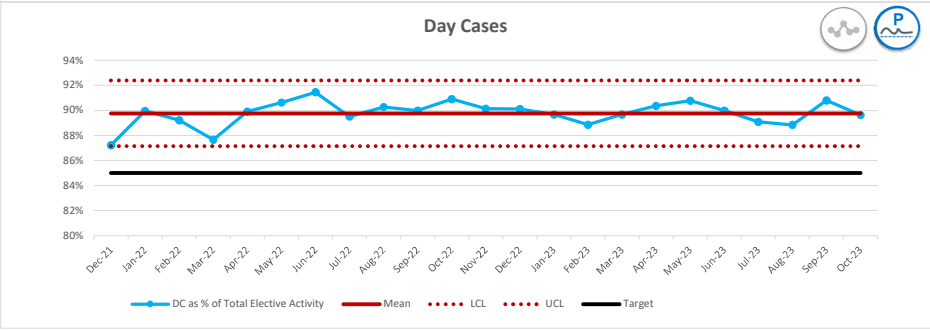
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
62. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 91.1% of 19/20 activity in month.**		**Variation: Common Cause (Normal) variation.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
64. % Patients discharged to their usual place of residence Target: No Current Threshold	**94.57% patients in month who were discharged to their usual place of residence.**		**Variation: Common Cause (Normal) variation.**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

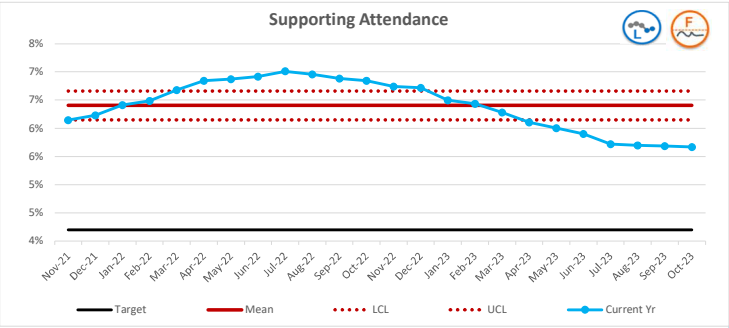
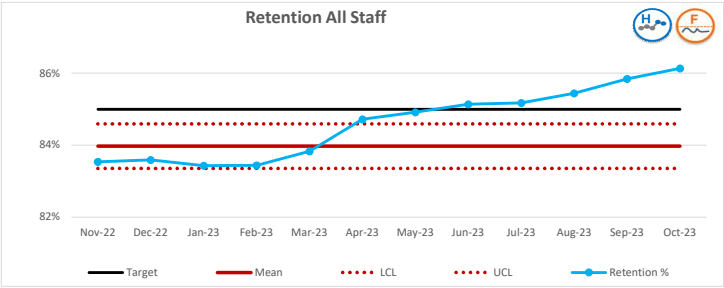
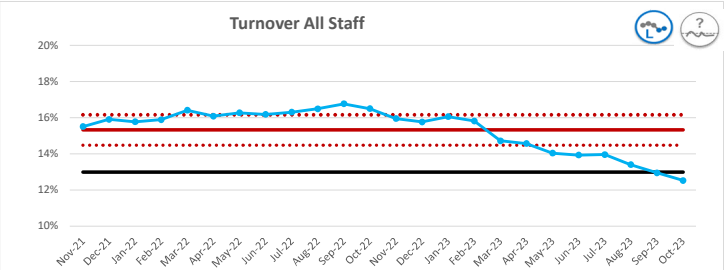
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
65. Theatre Utilisation (measured as productive operating time only) Target: 85%	85.8% Theatre utilisation in month (measured as productive operating time only). There were 89.64% Day cases, of total activity in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature. *PLEASE NOTE: This chart currently reports an inaccurate poistion, which cannot be resolved at present due cancellation discrepancies in the Theatres Block Dashboard. We expect this to be resolved by December 2023.*	Theatre Utilisation has improved, but has been steadily increasing since Apr 22 with the participation in the regional Theatre improvement programme. The performance is as a result of some utilisation improvement and changes in recording - this is in the process of being validated. The slight decrease in October was as a result of consultant sickness and it is predicted that this position will improve in November.	The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data. Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors.
66. Day case (measured as an aggregate of total cases) Target: 85%			Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	Daycase rates have been higher in 2023/24 with majority hitting the target.	The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates. Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

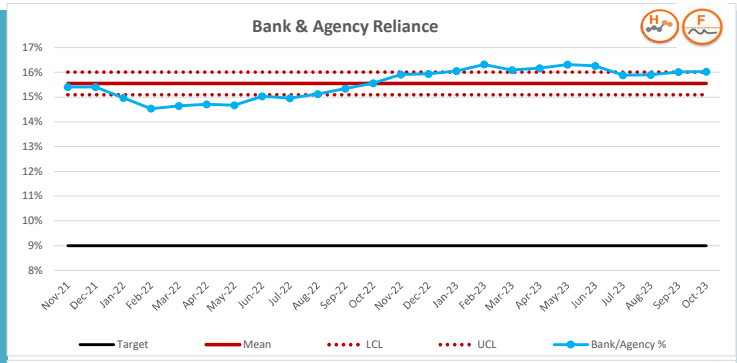
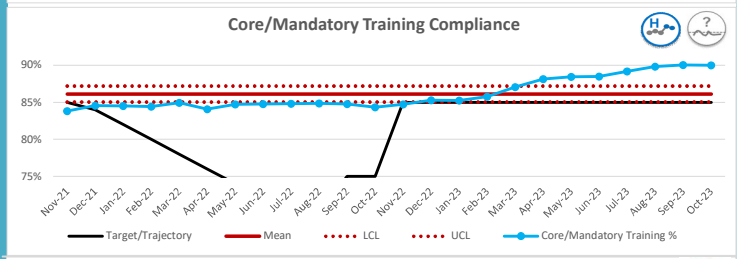
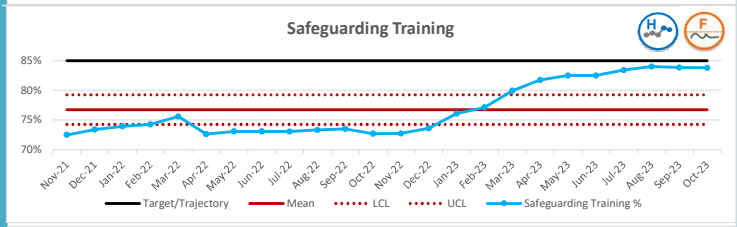
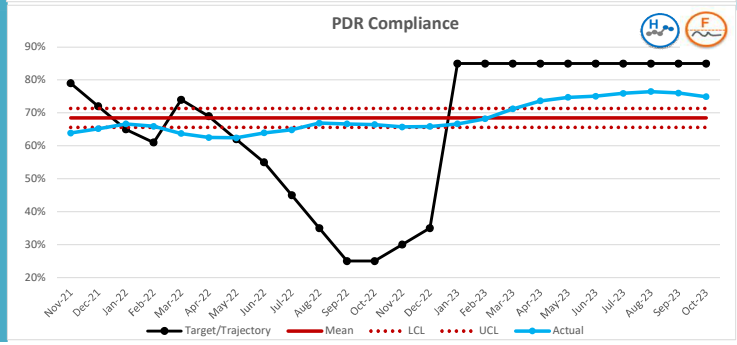
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
S Trust Strategy
RR200 Risk Register

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
68. Supporting Attendance Target: Below 4.2%	UoR SOF S The Trust's annualised sickness rate was 5.67%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence showing an Improving Variation. The annualised sickness absence percentage in October 2023 was 5.67%, a slight decrease from 5.7% in August 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.	October 2023 annualised absence is the lowest annual absence rate since April 2020. Sickness absence levels remain below 22/23 absence rates. 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.
69. Retention Target: 85%	UoR RR1108 RR1134 The Trust's annualised retention of all staff was 86.14%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Annualised retention showing an Improving Variation. Retention of all staff in October 2023 was above Trust target at 86.14%, an increase from 85.5% in August 2023. Retention for permanent staff in October 2023 remains above Trust target at 88.69%.	Retirements are reducing, with relocation the fastest growing reason for people leaving, work/life balance remains the main reason. 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.
70. Turnover Target: Below 13%	S CQC SOF UoR The Trust's annualised turnover of all staff was 12.53%.		Assurance: The Trust inconsistently passes / fails the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in October 2023 was above Trust target at 12.53%, a decrease from 13.35% in August 2023. Turnover of permanent staff in October 2023 was above Trust target at 11.67%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

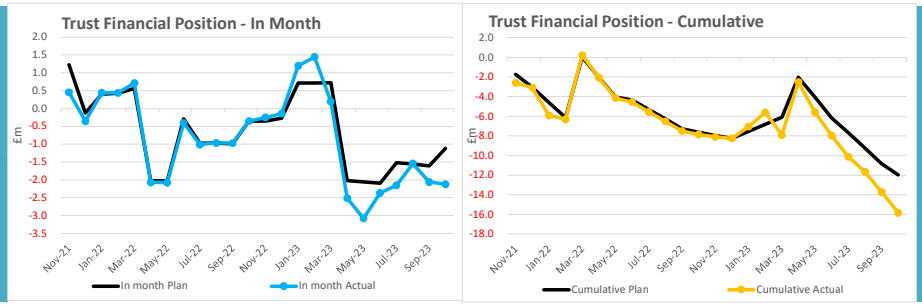
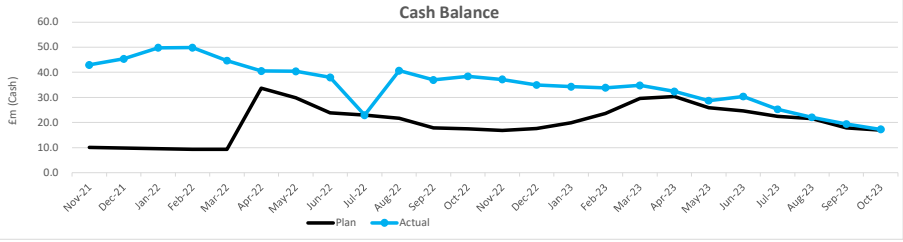
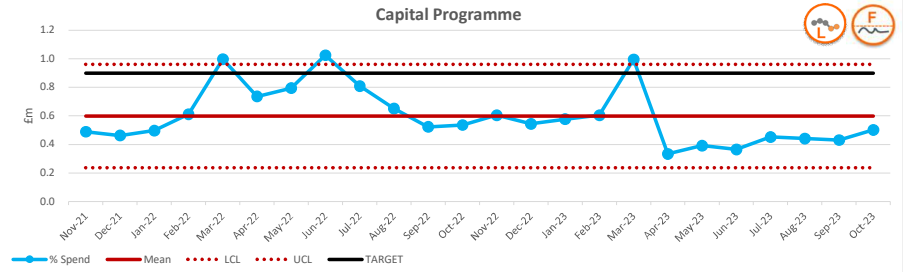
KEY:
SOF System Oversight Framework
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
71. Bank and Agency Reliance Target: 9% or Below	UoR Annualised Bank and Agency Reliance was 16.03%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Bank and Agency reliance is showing a Concerning Variation. Bank and Agency reliance in October 2023 was 16.01%, which is no change from August 2023 at 16.01%. Bank reliance continues to increase and is 11.6% in October 2023 as Agency reliance continues to decrease to 4.9% in October 2023.	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 Resourcing Task and Finish group is working with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this will allow the organisation to develop plans to improve the effectiveness of workforce deployment.
72.Core/Mandatory Training Target: 85%	UoR CQC Core/Mandatory training compliance was 90.01% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training (exclusive of Safeguarding) is showing an Improving Variation. In October 2023, CSTF Mandatory Training compliance was 90.01%, excluding Safeguarding Training (Children's and Adults); Safeguarding (Children's and Adults) compliance was 84%.	Compliance continues to be supported by the continual review of training and accessibility at the Mandatory and Role Specific Training Panel and the offer of face to face training. Care Groups report compliance at Operational People Committee with actions required to ensure targets are met. Changes have been made in terms of accessibility of Safeguarding training which has resulted in a slight increase in compliance.
73. Safeguarding Training Target: Trajectory	Safeguarding Training compliance was 83.8% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.		
74. PDR Target: 85%	S CQC Annualised PDR compliance was 74.93%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In October 2023, Appraisal compliance was 74.93%, a decrease from 76.05% in August 2023. Currently Appraisal rates are below the trajectories but higher than 2022.	A new electronic appraisal has been launched with associated guidance, dedicated extranet pages and training which was as a result of a workforce feedback regarding streamlining the process. It also includes EDI objectives and a wellbeing section. There is a current review of how Medical PDRs are recorded and reported, with an increase to overall PDR compliance expected following the review.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

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

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
75. Trust Financial Position **Target: Plan**				
76. Cash Balance **Target: On or better than plan**				
77. Capital Programme **Target: On plan 90%-100%**				

The Trust has recorded a deficit position of £15.82m at 31 October 2023 against a deficit plan of £11.96m. The position includes £0.7m additional income relating to a reduction of the ERF target to compensate for the impact of Industrial Action as well as a further assumed £0.5m as advised by C&M ICS.

The main drivers for the deficit being worse than plan are Industrial Action (IA) costs, activity delivered under plan and the cost of additional capacity in A&E.

In line with national guidance the Trust has submitted a forecast to plan (£15.7m) at M7. Following work with the ICS, the Trust is now forecasting a £21.3m deficit, which is £5.5m worse than plan. However there are significant risks to achieving this forecast.

The cash balance as at 31 October 2023 is £17.3m.

The current cash balance is £17.3m which is £0.3m better than the cash plan. In the main this relates to timing differences in the payment of trade and capital creditors and the timing of debtor receipts.

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

Capital expenditureat the end of month 7 is £7.26m against a plan of £14.47m.

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a concerning nature.

Annual Trust capital plan of £29.7m is £0.4m oversubscribed against £29.3m of capital funding. The monthly profile of the Trust plan has been updated to be more reflective of the expected position. With the updated profile, £11.11m was expected to be spent by 31 October 2023 giving a variance of £3.85m.

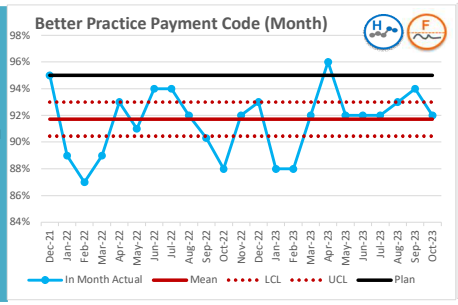
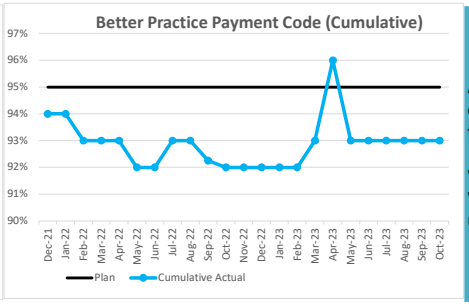
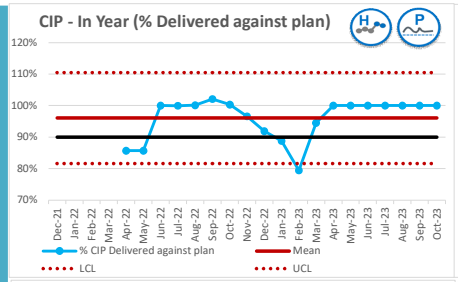
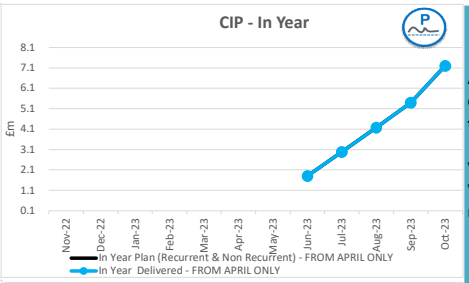
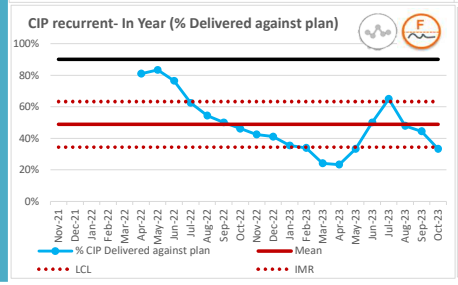
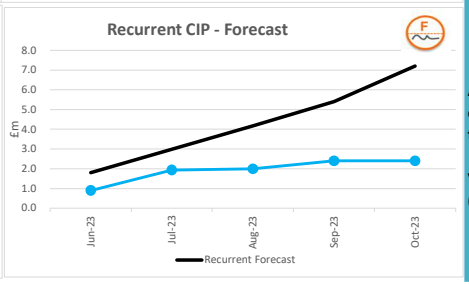
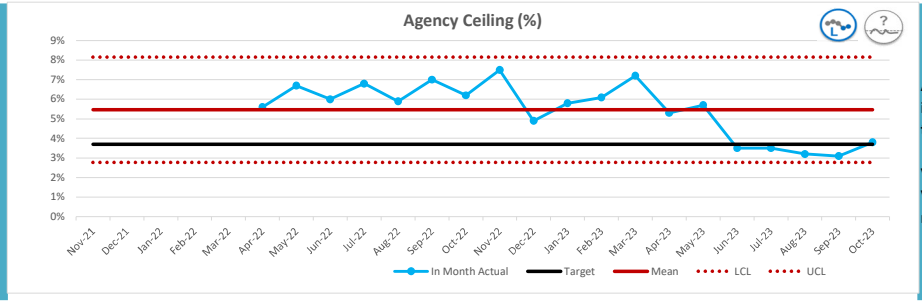
The underspend year to date is mainly due to the timing of externally funded schemes. In particular, the plan for TIF is £7.5m and for CDC is £3.3m which were profiled in 12ths whilst waiting for a detailed plan from cost advisors. There was also a subsequent delay due to additional funding requests. The majority of CDC expenditure is now expected in months 9 to 12.

The Trust requested profiling of £3m from 2023/24 to 2024/25 in relation to TIF and confirmation has been received that this has

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
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Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
78. Better Payment Practice Code **Target: Cumulative performance 95%**	The Better Payment Practice Code (BPPC) performance based on volume for NHS is 80% and non-NHS is 93%. The Better Payment Practice Code performance based on value for NHS is 82% and non-NHS is 92%. In October, the national average for BPPC was 91.2%, and the Cheshire & Merseyside average was 93.7%.	 	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Cumulative performance is 93.00% which is below the national target of 95.00%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.
79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**	UoR The month 7 CIP plan is £7.2m and £7.2m has been delivered.	 	Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	85% of savings have been identified for 2023/24 which is £15.3m of the £17.9m target.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT programme with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust. The plan for 2023/24 continues to be developed for the £17.9m target. A Director of Recovery has recently joined the Trust on a temporary basis to drive forward CIP delivery.
80. Cost Improvement Programme (recurrent forecast) – In year performance to date **Target: Recurrent Forecast is more than 90% of annual target**	£2.4m CIP has been delivered recurrently against the target of £7.2m.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	The Trust is working to identify additional recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust. Of the £15.3m identified, £9.9m is recurrent.	The Trust is in the process of identifying additional recurrent CIP schemes for 2023/24. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.
81. Agency Ceiling **Target: Agency spend should not exceed 3.7% of total pay (ICS target)**	UoR The Trust Agency spend in month is 3.8% against a target of 3.7%		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	For the months of June to September 2023 the monthly percentage has been below 3.7% due to moving agency staff onto the bank. However in October it increased to 3.8% due to additional medical agency in haematology, theatres and breast surgery.	The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: - Agency controls best practice - Rostering compliance - Rate card compliance - Establishment Control compliance (or an alternative approach) - Unplanned absences - Recruitment activity

Appendix 3 – Trust IPR Indicator Overview

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

13.	**Medication Safety**	Overview of the current position in relation to medication, to include: • Medication reconciliation within 24 hours. • Medication reconciliation throughout the inpatient stay. • Number of controlled drugs incidents. • Number medication incidents resulting in harm.
14.	**Staffing Average Fill Levels**	• Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
15.	**Care Hours Per Patient Day (CHPPD)**	• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
16.	**HSMR Mortality Ratio**	• Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
17.	**SHMI Mortality Ratio**	• Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
18.	**NICE Compliance**	• The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. This indicator monitors Trust compliance against NICE guidance.
19.	**Complaints**	Overall review of the current complaints position including; • Number of complaints received in month. • Number of dissatisfied complaints in month. • Total number of open complaints in month. • Total number of cases over 6 months old in month. • Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month. • Number of complaints responded to within timeframe in month. • Number of PALS complaints received and closed in month.
20.	**Friends and Family Test (Inpatient & Day Cases)**	• Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?
21.	**Friends and Family (ED and UCC)**	• Percentage of AED (Accident and Emergency Department) patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?
22.	**Mixed Sex Accommodation Breaches (Non-ITU)**	• Number of MSA Breaches in month (outside of ITU).
23. **24.** **25.** **26.**	**Sepsis**	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.

27.	**Ward Moves Between 10pm and 6am**	• Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
28.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.
29.	Postpartum Haemorrhage >1500ml	• To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. • PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the North West Coast Maternity Dashboard.
30.	3rd and 4th Degree tears	• To monitor rates of 3rd & 4th degree tears against North West Coast Regional Dashboard. • WHH are not currently an outlier for 3rd & 4th degree when compared to the North West Coast Maternity Dashboard, but 3rd and 4th degree tears are a significant outcome with the potential for long term impact of women's health and wellbeing.
31.	3rd and 4th Degree tears	• To monitor pregnancy bookings met within the 10 and 13 week target. • Timeliness of pregnancy booking is a key performance indicator. • WHH is currently an outlier for bookings before 10 weeks when compared to the North West Coast Maternity Dashboard. • WHH is also currently an outlier for bookings before 13 weeks gestation when compared to the North West Coast Maternity Dashboard
32.	Fractured Neck of Femur	• The % of patients treated in line with Best Practice Tariff (BPT). • The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)). • Shorter time to theatres significantly reduces risk of mortality and improves pain.
33.	*MUST nutritional assessment completion*	• To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE) • In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity
	Access & Performance	
34.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.

35. 67.	**RTT Open Pathways and 52 & 65 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
36.	**Four hour A&E Target and ICS Trajectory**	• All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.
37.	**A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.**	• % of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.
38.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
39.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
40.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
41.	**Cancer – 28 Day Faster Diagnostic Standard**	• All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.
42.	**Cancer 31 Days - First Treatment**	• All patients to receive first treatment for cancer within 31 days of decision to treat.
43.	**Cancer 31 Days - Subsequent Surgery**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.
44.	**Cancer 31 Days - Subsequent Drug**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments.
45.	**Cancer 62 Days - Urgent**	• All patients to receive first treatment for cancer within 62 days of an urgent referral.
46.	**Cancer 62 Days – Screening**	• All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers.
47.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
48.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
49.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
50.	**Discharge Summaries – Sent within 24 hours**	• The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
51.	**Discharge Summaries – Not sent within 7 days**	• If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
52.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
53.	**Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days**	• All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
54.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.

55.	**Super Stranded Patients**	• Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
56.	**Elective Recovery Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
57.	**Elective Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
58.	**Elective Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
59.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
60.	**% Outpatient referred to long covid service within 15 weeks**	•
61.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).
62.	**Reduction in Outpatient Follow Ups**	• % reduction of Outpatient follow ups compared to 19/20 activity.
63.	**COVID-19 Recovery Cancer First Treatment**	• % of people who received their first treatment for cancer compared to the equivalent month in 19/20.
64.	**% Patients discharged to their usual place of residence**	• % of patients who were discharged to their usual place of residence.
65.	**Theatre Utilisation (measured as productive operating time only)**	• Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. • Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.
66.	**Day case (measured as an aggregate of total cases)**	
	Workforce	
68.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
69.	**Retention**	Staff retention rate % over the last 12 months.
70.	**Turnover**	A review of the turnover % over the last 12 months.
71.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
72.	**Core/Mandatory Training**	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
73.	**Safeguarding Training**	A summary of safeguarding training compliance.
74.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
75.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
76.	**Cash Balance**	The cash balance at month end compared to plan.

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

Appendix 4 - Statistical Process Control

1.0 What is SPC?

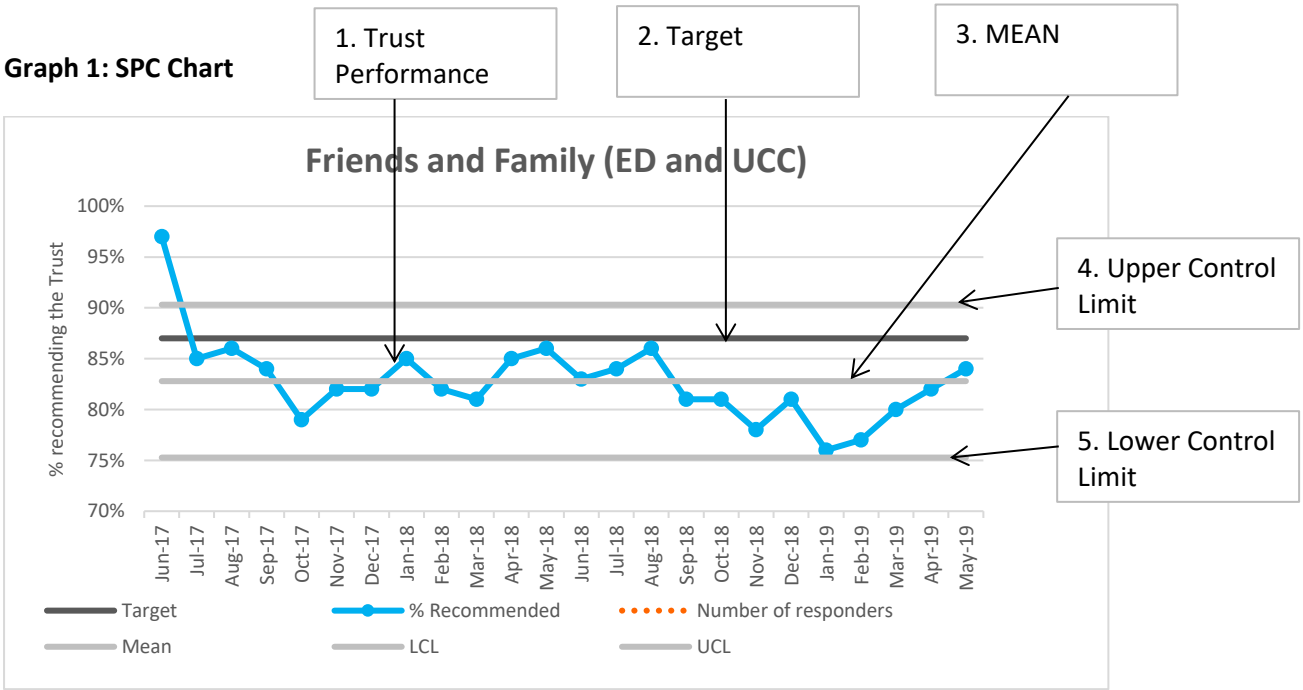
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

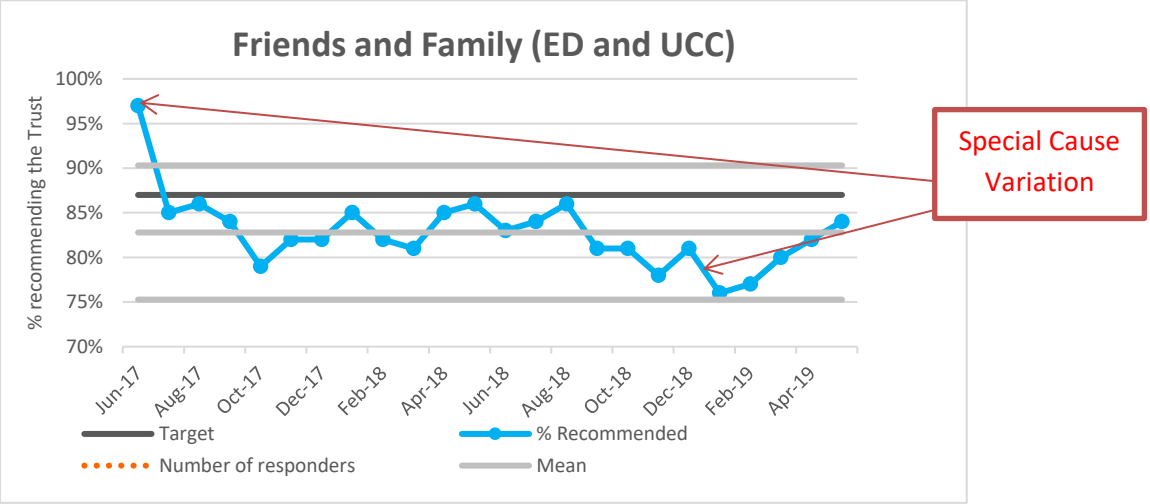


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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



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

Appendix 5

Warrington & Halton Teaching Hospitals NHS Foundation Trust **Appendix 5**

Income Statement as at 31st October 2023

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**308,683**	**25,693**	**25,927**	**234**	**179,318**	**178,478**	**-840**
Non NHS Clinical Income							
Private Patients	8	1	1	1	5	7	2
Non NHS Overseas Patients	60	5	34	29	35	70	35
Other non protected	728	61	22	-38	425	291	-134
Sub total	**796**	**66**	**58**	**-9**	**464**	**368**	**-96**
Other Operating Income							
Training & Education	9,093	758	1,149	392	5,304	6,208	904
Donations and Grants	2,095	0	186	186	2,095	1,245	-850
Miscellaneous Income	14,620	1,217	1,442	225	8,520	11,156	2,636
Sub total	**25,808**	**1,975**	**2,778**	**803**	**15,920**	**18,610**	**2,690**
Total Operating Income	**335,286**	**27,734**	**28,763**	**1,029**	**195,702**	**197,455**	**1,753**
Operating Expenses							
Employee Benefit Expenses	-248,897	-20,500	-21,904	-1,404	-146,781	-151,210	-4,429
Drugs	-20,191	-1,673	-1,888	-215	-11,882	-12,052	-170
Clinical Supplies and Services	-22,298	-1,829	-2,021	-192	-13,371	-14,526	-1,155
Non Clinical Supplies	-38,398	-3,221	-3,375	-154	-22,659	-24,219	-1,560
Depreciation and Amortisation	-14,278	-1,195	-1,139	56	-8,199	-7,890	309
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-344,062**	**-28,418**	**-30,327**	**-1,910**	**-202,892**	**-209,896**	**-7,004**
Operating Surplus / (Deficit)	**-8,775**	**-683**	**-1,564**	**-881**	**-7,190**	**-12,440**	**-5,250**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	44	44
Interest Income	518	19	92	73	474	934	460
Interest Expenses	-191	-16	-8	8	-112	-61	51
PDC Dividends	-5,679	-473	-473	0	-3,311	-3,311	0
Total Non Operating Income and Expenses	**-5,352**	**-470**	**-390**	**80**	**-2,949**	**-2,394**	**555**
Surplus / (Deficit) - as per Accounts	**-14,127**	**-1,153**	**-1,954**	**-801**	**-10,139**	**-14,834**	**-4,695**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,095	0	-186	-186	-2,095	-1,245	850
Add Depreciation on Donated & Granted Assets	475	40	40	1	277	279	2
Total Adjustments to Financial Performance	**-1,620**	**40**	**-146**	**-185**	**-1,818**	**-966**	**852**
Adjusted Surplus / (Deficit) as per NHSI Return	**-15,747**	**-1,114**	**-2,100**	**-986**	**-11,957**	**-15,800**	**-3,843**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/12/140 (a)	MEETING	Trust Board	DATE OF MEETING	10th October 2023

Date of Meeting	10 October 2023
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Jayne Downey
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/10/204	**Patient Story – The Importance of Shared Care**	The Committee received a presentation on the Importance of Shared Care, specifically a patient admitted to the Stroke Ward, and escalation as per Martha's rule, with an option for a second opinion. Lessons had been identified which included the need for improved education requirements for medical staff on medicines systems, in particular the possible implementation of an electronic system as part of the new EPR system.	The Committee received **substantial assurance** that lessons had been learned.	
QAC/23/10/205	**Hot Topic – Cancer Nurse Specialists**	The Committee received a presentation providing details on the role of Cancer Nurse Specialists Service (CNS) within the Trust and the impact that they have. Concerns were highlighted in respect of the capacity levels of CNS. The Committee discussed the potential impact of the CNS establishment and agreed that a risk should be added to the Corporate Risk Register and monitored in the Patient Experience Sub-Committee	The Committee received **moderate assurance** and noted the next steps.	**To be monitored at the Patient Safety Sub-Committee and a risk to be added to the Corporate Risk Register**

QAC/23/10/206	**Deep Dive – Fractured #Neck of Femur (NOF)**	A Deep Dive was presented on orthopaedics Neck of Femur care which provided a background to the performance of the service, recent progress and further work and actions to be taken over the next three months. The Committee noted the key areas of focus to be admissions, nerve block, Abbreviated Mental Test Score, nutritional assessment, surgery within 36 hours, orthogeriatric review, comprehensive falls assessment, bone health assessment, physiotherapist review, prompt mobilisation, delirium assessment and length of stay. The Committee were assured in respect of the governance process for monitoring the NoF service	The Committee received **moderate assurance** and noted the action plan to address concerns.	**A further update to be presented in January 2024**
QAC/23/10/213	**Paediatric Audiology Update**	The Committee received an update in relation to the Paediatric audiology incident. Of particular note was: • Remaining cases agreed following all MDT meetings and decision making • MDT planned on 31st October to determine where possible if any harm has occurred • To date 1 case of low harm identified – result of a delay in fitting hearing aids • Help line still open no calls since 21st July, all queries dealt with • FOI and media requests being managed	The committee discussed and noted the update and received **substantial assurance**.	**QAC 12.12.2023**

The Committee also received the following items;

QAC/23/10/207 - Board Assurance Framework & Risk Register
QAC/23/10/209 - Patient Safety & Clinical Effectiveness Sub-Committee Exception Report
QAC/23/10/210 - Quality IPR Metrics

QAC/23/10/211 - Maternity Update including; Ockenden, Maternity Incentive Scheme, ATAIN Q1, Maternity Neonatal Quality Review & Maternity Self-Assessment Tool (Bi-Annual Report)
QAC/23/10/212 - CQC Maternity Inspection Feedback
QAC/23/10/214 - Arbury Court update
QAC/23/10/215 - Digital Systems – Review of Clinical Safety Assurance
QAC/23/10/217 - Cardiopulmonary Resuscitation Decisions – 6 Monthly Position Report
QAC/23/10/218 - Update on High Level Enquiries & External Assessment/Inspections
QAC/23/10/219 - Clinical Audit Bi-Annual Report
QAC/23/10/220 - Patient Experience Bi-Annual Report
QAC/23/10/221 - Quality Improvement Progress Bi-Annual Report
QAC/23/10/222 - Ward Accreditation Bi-Annual Report
QAC/23/10/223 - Patient Equality, Diversity & Inclusion Sub Committee – Bi-Annual Report

Assurance Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/12/140a (ii)	MEETING	Trust Board	DATE OF MEETING	6 December 2023

Date of Meeting	14 November 2023
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/11/230	**Hot Topic – The Impact of Industrial Action – Patient Safety & Quality**	The Committee received a presentation which provided details of the impact of industrial action in relation to patient safety and quality. Of particular note was: • No complaints or PALS concerns received. • 5 category 2 and 1 unstageable pressure ulcer (during and up to 1 week following IA) some evidence of delayed repositioning. • 10 falls reported across strike days, • No concerning variation in MET call data It was noted that a number of mitigations had been put in place at times of industrial action.	The Committee received **moderate assurance** in relation to the impact of patient safety & quality due to industrial action.	**Ongoing monitoring of patient safety and quality in the Patient Safety & Clinical Effectiveness Sub-Committee**
QAC/23/11/231	**Deep Dive – Medicines Reconciliation**	The Committee received a presentation in relation to Medicines Reconciliation, specifically in respect of the percentage of medicines reconciliation completed within 24 hours, he percentage of medicines reconciliation completed during admission, pharmacy establishment vacancy rate and performance within each CBU.	The Committee received **moderate assurance** and noted plans to address concerns.	**Ongoing monitoring of patient safety and quality in the Patient Safety &**

		It was noted that there had been a significant improvement in the last two weeks of October. The following next steps were also noted: • Recruitment and retention focus • Expansion of pharmacy ED provision • Continual review of working practices • Consideration of the potential role of non-registered pharmacy staff		**Clinical Effectiveness Sub-Committee**
QAC/23/11/232	**Palliative Care End of Life Strategy**	The Committee received the 2023-2025 Adult Palliative and End of Life Care Strategy. The Committee noted that the intention of the new strategy to: • Maintain and improve clinical excellence • Maintain and enhance patient and family experience of dying in hospital • Support all teams to deliver high quality palliative and end of life care • Inform individuals about palliative care, the services provided and how to access this care.	The Committee received **substantial assurance** and supported the Palliative Care End of Life Strategy	**For approval at Trust Board 06.12.23**
QAC/23/11/233	**Patient Safety & Clinical Effectiveness Sub-Committee Exception report**	Of the items escalated to the Committee in the Patient Safety & Clinical Effectiveness Sub-Committee Exception report; two matters relating to fragile services were of particular note: Paediatric Ophthalmology – • Currently no paediatric ophthalmologist in the Trust and no lead for the service and part time associate specialist undertaking the paediatric work.	The Committee discussed the report and received **moderate assurance**	**Fragile Services Report to be presented to the Board 06.12.2023**

		• High risk patients are prioritised and are all offered an appointment in month and any patients that are at risk and need urgent treatment are referred to Alder Hey. • All children waiting over 17 weeks above target timeframe have an interim assessment. • Currently no service provision for squint surgery at WHH Urology – • Successful recruitment of x3 specialty doctors. Plan to convert the locum consultant post to a fixed term specialty doctor. • Progress is being made with the backlog in Urology but there remains a significant risk to patient outcome due to delays and insufficient capacity Other matters to note include the Theatre Safety Audit that highlighted two episodes of non-compliance in the recent quarterly safer surgery audit, the outcome of investigation of recent never event at CTSM awaited and the recent appointment to deputy AMD.		
QAC/23/11/234	**Moving to Outstanding Q2 update**	The Committee received a presentation providing an update on the enquiries received from the CQC in quarter 2 and details of the care services mock inspection programme. The Committee also received high level feedback following the formal maternity inspection that took place on 14th September 2023.	The Committee discussed the presentation and received **moderate assurance**	**Trust Board 06.12.2023**

QAC/23/11/237	**Maternity Update**	The Committee noted and discussed the following reports relating to the Trust's Maternity Service: • Ockenden • Maternity Incentive Scheme (MIS) including Saving Babies Live Care Bundle (SBLCB) • Maternity Incentive Scheme Yr 5 – Safety Action 4b (Anaesthetic, Neonatal & Medical Workforce Overview) • Transitional Care Audit Q2 • ATAIN Q3 Update • Maternity & Neonatal Review	The Committee noted and discussed the reports and received **substantial assurance**	**Trust Board 06.12.2023**
	Mental Health at WHH Update	A presentation was delivered providing an update on the Mental Health provision at the Trust following a previous presentation at the Committee in August 2023. The key updates included: • Risks added to risk register specific to mental health and updated regularly. • Mental Health Act Policy written. • Ligature policy re-written. • SOP for mental health patients in ED. • Missing person policy update in progress (links with Right Care Right Person). • Rapid tranquilisation policy re-written. • Training for appropriate member of staff • Training development with external partners – observational support and legal frameworks. • System escalation for mental health delays.	The Committee noted and discussed the update and received **substantial assurance**	**QAC February 2024**

The Committee also received the following items:

QAC/23/11/235 - Sepsis High Level Q2 Update
QAC/23/11/236 - Verbal update in relation to Liberty Protection Services

QAC/23/11/238 - Safeguarding Bi-Annual Report
QAC/23/11/239 - Learning from Experience Q2 Update
QAC/23/11/240 - DIPC Infection Control Q2 Update
QAC/23/11/241 - Violence Reduction Strategy Bi-Annual Update
QAC/23/11/242 - Strategy Update
QAC/23/11/244 - CIP/GIRFT Quality Impact Assessment Compliance *(for noting)*
QAC/23/11/245 - IG & Corporate Records *(for noting)*

Assurance Key:

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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/23/12/140c (i)	Meeting	Trust Board	Date Of Meeting	6th December 2023

Date of Meeting	18th October 2023
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/10/141	**Staff Story – Freedom to Speak up Champions**	Claire Grice and Adam Harrison-Moran, both Freedom to Speak Up Champions presented the Staff Story. They talked about the importance of Freedom to Speak Up within the Trust and why they became Champions. The role of Champion was about being visible, being able to signpost and support staff and about being there from start to end of the process. In relation to what's next, these include new Guardian for the Trust, dedicated time to support and develop champions, more visibility in areas (walk arounds), auditing data, which areas do not have champions, areas with more grievances, are all staff represented – to produce an action plan to continue the work of FTSU.	The Committee received **substantial assurance** from the FTSU Champions story and passed on their thanks to all FTSU Champions for the work they undertake.	**Not applicable.**

SPC/23/10/143	**Deep Dive – Agile and Flexible Working**	The presentation set out the flexibility framework and timeline, and noted this was a dedicated programme of work from the WHH People Strategy, in relation to "Enabling New Ways of Working through Culture Change" and embedding agile and flexible working principles as part of this, linked to the People Promise of working flexibly. 26% of the workforce had noted their work/life balance was either "poor" or "very poor". In the 'We are Flexible' staff survey the score was 6, which compared to a national average of 6. Pilot areas have been identified across the Trust to pilot flexible working using rostering. A leadership development package had also been developed aiming to empower leaders to promote, encourage and embed agile and flexible working within their teams.	The Committee received **moderate assurance** and requested an update from the pilot and programme of work before the end of March 2024.	**SPC March 2024**
SPC/23/10/145	**Chief People Officer Report**	The Committee received and discussed a paper summarising a number of key people related topics. The Committee noted the update regarding the HCA industrial action and organisation planning to mitigate any risks. The Committee approved the Workforce EDI IPR metrics to be reported to SPC.	The Committee received **substantial assurance** on the topics and approved the proposed Workforce EDI IPR.	**SPC November 2023**
SPC/23/10/146	**Workforce Brief on National, Regional, ICB or Local Issues**	CMAST People Services Benchmarking report had been presented to Chairs of Trusts in C&M. Purpose of development is to support collaboration at scale decisions by CPOs.	The Committee received the update on Collaboration at Scale	**Not applicable**

		The Sexual Safety in the Workplace Charter has been launched and the ICS and provider organisations have been asked to sign up to it. In signing up, there is a timeline set for all processes and actions to be in place. The Committee were asked to approve the Charter and to implement and follow the action plan.	and received **moderate assurance** The Committee approved the Trust signing up to the Sexual Safety in the Workplace Charter.	

The Committee also received the following items:

Matters to Note for Assurance

SPC/23/10/142 – Hot TOPIC – PATIENT SAFETY INCIDENT FRAMEWORK (PSIRF) update
SPC/23/10/144 - BOARD ASSURANCE FRAMEWORK (BAF) & CORPORATE RISK REGISTER (CRR)
SPC/23/10/147 – MONTHLY SAFE STAFFING REPORT

Sub-Committee Minutes/Notes

SPC/23/10/148 – WORKFORCE EQUALITY, DIVERSITY AND INCLUSION SUB-COMMITTEE (WEDISC)
SPC/23/10/149 - WORKFORCE RESOURCE GROUP (WRG)
SPC/23/10/150 - OPERATIONAL PEOPLE COMMITTEE

Assurance Key:

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/23/12/140c (ii)	Meeting	Trust Board	Date Of Meeting	6th December 2023

Date of Meeting	14th November 2023
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/11/156	**Hot topic: Changes to the Role & Responsibilities of the Health & Wellbeing Guardian**	The Committee received a detailed presentation around the changes to the roles and responsibilities of the Health and Wellbeing Guardian aligned to the national NHS People Plan. It was noted that there is a requirement to focus on culture, staff and training in relation to wellbeing more generally and that the Committee needs to identify how it can be assured that key decisions that are made demonstrate a proper impact assessment in terms of workforce wellbeing. There was also a need to reflect on system-wide working and the wider hospital role within population health. The Committee was joined in the discussions by Cliff Richards as the Health and Wellbeing Guardian.	The Committee discussed the presentation and received **moderate assurance** due to additional responsibilities attribute to the Health & Wellbeing Guardian It was agreed that the cycle of business to be changed to reflect an HWB guardian bi-annual update and good assurance given on the direction of travel aligned to new responsibilities.	**SPC December 2023**
SPC/23/11/157	**Deep Dive: Physician Associates**	The Committee received a detailed presentation about the history of Physician Associates, numbers, current experiences within the Trust and also future developments.	The Committee discussed the presentation and received **moderate assurance**. The	

		The Committee noted that there was a need to continue to actively promote positive communications around PAs in order to combat some of the negativity circling in social media, including some involving WHH staff. In addition, there is a commitment from the Trust that PAs continue to be part of the workforce and will be investing in significant training and development opportunities to continue to upskill the PAs within the organisation and attract new PAs as part of workforce planning. The Trust will also work to support more formalisation / regulation of the role	Committee were assured in relation to the Trust's approach, it was less assured concerning the approach of the wider system	
SPC/23/11/158	**Chief People Officer Report**	The Committee received and discussed a paper summarising a number of key people related topics. The Committee noted the progress on the staff survey in terms of participation rates and also influenza uptake within the organisation, including efforts to increase participation and respond to workforce concerns as vaccine hesitancy is higher than anticipated, which is reflected across other NHS organisations. The Committee continue to be assured regarding response to Industrial Action.	The Committee received **substantial assurance** on the topics noting vaccine hesitancy for the influenza campaign which may have an impact on participation rates.	**SPC December 2023**
SPC/23/11/160	**Safer Staffing Report**	The Committee received and discussed a paper summarising the staffing position across the organisation. The Committee noted the progress that had been made in relation to staffing and in particular the improving picture for reducing vacancies. The Committee continue to be assured regarding the mechanisms in place to support safe staffing within the organisation.	The Committee received **substantial assurance** on the organisation having safe staffing in place and improvements in vacancy rates.	**SPC December 2023**
SPC/23/11/161	**Workforce Integrated Performance Report**	The Committee received the Integrated Performance Report, which also included key people metrics relating to Equality, Diversity and Inclusion for the first time.	The Committee received **substantial assurance** on the work to improve the	**SPC January 2024**

		It was noted that there was an improving picture in terms of annualised sickness rates and also achievement of compliance regarding mandatory training. The Committee continue to be assured on the work to achieve the key people metrics and have requested further detail in relation to the impact of the new recruitment system and overview of the Time To Hire process.	people metrics with an update on the new recruitment system in January 2024.	

The Committee also received the following items:

Matters to Note for Assurance

SPC/23/11/159 – Workforce Brief on national, regional, ICB or local workforce issues
SPC/23/11/162 - Workforce Policies and Procedures Overview Quarterly Report Q2
SPC/23/11/163 – Improving People Practices Bi-Annual Report

Sub-Committee Minutes/Notes

SPC/23/11/164 – Workforce Resource Group (did not take place due to Industrial Action)

Assurance Key:

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/12/40d (i)	MEETING	Trust Board	DATE OF MEETING	6 December 2023

Date of Meeting	25 October 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/10/135	**Hot Topic – Risk Benefit of LLP**	The Committee received the report noting:- • An LLP is set up by consultants rather than the Trust and is open to all • The Trust drives the level of activity through the LLP, not the consultants • The Procurement route has been reviewed, direct award only allowable up to £663,540 including VAT, full procurement exercise is required above this limit • Risks include reduced take up of WLIs, other clinical staff may want to form part of the LLP or set up one in their own right and the LLP may attempt to increase the cost of procedures • More work required about how this will work for the Trust, to be taken forward by the Executive Team with an update to the next FSC	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC November 2023**
FSC/23/10/136	**Deep Dive – CIP Targets – Delivery in Unplanned Care**	The Committee received the report noting:- • £1.8m of £4.3m CIP target identified at month 6, £0.5m additional CIP identified since that date • £0.8m relates to GIRFT efficiencies, cash releasing benefit only realised if costs are reduced via reduction in number of beds open • Progress made on Unplanned Care GIRFT priorities (Right Bed, Right Patient, Right Time, Achievement of 76% ED 4 Hour Standard and Recovery of Elective Activity) • Query around capacity to deliver, work ongoing to identify what is required and will be reviewed further by the Director of Recovery	The Committee **noted** and discussed the report receiving **limited** assurance	**FSC November 2023**

		• Dashboard to be reported to November FSC through CIP report		
FSC/23/10/138	**Pay Assurance Report**	The Committee received the report noting:- • The Trust is going through organisational change to move a proportion of band 2s to band 3 (80%) • Risk around back pay with local industrial action ongoing • Compliance with NHSE price cap discussed, medical workforce are compliant however an outlier for non-medical workforce • Agency reliance is reducing with a switch off in general areas from November 2023 which should reduce the costs incurred • Overall the price cap is still exceeded, however improvements are being seen and are expected to continue	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC November 2023**
FSC/23/10/139	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance small decrease on last month to 68.97% • Slight increase in type 1 A&E attendances and significant increase in type 3 • 12 hour trolley waits down slightly from last month • Continuing to see improvements in ambulance handover • Slow down in improvements in average length of stay after significant improvements in previous months • RTT performance – 50.51% which is behind trajectory • The diagnostic performance is 77.3% which links to the recovery plan for elective surgery. The main modalities that are non-compliant are Echo and Respiratory Physiology, both areas are on an improvement trajectory • Cancer 62 day referral performance is 70.5% • From 1 October the cancer standards will be combined for reporting • Reduction in DNA being seen, 8% in September with a reduction to 7% in month	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC November 2023**
FSC/23/10/140	**Monthly CIP report & GIRFT**	The Committee received the report noting:- • CIP overview at month 6, the £5.4m target year to date was achieved (£2.4m is recurrent) • Gap of £2.8m remains the same as last month, however further £0.7m identified since report written, still more to do to identify further schemes • Increase of recurrent identified CIP from last month (£0.5m), still £5.5m non-recurrent CIP included in plans	The Committee **noted** and discussed the report, receiving **limited** assurance	**FSC November 2023**

		• M7 forecasting to deliver in line with plan, however starting to see a gap from M8 onwards • Significant risk around cash releasing efficiencies as 103.8% activity needs to be delivered in order to realise savings, currently running at 94% • Length of stay savings not being realised as unable to close beds therefore not cash releasing • Best case forecast in year - Planned care £2.1m (47%) Unplanned Care £1.6m (37%) CSS £2.4m (86%)summary • Additional project transformation capacity is required in order to deliver		
FSC/23/10/141	**Cost Pressures**	The Committee received the report noting:- • Challenge of unfunded cost pressures with £5.6m year to date of which £2.2 are new emerging pressures. • All pressures continue to be monitored • Overspends are being offset by underspends, this will be realigned as part of budget setting for 2024/25 • No capacity for cost pressures next year as part of the recovery plan	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC November 2023**
FSC/23/10/143	**Finance Report**	The Committee received a report noting:- • The month 6 ytd position is off plan by £2.9m with a deficit of £13.7m • The position includes an income adjustment in relation to IA, as agreed with the ICS, however this is a potential risk • Activity target is not being achieved • Short notice cancellations continue to be an issue and a driver of underperformance of activity • Reduction in agency spend (4.0% ytd) with last 4 months below 3.7% target • CIP delivered against plan, £5.4m ytd, noting back profiled plan • Revenue requests supported by the Executive Team are highlighted in the report • Capital is behind the Trust plan by £3.3m, the majority is on external schemes. • Reduction in oversubscription against the capital programme from £0.7m to £0.4m and minor changes to the contingency budget. • Risks highlighted around ED staffing, IA and lack of associated funding, CIP achievement and no provision for potential backpay for Band 2 to Band 3 • The best, likely and worst scenarios are highlighted noting the likely position has been shared with the ICS.	The Committee discussed and noted the paper receiving **limited** assurance. The Committee **approved** the capital requests.	**FSC November 2023**

FSC/23/10/144	**Revenue Request – Elective Recovery 2023/24**	The Committee received a revenue request noting:- • 78 week waits tracking significantly higher than plan, only Mid Cheshire has more 78 week waiters • 65 week waits towards the bottom of the C&M trusts • £484k already approved, estimated to bring down the number of patients requiring a first outpatient appointment by 31 March 2024 by 1,000 patients • However, circa 2,000 patients will still be awaiting an outpatient appointment by 31 March 2024 • Circa £1m investment would clear all 65 week waits by 31 March 2024 and clear all 78 week waits by January 2023 • Opportunities such as external funding, Industrial Action ceasing and internal efficiencies to reduce the £1m to £400k • Main benefit is the impact on the patient acknowledging the cost associated with delivery • No indications of additional tier 2 funding other than Cancer funding, the Trust has submitted a bid for £100k • No message received that the Trust can deteriorate the financial position in order to fund this, there is no more money • Support for discussion at Trust Board in November 2023	The Committee **supported** the revenue request for approval at Trust Board.	**Trust Board November 2023**
FSC/23/10/145	**Capital Position** **Schemes over £500k**	The Committee received a presentation noting:- • YTD spend is £5.22m, underspend against plan mainly due to timing • Full capital programme expected to be spent in year with work ongoing as part of 2024/25 planning to identify schemes to be brought forward if required • Oversubscription reduced from £0.7m to £0.4m in month, catering upgrade profiled across the financial year end with no impact on the end date of the scheme • Catering – running to June 2024 as expected, construction due to start this week • Induction of Labour – start date 13 November, due to complete in this financial year	The Committee **noted** the presentation, **approved** the changes to the capital contingency and **approved** the scheme to be deferred to 2024/25	**FSC November 2023**

FSC/23/10/145	**CDC activity and profitability**	• CDC – Increase in costs for programme for both Shopping City and New Build, scope didn't change materially. Risk identified around cost advisors increasing their estimate, recommended that this is reviewed by Internal Audit and taken to Audit Committee • 2024/25 activity plan developed with the services and the associated profitability has also been assessed • Increase in profitability from the original plan is due in the main to potential central costs funding in 2024/25 which was not initially expected	The Committee **noted** the presentation and **recommended** that Audit Committee review The Committee **noted** the presentation	

Assurance Key:

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

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

Items for noting

FSC/23/10/134 BAF & Risk Register
FSC/23/10/137 Update Radiology Waiting List Initiative
FSC/23/10/142 Medical Staffing Review
FSC/23/10/146 Digital Strategy Group Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/12/140d (ii)	MEETING	Trust Board	DATE OF MEETING	6 December 2023

Date of Meeting	29 November 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/11/154	**Hot Topic – Response to NHSE Letter**	The Committee received the report noting:- • C&M submitted a revised breakeven forecast for 2023/24 against a planned deficit of £51m (formal confirmation received of additional £51m for LUFT New Hospital Programme). • Plan has been reset for providers, WHH is one of two Trusts off plan. • WHH submitted position is a likely forecast of £21.2m compared to a plan of £15.7m • If the likely case worsens there would be an impact on cash with the requirement to borrow additional cash sooner. • G&A bed base submitted as part of the Operational Plan is different to the ICB Financial Plan, growth from January onwards and this has been accepted by the ICB. • Submitted a non-compliant 65 weeks plan, strongly suggested in the NHS E letter is that 65 weeks is a priority therefore the Trust needs a plan to deliver. An additional £0.4m investment is required which will reduce underperformance of income by the same amount and therefore a net impact of £nil on the financial position.	The Committee **noted** and discussed the report receiving **moderate** assurance	
FSC/23/11/155	**Deep Dive – Planned Care CIP/GIRFT**	The Committee received the report noting:- • £2.1m of £4.6m CIP target identified at month 7 (£2m recurrent) • £0.3m relates to high risk GIRFT efficiencies, cash releasing benefit only realised if activity is delivered above baseline • £0.8m high risk CIP Scheme of non-recurrent vacancies, due to level of WLI spend utilising budget.	The Committee **noted** and discussed the report receiving **limited** assurance	

		• Progress made on Planned Care GIRFT priorities • Activity delivering 91.75% against plan with the key reasons for underperformance being due to Industrial Action, vacancies, changes to baseline activity and sickness • Positive in terms of GIRFT and have brought schemes forward from 2024/25 to improve delivery in 2023/24		
FSC/23/11/156	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance small decrease on last month to 67.13% • Slight increase in type 1 A&E attendances in last two months and in line both regionally and nationally. Significant increase in type 3 (all on the Halton site) • 12 hour wait in A&E is a key driver for the Trust being in tier 1, an increase is also being seen nationally. • Slight deterioration in ambulance handovers however continuing to see good performance compared to local partners • RTT performance – 51.3% which is behind trajectory. • The diagnostic performance is 79.62% which links to the recovery plan for elective surgery. Sleep activity is starting to increase and Echo capacity is increasing from next month, both areas are on an improvement trajectory • Cancer 62 day referral performance is 64.3% • From next month the cancer standards will be combined for reporting	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC December 2023**
FSC/23/11/157	**EPRR Core Assurance**	The Committee received the report noting:- • Assessment regime changed with very slight differences between being fully and partially compliant. The majority of fully compliant areas from the self assessment have now moved to partially compliant following review. • Important to note it is a new threshold of assessment rather than a deterioration of policies and procedures in the Trust. • Action plan in place and to be worked through prior to next year's submission.	The Committee **noted** and discussed the report, receiving **moderate** assurance and will be reported to Trust Board	**Trust Board December 2023**
FSC/23/11/158	**Pay Assurance Report**	The Committee received the report noting:- • Seeing an improvement in nursing pay rates with the day rate the last one to be reviewed	The Committee **noted** and discussed the report, receiving	**FSC December 2023**

		• Main risks are the BMA rate, Band 2 to Band 3 Industrial Action and the increase in sickness moving into Winter • Discussion around workforce increasing, however less productive. Vacancy rate is coming down as posts are filled, and establishment is also growing due to site developments at Halton. More information to be included in the paper for next month	**moderate** assurance	
FSC/23/11/159	**Recovery Update including** **Monthly CIP report & GIRFT** **Cost Pressures**	The Committee received the report noting:- • SWOT analysis undertaken of CIP, GIRFT, Cost Pressures, UEC Improvement and Elective Recovery • Recovery Wednesday format to change including action notes to be followed up and reporting to FSC by exception. • Additional 2023/24 CIP schemes identified were presented, currently £1m identified with other ideas identified with values to be attributed. • CIP paper noted with discussion around the requirement to fully deliver the CIP programme and also go further in order to deliver the revised forecast • Risk highlighted around non-recurrent CIP delivery going into 2024/25, noted that this has been reported to the ICS and therefore they are aware of the pressure. • Cost pressure paper noted and risks highlighted as significant. Cost pressures are factored into the revised forecast and are currently being managed by underspends.	The Committee **noted** and discussed the report, receiving **limited** assurance	**FSC December 2023**
FSC/23/11/161	**Finance Report**	The Committee received a report noting:- • Risks highlighted around Activity, ED staffing costs, industrial action costs, cost pressures, CIP achievement and no provision for potential backpay for Band 2 to 3 • The best, likely and worst scenarios are highlighted noting the likely position has been shared with the ICS and there is a risk that this could move to the worst case.	The Committee **noted** the paper receiving **limited** assurance.	**FSC December 2023**
FSC/23/11/162	**Revenue Requests EBCMS**	The Committee received a revenue request noting:- • £2.2m revenue funding from NHS E has been allocated over 3 years to enhance Electronic Bed Capacity Management Systems (eBCMS) • There is a risk around ongoing costs £175k to fund the Head of Patient Flow post and IT maintenance in 2026/27 and ongoing recurrent costs of 136k from 2027/28. Agreed the ongoing costs will be assessed at a later point to determine if they can be managed in budget. • There is no duplication with ePCMS in terms of benefits identified	The Committee **supported** the revenue requests for approval at Trust Board.	**Trust Board December 2023**

		• Capital consideration, there is no capital funding, however capital is required to provide a centralised Care Coordination Centre. A capital request is to be drafted and will come to FSC for approval to enable this to be delivered within year.		
	ED Nursing	The Committee received a revenue request noting:- • Revenue request for £2.3m for the provision of further investment in ED nursing to increase the substantive staffing establishment. • Current staffing model is under established based on Nursing Workforce Standards and two regulatory standards are being breached which can't be rectified without the increased establishment. • The safer staffing tool has been used to determine what is required as well as using professional judgement to assess if this is correct, the main reason for additional resource is due to acuity • An increase in quality and safety is the aim of the case by increasing establishment and also increasing the substantive workforce rather than using temporary staffing • Corridor care is not built into the case other than needing to flex up at times of surge and then back down. • Supported to go to Board with an additional section to state that the level of staffing is required for the here and now in order to provide safer staffing however details of how phased spend could drop out if and when improvement schemes (including GIRFT) deliver and what financial impact that could have. An additional benefit is also to be added so that this can be monitored through the benefits realisation process.		
	Radiology WLI	The Committee received a revenue request noting:- • Radiology has been undertaking WLIs for a number of years, allowing ability to flex to demand. • Expenditure will be funded from vacancies elsewhere in the Care Group. This has been reported to FSC and Board as the additional spend is above plan and the vacancies could have added to the CIP delivery. • Realignment of budgets will be undertaken as part of 2024/25 budget setting to prevent underspends funding the required Radiology WLIs throughout the year.		

FSC/23/11/163	**Capital Position**	The Committee received a presentation noting:- • Small movement in capital contingency approved, now stands at £149k • Assurance provided around delivery of 2023/24 capital delivery based on previous years, concerns over delivery / underspends are monitored through CPG and will be escalated if required • Main area of underspend relates to TIF, request to reprofile £3m from 2023/24 to 2024/25 has been approved • Planning has started on the 2024/25 plan, over £2m of schemes that could be brought forward to 2023/24 if required to ensure delivery of the capital programme	The Committee **noted** the presentation and **approved** the changes to the capital contingency	**FSC December 2023**

Assurance Key:

	High Assurance - can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed. **Substantial Assurance -** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
	Moderate Assurance - can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.
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Note: *Please fill the Recommendation / Assurance/mandate to receiving body column with the correct colour and state the Committees' level of assurance i.e. No Assurance, Limited Assurance, Moderate Assurance, Substantial Assurance or High Assurance*

Items for noting

FSC/23/11/153 BAF & Risk Register
FSC/23/11/159 Benefits Realisation Q2
FSC/23/11/160 Sustainability Strategic Priorities Update
FSC/23/11/163 Schemes over £500k and TIF Update
FSC/23/11/164 Digital Strategy Group Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/12/140 e	MEETING	Trust Board	DATE OF MEETING	6 December 2023

Date of Meeting	16 November 2023
Name of Meeting & Chair	Audit Committee – Chaired by Mike O'Connor
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
AC/23/11/78	**Progress Report on Internal Audit Follow-Up Actions**	The report provided an update which highlighted one overdue management action, which was partially complete. Following on from the last Audit Committee meeting MIAA met with the IM&T team on 14 September 2023 to review the outstanding action and the mitigations that are in place. MIAA are satisfied that the mitigations in place demonstrate control and will confirm that the mitigations continue to operate until the revised deadline of 30 April 2024.	The Committee received **substantial assurance** that mitigations were in place to demonstrate control.	**Audit Committee 22.02.2023**
AC/23/11/79	**Internal Audit Follow Up Report**	The report provided a position statement on those recommendations past their original review date. All recommendations followed up had been implemented with the exception of one	The Committee received **substantial assurance** on the progress of actions	**Audit Committee 22.02.2023**

		recommendation in relation to the Badger Net Application review – one recommendation has been classed as partially implemented and subject to further follow up.		
AC/23/11/80	**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 since the last meeting one review had been completed. The subject of the review was Conflicts of Interest and received substantial assurance. The following five reviews remained in progress: • Fractured Neck of Femur pathway • Bank & Agency • Waiting List Management • Data Quality • Key Financial Systems Controls	The Committee received **substantial assurance** on the progress of actions	**Audit Committee 22.02.2023**
AC/23/11/82	**Review Losses & Special Payments Q2 2023/24**	The Committee received the report detailing the losses and special payments for the period 1st July 2023 to 30th September 2023. Of particular note was: • An increase in the amount of stock losses compared to the previous quarter. • An increase in Employer Liability Payments compared to the previous quarter. • Decrease in Public Liability Payments compared to the previous year. The Committee discussed the increase in stock losses and received assurance that mitigations were in place to minimise the losses.	The Committee received the reports and received **substantial assurance** of arrangements in place to mitigate losses.	**Audit Committee 22.02.2023**

AC/23/11/84	**Review of Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFI)**	Proposed amendments to the Scheme of Reservation & Delegation (SoRD) and Standing Financial Instructions (SFIs) were presented to the Committee. It was noted that the current versions of the SFIs and SoRD were due expire in March 2024 and November 2023, respectively.	The Committee supported the amendments to the SoRD & SFIs for submission to the Trust Board for approval.	**To be approved at Trust Board 6.12.23**

The Committee also received the following items;

AC/23/11/76 - Changes and updates to the BAF
AC/23/11/77 - Updates from Committee Chairs
AC/23/11/81 - External Audit Update
AC/23/11/83 - Review of Quotation & Tender Waivers Q2 2023/24

Assurance Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/141i**			
SUBJECT:	**Maternity Update – Ockenden Report**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates. This paper provides the Quality Assurance Committee (QAC) oversight of the update with regards to Ockenden recommendations, and the report will also be noted at Trust Board.			

	In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 30th September 2023 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 96.58% compliant and is on trajectory to be 100% compliant by 31st March 2024. • **Ockenden 2**: WHH is 78.08% compliant. Ockenden 2 does not have any national timelines. Following a review of all actions, WHH has set internal timelines to complete all actions by 31st March 2024.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to receive and discuss this report as per Ockenden recommendations.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/23/11/237i	
	Date of meeting	12th September 2023	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF	BM/23/12/141i

1. BACKGROUND/CONTEXT

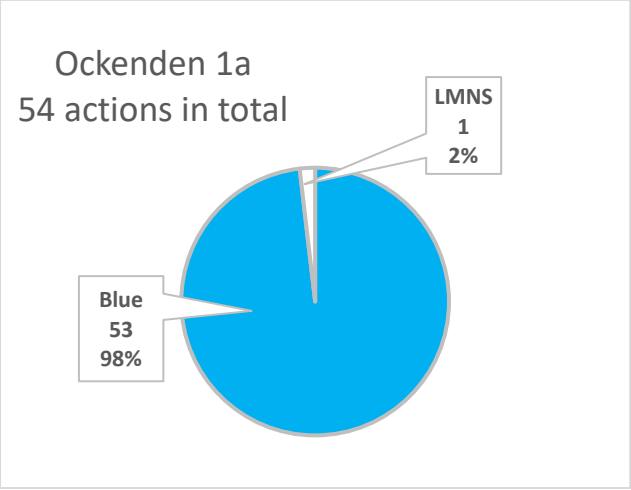
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

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

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

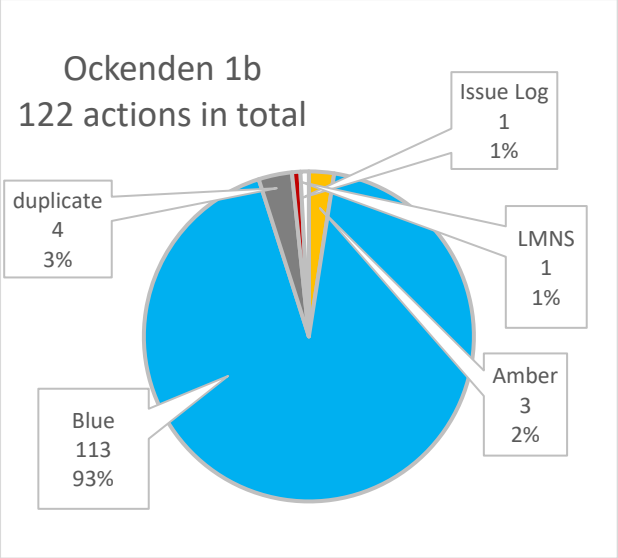
No change from previous month.

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

2.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



4 Outstanding Actions:

3 Amber Actions and 1 Action transferred to a BadgerNet Specific Issue Log.

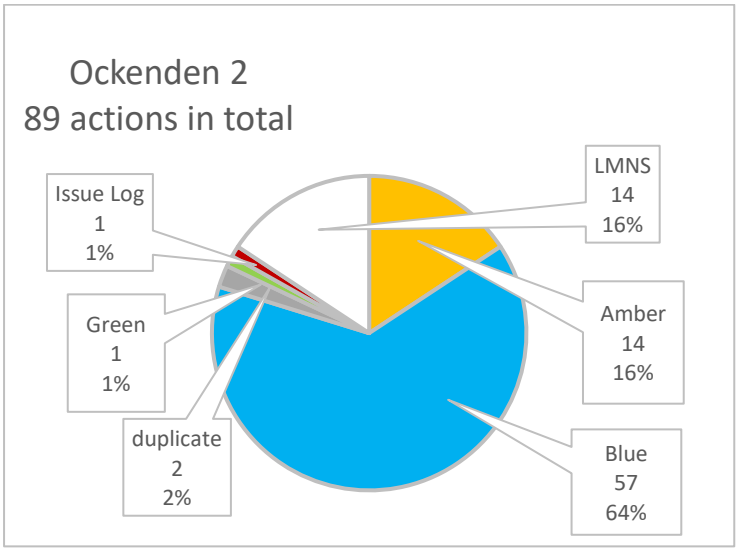
All actions due to be completed by 31 March 2024.

Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is currently 96.58% compliant an increase form 95.76% compliance in September 2023.

2.1.4 WHH Compliance with Ockenden 2 Report

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

Chart 3: WHH Ockenden 2 Compliance



16 Outstanding Actions:

14 Amber
1 Green
1 transferred to a BadgerNet Specific Issue Log.

All actions due to be completed by 31 March 2024.

- Excluding the 14 LMNS and 2 duplicate actions, Ockenden 2 action plan is 78.08% compliant (previously 75.34%).

a. WHH Risks for Escalation

Ockenden Part 2 identifies the introduction of specific roles within the maternity workforce:-

- The Lead Obstetrician in Fetal Surveillance role is included in a new Consultant post for which recruitment has commenced. Meeting this recommendation will be dependent upon successful recruitment and anticipated recruitment is six months.
- Within the Ockenden report additional supernumerary clinical skills facilitators are recommended. Work is ongoing to identify how to meet this requirement within existing establishments.

b. Ockenden Summary

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

- Ockenden 1a Action Plan is 100% compliant.
- Ockenden 1b Action Plan is 96.58% compliant.
- Ockenden 2 Action Plan is 78.08% compliant.

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

2. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This Report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting on 24th November 2023.

3. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 14th November 2023.

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/141ii**	
SUBJECT:	**Maternity Incentive Scheme Year 5**	
DATE OF MEETING:	6 December 2023	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY ***(KEY ISSUES):***	NHS Resolution (NHSR) is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards.

	Revised specifications and timelines were released in July 2023 and advised Trusts must submit the completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024. In addition, Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) now have an assurance role in relation to both the Maternity Incentive Scheme (MIS) and Saving Babies Lives version 3 (SBLCv3) as part of which there is a requirement to provide oversight of progress prior to the national deadlines for MIS Year 5 and SBLCBv3. The full timeline for the Cheshire and Merseyside LMNS MIS Year 5 and SBLCBv3 sign off processes is included in appendix one. This paper will update the Board of the position as at 31 October 2023 and trajectory of the 10 safety actions as recommended by NHSR. 1. **Safety Action 1** WHH is on track to be 100% compliant in all elements of Perinatal Mortality Review Tool (PMRT) following submission of Q1 PMRT report on 8 August 2023. 2. **Safety Action 2** WHH is on track to submit Maternity Services Data Set (MSDS) to the required standard. 3. **Safety Action 3** WHH is on track to demonstrate 100% compliance with transitional care services in place to minimise separation of mothers and their babies. 4. **Safety Action 4** WHH is on track to be 100% compliant for all medical and neonatal staffing specifications. 5. **Safety Action 5** WHH is on track to be 100% compliant in all elements of Maternity staffing specifications. 6. **Safety Action 6** There has been a challenge in extracting data required from the BadgerNet system to accurately define the current position. A BadgerNet update took place on 30th September 2023 which will support the service in extracting the relevant information. An element lead is required for pre-term birth. Funding for this post has been identified. As an interim a temporary development opportunity has been created. Recruitment of a diabetes specialist midwife is required. Funding for this post has been identified. A job specification is being drafted to ensure recruitment

	can commence as soon as funding is agreed. There is a requirement for a Diabetes Dietician to be allocated to the MDT clinic. At present there is limited capacity within the therapies team to support this requirement. Recruitment for a lead obstetrician for fetal surveillance was completed, with no successful candidates identified. Further recruitment has commenced but the inability to recruit remans a risk. 7. **Safety Action 7** WHH is on track to complete all Maternity Voice Partnership (MVP) specifications. 8. **Safety Action 8** WHH is on track to meet multi professional Core Competency Framework training standards. 9. **Safety Action 9** WHH is on track to be 100% compliant for providing Board assurance for maternity and neonatal safety and quality issues. 10. **Safety Action 10** WHH is on track to be 100% compliant with all requirements related to Healthcare Safety Investigation Bureau (HSIB) reporting and investigations and NHS Resolution Early Notification Scheme MIS Year 5 actions are on track to be compliant by the required timeframes and submission of the completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/23/11/237/ii	
	Date of meeting	14th November 2023	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Incentive Scheme Year 5 Update	AGENDA REF	BM/23/12/141ii

1. BACKGROUND/CONTEXT

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards.

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

Initial specifications and timelines were released in May 2023 followed by a revised version of the document in July 2023. Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024.

In preparation of the submission deadline a monthly update report will be provided. This paper will update the Board of the current Warrington and Halton position for the month of September 2023.

2. KEY ELEMENTS

The Women's and Children's Clinical Business Unit (W&C CBU) triumvirate has undertaken a benchmarking exercise and met with each Maternity Incentive Scheme (MIS) Action Lead to monitor progress of each safety action and specifications as stipulated in the MIS Year 5 Guidance relaunched in May 2023 and revised in July 2023.

As part of the Saving Babies' Lives Care Bundle (SBLCB) implementation, there is a requirement to provide oversight of progress with the ICB (LMNS). WHH is required to provide evidence for several MIS Safety Actions and to upload evidence for SBLCBv3 to the national implementation tool. This process is underway.

In addition to the provision of evidence, there is a requirement to attend quarterly quality improvement meetings with the LMNS to review and discuss progress. The first meeting was held on 28 September 2023. An interim feedback session was completed on 16 November 2023, and the second quarterly meeting is scheduled for 8 December 2023. Learning and feedback from the meeting on 16 November 2023 has been noted and evidence continues to be uploaded in line with LMNS deadlines.

2.1 MIS 10 Safety Standards and Warrington and Halton Teaching Hospital (WHH) position:

- **Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?**

WHH is on track to remain compliant with all specifications of SA2.

The W&C CBU present quarterly PMRT reports to QAC which are shared with the Trust Board. Quarter 1 (Q1.) was presented in August 2023 and Quarter 2 (Q2.) will be presented to QAC in November 2023. Each PMRT review is required to meet all MIS Standards in terms of reporting timelines, multi-disciplinary review and Duty of Candour.

- **Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**

WHH is on track to complete all SA2 specifications within specified timeframes.

- **Safety action 3: Can you demonstrate that you have transitional care (TC) services in place to minimise separation of mothers and their babies?**

A request for the TC action plan has been requested by LMNS by 30 October 2023 and this has been provided.

A task and finish group has been established to optimise the WHH transitional care offer.

Transitional Care quarterly reports are submitted to QAC and to Trust Board.

Safey Action 3 is on track to remain 100% compliant.

- **Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?**

LMNS has requested evidence of an audit of compliance; exception report and action plan to address any non-compliance, and Neonatal Unit meeting BAPM Neonatal Nursing standards/action plan.

There is a new focus on locum workforce and rest periods for doctors working non-resident on-call out of hours. Work is underway to develop an action plan to achieve full compliance with this aspect.

Subsequent to Quality Assurance Committee on 14th November 2023, further feedback was received from the LMNS on 23 November 2023 regarding these requirements and further evidence will be uploaded to meet this.

WHH is on track to remain compliant with all specifications of SA4.

- **<u>Safety action 5</u>: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**

LMNS has requested evidence of a staffing paper by 30 October 2023. This has been provided.

Maternity staffing is reviewed by Workforce Review meeting monthly. Maternity staffing is also included in the Trust bi-annual Safe Staffing Report.

Subsequent to Quality Assurance Committee on 14th November 2023, further feedback was received from the LMNS on 23 November 2023 regarding assurance in relation to midwifery workforce planning, further evidence will be uploaded to meet this.

WHH is on track to remain 100% compliant with MIS SA5 specifications.

- **<u>Safety action 6:</u> Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?**

LMNS has requested several pieces of evidence across various elements to be uploaded to the SBLCB Implementation Tool by 30 October 2023. This has been provided.

Element 1: Reducing smoking in pregnancy (existing element)

- Cheshire and Merseyside Tobacco Treatment Dependency (TTD) Pathway implemented.
- Work is ongoing to ensure all required data is collected and action plans have been developed following completion of gap analysis.
- A guideline has been developed to ensure alignment with SBLCBv3.

Element 2: Fetal Growth: Risk assessment, surveillance and management (existing element)

- Work continues to ensure all required data is collected and action plans have been developed following completion of gap analysis.
- A guideline review group is being developed to review guidelines and ensure alignment with SBLCBv3.

Element 3: Raising awareness of reduced fetal movement (existing element)

- Work is ongoing to capture the additional data required and guideline has been updated to align with SBLCBv.3.

Element 4: Effective fetal monitoring (existing element)

- Fetal monitoring training compliance for September is 88%, 93% and 72% for midwives, doctors and NHSP/agency midwives respectively.
- Fetal monitoring competency assessment compliance for September is 51%, 50% and 67% for midwives, doctors and NHSP/agency midwives respectively.
- Monthly monitoring of CTG Reviews and Fresh Eyes continues and an action plan to drive targeted improvement has been developed.

	May 23	Jun 23	Jul 23	Aug 23
CTG Reviews	70%	50%	65%	75%
Peer Reviews	35%	30%	30%	70%

- Following an unsuccessful external recruitment campaign to replace the Specialist Midwife - Fetal Surveillance, the role has now been appointed to as a three month secondment post whilst further permanent recruitment is completed. To maintain compliance with training this has been provided by an external provider this will continue until January 2024 when this will return in-house.
- Recruitment for a lead obstetrician for fetal surveillance has commenced.

Element 5: Reducing preterm births and optimising perinatal care (existing element)

- A pre-term birth / perinatal optimisation Midwife Lead is required. Funding for this post has been identified. A job specification is being drafted to ensure recruitment can commence as soon as funding is agreed. In the interim a temporary development opportunity has been created.
- There is ongoing work underway to support data collection.
- Guidelines has been updated to ensure compliance and alignment with SBLCBv3.

Element 6: Management of pre-existing Diabetes in Pregnancy (new element)

- Data reported to National Pregnancy in Diabetes (NPID) by medical team and diabetes specialist nurse.
- Joint medical clinic weekly with specialist nurse input and endocrinologist input.

- Recruitment of a diabetes specialist midwife is required. Funding for this post has been identified. A job specification is being drafted to ensure recruitment can commence as soon as funding is agreed.
- There is a requirement for a Diabetes Dietician to be allocated to the MDT clinic. At present there is limited capacity within the therapies team to support this requirement. This has been escalated. In the interim information sheet are provided and a Diabetes Specialist Nurse led pre-gestational diabetes phone clinic is held weekly to provide additional capacity and support.

Monitoring of compliance with Saving Babies' Lives Care Bundle Version 3

- A national Implementation Tool has been made available on the Maternity Transformation Programme's Future NHS platform. The tool supports providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory.
- The first quarterly meeting has taken place with the LMNS. A provisional self-assessment of compliance against each element has been reviewed and is now pending an LMNS validation of evidence process. When complete, this will provide a percentage of compliance for each element and will be shared as part of future reporting.
- The full timeline for the Cheshire and Merseyside LMNS SBLCBv3 sign off process is included in appendix one.

Safety action 6: Items for escalation:

1. There has been a challenge in extracting data required from the BadgerNet system to accurately define the current position. A BadgerNet update took place on 30th September 2023 which will support the service in extracting the relevant information. The Audit and Assurance Midwife is now extracting all the necessary data to provide a clearer position and ensure robust action plans are in place.
2. Element lead required for pre-term birth. Funding for this post has been identified. A job specification is being drafted to ensure recruitment can commence as soon as funding is agreed. In the interim a temporary development opportunity has been created.
3. Recruitment of a diabetes specialist midwife is required. Funding for this post has been identified. A job specification is being drafted to ensure recruitment can commence as soon as funding is agreed.
4. There is a requirement for a Diabetes Dietician to be allocated to the MDT clinic. At present there is limited capacity within the therapies team to support this requirement.
5. Recruitment for a lead obstetrician for fetal surveillance was completed, with no successful candidates identified. Further recruitment has commenced but the inability to recruit remans a risk.

- **<u>Safety action 7</u>: Listen to women, parents and families using maternity and neonatal services and coproduce services with users?**

A request for the MVP workplan has been requested by LMNS by 30 October 2023 and this has been provided.

WHH is on track to be 100% compliant in all specifications of SA7.

- **<u>Safety action 8</u>: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?**

A request for the training plan has been requested by LMNS by 30 October 2023. This is being shared with QAC at the November meeting and Trust Board in December. It will be shared with LMNS following sign-off.

  - A local training plan is in place for implementation of Version 2 of the Core Competency Framework.
  - The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.
  - The plan is developed based on the "How to" Guide developed by NHS England.
  - An updated training plan for 2024 to reflect the evolving maternity landscape has been drafted. This will be shared with the triumvirate for discussion and to November Quality Assurance Committee

Work is ongoing to ensure additional requirements regarding service user involvement in developing and delivering training is included in the design of training provision. Learning from local findings and incidents is utilised to inform training provision, evidence to support this is being collated. Training compliance is monitored monthly via CBU Governance meetings, and the monthly Quality & Safety paper presented to Quality Assurance Committee.

WHH is on track to meet training standards of SA8.

- **<u>Safety action 9</u>: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**

The LMNS has requested evidence of Perinatal Quality Surveillance Model (PQSM) review to show Trust level intelligence is being shared by 30 October 2023. This has been provided.

Significant additional reporting is required to provide assurance to the Board on maternity and quality issues in line with the Perinatal Quality Surveillance Model and to reflect local learning as a result of patient safety incidents.

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

This is reported to Quality Assurance Committee on a monthly basis as part of the Maternity & Neonatal Quality Update and then to the next Trust Board. Within Safety Action 9, there is also a requirement as follows:

"Evidence that a review of the Trust's claims scorecard is undertaken should be discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023."

This requirement was completed following presentation to Quality Assurance Committee on the 11th July 2023 when it was reported for year 2021/22 (the latest available data at that time), there are no new open claims within Obstetrics. The year 5 recommendations require at least one additional meeting to take place before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review of the claims scorecard as part of the PSIRF plan. There was no action plan for 2021/22 as there were no new open claims. It was however agreed at the July meeting of Quality Assurance Committee that the 2022/23 claims scorecard would be presented. This is provided below:

2022/23 claims scorecard

Volume of claims by Incident Year

Year	Open	Closed	Periodical Payments
2013/14	1	9	0
2014/15	0	1	0
2015/16	2	2	0
2016/17	1	1	0
2017/18	3	4	0
2018/19	1	2	1
2019/20	3	0	0
2020/21	3	2	0
2021/22	1	0	0
2022/23	1	0	0
Total	**16**	**21**	**1**

There was one new claim in 2022/23. This related to concerns regarding the removal of the placenta after birth.

Safety Action 9 also requires Board Safety Champions and the maternity quadrumvirate to be involved on the NHSE Perinatal Culture and Leadership programme. This work is underway at WHH. The quadrumvirate have attended two face to face session (over four days), action learning sets are in progress and a maternity and neonatal SCORE cultural survey is in progress.

WHH is on track to be compliant with all requirements of SA9.

- **Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?**

WHH is on track to remain 100% compliant with SA10 HSIB specification.

2.2 Summary

WHH is on track to be 100% compliant with MIS Year 5 Safety Standards within specified timeframes and submission of the completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024.

3. MONITORING/REPORTING ROUTES

Progress with MIS is shared and discussed at CBU Governance meetings. The content of this report will be shared at Women's Health Governance on 21 November 2023.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 14th November 2023.

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/23/12/141iii**			
SUBJECT:	**Quarter 2 2023-24 Perinatal Mortality Review/Audit**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**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 focusses attention on improving outcomes for this protected group.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 5) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports.			

This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 2 (Q2.) PMRT report for the period covering 01/07/2023 – 30/09/2023.

During Q2, WHH reported three babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK):

Two Stillbirth:

- One baby born at 30+3 weeks
- One baby born at 32+6 weeks

One Early Neonatal Death:

- One baby born at 37+3 weeks.

The key findings, learning, good practice, and action plan for these cases will be reported in the Quarter 3 2023/24 QAC following a PMRT review panel for each case.

WHH stillbirth rate for Q2 2023/24 was 3.32 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.42 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.

WHH Neonatal mortality rate during Q2 2023/2024 was 1.66 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

During Q2, WHH undertook three PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed:
three stillbirths:

- One baby born at 30+4 weeks.
- One baby born at 29+4 weeks.
- One baby born at 36+5 weeks.

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

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

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

	In one case, issues with care of the mother following confirmation of the death of her baby were identified that would have made no difference to the outcome for the mother. In one case there were no issues identified with the care of the mother following confirmation of the death of her baby. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/23/11/237iii	
	Date of meeting	14 November 2023	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 2 2023-24 Perinatal Mortality Review/Audit	AGENDA REF	BM/23/12/141 iii

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 5 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 2 PMRT audit data for 2023/2024 and highlights good practice and lessons learned during the mortality reviews. Q2 covers the reporting period from 01/07/2023 to 30/09/2023.

Definitions:

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

2. KEY ELEMENTS

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

During Q2 reporting period three cases were reported to MBRRACE-UK:

Two Stillbirths:

- One baby born at 30+3 weeks. Their death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case took place on 3rd October 2023 and will be included in the Q3 2023/24 Perinatal Mortality Review Audit report to QAC.
- One baby born at 32+6 weeks. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case is scheduled for 6th November 2023 and will be included in the Q3 2023/24 Perinatal Mortality Review Audit report to QAC.

One Neonatal Death:

- One baby born at a local trust at 37+3 weeks gestation and transferred from home to WHH in cardiac arrest at five days of age. Their death was notified to MBRRACE, and surveillance completed within the specified timescale. The PMRT review panel for this case is scheduled for 6th November 2023 and will be included in the Q3 2023/2024 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 2. WHH Stillbirth Rate:

- WHH Q2 stillbirth rate for 2023/2024 is 3.32 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.
- WHH had no intrapartum stillbirths in Q2.
- WHH had no term stillbirths (babies born from 37 weeks gestation) in Q2.

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 annual stillbirth rate for Q1-Q4 2022/23 was 2.03 per 1000 births. The 12-month rate for October 2022 – September 2023 is 2.42 per 1000 births. The MBRRACE-UK national rate is 4.1 per 1000 births.

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

Metric	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	12-month total
Number of live births	641	633	603	600	2477
Total number of stillbirths >24 weeks	2	1	1	2	6
Total Stillbirth Rate >24 weeks (per 1000 births)	**3.11**	**1.58**	**1.65**	**3.32**	**2.42**
Number of intrapartum still birth rate	**0**	**0**	**0**	**0**	**0**
Number of stillbirths >37 weeks	**1**	**0**	**0**	**0**	**1**

2.2 Q3. WHH Neonatal Mortality Rate:

There was one early neonatal death reported in Q2 2023/2024. This baby was born at 37+3 weeks gestation at a local trust and transferred from home to WHH at 5 days old in cardiac arrest. The key findings, learning, good practice, and action plan for this case will be reported following a joint PMRT review panel.

WHH Neonatal mortality rate during Q2 2023/2024 was 1.66 per 1000 live births. The MBRRACE-UK national rate is 2.7/1000 live births.

2.3 Quarter 2 PMRT Review Panel Key Findings

Synopsis of Findings

- One baby born at 30+4 weeks gestation was a stillbirth. The cause of death agreed was bilateral ventriculomegaly.
- One baby born at 29+4 weeks gestation was a stillbirth. The cause of death identified at post-mortem was fetal vascular malperfusion attributed to umbilical cord compression.

- One baby born at 36+5 weeks gestation was a stillbirth. The cause of death agreed was over-coiled cord and fetal vascular malperfusion secondary to diabetes

Surveillance Findings:

- All of the babies were of a singleton pregnancy.
- Two women were aged between 30-34.
  One woman was aged between 35-38.
- All of the women were identified as white ethnicity.
- All of the women spoke English as their first language.
- None of the women had any communication problems as a consequence of learning difficulties/hearing problems.
- One woman was of a healthy BMI between 18.5 - 24.9.
  One woman had an increased BMI between 25 - 29.9.
  One woman had a BMI of greater than 30 (associated with an increased risk of complications in pregnancy.)
- All women were non-smokers and had a carbon monoxide (CO) level below 3 parts per million (PPM).
- None of the woman booked late.
- In all cases there were no issues identified with the care provided in relation to safeguarding.

2.4 PMRT Grading of Care

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

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

During Q2 three PMRT stillbirth review panels took place. Parental perspective of the care they received were sought in all cases.
In one of the cases, issues with care of the mother and baby up to the point that the baby was confirmed to have died were identified which may have made a difference to the outcome for the baby.

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

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

In one of the cases, issues with the care of the mother following confirmation of the death of her baby were identified that would have made no difference to the outcome for the mother.

In one of the cases, there were no issues identified with the care of the mother following confirmation of the death of her baby. An action plan has been implemented (Table 5)

During Q2 there were no neonatal death PMRT review panels required.

Table 2: WHH PRMT Grading of Care

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	1
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	1	1
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-
Not Graded	-	-
Total Cases	Three cases	Three cases

2.5 Q2. WHH PMRT Panel Attendance

There have been three PMRT panel reviews in Q2 which were attended by multidisciplinary internal and external panel members.

Table 3: Q2 WHH PMRT Panel Attendance

	Number of participants involved in PMRT reviews. Total number of reviews from 01/07/2023 – 30/09/2023 = 3		
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	3	-	3
Admin/Clerical	3	-	3
Bereavement Midwife	3	-	3
External Rep	3	-	3
Management Team	3	-	3
Midwife	3	-	3
Neonatal Nurse	n/a	-	-
Neonatologist/Paediatrician	n/a	-	-
Obstetrician	3	-	3
Other	3	-	3
Governance Manager	3	-	3
Safety Champion	0	-	0

2.6 Maternity Incentive Scheme Year 5 Compliance

WHH is currently on track to be 100% compliant in all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 5.

Table 4: PMRT MIS Safety Action 10 Compliance

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

2.7 Learning and Good Practice

- The three cases have all been notified to MBRRACE and surveillance completed within the required timescale.
- Antenatal care was graded C in one of the PMRT panel meetings which included feedback from the parents. This relates to difficult engagement and compliance with diabetes care. Learning from this case forms part of the PMRT Action Plan (Table 7).
- Postnatal care was graded C in one of the PMRT panel meetings, which included feedback from the parents. In this case there was a missed opportunity to plan the labour care for a woman with a pre-existing pain condition. Learning from this case forms part of the PMRT Action Plan (Table 7).
- Postnatal care was graded A in one of the PMRT panel meetings, which included feedback from the parents.
- Parental involvement was sought in all cases as part of PMRT panel review.

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

There were four actions recorded from the Q2 2023/24 PMRT review panels and three actions remain in progress:

Table 5: PMRT Action Plan

Action	Lead	Start date	Due Date	RAG rating
Establish a working group to improve the pathways of care for women with diabetes in pregnancy	Tina Moors, Matron for Antenatal & Postnatal Care	31.07.23	31.12.23	
Develop a guideline for follow up when women miss or do not attend for care with the diabetes specialist team in pregnancy.	Lesley Mills, Nurse Consultant for Diabetes	31.07.23	31.12.23	
A comprehensive review and anaesthetic plan of care is required for women experiencing labour and birth with pre-existing conditions affected with pain.	Rita Arya, Consultant Obstetrician and Gynaecologist Jessica Bowen, Maternity Anaesthetic Lead Consultant Leanne Lawrenson, Antenatal & Community Manager	31.07.23	31.10.23	
Advice on fetal movements in pregnancy to be provided and reinforced at each antenatal contact to include ultrasound scan	Sue Thilwind, Obstetric Ultrasound Lead Midwife	31.07.23	3.08.23	

2.8 Summary

WHH Q2 PMRT audit recorded three babies reported to MBRRACE that were born between 01/07/2023 and 30/09/2023.

- One baby born at 30+3 weeks.
- One baby born at 32+6 weeks.
- One baby born at 37+3 weeks.

The key findings, learning, good practice, and action plan for these cases will be reported in the Quarter 3 2023/24 QAC report following the PMRT review panels due to be held on 2nd October 2023 and 6th November 2023.

- WHH stillbirth rate for Q2 2023/24 was 3.32 per 1000 births. WHH annual Mean stillbirth rate is 2.42 per 1000 births which is below the 2022 MBRRACE-UK national rate 4.1 per 1000 births.
- WHH Neonatal mortality rate during Q2 2023/2024 was 1.66 per 1000 live births. This includes one baby who was born at a local Trust at 37+3 weeks and transferred from home to WHH in cardiac arrest at 6 days old. The MBRRACE-UK national rate is 2.7 per 1000 births.
- Three PMRT review panels were held in Q2 which were attended by multidisciplinary internal and external panel members. PMRT reviews are all graded as either A B C or D as per outcome incurred.
- Parental perspective of the care they received were sought in all cases.
- In one of the cases there were issues with care of the mother and baby up to the point that the baby was born which may have made a difference to the outcome for the baby.
- In two of the cases there were issues with the care of the mother and baby up to the point where the baby was born that would have made no difference to the outcome for the baby.
- In one of the cases there were issues with the care of the mother following confirmation of the death of her baby which may have made a difference to the outcome for the mother.
- In one of the cases there were issues with the care of the mother following confirmation of the death of her baby which would have made no difference to the outcome for the mother.
- In one of the cases there were no issues identified with the care of the mother following confirmation of the death of her baby.
- Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee and there are three Q2 PMRT actions in progress.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 14th November 2023.

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/23/12/141iv**			
SUBJECT:	Monthly Maternity & Neonatal Quality Update			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	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):				
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 update in relation to maternity and neonatal quality for August and September 2023. The paper provides oversight of key national safety and quality issues in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 (Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues). This information is reported monthly to Quality Assurance Committee. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position This paper will also provide an overview of emerging regional/local issues as appropriate. including: • Maternity Triage • Compliance with PDRs In August and September there was one moderate harm incidents. There were no major or catastrophic harm events In September 2023 there were no moderate, major or catastrophic harm events. At the end of September 2023 compliance for mandatory training across maternity and child health colleagues is 86.5% for trust mandatory training and 85.49% for role specific mandatory training, both above the trust target of 85%. Safeguarding training is slightly below the trust target at 84.44%, which is a slight reduction from August 2023. Workforce measures related to retention and vacancy rate remain improved. Formal feedback from the 15 Steps Challenge completed in June 2023 has now been received. This is included in appendix one. The feedback has been shared with the midwifery leadership team who will implement changes

	where this is feasible. It should be noted a proportion of the feedback relates to footprint/estates issues for which there will not be short term solutions. The service will however continue to make improvements to mitigate the issues raised where possible and remain cognisant of the feedback in future planning. Feedback from families has been included in appendix three. A Maternity Safety Champion Walkaround took place on 10th October 2023 with a focus on maternity triage and maternity ward C23. Feedback from staff was both constructive and positive. To further embed a culture of listening to staff, a series of listening events are scheduled during November and December 2023. In addition, as part of the Perinatal Leadership programme a SCORE survey is currently underway. In September 2023 91.2% of attenders to maternity triage, an increase of 1.2% from August. 98.4% of attenders were seen within less than 30 minutes of arrival an increase of 2.4% from August. Performance against both measures is within KPI standards. There were 5 complaints received across the CBU in August and September 2023. Three of these complaints related to care within the maternity and neonatal services. One complainant has raised concerns related to medications given during labour, the investigation into this case is ongoing and a meeting is scheduled with the family. One complainant has raised concerns regarding their birth experience in 2015. An exploration of the issues raised is ongoing. The third complaint relates to treatment received during the antenatal period. An initial safety review has been completed and a written response is in progress. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..		

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/23/10/211iv QAC/23/11/237iv
	Date of meeting	10 October 2023 14 November 2023
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF	BM/23/12/141iv

1. BACKGROUND/CONTEXT

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

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

2. HARM INCIDENTS

There were 119 events reported across the CBU in August 2023.

Below shows a breakdown of patient safety events reported and investigations declared in August 2023:

Severity	Jul 2023	Aug 2023
1 – Negligible / None	115	109
2 – Minor	30	9
3 – Moderate	1	1
4 – Major	0	0
5 – Catastrophic	0	0
Total	146	119

There were eight Initial Safety Reviews undertaken, of which one has been declared as a Multi-Disciplinary Team (MDT) review, one reported to HSIB, and one has been declared an After-Action Review.

The MDT review relates a woman with an allergy to local anaesthetic who did not receive appropriate antenatal referral. The After-Action Review relates to a medication incident. The case referred to HSIB was in relation to a woman who attended to maternity triage with reduced fetal movements. This case has subsequently been rejected by HSIB.

There were no major or catastrophic harm events in August 2023. There was one moderate harm incident.

There were 129 events reported across the CBU in September 2023.

Below shows a breakdown of patient safety events reported and investigations declared in September 2023:

Severity	Aug 2023	Sept 2023
1 – No Harm	121	99
2 – Low Harm	13	30
3 – Moderate Harm	1	0
4 – Severe Harm	0	0
5 – Fatal	0	0
Total	135	129

Trust Board will note in a change in language in relation to the grading of severity of events in the above table. This is to reflect the move to the Learning From Patient Safety Events (LFPSE) model as part of the implementation of PSIRF. The committee will also note a recalibration in the number of patient safety events graded as No Harm (previously negligible/none) and Low Harm (previously minor). Again this reflects an adjustment in how events are categorised as part of the implementation of the LFPSE model.

There were fourteen Initial Safety Reviews undertaken across the CBU, of which one has been declared an After-Action Review.

This After-Action Review relates to woman readmitted to the ward with her baby following a diagnosis of mastitis and the families experience when her baby then demonstrated signs of being unwell.

There were no moderate, major or catastrophic harm events in September 2023.

To further improve the recording of patient safety events, a piece of work has recently commenced to facilitate automated recording of those events categorised as “critical incidents” within the BadgerNet patient record system into Datix. This would include, as an example, cases of post-partum haemorrhage and third and fourth degree tears. This automation will also ensure a further level of assurance all appropriate events are being reported to the Datix system in a timely manner as well as reducing duplication of documentation and the need for manual triangulation of cases.

3. WORKFORCE METRICS

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

At the end of September 2023 compliance for mandatory training across maternity and child health colleagues is 86.5% for trust mandatory training and 85.49% for role specific mandatory training, both above the trust target of 85%. This is reflective of the proactive management of this activity. Safeguarding training is slightly below the trust target at 84.44%, which is a slight reduction from August 2023. Work remains ongoing to further improve and sustain compliance in all these measures. Below shows the current position with regard to mandatory training as at 30/9/2023:



Compliance with PDR completion has not improved in September. Rates in September are 78.76% compared to 79.34% in August. This remains below the trust target of 85%. A revised action plan for improvement has been commenced..

Below shows the current position with regard to completion of PDRs as at 30/9/2023:



Compliance with key maternity specific mandatory training MAMU2 (which relates to CTG competence) and Prompt (multidisciplinary team skills drill training) remains good WHH are meeting the Maternity Incentive Scheme Year 5 target of 90% compliance for Prompt, however as yet not meeting for MAMU2. The end of

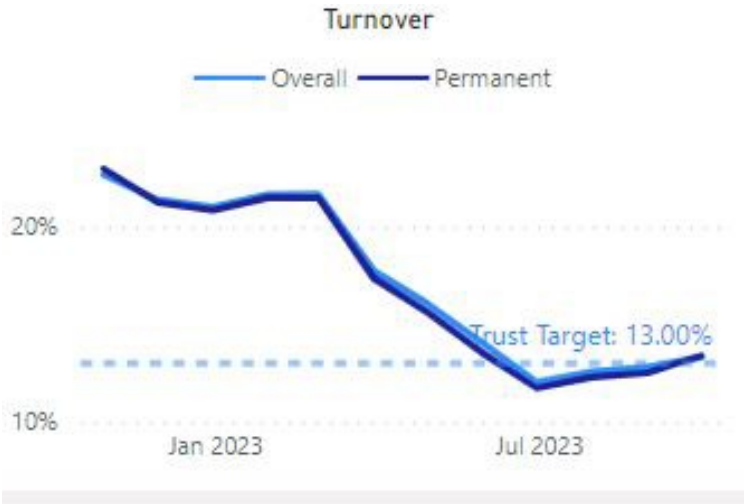
September position for MAMU2 is unchanged from the end of August as no MAMU2 training was facilitated in August. An action plan is in place to improve compliance with fetal surveillance training and competencies. A further update will be provided to December Quality Assurance Committee.

Compliance for MAMU2 at end of September 2023:

Staff Group	Fetal Surveillance training	Fetal Surveillance competencies
Midwives	88%	51%
Medical staff	93%	50%
Agency staff	72%	67%

Compliance with Prompt training at the end of September 2023 for all staff is 91.4% (an increase from 78.8% in August 2023). This improvement reflects the measures implemented as part of the ongoing action plan. Across staff groups, in both midwifery and maternity support worker cohorts, compliance is above 90% however for medical staffing compliance averages 86.4%. Medical compliance has been impacted by industrial action; work is ongoing to increase compliance in line with Maternity Incentive Scheme Year 5 measures.

Turnover for maternity and child health staff has shown a slight increase from 12.79% in August 2023 to 13.32% in September 2023. This is slightly above the trust target for turnover of 13% and as a result will be closely monitored to ensure it does not reflect a deteriorating position.



The vacancy rate for maternity and child health staff has reduced from a peak of 17.23%% in September 2022 to 9.19% in September 2023. There has again been a slight increase of 0.18% in September compared to August. This will be closely monitored as it is the second month where the vacancy rate has increased. This rate does however exclude those in the recruitment pipeline with many start dates scheduled for October and November 2023.



4. SERVICE USER FEEDBACK

Formal feedback from the 15 Steps Challenge completed in June 2023 has now been received. This is included in appendix one. The feedback has been shared with the midwifery leadership team who will implement changes where this is feasible. It should be noted a proportion of the feedback relates to footprint/estates issues for which there will not be short term solutions. The service will however continue to make improvements to mitigate the issues raised where possible and remain cognisant of the feedback in future planning.

The service has received feedback from a family with regard to their experience on the maternity ward, this included:

- The impact the ward environment has on the ability of new parents to rest.
- The impact of the behaviour of other families on the ability of new parents to rest
- The importance of providing those families whose babies are admitted to Neonatal Unit for care, a choice as to whether they would prefer a postnatal or antenatal bay or side room (dependent on availability).

The feedback regarding the ward environment and noise levels reflects a theme from recent service user feedback. A ward led quality improvement project will be initiated to respond to this feedback.

As part of the project to relocate maternity triage, feedback from families has been collated, this is included in full in appendix two. Feedback has been positive across all measures. Measures to further optimise the triage experience are being led by the Triage task and finish group.

The service has also received individual feedback regarding care experience from families. This is shared for information in appendix three.

The service has received individual feedback regarding care experience from two families. This is shared for information in appendix two.

5. STAFF FEEDBACK

A Maternity Safety Champion Walkaround took place on 10th October 2023 with a focus on maternity triage and maternity ward C23. Feedback from staff was both constructive and positive.

Triage staff reported a better experience for families following the relocation of maternity triage. It was acknowledged the staffing model was in process of being reviewed but recognised, in the interim, there were good processes for escalation at times of higher acuity.

Maternity ward staff shared good work underway in relation to pressure ulcers as a result of learning from a recent safety event as well as the roll out of the new Treating Tobacco Dependency (TTD) programme as part of the service wide piece of work around smoking cessation.

To further embed a culture of listening to staff, a series of listening events are scheduled during November and December 2023. In addition, as part of the NHSE quadrumvirate led Perinatal Cultural Leadership Programme a SCORE survey is currently underway.

6. MATERNITY TRIAGE

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

In addition, WHH maternity triage was noted as a red flag area as part of the maternity mock CQC inspection held in March 2023. This was due to its location and inability of staff to maintain oversight of those attending for care. Subsequently, Maternity Triage was relocated in August 2023 to a ore purposeful space.

Current performance

- In September 2023 502 maternity triage attendances were recorded in the BadgerNet patient record system.
- The shortest wait in September was 0 minutes. 23.1% of attendees were seen immediately on arrival.
- The longest wait for initial review was 45 minutes, this was due to high acuity within Maternity triage
- 91.2% of attenders were seen within 15 minutes of arrival (best practice guidance), an increase of 1.2% from August
- 98.4% of attenders were seen within less than 30 minutes of arrival (NICE guidance) an increase of 2.4% from August

- Whilst achieving our service KPIs in relation to maternity triage, it should be noted when comparing triage data for WHH compared to other trusts across the LMNS, WHH does have a higher proportion of 15 minute breaches than other providers.
- For the four week period 28/8/2023 – 1/102023 WHH had 7.19% triage breaches (at 15 minutes), other providers had a proportion of breaches ranging from 0.22% - 5.77%. This comparator data has been shared with the midwifery leadership team who will continue to work closely with the team to reduce the number of breaches thus supporting the service in achieving high performance against the 15 minute measure.
- Maternity Triage was inspected as part of the CQC visit in September. Feeback was positive noting the area was meeting the needs of women and ensuring effective implementation of a nationally recognised model for maternity triage.

Activity in place to support a safe service

- A new staffing model has been agreed. This will provide a robust staffing model across the ground floor maternity footprint (Nest MLU and Triage).
- This new model will also provide a telephone triage process away from the clinical area as per best practice guidance.

Next Steps

- Maternity triage task and finish group in place.
- Task and finish group to explore WHH outlier status in relation to 15 minute reviews and any further measures which can be implemented to support this.
- Ongoing monthly audit of triage delays in place Themes and trends will be identified and actions incorporated into the maternity triage action plan.
- Implementation of new staffing model
- Telephone triage to be moved from the clinical triage area
- Phone system to be upgraded

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

7. COMPLAINTS

There were five complaints received across the CBU in August and September 2023.

Of these complaints, three related to care within the maternity and neonatal services.

One complainant has raised concerns related to medications given during labour, in particular amounts of paracetamol prescribed. The investigation into this case is ongoing and a meeting is scheduled with the family

One complainant has raised concerns regarding their birth experience in 2015. An exploration of the issues raised is ongoing.

The third complaint relates to treatment received during the antenatal period. An initial safety review has been completed and a written response is in progress.

As per an action from the deep dive of complaints reported to September Quality Assurance Committee, a quarterly review of themes from complaints for Q2 2023-2024 is underway. Learning will feed into service activity and will be reported via CBU governance meetings and to Quality Assurance Committee and Trust Board via the regular Maternity & Neonatal Quality Update.

8. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

9. MONITORING/REPORTING ROUTES

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

10. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committees on 10th October 2023 and 14th November 2023.

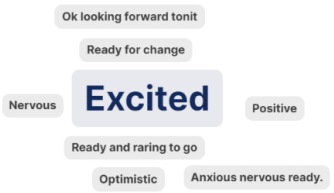
11. RECOMMENDATIONS

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

Appendix One- 15 Steps Challenge

WARRINGTON & HALTON
Maternity Voices
Working in partnership to improve maternity services

On **Friday 9th June** a group of **15 volunteers** took part in 15 Steps across the Maternity unit including neonatal.
The day began in the Croft Conference Room, using Slido we documented how we were feeling with some mixed emotions



We split into 3 groups and upon entering each area we asked the groups to document - **How do you feel? What do I see? Hear? What can I smell? Touch? How does it feel to be in this space?**

TRIAGE

Doesn't feel very private, very open and unfriendly. No natural light, cramped in. Can see lots of staff and women. Doorbell unclear, could have waited a while. Need to fix bell staff very busy at present but seemed very calm, Assured, confident, organised, clean, busy, Hydration station great idea.

C23

More privacy quite cramped staff lovely, Very warm. Staff are welcoming. Not much space on the wards/bays. No postnatal information on the walls. Not bright or welcoming feels very clinical. No break out space for dad or family, pleasant, Bathrooms are old, No breakout area or kitchen space for timeout. Little privacy can hear everything and everyone. Clean, busy, knowledgeable staff.

ANDU

Good information on display very friendly staff and hydration station accessible, Very small not private lots of patients in a small area. Hydration station great idea, No signage outside, clean, but crowded with lack of privacy, welcoming/helpful staff on hand but stretched to capacity, very little natural light Important

BUTTERFLY

Calming and quiet but would benefit from its own entrance. Good to have comfortable furniture and own bathrooms Beautiful suite. Smelt of lavender, no additional posters or information about. Good use of space to allow more space for all the family. Wallpaper is calming. Could do with new cot looks old and battered Pleasant and calm, tranquil, supportive, calm scents, very clean, organised, picturesque images/wallpaper (good for mindfulness), Calm

LABOUR SUITE

Very clinical could be more welcoming could be more like the nest? Reflect that as one birthing area, No links to the new nest. Nest feels very new and labour ward feels very old - not a great feeling. Only 2 pools 1 not working. Not very modern and feels very clinical. No kitchen or areas for parents to have timeout. . Theatres are clean. Being higher risk pulled the short straw. Very warm, low lighting, a little claustrophobic, skilled and diverse staff team. Busy but organised.

NEONATAL

Quiet very warm well decorated, Lots of information on walls, could break it up - medical info in the bays and the photos of the team and positive messages near the desk/entrance. Great news on technology for families to stay in touch with baby. Clean and felt bright and welcoming. Could improve patient flow entrance near c23 would be nice for separate entrance. Maybe enter c23 through what will be the old induction suite, Family centred, skilled staff, surroundings a mix of contemporary and old fashioned, great use of IT/skype/videos/Badgernet to keep families involved with NICU babies, Busy and caring

THE NEST

Team board is lovely but TINY and photos have no info on them. Would be nice to do pictures out of uniform and show they are 'real' people. Beautifully decorated. Affirmations on wall not very accessible in terms of font and colour. Friendly staff and great to hear outside area is being developed. Baths amazing but seem very high? Open and bright space. Images of the team (great). Feels new with lots of equipment and space. The open kitchen for patients and family is great. Feels modern. Impressed, contemporary, quiet, free of clutter, felt standalone/unlinked with the rest of maternity, Safe and caring

We ended the day reflecting on how we felt:

Learnt lots, proud to support WHH, encouraged, positive, tired!

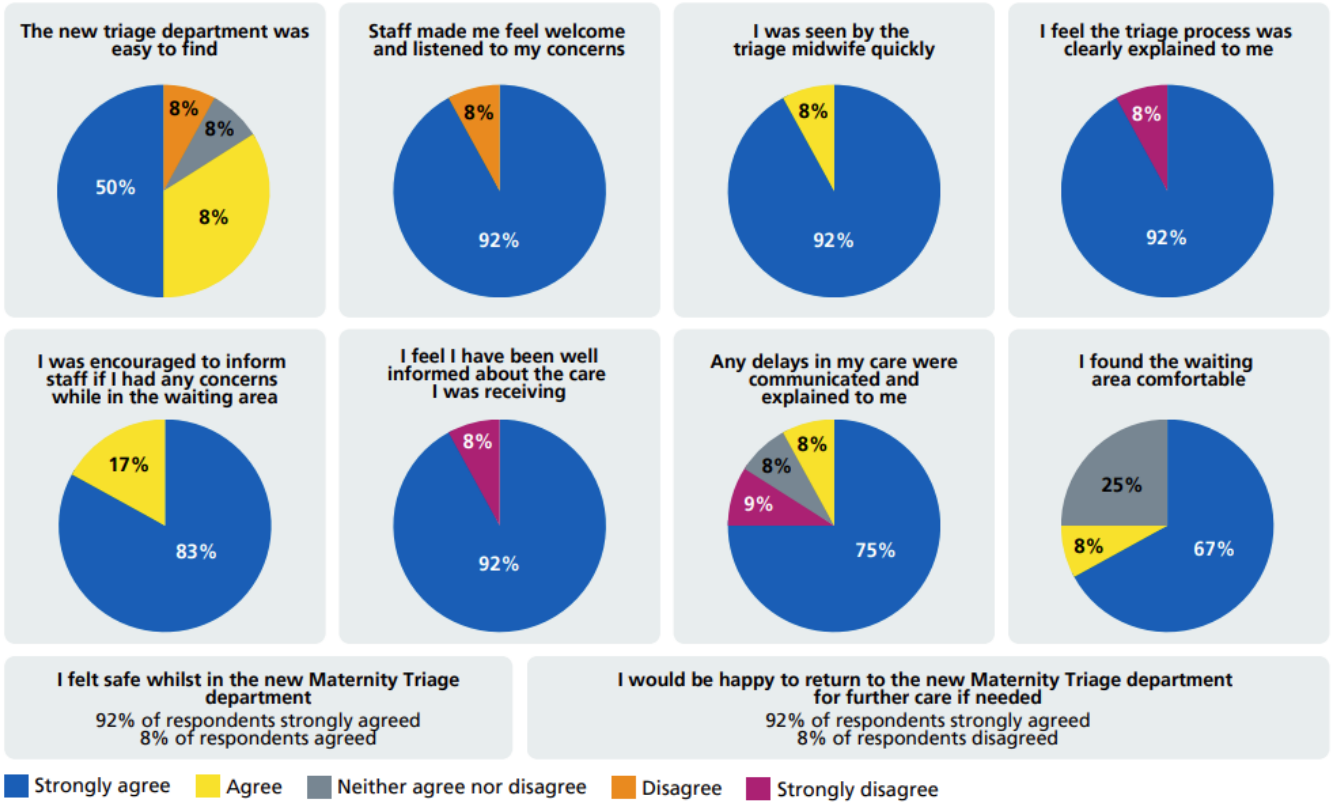
We could not return to the Croft Conference room as it was being used to support a family, whilst it was inconvenient we felt assured that patients are given the time needed and we were delighted our inconvenience was to enable patient centred care.

THANKYOU TO EVERY ONE OF YOU FOR YOUR KINDNESS AND HONESTY

Appendix Two- Service User Feedback

Maternity Triage patient feedback
August/September 2023

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust



Appendix Three – Email/Online feedback received:

Online review:

Outstanding services and facilities

★★★★★

Rated 5 stars out of 5

by Tansy Wright - Posted on 20 September 2023

Absolutely blown away by the level of care we received throughout the pregnancy, during the labour including an emergency c section and throughout of 3day stay post birth. The staff were incredible: extremely attentive, proactive and supportive. Every little concern that arose was very promptly picked up on and dealt with, we were also kept really well informed throughout and we were given the confidence to breastfeed and to care for our baby. We are so grateful for his safe delivery and for every bit of help, advice and care we were given.

Visited Maternity services on September 2023

Email feedback received (1) :

This is just a huge thank you email for the care, support and treatment provided to myself, partner and baby girl Penelope on the 08.08.23. I had such an awful experience at another hospital with my first son, that knowing I was going to need another C Section absolutely terrified me. However, the care and support I received from the start was just incredible.

Rachel from the C section team was so understanding and supportive and immediately put my mind at ease about the process of a c section at Warrington Hospital. I left the clinic that day more confident and calm. As Tuesday came, I was a bag of nerves and so emotional I had also started contracting so as you can imagine was a huge bag of emotions. I wish I could remember all of the staffs names because each individual involved in my care was just brilliant. The anaesthetist was amazing! She put my mind at ease, explained every single step of the spinal and what she was doing which really helped calm my nerves and made this experience so wonderful.

I met the lovely surgeon I think she was called Hannah, again she was so kind and in surgery she explained everything and before I knew it our darling Penelope was Born. Hannah is a credit to the hospital, she was so calming and immediately I felt at ease, there was another surgeon/consultant with her who also was fantastic and so caring and positive again I can't remember her name. All of the theatre staff involved in my c section that day were incredible I know there was Natalie, Gary and Colin! They were so funny and kept me talking and calm and updated me with what was

happening next and also took the most unbelievable pictures of my daughter being born.

Once the surgery was completed my midwife Jo (absolute angel), brought my daughter to me and I immediately had skin to skin with her which was just amazing. Once I was in recovery, Jo made me the most incredible tea and toast it honestly is like a reward eating that after surgery haha. But she also checked me over she was very attentive and made sure that I had skin to skin with Penelope which again was just the most incredible feeling. Jo really is a credit to the hospital, and maternity unit.

Finally ward c23, what an incredible ward!!

The staff go out of their way to help you, they are quick and efficient with pain relief they never keep you waiting. I had a lovely student nurse who looked after me at the night, she was first year and she was amazing. She is going to make a great midwife. Again I forgot names I think it was Jess but I'm sure you will be able to find out the staff members names who looked after me. Also, letting partners stay 24/7 on the ward is just amazing and I was so happy my partner Jack was able to stay with me and help and support me. Jess deserves an award, she was so helpful and supported me. In the morning the staff changed over and again the care I received was just amazing. The ward really is great and deserves an award!

I just want to say a huge thank-you to every one of you involved in our care, I had the most unbelievable, positive experience and I will forever cherish that.

Thank You

I had my little girl at Warrington on Saturday and the whole experience was excellent, I have a comparison with another Trust and so can say without doubt that care provided by and staff at Warrington are on another level. Please pass on my huge gratitude to the team.

Email feedback received (2) :

Hi,

I emailed you back in August, to say thanks, when I was pregnant and ended up on C23 and the sepsis pathway. I've since had my baby (early), once again the care was outstanding, and so I just wanted to email and say thanks again. Please feel free to forward this email to whoever would like to see it. Everyone who looked after me was amazing but I've pulled out individual names where I remember too. Apologies this is long but I really wanted to show just how amazing everyone has been with us.

It was a hard pregnancy and I visited triage many times - everyone there was great, especially Julie who I ended up seeing most times - I've seen times when they've been really busy in there, but they've always been kind, patient and even apologised

if there's been a delay in seeing patients. I struggle with the cervical exam and often had to ask for it to be stopped - everyone was always lovely about this.

My final visit was 3 October, where I had really painful period type pains and a small loss - Julie, having seen me several times, noticed how painful it was for me and Dr Rauf aired on the side of caution and admitted me for 24 hours. I'm so glad she did this, as just over 24 hours later, I had a baby, after C23 found I had premature membrane rupture and Group B strep! Paula (I think her surname began with a 'B', the Dr on C23 on 3 Oct) explained me to that she needed to do the cervix exam to check if my waters had gone - she was so lovely she put me at ease, sorted me some gas and air and was able to do that. I'm so glad she did! After she'd done the exam I went outside to make a call as I was overwhelmed, she was walking past and took the time to speak to me and explain what it meant.

The following morning I woke up to Denise from the birth suite introducing herself and her student, Chloe - I was being induced due to the above. I was given time to process this, make calls and then was moved from C23. Denise was amazing and made what could have been a difficult day fun! From letting me put pictures of my horses up in the room (don't ask!), to sorting a speaker for my playlist, and fairy lights, she went out of her way making sure I was comfortable. When I was on the drip and contracting she talked me through them and kept me calm, and she was so easy to chat to. She was especially great with my fear of cervix exams, which obviously couldn't be avoided, and did her best to keep me calm and was able to complete these for me.

Despite contracting, my cervix didn't dilate and we made the decision to go for a section. I say 'we' as I feel this was a decision that was medically led, but I was empowered to make too - it was what I wanted and I'd understood my options. I didn't feel pressured into anything.

The c section was a really pleasant experience - everyone involved put me and my partner at ease, the midwives who took over from Denise at 8 (I can't remember their names as I went to theatre at 10) explained what would happen and the Doctors involved were brilliant with us - the surgeon was Paula, which was great as I'd already built trust with her and she explained everything - and there was a lovely anaesthetist whose name I can't remember, but who was chatting to me during the procedure and again, she kept me calm and was really lovely. We even got pictures of my little boy being born and the placenta (which I wanted to see!)

After the procedure I had a reaction to one of the drugs which had a laxative effect. I was absolutely mortified but the two midwives looked after me and didn't make me feel embarrassed. When I got into C23, I was given a side room which made it slightly less embarrassing, and again I was poorly. Susan (midwife assistant) and I think Sarah was the midwife, literally cleaned me up, left the room, and had to do it

again, many times - they both treated me with dignity and, whilst I imagine this must have been really annoying, never showed this to me - they were just lovely.

On C23, I again was treated really well, like in August - Alison was lovely with me, I think she remembers me from when she looked after me in August, and nobody could have done anything more.

My little boy ended up in Neonatal for 13 days - how this was managed in theatre was really lovely, I had skin to skin and they told me they were taking him for the baby doctors to check him as he was grunting a bit - and my partner could go to him when he was checked. He actually needed to be on oxygen and have a procedure the following day, but this wasn't put over like this and so there was no panic as I lay recovering. C23 let me stay in for a week, until they really needed the bed, so I could be near him, which was so kind.

The neonatal team were brilliant - again, all of them, but as examples - Rachel (the sister in room 1), who stayed an hour late after her shift to make sure my little boy was ok after his procedure, as I was worried about it, but too poorly after the section to get over to the ward. The nurse who was on the Thursday night he had it done, came to c23, swopped bonding cloths with me and took my phone to get pictures (I was still quite immobile) - I didn't get her name. Rachel the nursery nurse who made sure I got pictures when I was discharged, Catherine who suggested a bigger teat size for his bottle which sorted his feeding issues, Minu who explained everything when he was in his incubator and showed us all about the passport, Emma who answered my 101 questions about everything to do with caring for a baby, and Dawn - who sat with me for 90 mins in the early hours of Saturday morning, helping me to try to express and learning how to feed him. I'm probably doing a disservice to others who cared for him, they were all fantastic.

Sorry this email is long but from start to finish the care we had was outstanding. I will never have another baby, it was very challenging all the way through - but, we are forever grateful for the care we had from Warrington which led to a positive outcome. When I think about the potential for a different outcome - the sepsis, the strep, the neonatal care which was immediately identified - and what could have happened if the teams hadn't have been so on it, it is unimaginable. The people who work in the areas I've mentioned managed to turn a frightening experience into a positive one - they're kind, knowledgeable and caring, positive and effective - and we will forever be grateful for what they did for us.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/141v**	
SUBJECT:	**Maternity Training Plan 2024**	
DATE OF MEETING:	6 December 2023	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

Further Information:

The paper relates to the training and development of staff to ensure they are able to provide safe, high quality care to pregnant people/those on the pregnancy continuum thus improving outcomes for this protected group.

EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides details of an updated maternity training plan to reflect the revised standards for training and competency as per the Core Competency Framework version 2 published on 31st May 2023. The revised training plan will be implemented with effect from 1st January 2024 and will ensure the service is able to achieve the necessary standards to meet the Core Completency Framework version 2, and, as a result the requirements of

	Saving Babies Lives Care Bundle Year 3 (SBLCBv3**)** and Maternity Incentive Scheme Year 5 (MIS year 5). Key changes to the training programme are as follows: • Reinstatement of the MAMU3 training day (Mandatory Maternity Update 3) for midwives and maternity support workers • Time within new MAMU3 programme and revised PROMPT Day (Practical Obstetric Multidisciplinary Training) to reflect requirements in relation to equality, equity and personalised care and learning from safety events. • Newborn Life Support to be included as part of MAMU3 to release capacity within the PROMPT day for other MDT requirements • Amendment to the programme for PROMPT to incorporate diabetes in pregnancy and to provide additional opportunity for focussed multidisciplinary team working • Human factors awareness to be included across all programmes.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/23/11/237v	
	Date of meeting	14 November 2023	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Training Plan 2024	AGENDA REF	BM/23/12/141v

1. BACKGROUND/CONTEXT

This paper provides details of an updated maternty training plan to reflect the revised standards for training and completency as per the Core Competency Framework version 2 published on 31st May 2023.

The revised training plan will be implemented with effect from 1st January 2024 and will ensure the service is able to achieve the necessary standards to meet the Core Completency Framework version 2, and, as a result the requirements of SBLCBv3 and MIS Year 5. Details of the core modules and proposed proigramme to ensure compliance aginst these models is included in appendix one.

2. KEY ELEMENTS

- **Reinstatement of the MAMU3 training day**

Reinstatement of the MAMU3 training day (Mandatory Maternity updates) for midwives and maternity support workers will allow those aspects of learning required of non-medical staff to be hosted within its own training day/ This will ensure the time available within the PROMPT day is dedicated to more robust, multidisciplinary team focussed training. The MAMU3 day also allows learning from MBRRACE (Mothers and babies: Reducing Risk though Audit and Confidential enquiries) and local incidents to be shared as well as reflecting the requirements of SBLCBv3 and local priorities. The content for MAMU3 is included in appendix two.

- **Design of programmes to reflect requirements in relation to equality, equity and personalised care and learning from safety events.**

The new MAMU3 programme and revised PROMPT training has been amended to ensure these both reflect requirements within the Core Competency Framework in relation to equality, equity and personalised care. In implementing the new programme the service will meet requirements related to maternal mental health and ongoing antenatal and intrapartum risk assessment. The programmes will also reflect the need to ensure staff are trained in personalised care planning, are aware of themes relating to equality and diversity as well as reflecting a new focus on the importance of cultural competence. Human factors awareness will be included across all programmes which will also incorporate the need for local training to reflect the learning from local safety events. The content for PROMPT in 2024 is included in appendix three.

- **Newborn Life Support to be included as part of MAMU3**

Newborn Life Support is training required by midwives and maternity support workers. As a result, this has been moved into the MAMU3 day to release capacity within the PROMPT day for other MDT requirements

- **Amendment to the programme for PROMPT to incorporate key aspects of SBLCBv3 and to provide additional opportunity for focussed multidisciplinary team working**

The programme for PROMPT has been amended to incorporate diabetes in pregnancy as required as part of SBLCBv3. The additional capacity within PROMPT will allow for a dedicated session for BSOTS (triage) which will support the service in optimising Maternity Triage. It will also provide increased opportunity for focussed multidisciplinary team learning and discussion in relation to fetal monitoring, reduced fetal movements, maternal critical care and management of labour. The new PROMPT programme also allows for an increase in time dedicated to the MDT practical skills drills from three hours to four hours.

3. MEASUREMENTS/EVALUATIONS

4. MONITORING/REPORTING ROUTES

5. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 14th November 2023.

6. RECOMMENDATIONS

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

Appendix One

Inclusion of core competency framework version 2: NHS England » Core competency framework version two

Inclusion of maternity incentive scheme year 5: MISyear5-update-July-2023.pdf (resolution.nhs.uk)

Core Modules:	Must Include:	How to facilitate:	Who must attend:
Saving Babies Lives Care Bundle **PROMPT Year 1**- monitoring growth restriction/Fetal monitoring-2022 **PROMPT Year 2**- Smoke free pregnancy/fetal monitoring/pre-term birth -2023 **PROMPT Year 3-** Reduced fetal movements/Fetal monitoring/Diabetes in pregnancy-2024.	• Smoking in Pregnancy • Fetal Growth Restriction • Reduced Fetal Movements • Fetal monitoring in labour • Preterm Birth • Diabetes in Pregnancy	• Classroom teaching in Halton Hospital Ward A4	90% attendance of relevant staff over a 12-month period For each element with eLfH module- every three years • Obstetric Consultants • All other obstetric doctors contributing to the obstetric rota (without the presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons) • Bank/agency midwives
Fetal Monitoring and surveillance (in the antenatal and intrapartum period) One day's full training (MAMU2) in addition to the local emergencies training day To be completed in all 3 years of PROMPT	Training must: • Be responsive to local incidents. • Include use of risk assessment at the start of and throughout labour complying with fetal monitoring guidelines • Include antenatal fetal monitoring, intermittent auscultation and electronic fetal monitoring. • Be tailored for specific staff groups.	• CTG Teaching with lead obstetrician and fetal surveillance Midwife to include: ○ Risk assessments ○ Intermittent Auscultation ○ Electronic Fetal Monitoring ○ System level issues e.g. human factors and situational awareness	90% attendance of relevant staff over a 12-month period • Obstetric Consultants • All other obstetric doctors contributing to the obstetric rota (without the presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons) • Bank/agency midwives

	• Be MDT and scenario based. • Include information about using the equipment that is available. • Include the surveillance of multiple pregnancies. • Include the principles of psychological safety and upholding civility in the workplace, human factors, and escalation	○ Use of local case histories ○ Use of local CTG machines • In addition, a full day's fetal monitoring training to be completed by midwives and obstetricians of all grades	
Maternity Emergencies and multiprofessional training PROMPT year 1-2022 Postpartum Haemorrhage (PPH)/ Impacted fetal head/Shoulder dystocia/Cord Prolapse PROMPT Yer 2-2023 Antepartum Haemorrhage (APH)/uterine rupture/shoulder dystocia/Pre-eclampsia/Cord prolapse/PPH Prompt Year 3-2024 Maternal Resuscitation/Care of the critically ill patient/Vaginal Breech Birth/Cord Prolapse/Shoulder Dystocia/PPH	4 of the 8 scenarios per year as outlines by the core competency framework, these are: • Antepartum and postpartum haemorrhage • Shoulder Dystocia • Cord Prolapse • Maternal collapse, escalation, and resuscitation • Pre-eclampsia/eclampsia/severe hypertension • Impacted fetal head. • Uterine Rupture • Vaginal Breech Birth • Care of the critically ill patient Over the 3-year period the aim is to cover all of the scenarios and should be based on local priorities. PPH will be conducted yearly in the classroom setting.	1 of the 4 scenarios must be conducted in the clinical area. PROMPT training is provided at Halton Hospital Ward A4 to simulate the clinical area setting. Live drills to continue in the clinical areas.	90% attendance of relevant staff over a 12-month period • Obstetric Consultants • All other obstetric doctors contributing to the obstetric rota (ST1-7), and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons) • Bank/agency midwives • Maternity Support Workers • Obstetric Anaesthetist Consultants • Other obstetric anaesthetist doctors who contribute to the obstetric rota • Maternity theatre staff, and neonatal staff are a vital part of the MDT but are not required to meet MIS 5 standards.
Equality, equity and personalised care	One topic from each of the following lists must be covered as a minimum: **List A:**	Classroom teaching.	90% attendance of relevant staff over a 12-month period

• Learning from incidents • Service user feedback • Local Learning • Local Guidance • Referral Procedures • 'Red flags' Year 1-2022-Ongoing antenatal and intrapartum risk assessment and risk communication Year2-2023- Bereavement Care/Personalised Care Year 3- Maternal Mental Health/Informed decision making/enabling choice, consent and human rights	• Ongoing antenatal and intrapartum risk assessment and risk communication • Maternal mental health • Bereavement Care **List B:** • Personalised care and support planning (including local plans) • Informed decision making, enabling choice, consent, and human rights. • Equality and diversity with cultural competence	Year 3 will be implemented on the extra training day being re-introduced in January 2024 MAMU3.	
Care during labour and immediate postnatal period Training must include: • Learning from incidents • Learning from national investigations • focus on deviation from the norm and escalation • include national training resources within local training • be tailored for specific staff groups depending on their work location/role Year 1-2022 OVB/GBS/Perineal Trauma/OASIS	Choose 2 subjects per year based on local priorities, audit report findings and locally identified learning. All competencies should be covered over a 3-year period. Subjects must include: • Management of labour during latent phase • VBAC and uterine rupture • GBS in labour • Management of epidural analgesia and recovery care after GA • Operative vaginal birth • Pelvic health and perineal trauma-prevention of OASI • Multiple pregnancy • Infant feeding • ATAIN	Classroom teaching with case study discussions. Separate infant feeding from infant feeding specialist and BFI training	90% attendance of relevant staff over a 12-month period • Obstetric doctors of all grades • Midwives including managers and matrons. It is not expected that anaesthetic doctors, maternity support workers and health care assistants attend this training

Year 2-2023 Management of epidural anaesthesia/recovery after GA/ VBAC and uterine rupture Year 3-2024 Maternal Critical Care/Management of labour during latent phase			
Neonatal Basic Life support Only registered RC-Trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. Neonatal consultants and ANNP's are qualified to deliver the training. If difficulty arises sourcing qualified trainers, units must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2023. As a minimum, training should be delivered by someone who is up to date with their NLS training.	Training must: • Be hands on and scenario based-tailored to learning from incidents. • Include knowledge and understanding of NLS algorithm. • Recognition of the deterioration of black and brown babies • Include recognition of deteriorating newborn and local escalation • SBAR • Include principles of psychological safety and upholding civility in the workplace for appropriate escalation • Include human factors. • Be tailored for specific staff groups depending on their work location and role	Theory and practical session in classroom teaching on MAMU3	90% attendance of relevant staff over a 12-month period • Neonatal Consultants or paediatric consultants covering neonatal units. • Neonatal junior doctors who attend births • Neonatal nurses (band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons) • Bank/agency midwives • Obstetric anaesthetists and maternity theatre staff are a vital part of the MDT but are not required to meet MIS 5 standards.

Appendix two - MAMU3 programme 2024

Time	Programme/Format/Staff Group
08.30-08.45	**Registration** Introduction to MAMU3 to be sent via email prior to course including one page updates for key areas of learning
08:45-11:00	Neonatal Basic Life Support (Midwives + MSW's)
11:00-11:15	**Break**
11:15-12:15	Neonatal Transitional Care (Midwives + MSW's)
12:15-13:30	Antenatal Screening (Midwives)
13:30-14:00	**Lunch**
14.00-15.00	Digital Documentation Overview (Midwives)
15:00-15:15	**Break**
15:15-16:15	Perinatal Mental Health/Informed Consent (Saving Babies Lives Care Bundle) (Midwives)
16:15:16:45	Smoking Cessation (Saving Babies lives Care Bundle) (Midwives)
16:45-17:00	Feedback and debrief

Appendix three – PROMPT Programme 2024

ANNUAL UPDATE 2021
PROMPT
PRactical Obstetric Multi-Professional Training ®

Time	Programme/Format/Staff Group	
08.00- 08.15	**Registration** Introduction to PROMPT to be sent via email prior to course.	
08:15- 09:15	Care During Labour and immediate PN period/Personalised Care (Midwives/Obstetricians) 2 topics from each core competency (**Maternal Critical Care/Management of labour during the latent phase**)	
09.15-10:30	Fetal Monitoring and Surveillance (in the antenatal and intrapartum period) (Midwives/Obstetricians) **BSOTS/Fetal Monitoring overview**	
10:30- 10:45	**Break**	
10:45- 11:45	Saving Babies Lives Care Bundle (Midwives and Obstetricians) **(Reduced Fetal Movements)**	
11:45- 12:45	Saving Babies Lives Care Bundle (Midwives and Obstetricians) **(Diabetes in Pregnancy)**	
12:45- 13:15	**Lunch**	
	Teams moves around each of the 3 workshops as per timings on programme. Team working/Communication/Situational Awareness are themes discussed throughout the scenarios. (MSW's/Midwives/Obstetricians/Anaesthetists)	
	Team 1	Team 2
13:15- 14:45	Vaginal Breech Birth/ Cord prolapse/Shoulder Dystocia/PPH	Maternal Resuscitation/Care of the critically ill woman/Sepsis
14:45- 16:15	Maternal Resuscitation/Care of the critically ill woman/Sepsis	Vaginal Breech Birth/ Cord prolapse/Shoulder Dystocia/PPH
16:15- 17:15	Postpartum Haemorrhage	
17:15- 17:30	Debrief and Feedback	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/141vi**			
SUBJECT:	**Maternity Self-Assessment Tool**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.			✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**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: This paper provides findings following completion of the NHS Maternity self-assessment tool, where services self-assess whether their operational service delivery meets national standards, guidance and regulatory requirements to ensure a safe, effective maternity service. The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the self-assessment tool are to ensure safer care for this cohort. Achieving the principles within the tool will have a positive impact on this group.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The revised Maternity self-assessment tool is a national assurance tool introduced to maternity providers in response to the Kirkup Report (2015) and Ockenden Report (2020) and findings of outstanding Care Quality Commissioners (CQC) to support trusts to benchmark			

<table>
<tr><td></td><td colspan="3">their services against national standards and best practice guidance.

The WHH benchmarking update aligns to the key themes identified within the recommended tool:
• directorate infrastructure and leadership
• multidisciplinary team dynamics
• governance infrastructure and ward-to-board accountability
• application of national standards and guidance
• safety culture across the Care Group and Trust
• comprehension of business and impact on quality

The tool identifies 159 criteria to be evidenced of which WHH can evidence for 63.5% of the criteria. An action plan will be developed to comply with all criteria.

This paper is asked to be noted for information.</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 note the contents of this report.</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/23/10/211v</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">10th October 2023</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">Choose an item.</td></tr>
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REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity self-assessment tool)	AGENDA REF	BM/23/12/141vi

1. BACKGROUND/CONTEXT

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

The tool has been designed for NHS maternity service providers to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

The tool is underpinned with a philosophy of promoting a positive leadership and safety culture and to inform the Trust Board and Commissioners of the current maternity quality improvement and safety programme.

2. KEY ELEMENTS

The Maternity self-assessment tool has been structured according to the six key areas important for the leadership and quality of maternity services that emerged in the diagnostic phase (year 1) of the Maternity Safety Support Programme (2018). These were:

- directorate infrastructure and leadership
- multidisciplinary team dynamics
- governance infrastructure and ward-to-board accountability
- application of national standards and guidance
- safety culture across the division and trust
- comprehension of business and impact on quality

3. MEASUREMENTS/EVALUATIONS

The Maternity self-assessment tool identifies 159 criteria to be evidenced against. WHH is fully compliant with 101, which equates to 63.5%. The 159 criteria have been RAG rated as follows: -

Red 18 (11.3%)

Amber	38 (23.9%)
Green	101 (63.6%)
N/A	2 (1.2%)

Those criteria identified as red can be themed within the following:

- Establishment of a formal maternity safety improvement plan
- Enhanced multidisciplinary working and focus on behavioural standards
- Safety huddles and Schwarz rounds
- Activity in line with local equity strategy
- Activity reflecting trust communications strategy

An action plan will be developed to reflect the need to meet the criteria currently identified as red or amber with a trajectory for improvement. The development of this action plan will take account of the need to cross reference with existing action plans to avoid duplication.

4. MONITORING/REPORTING ROUTES

Progress against the action plan will be monitored via the Quadrumvirate and through the Women's and Children's monthly governance meeting.

Best practice requires the self-assessment is completed every six months with a report to Quality Assurance Committee for discussion and for the report to then be shared with the Trust Board. A reviewed position will be presented to Quality Assurance Committee in Spring 2024 and then to Trust Board..

5. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 10th October 2023.

6. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/141vii**	
SUBJECT:	**Midwifery Safe Staffing Report**	
DATE OF MEETING:	6 December 2023	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

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 September 2023 and red flag position for the period January-June 2023 alongside other key workforce metrics.

	This paper will also provide specific assurance in relation to Maternity Incentive Scheme (MIS) Safety Action 5 standards as follows: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. • Evidence the maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. • The midwife: birth ratio The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 116.70 wte, which includes an additional 10% for non-clinical roles. The midwifery funded establishment at the 30th September 2023 was 126.76 wte. The overall ratio for Warrington & Halton Teaching Hospitals NHS Foundation Trust of 21.3 births to WTE is in line with NICE best practice and the service's individualised Birthrate Plus® report which recommended a ratio of midwives to women as one midwife per every 24 women. The vacancy rate for registered staff as at 30th September 2023 is 13.31%, an improvement of 6.66% from December 2022 when the vacancy rate was 19.97%. The vacancy rate excludes 8.8fte registered staff in the recruitment pipeline and due to start in quarter 3 2023/24 which will further improve the position. Midwifery retention rates continue to follow a positive trajectory. Turnover for permanent registered staff has decreased from 30.15%% in January 2023 to 15.07% in September 2023 (a reduction of 15.08%). Sickness rates for September 2023 for registered midwifery staff were 7.88%, this was an increase from

	August 2023 when the rate was 5.89%. It was however on a par with September 2022 when the rate was 7.78%. Monitoring of safe staffing levels is a requirement of MIS Safety Action 5. Within the maternity service, staffing red flags across the maternity service are recorded within the Safe Care module of the health roster. As part of Safety Action 5 there is a requirement to closely monitor two key measures: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour In the period 1st Jan 2023 – 30th June 2023 there are 4 episodes recorded in SAFECARE where the Birth Suite Coordinator is NOT supernumerary. This is 1.1% of shifts and occurs rarely. In the period 1st Jan 2023 – 30th June 2023 there are no episodes recorded in SAFECARE where a woman in active labour is NOT receiving one-to-one care. A robust process for workforce planning and escalation is in place within the maternity service. This includes: • Daily Senior Walk Around • Daily Safety Huddle • Maternity Bleep Holder • Daily Safe Staffing Meeting These measures facilitate effective management of staffing resources and ensure effective oversight of safe staffing across the service.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to receive and discuss this report and for the report to be shared with the Trust Board.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	SPC/23/11/167	

	Date of meeting	23 November 2023
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Midwifery Safe Staffing Report	AGENDA REF	BM/23/12/141vii

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 Maternity Incentive Scheme (MIS) Safety Action 5 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

This paper provides an overview of the staffing position at as 30th September 2023 and red flag position for the period January-June 2023 alongside other key workforce metrics.

2. MIDWIFERY ESTABLISHMENT

This report summaries the current funded and actual staffing establishment as of the 30th September 2023 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 is 116.70 wte, which includes an additional 10% for non-clinical roles.

Full details of the calculations used to demonstrate how the establishment has been calculated are detailed below:

Birthrate Plus® Staffing: inclusive of 23% uplift

Warrington & Halton Hospitals NHS Foundation Trust • Total Deliveries 2609 • Total Community Cases 2810 (Includes Homebirths)	
Clinical WTE required	
Birthing Suite: • Births • A/N cases • Non-viable pregnancies • IOLs	28.08wte RMs
Triage (BSOTS Model)	11.02wte RMs
The Nest • Births & postnatal care • Unplanned attenders • Transfers to D/S	5.51wte RMs
Maternity Ward • A/N Admissions • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	27.74wte RMs & MSWs *Includes MSWs*
Outpatients Services • Midwife clinics • Obstetric Clinics • Midwife scanning clinics • DAU	4.95wte RMs 1.31wte RMs
Community Services: • Home births • Community AN & PN care • Attrition	27.48wte RMs & MSWs *Includes MSWs*
Total Clinical WTE	106.09wte

Breakdown of Birthrate Plus Recommended Staffing Table 5

The Maternity funded establishment at the 30th September 2023 is 126.76 wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling.

There is a positive variance of 10.06 wte registered midwives which reflects the additional investment made by the Trust initially to support the continuity of carer model for maternity. Some of this additionality has now been transferred to the core team to provide a more robust Maternity Triage and Nest staffing model and as a result better embed the Birmingham Symptom Specific Obstetric Triage System (BSOTS) and reflects the recommendations of the Ockenden report with regard to pausing continuity of carer to ensure safe staffing across maternity services.

The positive variance also reflects the additional posts required to meet the recommendations of the Ockenden Report and Saving Babies Care Bundle v3 which have been introduced since the last Birthrate Plus® assessment. .

Birthrate Plus® incorporates a review of managers and specialist midwives employed and the roles at WHH are in line with the recommended 8-10%. Currently specialist and management roles equate to 11.6 WTE (9.1%), this will increase to 12.6 wte (9.9%) with the addition of three new roles at the end of 2023, Specialist Midwife – pelvic health, Specialist Midwife Diabetes, Specialist Midwife Pre term Birth in line with Saving Babies Lives Care Bundle v3 and the Three Year Delivery Plan for Maternity and Neonatal Services.

The overall ratio for Warrington & Halton Teaching Hospitals NHS Foundation Trust of 21.3 births to WTE is in line with NICE best practice and the service's individualised Birthrate Plus® report which recommended a ratio of midwives to women as one midwife per every 24 women.

The vacancy rate for registered staff as at 30th September 2023 is 13.31%, an improvement of 6.66% from December 2022 when the vacancy rate was 19.97%. The vacancy rate excludes 8.8fte registered staff in the recruitment pipeline and due to start in quarter 3 2023/24 which will further improve the position.

NHSP resource is used to fill vacant shifts and this is managed proactively on a daily and weekly basis.

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.

3.2 WHH Midwifery Red Flags

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

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

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

3.3 WHH Midwifery Red Flags reported

Midwifery Red Flags reported (January 2023 – June 2023)

Red Flag Reason	Number of Red Flags raised					
	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
Delay in med review triage	0	0	0	0	0	0
Delay in review of CTG	0	1	0	0	0	0
Delay in triage >15min	0	0	2	2	0	2
Delayed IOL	0	1	4	1	0	2
Delayed MEOWS	0	0	0	0	0	0
Delayed Pain relief	0	0	0	0	0	0
Inadequate Triage	0	0	0	0	0	0
Missed Medication	0	0	0	0	0	0
Missed/Delayed Observation	0	0	0	0	0	0
Any occasion where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0	0	0	0
Delay in ONGOING IOL	0	0	3	1	1	2
Shortfall in RM Time	0	2	5	1	9	9
Birth Suite Coordinator NOT supernumerary	0	1	0	0	0	3
NEST Divert – Staffing	0	0	0	0	4	3
NEST Divert - Acuity	0	0	0	0	0	0
AMBER Alert - Staffing	0	0	0	1	0	6
AMBER Alert - Acuity	0	0	0	0	0	0
Red Status (Deflect)	0	0	0	0	0	0
Time critical activity	0	0	0	0	0	0
Homebirth Service unavailable	0	0	0	0	0	0

3.3.1 Birth Suite Coordinator NOT Supernumerary

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

In the period 1st Jan 2023 – 30th June 2023 there is 4 episodes recorded in SAFECARE where the Birth Suite Coordinator is NOT supernumerary. This is 1.1% of shifts and occurs rarely. When this occurred measures were taken as soon as was possible to release the Birth Suite Coordinator back to supernumerary status.

Date	Information recorded in SAFECARE	Information recorded in BR+ Acuity Tool
25.2.23	Coordinator received handover of VBAC IOL on Birth suite not currently requiring 1:1 care	Not Recorded
2.6.23	Birth Suite co-ordinator not supernumerary attending triage dept.	Co-ordinator unable to maintain supernumerary status
3.6.23	Birth suite co-ordinator caring for HDU patient	Co-ordinator unable to maintain supernumerary status
23.6.23	Both Coordinator and bleep holder unable to remain supernumerary on handover	Not recorded

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

If there is an occasion where a woman in active labour is NOT receiving one-to-one care the Birth Suite Coordinator will escalate to the Maternity Bleep Holder and mitigating action is taken to address the issue. A red flag is recorded on SAFECARE. In the period 1st Jan 2023 – 30th June 2023 there are no episodes recorded in SAFECARE where a woman in active labour is **NOT** receiving one-to-one care.

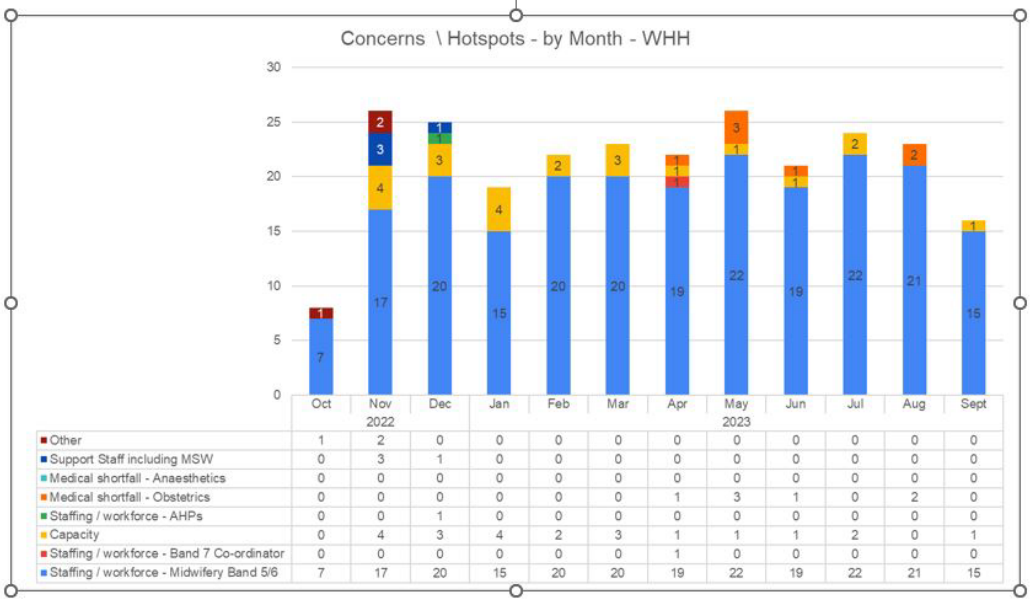
4. WORKFORCE PLANNING & ESCALATION PROCESSES

4.1 Daily Senior Walk Around

A member of the senior midwifery team including the Director of Midwifery, Deputy Head of Midwifery, Consultant Midwife, Matrons, and Ward managers will undertake a walk-around of the maternity unit three times each day. This provides leadership visibility to the midwifery workforce as well as to women and their families. It also provides an opportunity to share safety messages and it also provides the senior leadership team with a 'temperature check' of the maternity unit culture, in addition to direct oversight.

As part of the morning walkaround, a full review of the staffing position in each area will be completed. This provides an opportunity, if required to reallocate staff to ensure staffing resource is prioritised to the areas of highest acuity/most need. The LMNS daily acuity tool "Sitrep" will also be completed as part of this walkaround which facilitates effective data capture in relation to staffing and acuity. The reporting pack collated by the LMNS from this data collection and circulated to Trusts each month is an additional tool in identifying themes and patterns with regard to staffing concerns which will inform longer term workforce planning. Sitrep reporting at 30th September 2023 is included on page 11:

- There has been a **30%** decrease in the number of hotspots / concerns reported from **23** in August to **16** in September, driven by a reduction in the number of staffing / workforce midwifery band 5/6 concerns and medical shortfall – obstetrics.
- Staffing / workforce midwifery Band 5/6 hotspots / concerns continue to be the highest reported concern. Capacity remains a cause of concern, reported on 1 occasion during September.



	Oct	Nov 2022	Dec	Jan	Feb	Mar	Apr	May 2023	Jun	Jul	Aug	Sept
Other	1	2	0	0	0	0	0	0	0	0	0	0
Support Staff including MSW	0	3	1	0	0	0	0	0	0	0	0	0
Medical shortfall - Anaesthetics	0	0	0	0	0	0	0	0	0	0	0	0
Medical shortfall - Obstetrics	0	0	0	0	0	0	1	3	1	0	2	0
Staffing / workforce - AHPs	0	0	1	0	0	0	0	0	0	0	0	0
Capacity	0	4	3	4	2	3	1	1	1	2	0	1
Staffing / workforce - Band 7 Co-ordinator	0	0	0	0	0	0	1	0	0	0	0	0
Staffing / workforce - Midwifery Band 5/6	7	17	20	15	20	20	19	22	19	22	21	15

4.2 Daily Safety Huddle

The Daily Safety Huddle is attended by representatives from all clinical areas, including the neonatal team. The safety huddle monitors staffing and acuity across the unit, including provision of 1:1 care in labour and the supernumerary status of the Birth Suite Co-ordinator. If there is an occasion when 1:1 care in labour is in jeopardy and/or the Birth Suite Co-ordinator does not have supernumerary status this is promptly escalated to the Maternity Bleep Holder. Mitigating action is then taken to address the issue and the corresponding Red Flag is uploaded to the SAFE CARE electronic system as appropriate.

4.3 Maternity Bleep Holder

A maternity bleep holder is allocated for the maternity service each day. In hours this will be either the Deputy Director of Midwifery, Consultant Midwife, Matron or Ward Manager. Out of hours this is the Birth Suite coordinator. When a red flag is raised in the Safe Care module of the health roster it prompts a response from the Maternity Bleep Holder to review staffing and acuity across the maternity footprint to ensure safe care for women and their families is maintained.

The Maternity Bleep Holder also works with the multidisciplinary team to respond to unanticipated absence e.g. staff sickness or an increase in demand within the maternity service. The bleep holder will reallocate staff including specialist and other midwifery colleagues as part of a dynamic risk assessment of service need.

The service utilises North West Maternity Escalation Policy & Operational Pressures Escalation Levels Maternity Framework (OPELMF) to ensure the review of activity and related actions are completed in a structured way. Out-of-hours midwifery red

flags are recorded and acknowledged as soon as is reasonable and reviewed the following working day by the Matron on duty for learning and sharing.

4.4 Daily Safe Staffing Meeting

Midwifery staffing levels are reviewed by the maternity ward manager group at least once each day as part of a safe staffing meeting. At this meeting managers will assess planned staffing for the week ahead against the agreed establishment for each clinical area taking into account any new sickness absence, other absence and uptake of bank shifts. A staffing overview is maintained with all shifts for the week ahead RAG rated. From the safe staffing meeting actions are agreed to resolve any amber or red shifts and to mitigate shortfall as appropriate. All shifts identified as red are escalated to the Director of Midwifery to ensure senior oversight of forthcoming staffing issues.

5. OTHER WORKFORCE METRICS

Midwifery retention rates continuing to follow a positive trajectory. Turnover for permanent registered staff has decreased from 30.15%% in January 2023 to 15.07% in September 2023 (a reduction of 15.08%).

Sickness rates for September 2023 for registered midwifery staff were 7.88%, this was an increase from August 2023 when the rate was 5.89%. It was however on a par with September 2022 when the rate was 7.78%. The rolling 12 month rate is 6.8%, this compares favourably to September 2022 when the 12 month rolling figure was 11.38%.

Absence data is shared with all line managers to ensure appropriate measures are in place to support those experiencing health issues as well as effective use of the welcome back process and the attendance management policy. As a result of the focus on Welcome Back conversations, there has been ongoing improvement, with a rate of 88.46% in September 2023 compared to 80% in August 2023.

Proactive management of matters relating to workforce are ongoing to ensure the service is able to sustain the positive direction which has been achieved since the beginning of 2023.

6. ASSURANCE COMMITTEE

The content of this report has previously been noted at Strategic People Committee on 23rd November 2023.

7. 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/23/12/141viii**			
SUBJECT:	**2023-2024 Quarter 1 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**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. Achieving the principles within ATAIN will have a positive impact on this group.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	• Q1 2023/24 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 6.15%, which represents the second consecutive quarter the service has failed to meet the national target since the service met the ATAIN targets in 2021. However, the percentage of avoidable admissions has not risen, therefore the increased term admissions does not appear to reflect a deterioration in the standard of care.			

	• The service mean for the previous year is 5.4%, which is below both the regional NWNODN (North West Neonatal Operational Delivery Network) and national targets of 5.6% and 6% respectively. • All term admissions in Q1 were reviewed and learning from these cases informs the ATAIN action plan. • The ATAIN action plan is monitored via WCH Governance. • A quality improvement project is currently underway to put in place a further enhanced transitional care offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/23/10/211iii	
	Date of meeting	10 October 2023	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	2023/2024 Quarter 1 Avoiding Term Admission into Neonatal Unit (ATAIN)	AGENDA REF	BM/23/12/141viii

1. BACKGROUND/CONTEXT

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

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

This paper describes the current position of Warrington and Halton Teaching Hospital (WHH) against Safety Action 3 of MIS Year 5 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 5 specify the ATAIN action plan should be shared with Trust Board, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meetings.

2. KEY ELEMENTS

WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies that were admitted to the Neonatal Unit (NNU) during the Q1 reporting period from 1st April 2023 to 30th June 2023.

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

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

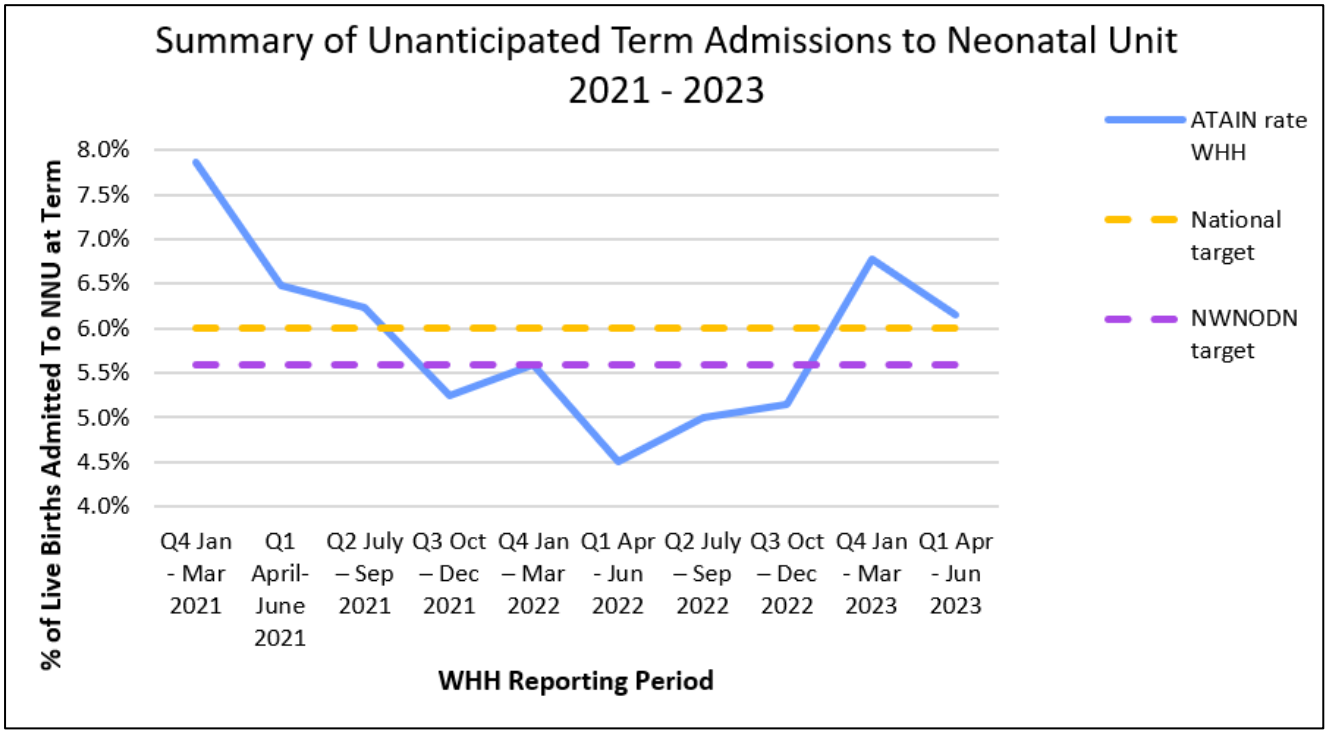
Summary of unexpected term admissions to NNU

The Q1 ATAIN Rate was 6.15%. Out of 37 term admissions, one case was not reviewed as part of the ATAIN process – the baby was admitted due to social care/safeguarding issues around the mother. This case is still included in the term admissions figures. Without this case, the percentage of term admissions would be 5.98%, which is within National Target.

Although the overall ATAIN rate has not met the national target on this occasion, there is clear improvement compared to the last quarter and the current rate is now much closer to the target. The number of avoidable admissions has not increased, further strengthening that there is no deterioration in the standard of care.

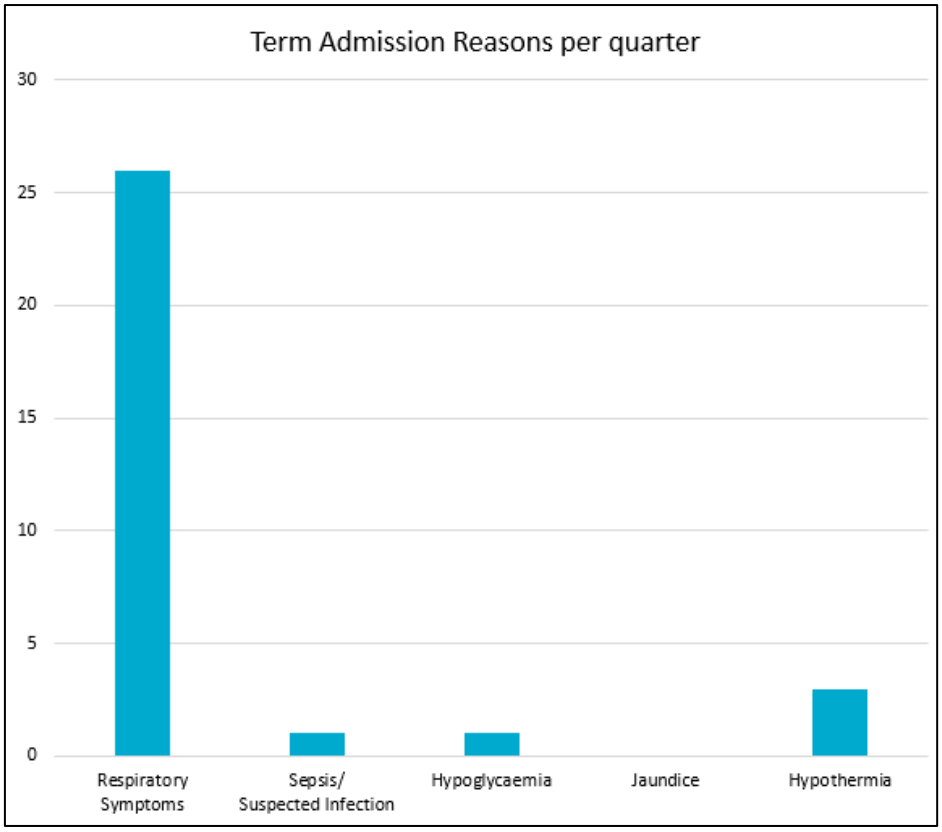
However, to ensure we maintain low avoidable rates, a monthly audit of all ATAIN elements (asphyxia, temperature control, jaundice, hypoglycaemia and respiration) is in progress.

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



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

WHH Number Live Births 2022-2023		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions
Q2 Jul-Sep 2022	682	34	4.98%	21	61.8%	5	14.7%	0	0%	0	0%	0	0%
Q3 Oct-Dec 2022	642	33	5.14%	18	54.5%	3	9.1%	0	0%	0	0%	0	0%
Q4 Jan-Mar 2023	635	43	6.77%	19	47.5%	3	7.5%	4	10%	2	5%	1	2.5%
Q1 Apr-Jun 2023	602	37	6.15%	26	70.3%	1	2.7%	1	2.7%	0	0%	3	8.1%



70.3% (26) of term admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Of these, 19 cases were diagnosed with Transient Tachypnoea of the Neonate (TTN). Of the babies with TTN, 3 cases were deemed avoidable admissions with the following MDT outcomes and actions:

	MDT reason for case to be graded as avoidable admission	Actions to reduce occurrence
1	Elective caesarean section could have been delayed by 1-2 weeks as per Saving Babies' Lives 2 and Saving Babies' Lives 3.	Feedback given to consultant. There is already previous work highlighting the importance of appropriate timing of elective caesarean section.
2	It was uncertain as to whether the admission was avoidable or not. It was felt that earlier delivery could have been considered but may not have changed the outcome. Although, a general anaesthetic may have been avoided, which may have resulted in less respiratory impact on the baby.	Reflective discussion with registrar around decision to perform ARM (artificial rupture of membranes) when there was already clear indication for an emergency caesarean section.
3	Given the unexpectedly low cord pH at delivery, which would not be expected even with significant adhesions delaying delivery, had the patient had a CTG on the ward, delivery would have been expedited if there had been any concerns.	Review of category 3 emergency caesarean sections to be undertaken to ensure that elective caesarean sections done as a category 3 emergency do not receive compromised care/provide further evidence for an extra elective caesarean section list. Since this review, funding has been agreed for a further elective caesarean section list. Elective caesarean section guideline to be reviewed to add in information around what antenatal care is required for elective caesarean section patients prior to transfer.

Of the other respiratory-related admissions:

- 3 babies had Respiratory Distress Syndrome (RDS) (all deemed unavoidable admissions)
- 1 baby had a pneumothorax – avoidable admission with learning including reflection with trainee, reflection with midwives around commencement of continuous CTG monitoring following thick meconium liquor and shared learning regarding latent phase of labour not appropriate to be supported on the Midwifery Led Unit.
- 1 baby had upper airway/nasal congestion (unavoidable admission)

- 1 baby suffered postnatal collapse (avoidable admission currently under local review as part of complaint response)
- 1 baby still required oxygen with increased work of breathing at >30 minutes of age (unavoidable admission).

Themes and Learning: Outcomes of ATAIN review

WHH July 2022 – June 2023	Number of Term Admissions	Outcome of ATAIN review	
		Avoidable Admissions	Unavoidable Admissions
Q2 Jul – Sept 2022	34	13	21
Q3 Oct – Dec 2022	33	5	28
Q4 Jan – Mar 2023	43	7	32
Q1 Apr – Jun 2023	37	7	29

One case was not reviewed as part of the ATAIN process – the baby was admitted due to social care/safeguarding issues around the mother. However, this case is still included in the term admissions figures. Without this case, the percentage of term admissions would be 5.98%, which is within the national target.

Reasons for categorising term admissions as avoidable included:

- Elective caesarean section could have been delayed by 1-2 weeks as per Saving Babies' Lives recommendations.
- Baby cold on postnatal ward due to environmental factors
- Earlier delivery could have been considered, possibly avoiding a general anaesthetic
- Earlier CTG monitoring may have indicated foetal compromise earlier than detected, which would have resulted in earlier delivery.

Good Practice:

- Generally excellent neonatal care resulting in reduced separation of mother and baby noted.
- Excellent assessment of risk factors and appropriate plan by clinician.
- Excellent documentation noted in a number of cases.
- Thorough safety netting at each point of attendance/admission and prompt escalation to MDT in recovery following feeding concerns.
- Partner referred to stop smoking service.
- Prompt escalation of pathological CTG.
- Prompt response to mother's concerns regarding baby with prompt escalation to MDT and timely transfer to NNU.

Learning Points/Themes/Actions:

- Environmental factors on postnatal ward during heat wave in June identified and addressed.
- Review of elective caesarean guideline to add in the antenatal care required for elective caesarean section patients prior to transfer to theatre.

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

A quality improvement project is currently underway to put in place a robust transitional care offering, which will reduce term admissions and separation of mothers and babies. This will ensure that transitional care is provided for all eligible babies including on transfer from Birth Suite, as step-up from normal care and as step-down from care on the Neonatal Unit.

Recommendations:

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

3. MONITORING/REPORTING ROUTES

The ATAIN action plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This report was shared at the Women's and Children's Clinical Business Unit Governance meeting on 13th October 2023

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 10th October 2023.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE
14 November 2023

Move to Outstanding Q1

Kimberley Salmon-Jamieson,
Chief Nurse/Deputy Chief Executive



CQC Position and Enquiries Q2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- CQC Engagement meeting held on 11 September 2023. Focus of the meeting was ED
  - NWAS turnaround times
  - 4 and 12 hour performance
  - Winter Planning
  - Mental Health patients in ED
  - Waiting list management

Enquiries Received by Area	Number
Urgent and Emergency Care	15
Surgery	7
Maternity	7
Medical Care	7
Clinical Support Services	4
Digestive Diseases	5
Incident report requests relating to falls	6
Incident report requests relating to unstageable ulcers	8
Whistleblowing enquiries received and closed, supported by FTSU walkrounds	

WHH Mock Inspection Programme: Core Services

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Date Mock Inspection Undertaken/ Planned	Area	Formal CQC Inspection
4th April 2022 and June 2023	Urgent and Emergency Care	
2nd March 2022 and 9th March 2022	Surgery	
31st March 2023	Maternity	**14 September 2023**
0ctober 2023	Halton Urgent Care Centre	
Mock Inspections Planned –Core Services		
December 2023	Medical Care	
January 2024	Surgery	
February 2024	End of Life	
March 2024	Critical Care	
April 2024	Outpatients	
May 2024	Children's Services	

- Internal benchmark review of well led position is being undertaken.

Formal Maternity Inspection 14 September 2023

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- High Level Feedback following inspection:

Staff articulation of Enhanced Care	Staff articulation of Transitional Care	Oversight of post-partum haemorrhage

Areas of Good Practice Identified

Positive culture across units / welcoming	Positive experience reported from women/birthing people	Opening of new triage unit	Positive work with at risk groups

- No specific risks or concerns were escalated by the CQC inspection team on the day of inspection
- Letter received from the CQC on 22nd September 2023, detailing the following as **significant concerns**
  - Enhanced Care
  - Transitional Care
  - Postpartum haemorrhage rates
- Additional evidence was submitted at the request of CQC within timeframe.
- Further meeting held with CQC on 29th September 2023 to discuss content of the Trust letter of response which has been submitted.
- CQC satisfied with Trust response.
- Final report to be released within 50 days – November 2023.

ED Mock Inspection

Warrington and Halton Teaching Hospitals NHS Foundation Trust

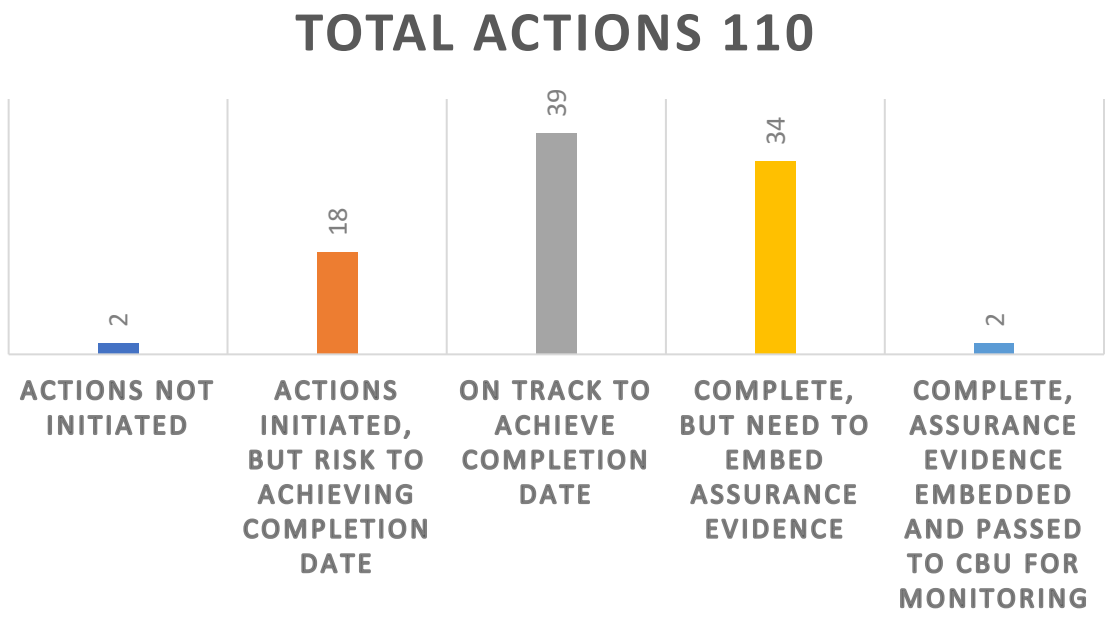
Mock undertaken 22 June 2023

- Detailed action plan in place – Progress tracked weekly through the ED Quality Improvement Group Meetings (Executive led).
- Priority plan in place, which includes regulatory risks from 2019

Crowding in the emergency department must be 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 deterioration Regulation 12(2)(a)(b)
Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons to ensure patient safety. To include all professional groups. Regulation 18 (1)
Ensure that systems and processes are in place and effective to assess, monitor and drive improvements in the quality and safety of services provided. Regulation 17

- Progress has been made against the action plan with estates work undertaken, a review of NEWS2, a review of triage and the introduction of continuous flow, amongst other measures.
- The above regulatory measures from 2019 remain a risk in terms of crowding, now impacted further by care on the corridor.
- Work around clinical deterioration has also been chosen as one of the Trust three PSII's.

Detailed ED Master Action Plan



UCC Mock Inspection 11 October 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Areas for Improvement

- Storage of waste domestic and clinical.
- Fridge checks inconsistent.
- High number of consistent inappropriate attends namely dressings – Discussed at Clinical Quality Focus Group with PLACE.
- Increased number of patients with high clinical acuity.
- Air conditioning unit required for storage of medicines.

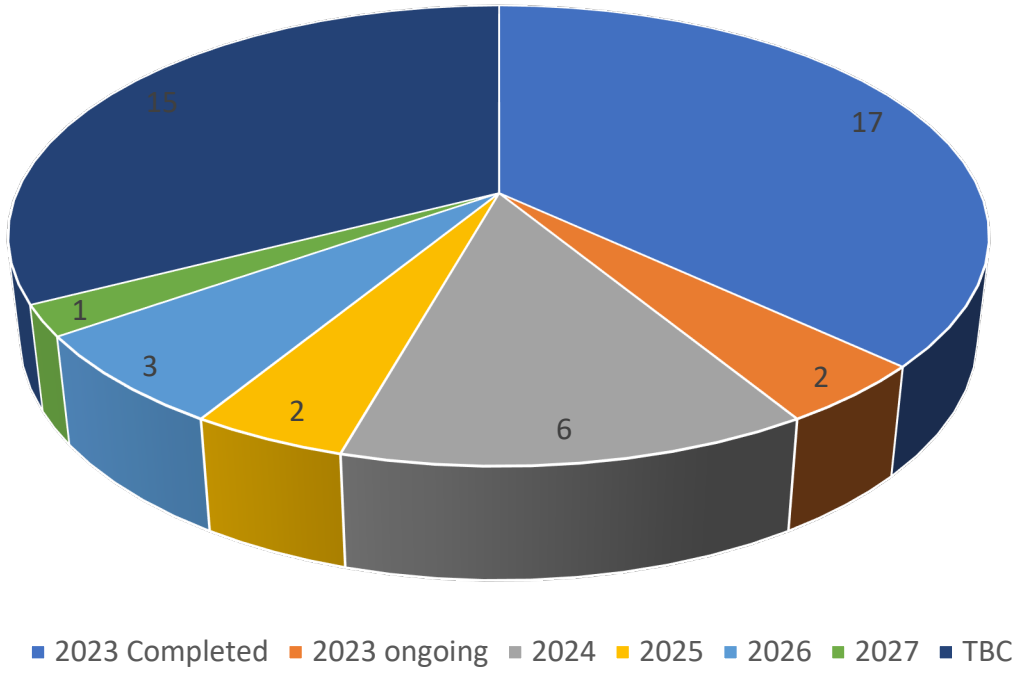
Areas of Good Practice

- Developed in house trauma course.
- Positive staff culture including bank staff.
- Medicines management.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Accreditation and Peer Review Position Statement

46 Accreditations & Reviews



Scheduled assessments for the remainder of 2023

Department	Accreditation/Review
Estates & Facilities	• Environmental Health Officer (Halton) • PLACE
Workforce Equality Diversity & Inclusion	• Anti-Racism Framework

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Achievements

- Medical Examiner programme – 100% of inpatient deaths have received scrutiny. 100% roll out for GP and hospice. Reviewing around 90% of community deaths – regionally first to achieve this.
- NO longer in GMC enhanced monitoring.
- Successful Quality Academy Showcase. External speakers including Prof Michael West. Staff morale, motivation – very positive. Annual event! 110 staff attended.
- Shortlisted for award -Your Future, Your Way.
- Implementation of a ‘Shared learning forum’.
- Implementing NHS impact for patient care – co-production.
- Awarded Outstanding Contribution to Equality, Diversity and Inclusion in Health and Social Care – RCN North west Black History Month 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/143**			
SUBJECT:	**Fragile Clinical Services**			
DATE OF MEETING:	6 December 2023			
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.	✓		
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) 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. **#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 , 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:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper 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 Paediatric Ophthalmology Gynaecological surgery ENT Orthopaedics – Fractured Neck of Femur		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	Trust board is asked to: - Note the current list of Fragile Services and associated high level progress updates - Note the escalation of ENT services to fragile service oversight - Receive further Fragile Services reports		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF	BM/23/01/143

1. BACKGROUND/CONTEXT

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

For the purposes of the Fragile Services Oversight program the Trust defines a Fragile Service as: 'A service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with 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. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

Ear Nose and Throat Surgery

Designated as a Fragile Service – PSCESC November 2023

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Significant medical staffing challenges
- 'Routine' New patient waiting list has grown very significantly, 'urgent' numbers remain high and static
- Emergent growth in 2 week wait cancer demand
- ENT currently has the Trusts largest backlog

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

  Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
- Current mitigations
  - Outsourcing sessions funded
- Ongoing improvement plan actions:
  - GIRFT Further, Faster baseline assessment and action plan outstanding
  - Capital bid for scope and stacker equipment
  - Triage and clinical waiting list validation exercise underway

3. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Gynaecological Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues with some diagnostic equipment pressures (hysteroscopes – now resolved)
- 6 incidents of moderate harm identified in year (Jan – Nov 23) which have been subject to appropriate investigation and Duty of Candour has been discharged. 3 relate to a delay in diagnosis with no further ongoing harm. 2 new moderate harms identified since previous report to board.
- Service has recovered its 2WW position – monitored daily as remains a challenge.
- Completed Actions
    - Full complement of hysteroscopes now purchased and in service.
    - Gynaecological surgery capacity supported by approved elective c-section revenue request.
    - Full consultant job plan review completed informed by demand and capacity exercise.
    - 3 consultants recruited (2 replacement and 1 new post) – start dates Jan – March 2024
- Current mitigations
    - Insourcing and WLI as appropriate/available
    - Waiting list validation process underway utilising AI risk stratification and a repeat harm review on all P2 waiters
    - Daily 2WW performance tracker in place
- Ongoing improvement plan actions:
    - Further new Consultant post to advert – interviews December 2023
    - Triage/Advice and Guidance workstream
    - Pathway development with assigned consultant

Urology

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- 5 in year incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged. 1 new harm identified since previous report to board.
- Transperineal Biopsy and Surveillance cystoscopy position improved.
- P2 backlog remans static
- Ongoing risk of harm remains given P2 and surveillance cystoscopy backlogs
- Service exceeding clinical activity targets (>105% of 19/20 activity)
- Completed Actions
    - Revenue requests approved for additional medical staff
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved
    - 3 Middle Grade doctors recruited
- Current mitigations

    - Robust stent register process in place
    - Hot stone list implemented at Warrington site
    - 10 PCNL Stone patients transferred to Chester
- Ongoing improvement plan actions:
    - Mutual aid request to C&M Hub and WWL
    - 1 locum consultant post out to advert
    - Plan to reintroduce PCNL at Warrington site with new IR Radiologist
    - Development of plan for specialist nurse delivered cystoscopy

Ophthalmology - Paediatric Ophthalmology

- Demand and capacity mismatch – driven predominantly by workforce issues
- Significant consultant workforce issues – Associate Specialist in post
- Locum consultant recruited to commence Feb 2024
- New patient waiting list managed by Associate specialist activity – operative and follow up backlogs remain an issue
- No harm identified to date
- Current mitigations:
    - Monthly review of all high risk and 17 week plus patients
    - Regular interim orthoptic/optometry review if potential risk to sight
    - Re-prioritisation as clinically indicated by patient level risk
    - Agreement with Specialist Trust to support a number of undated patients on operative waiting list
    - Agreement with specialist Trust to accept paediatric emergencies and any patients deemed at risk of sight loss requiring surgery
    - Additional activity from external consultant as available
- Ongoing improvement plan actions:
    - Recruitment – further new consultant post out to advert
    - Further negotiation with Specialist Trust underway regarding mutual aid for listed and dated patients – unlikely to provide additional capacity
    - Capital request in development for Retinal Screening Camera to increase capacity for Retinopathy of Prematurity screening

Orthopaedics – Fractured Neck of Femur

- Demand and capacity mismatch – driven predominantly by increased demand, increased pressures on bed base and insufficient theatre capacity for Trauma workload
- Significant improvement in month across majority of performance indicators
- Prompt surgery remains a significant challenge
- Current mitigations:
  - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
  - Additional orthogertiatrican and orthogeriatric fellow in post
  - Additional ad hoc fractured neck of femur list utilising bank locum consultant
- Ongoing improvement plan actions:
  - Focused improvement plan to deliver 'prompt surgery'
  - Agreement of ringfencing process to allow direct admission to specialist ward

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

None

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services and associated high level progress updates
- Note the escalation of ENT services to fragile service oversight
- Receive further Fragile Services Oversight reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/144**			
SUBJECT:	**Communications & Engagement Dashboard Q2**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#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. **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation, and financial position.			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information: The Trust must ensure open and transparent communications engagement which takes into account disadvantage suffered by people due to their protected characteristics.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information: As above for 1.			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**

	Further Information: As above for 1.		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This quarterly impact report highlights key communications and engagement activity that has taken place in Quarter 2 of 2023/24 (July to September). It provides a snapshot of key achievements and projects that the Communications and Engagement Team has been involved in, as well as a summary of media coverage and an update on our Experts by Experience programme and activity.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors	
	Agenda Ref.	COG/23/11/72	
	Date of meeting	9 November 2023	
	Summary of Outcome	Update noted at CoG	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and Engagement Impact report

Quarter 2 (July to September) 2023

The team

The Communications and Engagement team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including – content development for trust's corporate social media channels and updates to the website
- Identity and branding
- Design work
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information
- Freedom of Information (FOI) requests

During the Q2 period (July to September 2023) the Communications and Engagement Team…..

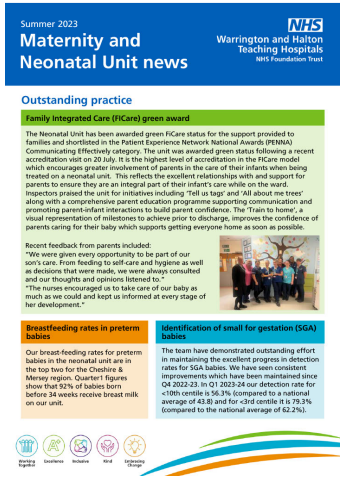
- processed and allocated **123** separate communications 'Job Request' forms for design, film, photography and communications campaign support
- issued **17** media releases/statements
- handled **20** enquiries from local, regional and national print and broadcast media
- processed **302** emails through the enquiries inbox
- received **197** Freedom of Information (FOI) requests
- processed and issued **189** FOI request responses

Q2 achievements overview

- Coordinated Team WHH to attend Warrington Disability Awareness Day in July
- Promoted and supported the Annual Members' Meeting including arranging guest speaker
- Supported ongoing communications to minimise the impact of industrial action
- Incorporated the re-fresh of materials to reflect new brand and style guidelines into the existing team workload
- Introduced a new format of the Trust weekly e-bulletin The Week to reflect new brand style and more focused communications approach
- Supported and promoted the Delamere 10 year anniversary celebrations
- Worked with radiology colleagues to organise a celebration event for the opening of the new ED CT Scanner and promote the development
- Attended and coordinated a Team WHH presence at the Warrington Mela in September to support engagement with our diverse communities
- Provided communications support for the CQC inspection of maternity services, including preparing trust wide communications, updating materials and producing a best practice newsletter
- Continued to develop our engagement and involvement offer including working with Aqua to develop a 'lived experience' training programme for our Experts by Experience

The following slides detail the outputs and outcomes of key campaigns during the quarter




Summer 2023

Maternity and Neonatal Unit news

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Outstanding practice

Family Integrated Care (FICare) green award

The Neonatal Unit has been awarded green FICare status for the support provided to families and shortlisted in the Patient Experience Network National Awards (PENNA) Communicating Effectively category. The unit was awarded green status following a recent accreditation visit on 20 July. It is the highest level of accreditation in the FICare model which encourages greater involvement of parents in the care of their infants when being treated on a neonatal unit. This reflects the excellent relationships with and support for parents to ensure they are an integral part of their infant's care while on the ward. Inspectors praised the unit for initiatives including 'Tell us tags' and 'All about me trees' along with a comprehensive parent education programme supporting communication and promoting parent-infant interactions to build parent confidence. The 'Train to home', a visual representation of milestones to achieve prior to discharge, improves the confidence of parents caring for their baby which supports getting everyone home as soon as possible.

Recent feedback from parents included:
"We were given every opportunity to be part of our son's care. From feeding to self-care and hygiene as well as decisions that were made, we were always consulted and our thoughts and opinions listened to."
"The nurses encouraged us to take care of our baby as much as we could and kept us informed at every stage of her development."

Breastfeeding rates in preterm babies

Our breast-feeding rates for preterm babies in the neonatal unit are in the top two for the Cheshire & Mersey region. Quarter1 figures show that 92% of babies born before 34 weeks receive breast milk on our unit.

Identification of small for gestation (SGA) babies

The team have demonstrated outstanding effort in maintaining the excellent progress in detection rates for SGA babies. We have seen consistent improvements which have been maintained since Q4 2022-23. In Q1 2023-24 our detection rate for <10th centile is 56.3% (compared to a national average of 43.8) and for <3rd centile it is 79.3% (compared to the national average of 62.2%).





Phlebotomy eBooking Project engagement

The Phlebotomy eBooking Project will create an online way to book blood test appointments requested by GPs via the Trust or other community services.

Currently appointments are booked by the patient via a call centre.
Plans for eBooking will enable patients to book online via URL (sent via text to patient's mobile)

Experts by Experience (EbyEs) were requested to join in discussions and testing

- Nine EbyEs recruited
- Initial stage of engagement - virtual EbyE background discussions
- Second stage of engagement - online system demos undertaken
- All EbyEs were positive about the eBooking option
- Concerns about digital exclusion were allayed by explaining that eBooking is in addition to existing call centre

Benefits

- Supports paperless strategy and reduces printing costs
- Reduces call centre pressure
- Improves patient choice and satisfaction

Outcomes

- During the pilot approx 70% of patients chose the online booking system



"It's wonderful to be included in demonstrations and discussions, to contribute ideas and to be able to ask questions. I love the fact that we saw the system in real-time, to show us every aspect of the appointment journey. It really helps to know what to expect"

Lorraine - WHH Expert by Experience

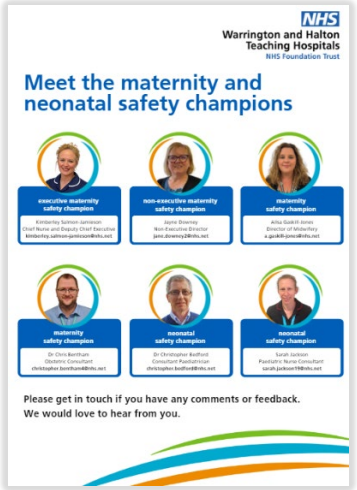
WHH brand refresh

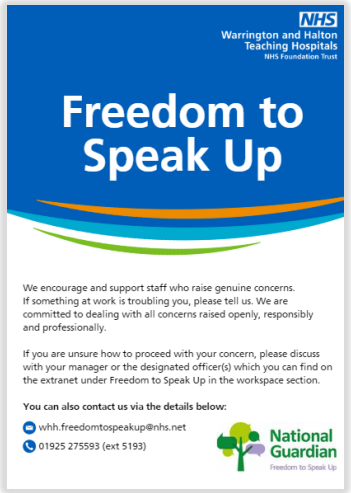
Following the refresh of the Trust brand, the team has updated 47 different materials, including internal document templates, digital artwork, social media graphics, posters and internal communications channels to reflect the new brand guidance and improve accessibility.

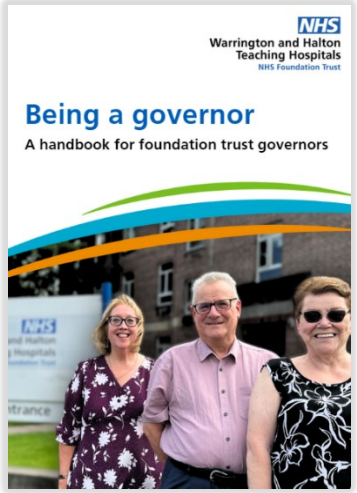
A style guide, brand guidelines and templates for staff to use have been shared and promoted.

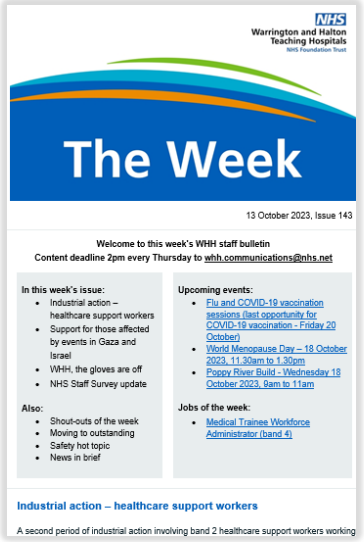
Work is ongoing to review and refresh materials as they require updating but examples include:

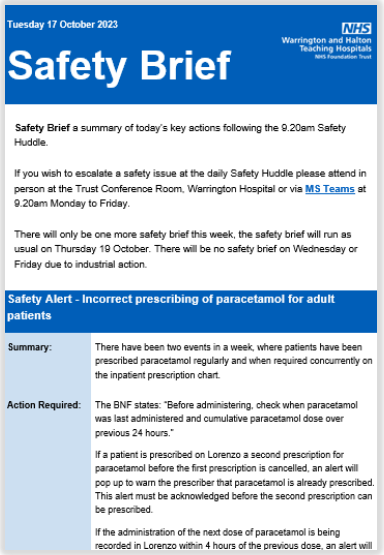


















Patient Safety Incident Response Framework (PSIRF) Learning from Patient Safety Events service (LFPSE)

PSIRF was introduced on 1 September 2023 to replace the Serious Incident Framework, which has been in place since 2015.

LFPSE was introduced to support with PSIRF by improving the quality of data collected from across the NHS and how it is reviewed and analysed with updates to the existing Datix incident reporting and risk management system.

The Communications Team have supported with communicating the changes over the last 12 months on the lead up to the launch.

Communicating via:

- Regular GMWHH from subject experts
- Dedicated extranet workspace
- Team Brief updates
- Countdown in The Week
- MS Teams lives and meetings with subject experts

The Chief Nurse and our Patient Safety Partners (PSPs) took part in a national video by NHS England for World Patient Safety Day on 17 September on PSIRF and its introduction at WHH.

Media

The **17** media releases/proactive external announcements issued during Q2 included:



WHH Research and Development Team honoured at regional awards

Read the release.



Services under way as part of £15m diagnostics expansion at Warrington and Halton Teaching Hospitals NHS Foundation Trust

Read the release.



Living Well Hub - Everything you need to know about the new Living Well Hub

Read the release.



Double celebration for WHH's Neonatal Unit's Family Integrated Care (FICare) model

Read the release.

Engagement, Involvement & Insight

During Q2 (Jul to Sep 2023) we recruited **37** Experts by Experience

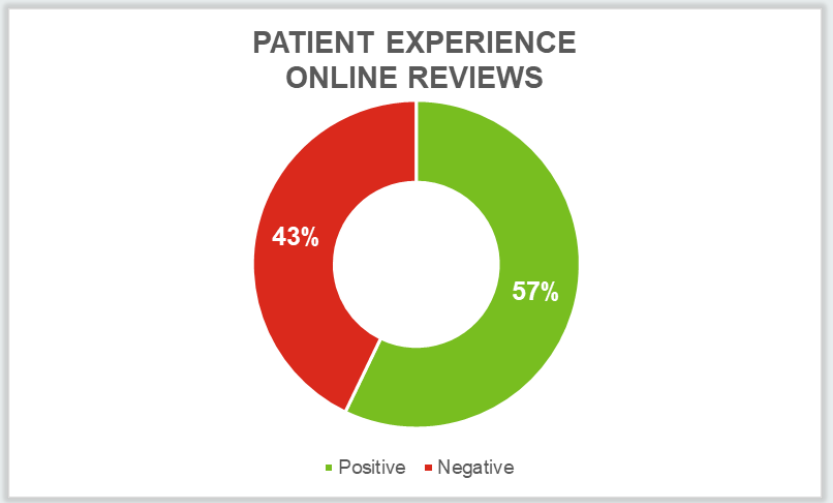
We received requests for engagement support for the following projects:

- Online Pre-Op Assessment Forms
- Sepsis Improvement
- Patient Engagement Portal tender – including attending demonstrations
- Call 4 Concern Telephone Line
- Experts by Experience development of Trust research priorities
- Experts by Experience input into the naming of Patient Engagement Portal
- Experts by Experience feedback on maternity explainer animation scripts

Children's Ward Accessiblity Visit

In August a group of EbyEs visited Warrington Hospital's Children's Ward areas and worked with the Matron of Child Health to suggest ways to improve facilities and make reasonable adjustments to best support children with complex needs using Trust services.





A total of 49 online reviews from patients rating their WHH experience were published in Q2.

Sources of data:

- NHS Choices
- Google reviews
- I want great care

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/145**	
SUBJECT:	**Bi-monthly Strategy Highlight Report**	
DATE OF MEETING:	6th December 2023	
AUTHOR(S):	Stephen Bennett, Head of Strategy & Partnerships	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#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. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#1757** If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety. **#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 maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation, and financial position. **#1846** if the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage
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 following Strategy Highlight Report provides a progress update on key strategic projects and initiatives that underpin a number of WHH's strategic (QPS) priorities.

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the report for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Strategy Update
September-October 2023

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	Details of key stakeholders engaged during the reporting period		
Section 3 - Key Strategic Projects			
Page	**Project**	**Strategy Lead**	**Status**
Slide 5	Living Well Hub in Warrington	Stephen Bennett/Caroline Lane	
Slide 6	Runcorn Town Deal	Carl Mackie/Viviane Risk	
Slide 7	Community Diagnostic Centre	Stephen Bennett/Lefteris Zabatis	
Slide 8	New Hospitals Programme and strategic estates	Carl Mackie/Viviane Risk	
Section 4 - Other Trust Strategic Updates			
Slide 9	Summary of other Trust strategy related updates		
Section 5 - Place-based Strategic Updates			
Slide 10	Summary of strategic updates from local places (Warrington and Halton)		
Section 6 - Cheshire and Merseyside Strategic Updates			
Slide 11	Summary of strategic updates from Cheshire and Merseyside		

Key Messages

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- A draft of the Trust's refreshed Estates Strategy was reviewed by Trust Board on 1st November. The Estates Strategy will incorporate a refreshed new hospitals plan, as well as key strategic estates priorities for the next 5 years.
- The Trust's bid to be one of two endoscopy hubs within Cheshire and Merseyside was successful. Plans will now be developed and delivered at pace to provide additional endoscopy capacity on our Halton hospital site.
- An Active Travel Wellbeing Worker will be based in the Halton Health Hub at Runcorn Shopping City from November. Working from the hub on a Wednesday and a Thursday, this role is designed to encourage Runcorn residents to better engage with their own ways to wellbeing, with specific focus on access to active travel opportunities across the Halton Borough. This project is being delivered in partnership with Liverpool City Region and Wellbeing Enterprises, a community interest company.
- All major structural works have now been completed at the Warrington Living Well Hub. The hub is due to open to residents early in the new year. A general manager of the hub has been recruited. The planned service offers include families and children, pre-frailty, falls, dementia, women's health, care leavers and healthy lifestyles. WHH services will include maternity, cardiac rehab and physiotherapy.

Stakeholder Engagement Overview

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Sherree Fagge	Deputy Director of Nursing for Women's Health, NHS England	Development of a targeted women's health offer from the Living Well Hub
Prof Judy McKimm	Interim Pro Dean and Professor of Medical Education, University of Chester	Links between Living Well Hub and University of Chester and potential for medical student placements
Bob Adams	Director of Liverpool Office, Kier Construction	Community Diagnostic Centre (CDC) capital costs
Prof Basma Ellahi	Public Health and Nutrition, University of Chester	Inclusion, equality and diversity of service access in Living Well Hub
Ian Triplow	CDC Programme Director Cheshire & Merseyside	Community Diagnostic Centre – capital funding and activity planning for 24/25
Lauren Sadler	Transformation and Change Lead – Warrington Together Partnership	Warrington Place programme development
Jamie Foster	Partner, Hill Dickinsons	Final discussions with core partners in Living Well Hub project around Collaboration and Contribution Agreement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme across Warrington and Community-Led Support programme board
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities
Barry Geden	Commissioner, Warrington ICB	Mobilisation of Community Spirometry service in CDC
Melanie McLaughlin	Head of Adult Services – Warrington, Bridgewater	Inclusion of targeted community services within Living Well Hub
Alison Cullen	CEO, Warrington Voluntary Action	Development of Talking Point service in Living Well Hub and potential voluntary sector support for a virtual hub
Steven Broomhead	CEO, Warrington Borough Council	Living Well hub
David Herne	Director of Public Health, Warrington Borough Council	Living Well Hub and continued involvement of Public Health services in the delivery of the planned operating model
Laurence Pullan	Head of Communications, Warrington Borough Council	Development of communications plan for Living Well Hub
Safeera Ahmed	NHS Transformation Unit	Children and Young People's Diagnostics Strategy, C&M
Stephen Young	CEO, Halton Borough Council	CDC, estates strategy

Stakeholder Engagement Overview

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Linda Buckley	MD CMAST Provider Collaborative, Cheshire & Merseyside	Provider Collaborative leadership
Wesley Rourke	Operational Director, Economy, Enterprise and Property	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Wayne Longshaw	Integration Director, Mersey and West Lancs (MWL)	Service collaboration opportunities
Steve Park	Growth Director, Warrington Borough Council	Local plan, new hospitals, Estates planning
Karl Redmond	New Hospitals Programme, NHSE	New hospitals, estates planning
Rick Howell	Strategic Lead Commissioning, WBC	Contribution and Collaboration agreement for Living Well Hub
Amanda Ridge	Associate Director Transformation and Partnerships- Warrington	Place-based transformation, including same day emergency care
Andrea Long	Head of Estates, North West Ambulance Service	Strategic estates collaboration opportunities across Warrington and Halton
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M clinical strategy
Dani Jones and Alfie Bass	Director of Strategy and Medical Director, Alder Hey	Paediatric surgical hub
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy, Living Well Hub
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
Steve McGlade	Head of Estates, Cheshire Constabulary	Strategic estates collaboration opportunities across Warrington and Halton
Nick Armstrong	Estates, Cheshire and Merseyside ICB	Strategic estates planning, Warrington
John Smith and Mark Swift	Liverpool City Region CA CEO, Wellbeing Enterprises	Active travel hub in Halton Health Hub
David Mills	Deputy Medical Director, Bridgewater	Living Well Hub, Runcorn Health and Education hub
Leigh Thompson, Tim McPhee	Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan

Living Well Hub in Warrington

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Project overview

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

Progress since last report

- All major structural works on the building are now complete with the rooftop extension and the installation of the new lift..
- Confirmation received from three of the four core partners (Warrington Borough Council, Bridgewater and WHH) around approval of Collaboration and Contribution Agreement to underpin the ongoing revenue costs of the project. Mersey Care still to confirm at the time of writing this report.
- Appointment of the new General Manager for the Hub, due to commence in post in November.
- Site visits to the facility are now increasing as the build programme nears completion. Site visits in October included local councillors, representatives from the various operational delivery groups and senior leaders from partner organisations.
- Work with a broad range of partners continues to develop and finalise the operating model for the Hub from go-live. Planned services offers include Families and Children, Pre-Frailty/Falls/Dementia, Women's Health, Care Leavers and Healthy Lifestyles.

Latest Images/Links/ Further information

What is the new Living Well Hub that is coming to Warrington? | Warrington Guardian



What does this mean for WHH?

Delivery of WHH services, including midwifery, cardiac rehab and physio and 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.

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** ✓

Upcoming Key Milestones

Milestone	Date
Completion and signing of Collaboration and Contribution agreement between 4 core partners	Nov 23
Finalise timetable	Nov 23
Build work completed	Dec 23
Launch of Hub	Jan 24

Contact details

Caroline Lane
Strategic Project Manager
caroline.lane10@nhs.net

Runcorn Town Deal

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

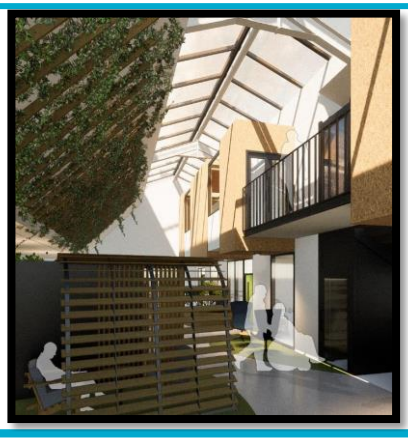
Project overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long term conditions from a central location in Runcorn.
The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

Progress since last report

- Cassidy & Ashton instructed to develop scheme to RIBA Stage 4 (final design stage before going to market)
- Governance for management of the refurbishment under consideration by core partners
- Transport statement drafted ahead of submission of Planning Application

Latest Images/Links/ Further information






Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

What does this mean for WHH?

Delivery of WHH services, including maternity and respiratory, 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.

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** ✓

Upcoming Key Milestones

Milestone	Date
Planning Application Submitted	Oct 23
Ongoing revenue funding principles ratified	Jan 24
RIBA stage 4 documentation produced	Feb 24
Opening	Summer 25

Community Diagnostic Centre

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Project overview

As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.
The final approved CDC Programme will cover three phases. Phase 1 (now complete) will develop a range of diagnostic services within the Nightingale Building at Halton. Phase 2 will see diagnostic services established within the Halton Health Hub at Runcorn Shopping City. Phase 3 will see the development of a small new build extension to the CSTM building on the Halton site to accommodate CT and MRI services.

Progress since last report

- The **Phase 2** works (at Halton Health Hub, Runcorn Shopping City) continue at pace, and the project is scheduled to complete in early December 2023.
- Cost estimates for **Phase 3** (New Build CDC) were completed following completion of stage 3 designs and stood above planning figures, which were based upon previous cost estimates from June 23.
- Meeting held on 5th October with KOK (cost advisors) and Kier (build contractors) to explain reasons behind difference between September and June cost estimates and agree urgent actions to bring costs back in line with planning figures.
- Value engineering exercise to reduce estimated costs completed along with Kier review of overheads, risks and contingency.
- Discussions with regional and national CDC programme team to explore possibility of additional funding.
- Additional funding from national team verbally agreed to offset latest version of cost estimates (adjusted for value engineering and reduced Kier overheads etc.)

Latest Images/Links/ Further information







What does this mean for WHH?

Additional capacity to undertake diagnostics for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.
New estate at Halton General Hospital, which supports new hospitals plans and estates strategy.

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
Planning Permission for New Build Received	Dec 23
Services within Halton Health Hub to commence	Dec 23
Services within new build CDC to commence	Dec 24

Contact details

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Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New Hospitals and strategic estates planning

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Project overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital for Warrington, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending CSTM to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

Progress since last report

- A refresh is underway of the Trust's Estates Strategy, which will incorporate a refreshed new hospitals plan. This includes an outline of expected key milestones across the next 5 year period.
- Discussions held with Place Directors, Warrington Borough Council and Halton Borough Council to support development of revised new hospitals plans and agree strategic estates priorities.
- Discussions undertaken with key partners including Cheshire Constabulary and North West Ambulance Service around potential opportunities for strategic estates partnership working, including shared facilities.

Latest Images/Links/ Further information





Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

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.

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
New hospitals strategic oversight group meeting to discuss revised plans and strategy with stakeholders, including MPs.	Nov 23
Estates Strategy to be finalised and approved.	Dec 23
High level business cases to be developed for agreed strategic estates priorities.	Feb 24

Other Trust strategic updates

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Halton Health Hub Active Travel pilot scheme

- Wellbeing practitioner based in Halton Health Hub to encourage uptake of active travel opportunities
- Additional linkage to ongoing social prescribing and Health and Care system wayfinding across the borough
- Project in partnership with Liverpool City Region Combined Authority and Wellbeing Enterprises Community Interest Company.
- Pilot due to launch November 2023

Targeted Investment Fund (TIF) Programme – Developing elective services on the Halton site

- Currently in construction for the daycase unit and theatre 5 at CSTM. Working closely with estates and contractors around mechanical, electrical and plumbing.
- Works have started to prepare areas in Nightingale Building for TSSU development.
- Design works completed for additional Endoscopy rooms and Theatre 3.
- Operational teams working through plans around the delivery of activity whilst construction works are taking place

Place based strategic updates

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington

- A key programme of work to develop a Warrington wide estates strategy and delivery plan has commenced. The second workshop was held in October, including an update on estates strategies from both Mersey Care and Bridgewater and the development of an approach for neighbourhood level service and estates planning.
- A review of urgent and emergency care on the day demand and capacity has commenced across Warrington, which aims to address some of the pressure on our ED department and on GP services.
- The Trust has submitted bids to Warrington's Transformation Fund. Outcomes of bids are expected in December 2023. Applications include:
  - Additional ongoing revenue funding of the Living Well Hub. If successful, this will reduce the financial burden on the four core partners for the project, WHH, Bridgewater, Mersey Care and Warrington Borough Council.
  - Support development of a Living Well virtual hub. This would produce a digital resource which would be a central directory for all things health and wellbeing in Warrington.
  - A Falls Response Service to reduce provide efficient triage and access to specialist services to those who have fallen, reducing the demand on both Ambulance and Hospital services
- The Trust is also submitting bids to the Warrington Shared Prosperity Fund pot, including applications for:
  - Development of additional public sector estate within Warrington Town Centre,
  - Support for the development of a Living Well virtual hub, as above.
- The Local Government Association is currently working with a number of local partners, including the Council and the Trust to strengthen the role of the Warrington Health and Wellbeing Board in governing health and care aspirations of Warrington residents. An updated Health and Wellbeing Strategy is expected in May 2024.

Halton

- Halton has been selected as one of 6 towns nationally to be supported by the Lloyds Bank Foundation. Support will be focussed on ensuring a sustainable community model, where 3rd sector organisations are able to thrive and work effectively alongside the statutory sector to deliver maximum benefit to residents.
- One Halton is providing PMO support to each of its priority workstreams, assisting with the development of plans, outcome measures and KPIs to ensure that the One Halton programme is able to more effectively deliver for the residents of Widnes and Runcorn. The five priority workstreams are:
  - Starting Well
  - Living Well
  - Ageing Well
  - Wider Determinants
  - Integrated Neighbourhood Teams

WHH Director of Strategy and Partnerships, Lucy Gardner is joint lead for the wider determinants work. Priority areas have been agreed, based on detailed analysis and evidence, which include access to education and employment, housing, green spaces and reducing violent crime.

Cheshire and Merseyside strategic updates

Warrington and Halton Teaching Hospitals NHS Foundation Trust

C&M pathology
A business case is in development for a shared LIMs (Laboratory Information System) for C&M. National capital funding has been secured. Delivery is due to commence in March 2024.
The procurement process for the shared single LIMs has commenced, the Trust has been integral in the development of the specification to ensure that the new LIMs meets our needs.

C&M paediatrics
Paediatrics, including paediatrics elective recovery, has been identified as a priority within C&M. The Trust is in initial discussions with Alder Hey, including how we can support elective recovery, which may include increased paediatric surgical provision at WHH.
A paediatrics diagnostics strategy for C&M is in development and the Trust has been invited to input to ensure alignment to our priorities.

C&M endoscopy
The two C&M Endoscopy bids have been secured, including additional endoscopy capacity on our Halton site, with WHH as a regional hub. Work has commenced with finance around funding allocation and contractors around delivery of agreed plans for construction.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

EPRR Annual Assurance Process Update
Trust Board

Daniel Moore, Chief Operating Officer and AEO for EPRR

6 December 2003

The Annual Assurance process

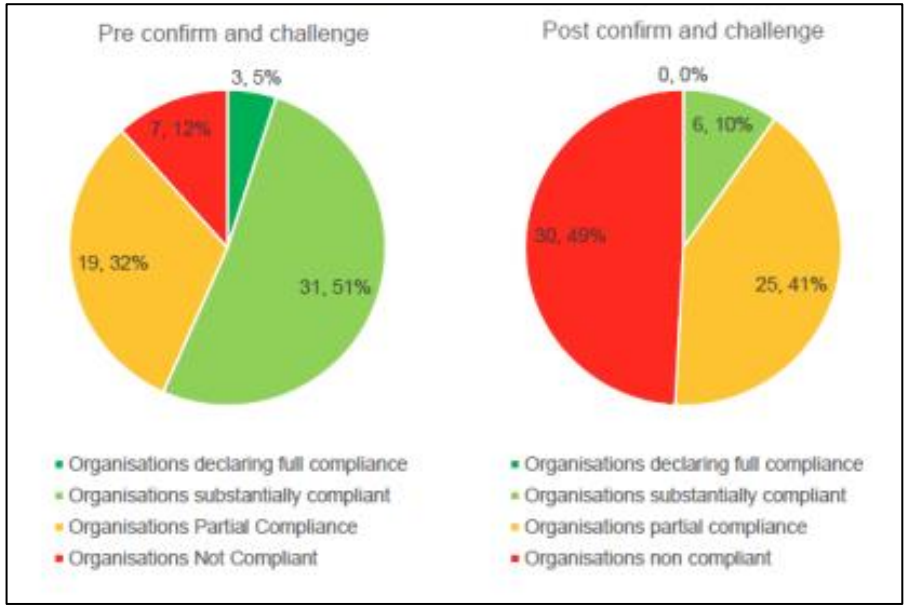
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

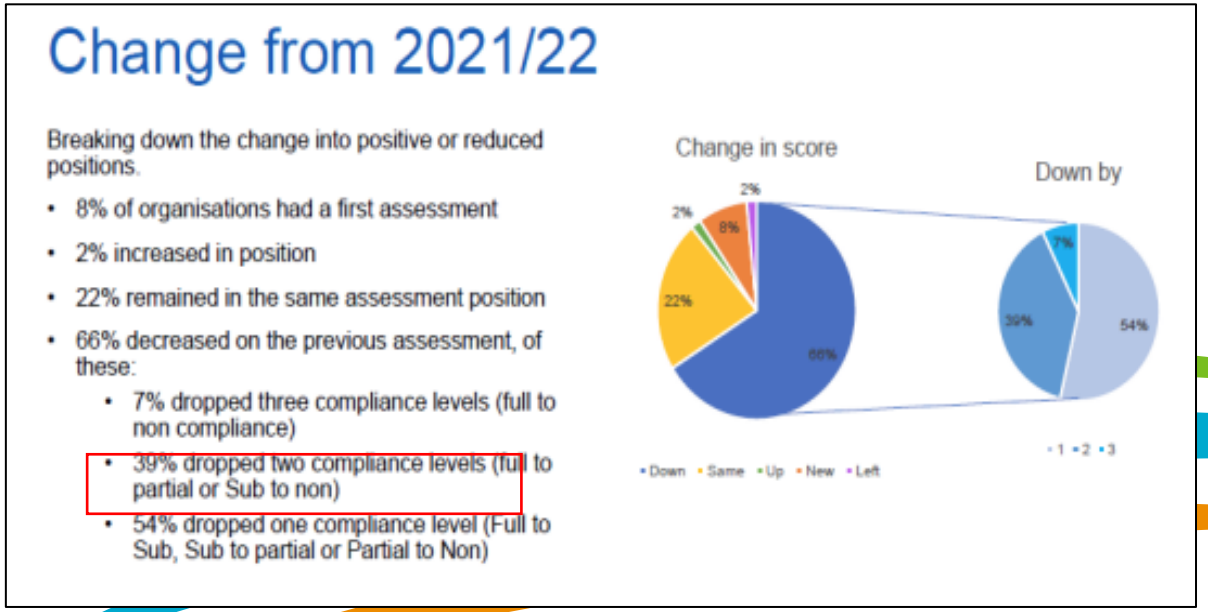
New process announced May 2023
Overview of changes to the NHS England EPRR Core Standards assurance process

Recognition of the need to change following the COVID-19 Pandemic, BREXIT, Manchester Arena attack.
A clear need to improve the standard which organisations must achieve and the burden of proof in regard to robust Governance, proactive planning and tried and tested plans.

In 2022 The midlands region took part in an exercise which involved a detailed analysis of compliance evidence against Each core standard, alongside the organisations self-assessment.

- Substantial differences between the self-assessment results and the evidential review.





The Impact For WHH

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

6th October - Core Assurance report presented to the Board of Directors scoring 92% - Substantial compliance

19th October – First feedback of the check and challenge process

6th November – Final check and Challenge process scoring 5% - Non-Compliant

- No non-complaint domains
- Substantive EPRR Manager on Mat leave until January 2024. Agency locum covering currently.

Domain	Total Applicable Standards	Fully Compliant			Partially Compliant			Non Compliant		
		SA	1st	2nd	SA	1st	2nd	SA	1st	2nd
Governance	6	6	0	1	0	6	5	0	0	0
Duty to Risk Assess	2	2	0	0	0	2	2	0	0	0
Duty to Maintain plans	11	10	0	0	1	11	11	0	0	0
Command and control	2	2	0	0	0	2	2	0	0	0
Training and Exercising	4	3	0	0	1	4	4	0	0	0
Response	7	6	0	0	1	7	7	0	0	0
Warning and informing	4	4	0	0	0	4	4	0	0	0
Cooperation	4	4	1	2	0	3	2	0	0	0
Business Continuity	10	8	0	0	2	10	10	0	0	0
Hazmat / CBRN	12	12	0	0	0	12	12	0	0	0
Totals	**62**	**57**	**1**	**3**	**5**	**61**	**59**	**0**	**0**	**0**

What happened across C&M?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Similar scenario to what happened in the Midlands has played out in the Northwest.

Significant upset across the ICB and Providers

Significant upset amongst the EPRR Managers

Chief Operating Officers asked the ICB for an urgent review and response – ICB email response from Anthony Middleton 25/10 **See Appendix 1.**

An agreement that the Regional Lead for EPRR would produce a letter to go to all Boards to explain the process and the Rationale for the significant drop in performance – **See Appendix 2.**

"It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given The competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important To note that this does not signal a material change or deterioration in preparedness but should be considered as a revised And more rigorous baseline in which to improve plans for preparedness, response and recovery"

Next Steps

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Shared with the Board of Directors before 31/12/23

Clarify the reportable rating and compliance statement
Any impact on organisational compliance obligations legally – update risks accordingly.

A full review of what is required to restore substantial compliance for 24/25 – work is already underway
Workforce resource – testing and compliance
Access to courses and training materials

Work this the Local Health Resilience Partnership to identify areas of collaboration

The Substantive EPRR Manager returns in January 2024 to help support improvement work

The workplan to be monitored via Event Planning Group chaired by the Chief Operating Officer and AEO for EPRR and report into Finance and Sustainability Committee.

Appendix 1.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

EPRR Annual Assurance Concerns

Reply | Reply All | Forward

AM Anthony Middleton <Anthony.Middleton@cheshireandmerseyside.nhs.uk>
Wed 25/10/2023 08:53

To KENDALL, Hayley (WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST); 'Gary Price'; NEARY, Lesley (SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST); 'Beth Weston - Liverpool University Hospitals NHS Foundation Trust (Beth.Weston@liverpoolft.nhs.uk)'; MOORE, Daniel (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST); **+10 others**
Cc Nicola Barnes; Beth Warburton
Archive 24/10/2024
You forwarded this message on 25/10/2023 09:23.

Dear Colleague,

Following on from the concerns raised about this years EPRR annual assurance I have had a number of frank conversations with NHSE over the past few days, as I know some of you have too.

I have noted a number of points below in terms of lessons learnt and the way forward:

- This year's assurance has been much more stringent in that documented evidence was required as opposed to self-assessment.
- The assurance process this year follows on from the pilot region of the midlands last year, where similar "down scoring" occurred.
  - It is accepted that whilst the outcome from the midlands was well known in EPRR circles, and national expectation was that other regions assurance would likely fall as it was rolled out, there was not a step up in awareness, nor a different approach in preparation for the years round.
- It is recognised that precise clarity around what form or evidence would be required for the standards was only published at the end of July.
- It is recognised that there is some limited evidence of inconsistency in panel challenge from across organisations.

Whilst the above is clear recognition of a sub optimal approach to planning I would also say that having seen some of the evidence submitted it is clear it does not meet the required standard, in some cases is many years out of date and would therefore challenge the validity of previous self-assessment declarations.

Next Steps:

- The ICB has performed a theme analysis of the challenges for all providers and is looking to highlight the inconsistency issue which has been reported by some organisations.
- The meeting on the 24th October with EPRR leads clearly articulated the frustration with the process, and the perceived damage reputation from the "profession" and the organisations which I am sure we will do our utmost locally to support.
  - To support board awareness Paul Dickens (Regional head of EPRR – North West/North East) has agreed that when the final outcome letter is sent to all organisations it will make very clear the context for the changes this year and the national expectation of "down scoring"
  - I understand Joan Spencer is helpfully assisting with the scribing of that section, which will go to not only all C&M Organisations but also the organisations across the North West and North East
- The discussion with EPRR leads suggested that an extension to the timescale to provide challenged evidence would be of limited value, as information which was to hand could be provided but other evidence which was out of date would require a much longer timescales to feed through the governance arrangements of the Trust – Therefore I have not pursued an extension any further.
- Paul Dickens has offered to come to a COO's meeting in a few weeks to discuss further and hear concerns, which are also beginning to surface from other regions who are 1-2 weeks behind us in this process.
- Whilst this will remain an NHSE led process next year – I will ensure that across Cheshire & Merseyside the ICB will take a similar approach to how we fulfil the annual operational planning rounds, or winter planning by the stepping up support arrangements at fixed points during the year starting with a kick off event in the new year, followed by a step up to weekly drop in sessions as we near the submission dates.

I hope the above information is useful, but would be happy to discuss direct or collectively via the COO's meeting.

Best wishes
Anthony

Classification: Official-Sensitive

NHS England

NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL November 2023

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

The 2023/24 EPRR Assurance model

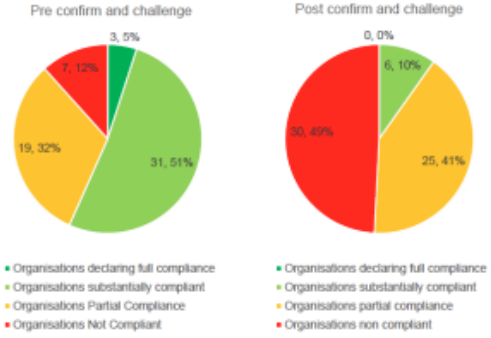
In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

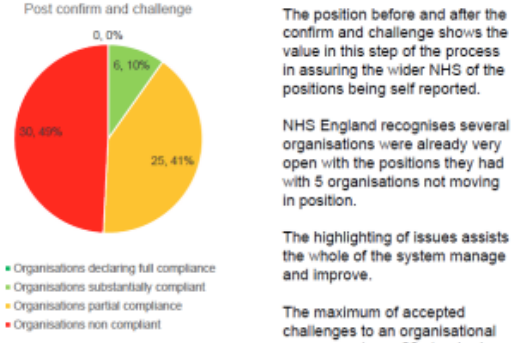
This model required commissioners and providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

NHS England Midlands

Levels pre and post confirm and challenge





The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

The maximum of accepted challenges to an organisational assessment was 30 standards.

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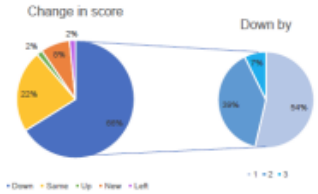
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NHS
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Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

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The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year's assurance cycle.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/147**			
SUBJECT:	**Fit and Proper Person Policy**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust must ensure that director level appointments and their deputies meet the 'fit and proper persons test' requirements. The regulations place a duty on NHS providers not to appoint a person or allow a person to continue in the position if the test is not met. The regulation has been integrated into the Care Quality Commission's (CQC) registration requirements and falls within the remit of their regulatory and inspection approach under Well Led. The first version of the WHH Fit and Proper Persons Policy was approved by the policy review group 26 July 2023. Since then, NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations			

	made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). The FPPT is carried out on an individual board member basis, and in the annual submission to the NHS England regional director, the chair will provide the overall summary of the FPPT outcome for the board. The WHH Policy extends to Deputy Directors, which is not a national requirement but promotes best practice. The key updates to the previous WHH FPPP are: • Introduction of a clear flow chart for the process • a set of standard competencies has been introduced for all board directors. • Introduction of a means of retaining information relating to testing the requirements of the FPPT for individual directors – in ESR. • a standardised reference template has been introduced whenever a director leaves an NHS board, an extension of the applicability to some other organisations, including NHS England and the CQC • FPPT data fields have been developed in ESR which enables the FPPT assessment elements to be recorded, along with some high-level detail where appropriate and to be shared where required. • All those within the scope of the policy have been issued with a privacy notice detailing the information that will be held and shared via ESR. • An annual submission will be made to Regional Director NHS England, confirming all Board members satisfy the fit and proper person test requirements – this will be done through a nationally approved template see appendix 6. The revised WHH Fit and Proper Person Policy is compliant with the national FPP Framework issued by NHSE.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the Fit and Proper Person Policy		
PREVIOUSLY CONSIDERED BY:	**Committee**	Policy Review Group	
	Agenda Ref.	**W&HHFT/PRG/11/23/77**	
	Date of meeting	15 November 2023	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED:	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

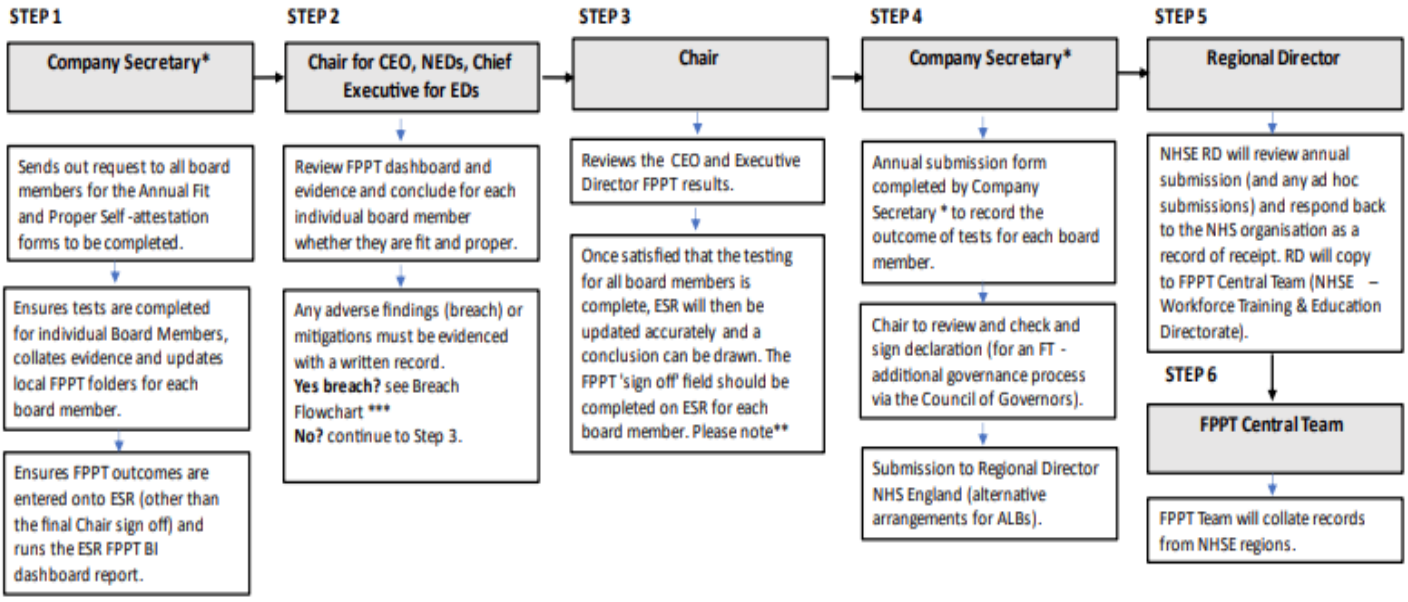
Fit & Proper Persons Policy			
Lead Executive	Chair		
Author's Details	John Culshaw, Company Secretary and Associate Director of Corporate Governance		
Type of Document	Policy		
Target Audience	The target audience relates to The Chair, Executive Directors, their deputies and Non-Executive Directors, permanent, interim, Associate NED positions, irrespective of their voting rights, Company Secretary/Associate Director of Corporate Governance, and the Freedon to Speak up Guardian. This includes those Directors who were already in post when the 2014 Regulations came into force.		
Document Purpose	The Trust must ensure that director level appointments and their deputies meet the 'fit and proper persons test'. The regulations place a duty on NHS providers not to appoint a person or allow a person to continue in the position if the test is not met. The regulation has been integrated into the Care Quality Commission's (CQC) registration requirements and falls within the remit of their regulatory and inspection approach under Well Led. This policy supports the implementation of the recommendations from the Kark Review and the NHS England Fit and Proper Person Framework for board members (August 2023). An annual NHS FPPT report will be submitted to the Regional Director NHS England **(Appendix Six).** The policy also provides details on the information that ESR will hold about board members. This is in line with the WHH FPPT Privacy Statement **(Appendix Seven).**		
Ratification Meeting	Policy Review Group		
Approval Meeting	Audit Committee & Executive Team Meeting		
Implementation Date	Tuesday, 14 November 2023	Review date	14 November 2024
WHH Documents to be read in conjunction with			
	Disciplinary Policy Recruitment and Selection Policy		
Document change history			

Version	2
What is different?	Revised in line with the recommendations from the Kark Review and the NHS England Fit and Proper Person Framework for board members (August 2023).
Appendices/electronic forms	Appendix One: Roles Subject to FPP Requirement at WHH Appendix Two: FPPT annual/new starter self -attestation Appendix Three: Allocation of Roles when Dealing with Concerns Appendix Four: Board Member Reference Template Appendix Five: Letter of Confirmation Fit and Proper Person (Chair) Appendix Six: Annual NHS FPPT submission reporting template Appendix Seven: WHH Board member FPPT Privacy Notice
What is the impact of change?	NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. The framework introduces a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC. The FPPT is carried out on an individual board member basis, and in the annual submission to the NHS England regional director, the chair will provide the overall summary of the FPPT outcome for the board. FPPT data fields have been developed in ESR which enables the FPPT assessment elements to be recorded, along with some high-level detail where appropriate.
Training Requirements	Chair & Chief Executive - Fit and proper Persons Regulation and Fit and Proper Person Framework training on local induction.
Keywords	

Contents

Flow Chart 1 - Process 4
Flow Chart 2 – FPPT Breach Identified 7
2. Executive Summary 8
3. Purpose & Scope 9
4. Duties & Responsibilities 10
5. Policy Details 11
6. Document monitoring 20
7. Glossary of Terms 20
8. Associated Documents 21
9. Sources/References 21
10. Training Needs Analysis 22
Appendix One: Roles Subject to Fit and Proper Person Test / Requirement 23
Appendix Two: Fit and Proper Persons Test annual / new starter self-attestation 24
Appendix Three: Allocation of roles when Dealing with Concerns 26
Appendix Four: The Board Member Reference Template 27
Appendix Five: Letter of Confirmation 35
Appendix Six: Annual NHS FPPT Submission Reporting Template 37
Appendix Seven: Board Member FPPT Privacy Notice 42
Equality Impact Assessment 46

Flow Chart 1 - Process



*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

Step 1: (carried out by) Company Secretary*

- Sends out request to all board members for the annual fit and proper self-attestation forms to be completed.
- Ensures tests are carried out for individual board members, collates evidence and updates local FPPT folders for each board member.
- Ensures FPPT outcomes are entered into ESR (other than the final chair sign-off) and runs the ESR FPPT business informatics (BI) dashboard report.

Step 2: Chair for CEO, Non-Executive Directors (NEDs), Chief Executive for Executive Directors

- Review FPPT dashboard and evidence and conclude for each individual board member whether they are fit and proper.
- Any adverse findings (breach) or mitigations must be evidenced with a written record.
- Is there a breach?
  - Yes: see 'FPPT breach identified' section below
  - No: continue to step 3.

Step 3: Chair

- Reviews the executive director FPPT results.
- Once satisfied that the testing for all board members is complete, ESR has been updated accurately and a conclusion can be drawn, the FPPT sign-off field should be completed on ESR for each board member.
- SID/deputy chair to carry out FPPT on the chair and sign-off.
  - for a foundation trust: additional governance process via the council of governors.

Step 4: Company Secretary*

- Annual submission form completed by company secretary* to record the outcome of tests for each board member.

- Chair to review and check and sign declaration form.
  - for a foundation trust: additional governance process via the council of governors.

- Submission to NHS England regional director (alternative arrangements for ALBs).

Step 5: NHS England Regional Director (RD)

- RD will review annual submission (and any ad hoc submissions) and respond back to the NHS organisation as a record of receipt.

- RD will copy to FPPT Central team (NHS England – WTE directorate).

Step 6: FPPT Central Team

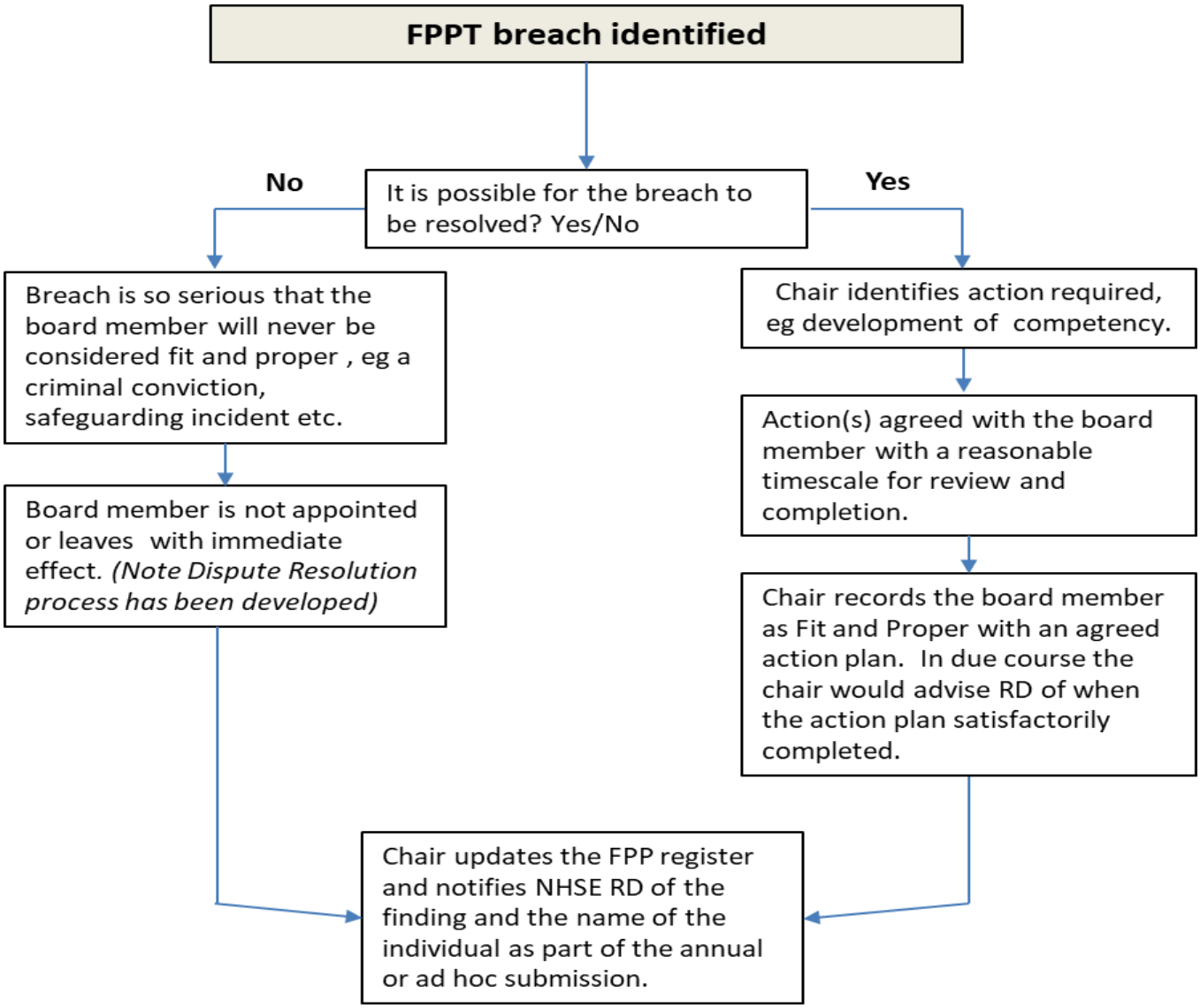
- FPPT team will collate records from NHS England regions.

*** Or senior members of staff nominated by and on behalf of the chair, eg HR Director or their nominee.**

FPPT breach identified

As above, this process is illustrated in Flowchart 2 below, and expanded text beneath:

Flow Chart 2 – FPPT Breach Identified



Is it possible for the breach to be resolved?

- If yes:
  - Chair identifies action required, eg development of competency.
  - Action(s) agreed with the board member, with a reasonable timescale for review and completion.
  - Chair records the board member as fit and proper with an agreed action plan. In due course, the chair would advise RD of when the action plan is satisfactorily completed.
- If no:
  - Breach is so serious that the board member will never be considered fit and proper, eg a criminal conviction, safeguarding incident, etc.
  - Board member is not appointed or leaves with immediate effect. (Note – dispute resolution process has been developed.)
- In either case, process is concluded by chair updating the FPP register and notifying the RD of the finding and the name of the individual as part of the annual or ad hoc submission.

2. Executive Summary

2.1 The 'fit and proper persons' test set out in Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities)* Regulations 2014 (referred to as the 2014 Regulations) came into force on 27th November 2014 and is aimed at making sure those individuals who have authority in organisations that deliver care, are responsible for the overall quality and safety of that care, and can be held accountable if standards of care do not meet legal requirements.

This has now been revised in line with the recommendations from the Kark Review and the NHS England Fit and Proper Person Framework for board members (August 2023).

2.2 The policy applies to all **board appointments** i.e., Executive and Non-Executive Directors. It also applies to those in a Deputy Director role permanent, interim, and Associate NED positions, irrespective of their voting rights.[1]

2.4. The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to ensure evidence is made available to the CQC on request.

2.5 The Company Secretary/Associate Director of Corporate Governance will ensure the compliance with this policy, working closely with the Workforce Team and will ensure that evidence of compliance is maintained on the personal files of those directors identified above.

2.6 The Company Secretary/Associate Director of Corporate Governance will complete and annual submission form to record the outcome of tests for each Board member. This form will be submitted to the Regional Director of NHS England.

2.7 Where matters are raised that cause concerns relating to an individual being fit and proper to carry out their role the Chair will address this in the most appropriate, relevant and proportionate way.

2.8 Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance. Where this does not lead to a satisfactory resolution for the board member, other options are available as detailed in section 5.7.1.

3. Purpose & Scope

3.1 The policy applies to all board appointments i.e., Executive and Non-Executive Directors. It also applies to those in a Deputy Director role, permanent, interim, and Associate NED positions, irrespective of their voting rights. **(Appendix One).**

3.2 Implementation of the Policy ensures the Trust complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement. The requirement was introduced to ensure that those individuals who have authority in organisations that deliver care are responsible for

[1] See Appendix One for list of individuals which is reviewed annually by the Company Secretary/Associate Director of Corporate Governance

the overall quality and safety of that care and as such can be held accountable if standards of care do not meet legal requirements.

3.3 Whilst providers have a general obligation to ensure that they only employ individuals who are fit for their role, the 'fit and proper persons' test must be applied to those individuals identified above and there must be systems and processes in place to provide ongoing assurance that the requirements are met. There is a duty on the organisation to take actions to ensure ongoing compliance.

4. Duties & Responsibilities

Role	Responsibilities
Chair	Discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Once satisfied the test for all Board members is complete, the Chair will complete the FPP sign off on ESR.
The Company Secretary/Associate Director of Corporate Governance	To maintain this policy and oversee implementation, conducting an audit of personal files for all existing Directors for review and sign off by the Trust Chair. To manage the annual self-attestation process on behalf of the Chair. Complete the annual submissions form to record outcome of tests for each Board member. Submit to regional Director NHSE.
Chief People Officer	Ensure support is provided in compiling an evidence checklist prior to appointment.
Senior Independent Director (SID)	Oversees the application of the Fit and Proper Person role for the Chair. Additionally, with the support of the Company Secretary/Associate Director of Corporate Governance the SID can undertake investigations into any concerns raised about the Chair, including where the Chair has notified the SID they may no longer comply with Fit and Proper Persons requirements.
Audit Committee	To review and approve the policy on behalf of the Trust Board. To receive an annual report on the effectiveness of and compliance with this policy.
Trust Board	To receive an annual report on the effectiveness of and compliance with this policy.

Council of Governors	To receive an annual report on the effectiveness of and compliance with this policy.
The Board & Deputy Directors	To complete the fit and proper person requirements and provide evidence to support requirements.
Freedom to Speak Up Guardian	To complete the fit and proper person requirements and provide evidence to support requirements.
Regional Director of NHS England	Will review the annual submission and respond back to the organisation as record of receipt and will copy to the FPP central team
FPPP Central Team	Will collate records from NHSE regions.
CQC	The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations.

5. Policy Details

5.1 Meeting the Requirements of Regulation 5 and the NHS England Fit & Proper Person Test Framework for Board Members

5.1.1 The introduction of the fit and proper person's requirements (FPPR) places the ultimate responsibility on the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Further detail is provided in the CQC Guidance for providers and CQC inspectors, January 2018[2]

5.1.2 The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to the Care Quality Commission on request.

5.1.3 Individuals who fall into the categories listed in **Appendix Three** must satisfy the Chair that they:

- are of good character
- have the necessary qualifications, competence, skills and experience
- are able to perform the work that they are employed for after reasonable

[2] CQC Guidance_fit_and_proper_person_policy_Jan_2018

adjustments are made
- have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of any regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
- can supply information as set out in Schedule 3 of the Act, i.e. documentation to support the FPPR.

5.1.4 When assessing whether a person is of good character, Paragraph 5 (4) of the regulation states that trusts should make every effort to ensure that, as a minimum, they seek all information to confirm the matters listed in Part 2 of Schedule 4.

5.1.5 In accordance with Part 2 of Schedule 4, a person will fail the good character test if they:

- have been convicted in the United Kingdom or elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

5.1.6 Part 1 of Schedule 4 lists categories of 'unfitness' that would prevent people from holding office or necessitate their removal from their position as a director, and for whom there is no discretion. An individual can be deemed 'unfit' if, they:

- are an undischarged bankrupt
- are the subject of a bankruptcy order or an interim bankruptcy order
- are subject to a moratorium period under a debt relief order
- have an undischarged arrangement with creditors
- are on any barring list that stops them working with children and / or vulnerable
  adults, and
- are not prohibited from holding the position under any other law (e.g. under the
  Companies Act or Charities Act)

5.2 General Document Principles

5.2.1 New Appointments

In order to confirm that an individual is of good character, the Trust, or nominated representative, will undertake pre-employment checks as determined by the NHS employment standards[3]. These will include:

- Employment history:*
  – to include detail of all job titles, organisation departments, dates, and role descriptions.
  – Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained

- Board Member Reference A standardised board member reference process will be followed (as detailed in the NHSE Fit and proper Person Framework and using the Board member Reference Template **(Appendix Four).**

If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

- qualification and professional registration checks (the original for inspection and verification)
- right to work check
- proof of identity
- an appropriate DBS check (on a case-by-case basis and if they have a role that falls within the DBS eligibility criteria). Including date DBS received.
- search of insolvency and bankruptcy register
- disqualified directors check
- Disqualification from being a charity trustee check.
- Social Media check
- Medical Clearance Dated (including confirmation of OHA)
- Employment tribunal judgement check
- Disciplinary findings – That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement relevant to FPPT, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.

[3] NHS Employers Employment Check Standards, the Rehabilitation of Offenders Act (1974), guidance issued from the Disclosure and Barring Service (DBS), statutory guidance for Regulated Activity and Home Office

- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Self-attestation form signed **(Appendix Two)**
- Sign-off by chair/CEO.
- NHS FPPT letter of confirmation submitted to the Regional Director NHS England **(Appendix Five)**

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

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5.2.2 The above will be overseen by the Chief People Officer & Company Secretary/Associate Director of Corporate Governance and evidence of the checks will be documented on the individual's personal file and saved on ESR.

5.2.3 An Annual NHS FPPT submission report will be submitted to the Regional Director NHS England **(Appendix Six).**

5.3 Annual Review of Existing Directors

5.3.1 The Trust shall regularly review the fitness of directors to ensure that they remain fit for the roles they are in. The following processes will take place annually:

- An audit of the retained evidence of documentation required as listed above (5.2.1)
- Verification of the documentation completed for the director appraisals.
- A completed Declaration of Interest form (via Civica Declare[4])
- Self-attestation form signed to be completed as part of annual appraisal **(Appendix Two)**
- Sign-off by chair/CEO.
- An Annual NHS FPPT report will be submitted to the Regional Director NHS England **(Appendix Six)**

5.3.2 The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust's values and behaviours Framework.

[4] Civica Declare is the Trusts fully integrated end-to-end cloud governance software, enabling declarations of interest to be captured and published, Declarations are publicly available on the Trusts Website.

5.3.3 The Chief Executive Officer (CEO) will be responsible for appraising Executive Directors; the Chair will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chair and the Chair will be appraised by the Senior Independent Director which will include feedback from Governors.

5.3.4 Copies of the appraisal and evidence of the annual FPP review process will be kept on the individual's personal file and on ESR (see section 5.5).

5.4 Additional Considerations

There will be additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence. These additional considerations, are listed below and full detail are given with in the NHS England Fit and Proper Person Test Framework for board members:

- **Joint appointments across different NHS organisations** - Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system. For instance, where joint appointments of a board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care.

- **Shared roles within the same NHS organisation** - Where two individuals share responsibility for the same board member role (eg a job share) within the same NHS organisation, both individuals should be assessed against the FPPT requirements

- **Temporary Absence** - For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (eg sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same board member. As such there is no requirement to approve another permanent individual for the role of board member.

5.5 Record Retention

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally.

All Board members will receive the Board Member PPPT Privacy Notice, with details on the type of personal information the Trust will collect and process **(Appendix Seven).**

5.5.1 Information held in ESR

NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care. Data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members.

The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

ESR will hold information about each board member in line with the criteria detailed below in section 5.5.2.

The following individuals have access to the FPPT fields in ESR:

- Chair
- Chief Executive Officer (CEO)
- Senior Independent Director (SID)
- Deputy Chair
- Company Secretary
- Human Resources Director (HRD)/chief people officer (CPO).

Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The ESR FPPT data fields will be maintained to ensure information about the serving board member is current.

This will mean that ESR is specifically updated for:

- All board members within an NHS organisation
- New board members who have been appointed within an NHS organisation
- Whenever there has been a relevant change to one of the fields of FPPT information
  held in ESR (as per section 5.5.2 below)

- Updates for annual completion of the full FPPT
- Annual completion of FPPT confirmed by chairs.

The Trust will conduct an annual review to verify that ESR is appropriately maintained. The chair will be accountable for ensuring that the information in ESR is up to date for their organisation supported by the Company Secretary/Associate Director of Corporate Governance.

5.5.2 The information that ESR will hold about board members is detailed below

- First name*
- Second name/surname*
- Organisation* (that is, current employer)
- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
  - This would include detail of all job titles, organisation departments, dates, and role descriptions.
  - Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- References:*
  - Available references from previous employers, board member references, including resignations or early retirement. Using the Board Member Reference Template **(Appendix Four)**
- Last appraisal and date
- Training & Development

- Disciplinary findings
  - That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement relevant to FPPT, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
- Date DBS received* †
- Disqualified directors register check

- Date of medical clearance* (including confirmation of OHA)
- Date of professional register check (e.g. membership of professional bodies)
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference (BMR)*
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

The annual FPPT requires an NHS organisation to validate all fields above – except for:
* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.
† While not requiring annual validation, DBS checks will be done on a three-year cycle

5.6 Dealing with Concerns

5.6.1 Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person and provide details of the issue.

5.6.2 If the Trust discovers at any point, information that suggests an individual does not meet the 'Fit and Proper Persons' criteria, the matter shall be referred immediately to the identified concern handler **(see Appendix Three).**

5.6.3 The investigation/inquiry lead **(see Appendix Three)** shall take appropriate and timely action to investigate and rectify the matter, taking expert advice as necessary and ensuring any issues are dealt with in accordance with the relevant Trust's policies. Any concerns will be referred to the Nomination & Remuneration Committee for Executive Directors; for Non-Executive Directors, the Council of Governors' Nominations & Remuneration Committee will determine the course of action. Where appropriate, findings in relation to a person's fitness may be referred to the relevant professional / regulatory body(ies).

5.6.4 The investigation/inquiry lead, in discussion with the relevant Committee, will put in place interim arrangements, if required, during any period of

investigation. The suspension or removal of any Director will be in accordance with Trust policy, with the decision to remove resting with the Nomination & Remuneration Committee for Executive Directors and with the Council of Governors' Nominations & Remuneration Committee for Non-Executive Directors.

5.7 Dispute resolution

5.7.1 Data and information

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and NEDs and ICB Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the SID or deputy chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
  - referring the matter to the ICO
  - (for Executive Director roles only*) taking the matter to an employment tribunal (ET)
  - instigating civil proceedings.

5.7.2 Outcome of FPPT assessment

Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles
  - the matter will be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.

- where this results in a board member being terminated from their appointed role, a Board Member Reference (BMR)** must be completed and retained by the local organisation in accordance with the Fit and proper Person Framework.

- For non-NHS England-appointed roles (executive and non-executive) – Trust policy and constitution arrangements will be followed. The Trust may take legal advice or seek advice from NHS England. At any point, employees have the right to take the matter to an ET*.

* Chair and non-executive board members cannot take their organisation to ET (Employment Tribunal) unless in relation to discrimination, but they can instigate civil proceedings.

** Exit BMR to be drafted by chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.

6. Document monitoring

6.1 The Fit & Proper Person Policy and procedure is reviewed and approved through the Audit Committee on behalf of the Trust Board.

6.2 The Audit Committee, Trust Board and Council of Governors will receive an annual report on the effectiveness of, and compliance with this policy and the NHS England Fit and Proper person Framework.

6.3 An annual submission will be made to Regional Director NHS England, confirming all Board members satisfy the fit and proper person test requirements (**Appendix Six)** Annual NHS FPPT submission reporting template)

7. Glossary of Terms

- **Fit and proper persons' test** - A test set out in regulation 5 of the Health and Social Care Act to define and assess the ongoing good character of very senior employees.
- **Disclosure and Barring Service (DBS) -** DBS is an executive non-departmental public body of the Home Office. It helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.
- **Disclosure -** Document containing information about an individual's criminal records.
- **Insolvency and bankruptcy register** – government register listing Directors who have been declared bankrupt or insolvent.

- **Civica Declare** - The Trusts fully integrated end-to-end cloud governance software, enabling declarations of interest to be captured and published.

8. Associated Documents

- Disciplinary Policy
- Conflicts of Interest Policy
- Verification of Professional Registration Policy
- Employee Performance Management Policy & Procedure
- Recruitment and Selection Policy
- Freedom to Speak Up: Raising Concerns (Whistleblowing)
- Managing Conflicts of Interest Policy
- Professional Clinical Registration Policy
- Recruitment and Selection Policy

9. Sources/References

CQC Guidance: Fit and Proper Persons
Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2009
http://www.legislation.gov.uk/ukdsi/2009/9780111487006/contents
DBS Referral Guidance
https://www.gov.uk/government/organisations/disclosure-and-barringservice/series/dbs-referrals-guidance--2
NHS Employers. Employment Checks
https://www.nhsemployers.org/your-workforce/recruit/employment-checks
Safeguarding Vulnerable Groups Disclosure and Barring Arrangements.
CCS0119367774-001_Barring_Referrals_Document__Flowchart_A5_Booklet_V3_DG-2.pdf (publishing.service.gov.uk)
Bribery Act 2010, c.23
http://www.legislation.gov.uk/ukpga/2010/23/contents
Fraud Act 2006, c.35
http://www.legislation.gov.uk/ukpga/2006/35/contents
Kark Review of the Fit and Proper Persons Test - 2019
Kark review of the fit and proper persons test - GOV.UK (www.gov.uk)
NHS England: Fit and Proper Persons Test Framework – for Board Members
PRN00238-i-Kark-implementation-fit-and-proper-person-test-framework.pdf (england.nhs.uk)

10. Training Needs Analysis

Staff Role	Training Requirement	Frequency	Training Delivery Method
Appropriate training documentation will be provided to those who carry out checks or have other responsibilities under this policy.	Fit and proper Persons Regulation and Fit and Proper Person Framework training on local induction.	One off training	Reading CQC Fit and Proper Persons Regulation, the WHH Fit & Proper Persons Policy and the NHSE Fit and Proper Persons Framework To be marked as completed by Company Secretary.

If training is required, please consider the following: who needs the training (and how often); who will deliver it and how will they do this (e.g. duration/ location); what are the objectives it will meet and how will you assess learner competence; how quickly do staff need to be trained and do we have the resources to deliver this; are there any funding implications; where will completion of this training be recorded (and who will do this).

Please refer to Trust Procedural Document Control Policy for support on how to complete this section and who to contact.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix One: Roles Subject to Fit and Proper Person Test / Requirement

Roles Subject to Fit & Proper Person Test/Requirement

Title	Named Posts
Chair	
Non-Executive Directors	
Associate Non-Executive Directors	
Executive Directors	Chief Executive
	Deputy Chief Executive
	Chief Finance Officer
	Chief Nurse
	Chief Operating Officer
	Executive Medical Director
	Chief People Officer
Non-Voting Directors	Director of Strategy & Partnerships
	Director of Communications & Engagement
Company Secretary/Associate Director of Corporate Governance	
Freedom to Speak Up Guardian	
Deputy Executive Directors	Deputy Chief Finance Officer
	Director of Integrated Governance and Quality
	Deputy Chief Nurse (s)
	Director of Operations and Performance/Deputy Chief Operating officer
	Deputy Executive Medical Director
	Deputy Chief People Officer

*Job roles not on this list are not within the scope of the Fit and Proper Person Regulations

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix Two: Fit and Proper Persons Test annual / new starter self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to complete as applicable, eg the company secretary] on behalf of the chair.

Fit and Proper Person Test annual/new starter self-attestation

Warrington and Halton Teaching Hospital NHS FT

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.
Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	

Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix Three: Allocation of roles when Dealing with Concerns

Allocation of roles when Dealing with Concerns (5.4)

Subject of Concern	Concern Handler	Investigation / Inquiry Lead	Determining Body
• Trust Chair	SID, Company Secretary	SID, Company Secretary & Lead Governor	Governor Nominations & Remuneration Committee (GNARC)
• Chief Executive • Executive Directors	Trust Chair *At the discretion of the Chair, they may involve the Senior Independent Director (SID), relevant Non-Executive Director (NED) or where appropriate, external advisors.	Trust Chair	Nominations & Remuneration Committee (NARC)
• Non-Executive Director • Associate Non-Executive,	Trust Chair *At the discretion of the Chair, they may involve the Senior Independent Director (SID), relevant Non-Executive Director (NED) or where appropriate, external advisors.	Trust Chair	Governor Nominations & Remuneration Committee (GNARC)
• Deputy Directors • Freedom to Speak Up Guardian	Chief Executive *all concerns will be notified to the Trust Chair	Chief Executive	Nominations & Remuneration Committee (NARC)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix Four: The Board Member Reference Template

The board member reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Board Member Reference request for NHS Applicants:
To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)

B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*		
5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		

7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □

If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)?	Yes □	No □

(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □

If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix Five: Letter of Confirmation

Letter of confirmation

[DATE]

Dear [CHAIR NAME[5]],

Fit and Proper Person Test

This confirmation letter is provided in connection with [name of board member, job title of board member, organisations that the joint board member post covers] for [year of test, eg 2023/24] as at [date of conclusion of annual[6] FPPT for the individual] for the purpose of the Fit and Proper Person Test.

As Chair of Warrington & Halton Teaching Hospitals NHS FT, I confirm that I have carried out the Fit and Proper Person Test for [name of board member].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [name of board member] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [name of board member] is fit and proper as at [date of conclusion of test], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

[5] This is the name of the chair of the other organisation that the joint board appointment is made with.

[6] It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

I confirm that I have received the outcome for the FPPT for [name of board member] and that I have provided any necessary information for you to reach this conclusion.

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix Six: Annual NHS FPPT Submission Reporting Template

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: FPPT outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	**Completed by (role)**	**Name**	**Date**	**Fit and proper? Yes/No**
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	**Yes/No**	**If 'no', provide detail:**		
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	**Yes/No**	**If 'yes', provide detail:**		
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix Seven: Board Member FPPT Privacy Notice

Board Member FPPT Privacy Notice

Warrington & Halton Teaching Hospitals NHS Foundation Trust is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The FPPT in ESR is commissioned by NHS England.

Contact: **Carl Roberts, Associate Chief People Officer**
Address: **Warrington & Halton Teaching Hospitals NHS Foundation Trust, Lovely Lane, Warrington, WA5 1QG**
Phone Number **01925 662253**
Email: **carl.roberts@nhs.net**

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. **Name, position title (unless this changes).**
2. **Employment history – this includes details of all job titles, organisations, departments, dates, and role descriptions.**
3. **References.**
4. **Job description and person specification in their previous role.**
5. **Date of medical clearance.**
6. **Qualifications.**
7. **Record of training and development in application/CV.**
8. **Training and development in the last year.**

9. **Appraisal incorporating the leadership competency framework has been completed.**

10. **Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.**

11. **DBS status.**

12. **Registration/revalidation status where required.**

13. **Insolvency check.**

14. **A search of the Companies House register to ensure that no board member is disqualified as a director.**

15. **A search of the Charity Commission's register of removed trustees.**

16. **A check with the CQC, NHS England and relevant professional bodies where appropriate.**

17. **Social media check.**

18. **Employment tribunal judgement check.**

19. **Exit reference completed (where applicable).**

20. **Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.**

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements. [If applicable] We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, eg CQC and NHS England.

We use the information that you have given us to:

- Conclude whether or not you are fit and proper to carry out the role of Board Director
- Inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies. Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our policies and procedures.

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.
- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.

- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.

- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.

- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.

- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.

- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at whh.dataprotection@nhs.net, 01925 635911 (internal ext 5673), Data Protection Officer, Warrington & Halton Teaching Hospitals NHS Foundation Trust, Lovely Lane, Warrington, WA5 1QG.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at [Insert your organisation's contact details for data protection queries]. You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Equality Impact Assessment

1. **This section asks you to consider a few questions relating to your policy, process, procedure or decision.**

Initial Screening	Yes	No
1.1. Does your policy affect people (Patients/Workforce/Public)?	☒	☐
1.2. Does the policy affect one or more group of people in a different way to another?	☐	☒
1.3. Does the policy offer opportunity to promote equality?	☒	☐

1.4. Does your policy impact positively, negatively or neutrally on any of the below characteristics/groups?
If yes, please indicate how and which type (positive or negative) in the 'Barriers/Impact' section:
Neutral impact is where there will be no change in actual/potential impact on this protected group.

Initial Assessment	Scale	Barriers/Impact
▪ Age	Neutral	No barriers/impact have been identified as part of the policy review.
▪ Disability - learning disabilities/difficulties, physical/hidden disability, sensory impairment and mental health problems	Yes	Positive – the policy defines how reasonable adjustments would be applied to / put in place for an individual as part of the fit and proper person's review. This would not be taken into account prior to a reasonable adjustment being applied therefore not disadvantaging someone who requires a reasonable adjustment to complete their work. Positive – language used within the policy has also been updated to be reflective of the inclusive language guidance developed by the Trust.
▪ Gender reassignment	Yes	Positive – the language of this policy has specifically been reviewed through an inclusive lens. Terminology referring to s/he has been removed to be gender inclusive.
▪ Race	Neutral	No barriers/impact have been identified as part of the policy review.

▪ Religion or belief	Neutral	No barriers/impact have been identified as part of the policy review.
▪ Sex	Yes	Positive – the language of this policy has specifically been reviewed through an inclusive lens. Terminology referring to s/he has been removed to be gender inclusive.
▪ Sexual orientation including lesbian, gay and bisexual people	Yes	Positive – the language of this policy has specifically been reviewed through an inclusive lens. Terminology referring to s/he has been removed to be gender inclusive.
▪ Marriage and civil partnership – including same sex relationships	Neutral	No barriers/impact have been identified as part of the policy review.
▪ Pregnancy and maternity/paternity	Neutral	No barriers/impact have been identified as part of the policy review.
▪ Carers	Neutral	No barriers/impact have been identified as part of the policy review.
▪ Social factors - deprivation, homelessness, education etc.	Neutral	No barriers/impact have been identified as part of the policy review.
▪ Armed Forces and Military Veterans	Neutral	No barriers/impact have been identified as part of the policy review.

1.5.	Is the impact of the policy likely to be negative?	☐ **Yes**	☒ **No**

1.6.	If yes, please summarise if the impact can be avoided or are there any alternatives?	

1.7.	Does your policy support positive action for underrepresented groups.	☐ **Yes** ☐ **No** ☒ **N/A**

If you have answered no and neutral to all of the questions in section 1 then a full Equality Impact Assessment is not required. Where you have answered yes, please move to section 3.

2. Does your policy support the general aims of the Public Sector Equality Duty (Equality Act 2010)?

Yes ☒ **No ☐**	**1.** Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Equality Act 2010 **2.** Advance equality of opportunity and remove disadvantages between those who share a protected characteristic and those who do not

	3. Foster good relations between people who share a protected characteristic and those who do not

3. Please assess your proposals analysis equality reference scale:

☐	**High –** This policy shows a **high degree of negative or positive** impact to one or more protected characteristics or one or more general aims of the Equality Act 2010 or Armed Forces Act 2021 (where rationale cannot be justified)
☐	**Medium –** This policy shows a **medium degree of impact** (positive or negative) to one or more protected characteristic.
☒	**Low –** This policy **does not have any impact to any protected characteristic** or general aim of the Equality Act 2010 or Armed Forces Act 2021.

If your analysis has scored **high**, then a full Equality Impact Assessment should be completed (Stage 2). This can be found here. If your analysis has scored **low or medium** when considering the evidence detailed above, then a full Equality Impact Assessment may not be required.

If you require any support, please contact the Equality, Diversity and Inclusion Team at whh.equalityimpactassessments@nhs.net

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/148**
SUBJECT:	Membership Strategy 2023-2025
DATE OF MEETING:	6 December 2023
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): ***(Please DELETE as appropriate)***	**#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation, and financial position.
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	The WHH Membership Strategy builds on the success of our Working with People and Communities Strategy 2022-2025 and seeks to help us progress as a Foundation Trust that better supports its members and actively recruits new members. The strategy will address how we plan to communicate and engage with our members'. The strategy is reflective of the Trust Strategy

	("Our Strategy 2023-25") which articulates our Vision to be a great place to receive healthcare, work and learn. Taking on board the discussions at GEG and Council of Governors meetings it is recognised that a standalone Membership Strategy will help to improve membership recruitment and engagement and enable the Council of Governors set implementation plans to successfully deliver the objectives set out within the Strategy. **The Objectives are:** **Objective 1**: **High Quality Information** Provision of high-**quality** Information to WHH Members to provide them with the knowledge they need to understand the offer of membership at WHH and to be ambassadors for the Trust. **Objective 2: Inclusivity** Ensure our membership is reflective of the different **people** and communities, we serve, with a focus on attracting younger members and those from groups that are currently underrepresented. **Objective 3: Sustainability** Taking meaningful steps so we can make sure that we are promoting **sustainability** in all membership communications and activities. The strategy details the Governance arrangements around reporting on the progress against the 3 objectives. The Governor Engagement Group and Council of Governors will receive quarterly progress reports. The Membership Strategy has been approved by the Council of Governors at its meeting on the 9th November 2023 and is now being presented to Board for ratification.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to ratify the WHH Membership Strategy 2023 - 25		
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors	
	Agenda Ref.	**COG/23/11/69**	
	Date of meeting	9 November 2023	
	Summary of Outcome	Approved	

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Membership Strategy

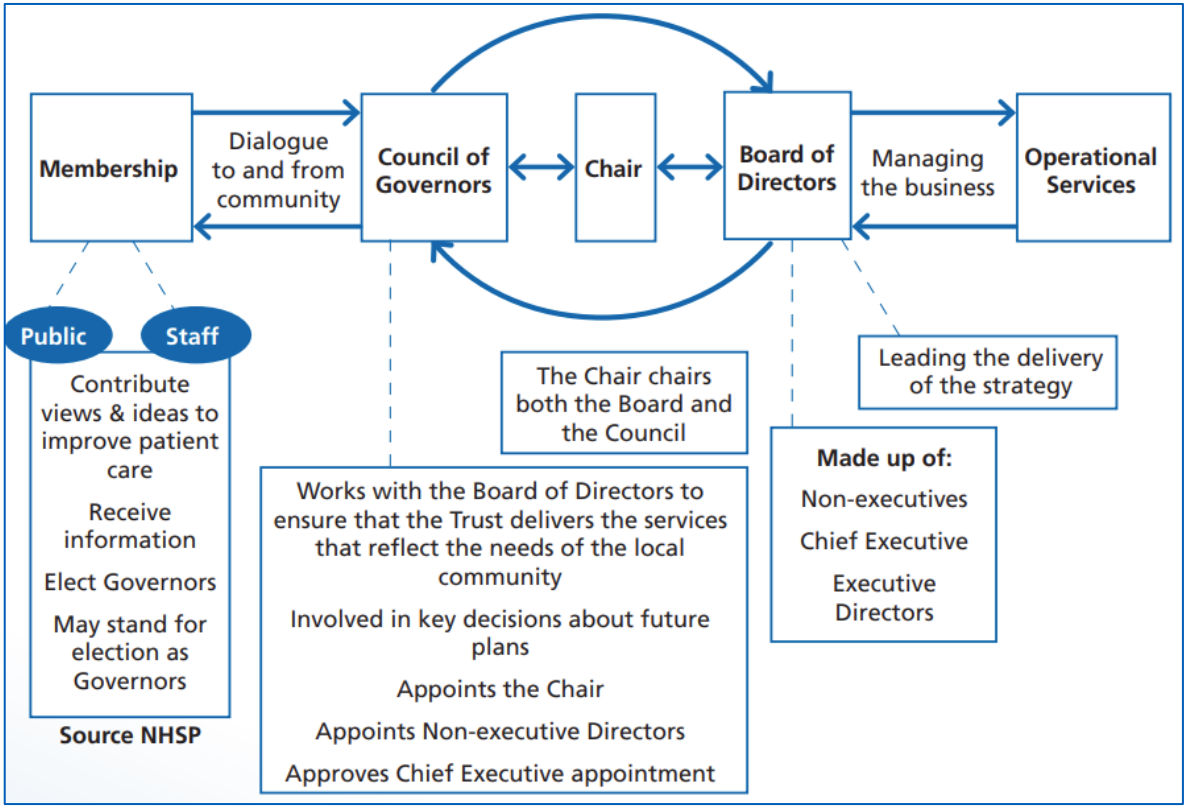
2023 - 2025



Introduction and Context

Warrington & Halton Teaching Hospitals (WHH) NHS FT, achieved Foundation Trust status in 2008. A Foundation Trust is an NHS organisation which gives greater opportunities for people, patients and staff who have an interest in the Trust to have more of a say about the way in which services are provided. Foundation Trust status is only awarded to hospitals who have shown they demonstrate the highest clinical standards, quality leadership and a great record of patient responsiveness and safety.

As a Foundation Trust WHH is accountable to the local community, the patients it cares for and the people it employs through its membership. By becoming members, local people and our staff can have a say in how services will be designed and delivered, and by becoming or voting for Governors, perform a vital role in holding non-executive Board members to account for the performance of the Trust. As such an involved, informed, representative and vibrant membership is integral to the anchoring of the Trust to our Integrated Care System (ICS) of Cheshire & Merseyside and delivering the WHH mission to be outstanding for our patients, our communities and each other. This vital linkage between membership and the Trust is illustrated through the diagram below.



We strive for our membership to reflect the broad and diverse public communities we serve as well as patients, their families and carers, and our staff. CIVICA Engagement Services (CES) is our membership database provider, they hold and manage our public membership data. Members of the public can become a member of WHH by completing an online form https://secure.membra.co.uk/join/warringtonhalton. Staff automatically become a member of the Trust when they are employed.

Members are grouped into the following constituencies:

Public

- Warrington North
- Warrington South
- Halton
- Rest of England

Staff

- Medical
- Nursing and Midwifery
- Support
- Clinical Scientists or Allied Health Professional
- Estates, Administration & Managerial

This Membership Strategy builds on the success of our Working with People and Communities Strategy 2022-2025 and seeks to help us progress as a Foundation Trust that better supports its members and actively recruits new members. The strategy will address how we plan to communicate and engage with our members'. The strategy also ties in with the Trust Strategy "Our Strategy 2023-25" which articulates our Vision to be a great place to receive healthcare, work and learn.

The strategy will seek to address ways to retain active members and recruit new members particularly from underrepresented groups. Most importantly, it aims to show members that their contributions towards the development of the Trust are valued. The Membership Strategy run will from 2023 until 2026 with the following key themes:

- High-Quality Information
- Inclusivity
- Sustainability

Definitions

NHS – National Health Service

GEG – Governor Engagement Group

CoG – Council of Governors

Constitution – Is a document that sets out the rules for how the organisation is governed.

Integrated Care System (ICS) – WHH is part of The Cheshire and Merseyside Integrated Care System. Integrated care systems (ICSs) are partnerships that bring together the health and care organisations in a particular local area, to improve population health and healthcare, tackle unequal outcomes and access, enhance productivity and value for money and help the NHS to support broader social and economic development.

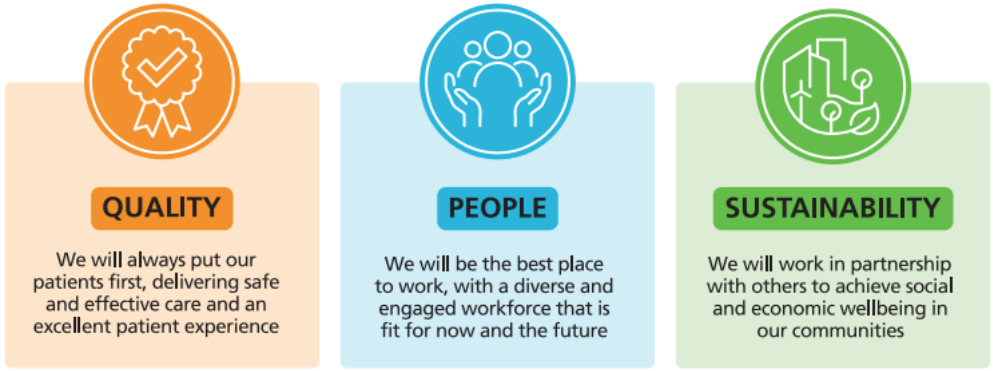
Engagement

The Governor Engagement Group (GEG) is a subcommittee of the Council of Governors at WHH and is chaired by a public Governor. It has delegated authority from the Council of Governors to make decisions on behalf of and be accountable to the Council of Governors with regards to ensuring WHH is effectively recruiting and engaging with its membership, reviewing the membership priorities as well as representing the interests of the patients, carers, families and the general public in the areas served by the Trust. The Governor Engagement Group will be consulted on the content of the Membership Strategy, they will be responsible for reviewing it and recommending the Strategy for approval by the Council of Governors.

A key element in achieving success is to build on the partnerships we have as well as developing new ones. This includes relationships with internal and external stakeholders, some examples of these stakeholders are; patients & their families, carers, public, staff, Multi-Ethnic Staff Network, PROGRESS Staff Network – supporting the LGBTQIA+ Community, Disability Awareness Network, Armed Forces and Military Veterans Community Staff Network, WHH Charity, Experts by Experience, Warrington & Vale College, Warrington Council, Halton Council, Chester University, Volunteers and Warrington Sikh Gurdwara.

Our partners will help us steer the membership directive so that the priorities can be achieved, it is important that we get people involved and embed the themes into the organisation through the wider Strategic Aims and the 12 Strategic Objectives that sit beneath, as per ‘Our Strategy 2023-25’.

WHH Strategic Aims:



Strategic Objectives

The membership strategy will seek to address ways to increase the recruitment and retention of active members ensuring we are not just attracting people to become members but also keeping our current members informed and engaged. Most importantly, it aims to show members that their contributions towards the development of the Trust are valued. The new strategy will run from 2023 until 2026 with the following objectives:

1. **High Quality Information**
   Provision of high-**quality** Information to WHH Members to provide them with the knowledge they need to understand the offer of membership at WHH and to be ambassadors for the Trust.

2. **Inclusivity**
   Ensure our membership is reflective of the different **people** and communities, we serve, with a focus on attracting younger members and those from groups that are currently underrepresented.

3. **Sustainability**
   Taking meaningful steps so we can make sure that we are promoting **sustainability** in all membership communications and activities.

Strategic Objective 1 – High Quality Information				
Priorities	**Actions**	**Outcomes**	**Measurements**	**Owner**
Educate current and prospective members on the membership offer at WHH. Reinforcing the various ways members can contribute their views, thoughts and ideas to help shape WHH and showcasing what the Trust is doing in response to the feedback received. Keep members and partners updated on developments at WHH plus the activity of the Council of Governors so that we can promote engagement and also attract new members. Retention of active members and recruitment of new Members. Development of suitable Induction Training for newly elected Governors & Development Training for current Governors	Intentional and consistent use of social media channels as well as traditional methods like email to communicate messages. Refining the membership offer and the role of the Governors by breaking down the benefits through infographics and videos. Online/hybrid surveys or polls and questionnaires to understand how members feel about the membership. Hosting information events on topics that members tell us are important to them. Performing a database cleanse – to retain active members and identify underrepresented groups, which will then be a target for recruitment activities. The Governor Engagement Group to be involved in the development of agendas for Governor Induction and Development Training	Events will be better attended by Members. WHH Newsletter circulated at least 3 times per year to those Members we have email addresses for. Meaningful and targeted induction and development training programmes for Governors.	Number of public and staff members attending Trust events.	Governor Engagement Group All Governors Corporate Governance & Membership Manager Head of Communications & Engagement

Strategic Objective 2 – Inclusivity				
Priorities	**Actions**	**Outcomes**	**Measurements**	**Owner**
Focusing on reaching out to the target groups which are underrepresented such as under 35's, public male members as well as those in ethnic minority groups. Simplifying our communications so that the message is clear and accessible.	Introduce a Member Welcome letter, explaining the benefits of FT Membership at WHH Refresh the Trust Newsletter with a focus on Membership. Partnering with internal stakeholders such as staff networks, patient experience colleagues and so on for joint collaborative work that promotes the membership across teams. Partnering with external stakeholders such as schools, youth groups, colleges, universities, religious centres, and other health related forums to explore areas of joint working. Making communications accessible such as videos and in alternative languages and formats. Target our staff members by ensuring our staff Governors are more visible across the Trust.	Increase the understanding of the benefits of FT membership. More frequent circulation of a Trust Newsletter – at least 3 times per year. Posters of Governors printed and visible across Trust sites	An increase in members from the underrepresented groups, this will be measured using the analytic tools available on Civica Engage Increased Governor attendance at Community events particularly those with a target audience of underrepresented groups.	Governor Engagement Group All Governors Corporate Governance & Membership Manager Head of Communications & Engagement Director of Communications & Engagement

Strategic Objective 3 – Sustainability				
Priorities	**Actions**	**Outcomes**	**Measurements**	**Owner**
Being environmentally conscious in production of our marketing material. Playing an active role in contributions to the sustainability agenda at WHH. Carrying out a database cleanse to Improve the quality of the data we hold for public members, retaining active members only and recruit new members particularly from underrepresented groups.	Cutting back on the use of non-renewable materials and/ or opting for recyclable alternatives in all our print (posters, Newsletter, Handbooks, leaflets, etc) Using digital communications rather that paper/printed communications materials Asking members (who we hold postal addresses for only) to opt in to being a member of the Trust and to provide their email addresses, this will be included as part of the Governor Elections mail outs.	Develop creative and engaging membership communications using email, and social media. Increasing the number of email address we have for public members	An analysis of email circulations will show that members are reading emails/Newsletters for a longer period of time showing increased engagement with our revised communication methods. We will increase the number of email addresses we have for public members.	Governors Engagement Group All Governors Corporate Governance & Membership Manager Head of Communications & Engagement

Governance

The Governor Engagement Group (GEG) will be responsible for reviewing and supporting the implementation of this strategy to ensure that the objectives are achieved.

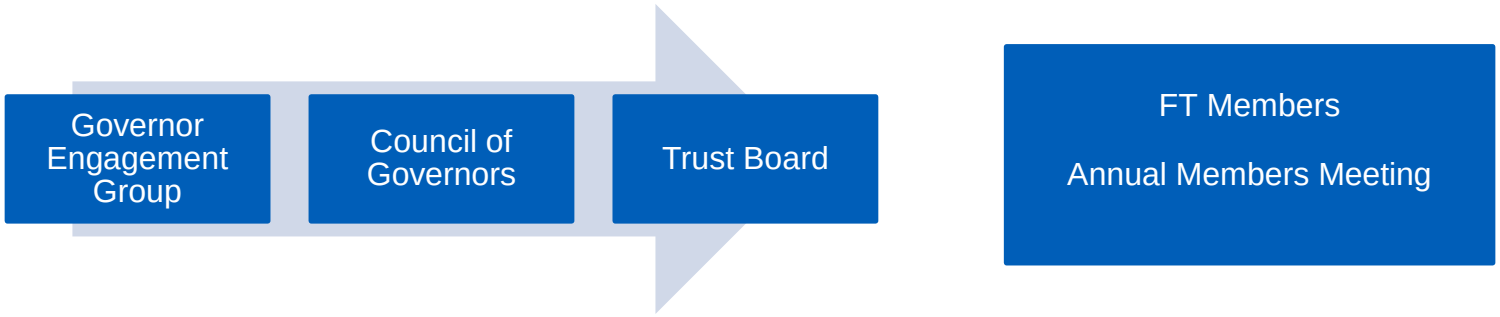
The GEG meet on a quarterly basis to review the membership numbers and demographics as well as level of engagement with membership communication materials and events. Through ongoing evaluation of the objectives as set out in the strategy, the GEG is responsible for fulfilling the priorities and reporting on progress into the Council of Governors quarterly at a formal meeting.

As stated within the Trust Constitution, The Council of Governors shall present to the members (at the Annual Members Meeting):

- a report on steps taken to secure that (taken as a whole) the actual membership of its Public Constituency and of the classes of the Staff Constituency are representative of those eligible for such membership.
- The progress of the Membership Strategy

In addition, the Council of Governors will present:

- a report on steps taken to ensure that the Trust's membership is representative of those eligible for membership.
- any changes to the Membership Strategy



Duties, Roles and Responsibilities

Governor Engagement Group – Responsible for reviewing and implementing this strategy to ensure that the priorities are achieved. They are responsible for fulfilling the priorities and reporting on progress into the Council quarterly and recommending approval of the Membership Strategy top the Council of Governors.

Council of Governors – Receiving quarterly progress reports against the priorities detailed within the strategy and approving the membership Strategy.

Governors – Ensuring they are familiar with the membership Strategy and use the strategy to guide them in their communications with members.

Trust Board – Receiving and ratifying the Membership Strategy

Lead Governor/Chair of the Governor Engagement Group – Reporting on steps taken to ensure that the Trust's membership is representative of those eligible for membership. any changes to the Membership Strategy the Annual Report and at the annual members meeting.

Approvals Log					
Stage 1		**Stage 2**		**Stage 3**	
Governor Engagement Group (1st Draft)	1st August 2022				
Governor Engagement Group (final)	1st November 2023	Council of Governors	9th November 2023	Trust Board	6th December 2023

Appendix

Matrix of enabling strategy priorities aligned to Trust Quality, People and Sustainability Aims.

	Trust Strategic Objectives 2023 - 2025	Objective 1	Objective 2	Objective 3
Quality	**1. Patient safety** We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	☑		
	2. Clinical effectiveness We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.	☑		
	3. Patient experience We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	☑		
	4. Research, Development and innovation We will work in partnership on high quality clinical research for the benefit of patients, public and staff.	☑		
People	**5. Looking after our people** We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.		☑	
	6. Innovating the way we work We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.		☑	
	7. Growing our workforce for the future We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.		☑	
	8. Belonging in WHH We will enable staff to have a voice through the development of a just and learning culture.		☑	
Sustainability	**9. Working in partnership** We will work collaboratively to provide sustainable, high quality acute services and to support prevention and integrated care in the community.			☑
	10. Working responsibly We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.			☑

	11. Sustainable estate and digitally enabled We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.			☑
	12. Financial sustainability We will develop and deliver financial sustainability plans with our staff, system partners and stakeholders.			☑

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/149**			
SUBJECT:	**Review of Scheme of Reservation & Delegation and Standing Financial Instructions**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	Karen Spencer, Head of Financial Services			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance Officer			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	√		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):(*Please DELETE as appropriate)*	**#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			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				√
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				√
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				√
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Standing Financial Instructions (SFIs) determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SORD). This paper proposes some minor changes to both the SORD and SFIs.			
PURPOSE: *(please select as appropriate)*	**Approval** √	**To note**	**Decision**	
RECOMMENDATION:	The Trust Board is asked to review and approve the proposed changes to the SORD and SFIs.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee
	Agenda Ref.	AC/23/11/84
	Date of meeting	16/11/23
	Summary of Outcome	Changes were supported and approval is recommended.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO TRUST BOARD

SUBJECT	Review of Scheme of Reservation & Delegation and Standing Financial Instructions	AGENDA REF	BM/23/12/149

1. BACKGROUND

The Trust's Standing Financial Instructions (SFIs) determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SORD). This paper proposes some minor changes to both the SORD and SFIs.

2. KEY ELEMENTS

The current versions of the SFIs and SORD expire in March 2024 and November 2023 respectively.

A review has been conducted and the following changes have been made.

SFIs

- Changed Chief Finance Officer & Deputy Chief Executive to Chief Finance Officer.
- Changed NHS England & Improvement to NHS England.
- Change NHSE/I to NHSE.

SORD

- Changed Chief Finance Officer & Deputy Chief Executive to Chief Finance Officer throughout the document.
- Table A, page 35, section 34, item d, taken out first two points regarding waiving the requirement to request tenders and quotes. This has been replaced with one that covers both.
- Table B, page 46, section 8, added in a section for waivers which links to the change above in Table A – this was previously missing from Table B.
-

3. RECOMMENDATIONS

The Trust Board is asked to review and approve the proposed changes to the SORD and SFIs.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting - Part 1

Wednesday 6 December 2023
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

Supplementary Pack

BM/23/11/150 – Learning from Experience Summary Report Q2 *(Quality Assurance Committee 14.11.23)*
BM/23/11/151 – Director of Infection Prevention & Control Q2 *(Quality Assurance Committee 14.11.23)*
BM/23/11/152 – Violence Reduction Strategy *(Quality Assurance Committee 14.11.23)*
BM/23/11/153 – Digital Strategy Group Update *(Finance and Sustainability Committee 29.11.23)*
BM/23/11/154 – WHH Influenza Vaccination Approach 2023/24



Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/11/150 – BM/23/11/151**			
SUBJECT:	**Supplementary Papers**			
DATE OF MEETING:	6 December 2023			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
	SO1: We will.. Always put our patients first delivering safer and effective care and an excellent patient experience.	√		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All Risks			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
	Further Information: ***Each paper is individually marked from September 2023***			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
	Further Information: ***Each paper is individually marked from September 2023***			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
	Further Information: ***Each paper is individually marked from September 2023***			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 6 December 2023 No actions are required from the Trust Board they are provided for information only. The papers provided are: • **BM/23/11/150 – Learning from Experience Summary Report Q2** (*presented at Quality Assurance Committee 14.11.23)*			

	• **BM/23/11/151 – Director of Infection Prevention & Control** *(presented at Quality Assurance Committee 14.11.23)* • **BM/23/11/152 – Violence Reduction Strategy** *(presented at Quality Assurance Committee 14.11.23)* • **BM/23/11/153 – Digital Strategy Group Update Report** *(presented at Finance and Sustainability Committee 29.11.23)* • **BM/23/11/154 – WHH Influenza Vaccination Approach 2023/24**		
PURPOSE: ***(please select as appropriate)***	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above	
	Agenda Ref.	As listed above	
	Date of meeting	As noted above	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/150**	
SUBJECT:	**Learning from Experience, Quarter 2 2023/24**	
DATE OF MEETING:	6th December 2023	
AUTHOR(S):	Layla Alani, Director Governance, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	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. **#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:***	

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

	a protected characteristic and those who do not			
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Learning from Experience Report, Quarter 2, 2023/24 provides an overview of the Learning from Experience across the organisation. The information within the report is extracted from the Datix Incident Management System and other Clinical Governance functions to triangulate the data and learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Quality Improvement and Research and Development related to Quarter 2, 2023/24			
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/23/11/239**		
	Date of meeting	Tuesday 7th November 2023		
	Summary of Outcome	Report discussed and noted.		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO TRUST BOARD

SUBJECT	Learning from Experience, Quarter 2 2023/24	AGENDA REF:	BM/23/12/150

1. Background

The Learning from Experience Report, Quarter 2, 2023/24 relates to data reviewed during the period 1st July 2023 to September 2023 (Q2). It contains both quantitative and qualitative data analysis using information obtained from the Datix Risk Management System and other governance functions to triangulate the data and learning from incidents, complaints, claims, health and safety, clinical audit, compliance, quality improvement and research and development.

The report includes a summary of themes, trends and key findings that have influenced learning and action to support and sustain improvement.

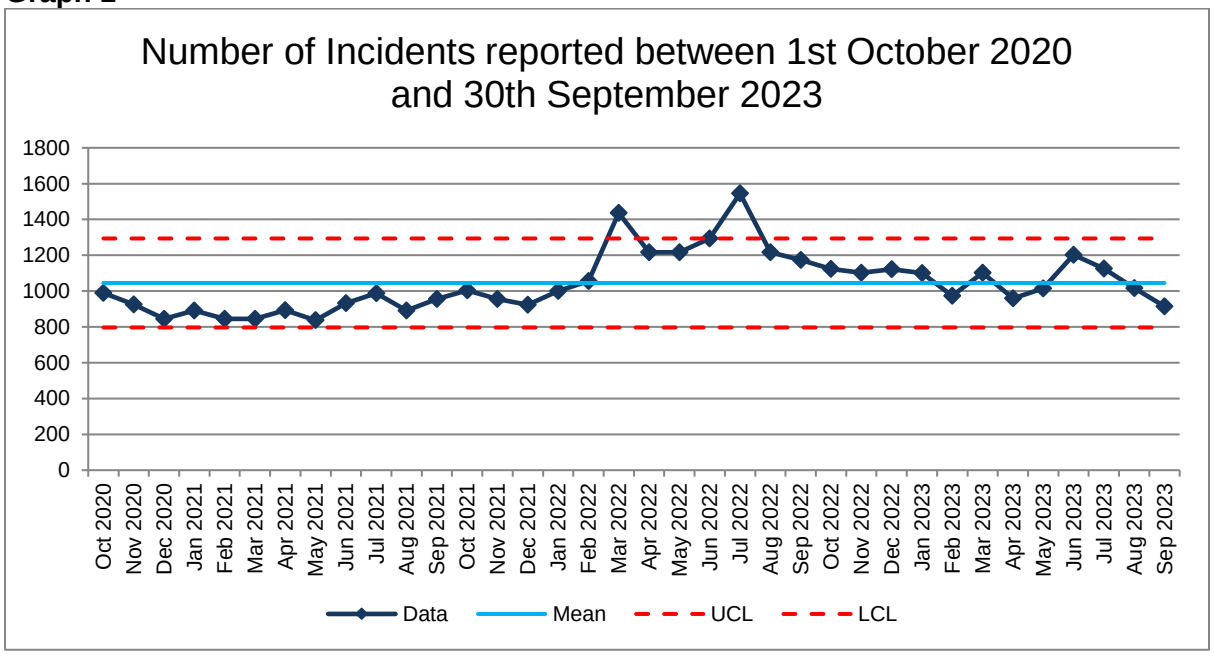
2. Key Elements

2.0 Learning from Incidents

2.1 Incident Reporting Position

In 2023/24 Q2, a total of 3057 incidents were reported compared to 3177 incidents reported in 2023/24 Q1. This represents a decrease of 120 incidents (4%). The areas with the largest decrease in the number of incidents reported is Urgent and Emergency Care with a variance of 67 (7%) and Women's and Children's (43) (10%).

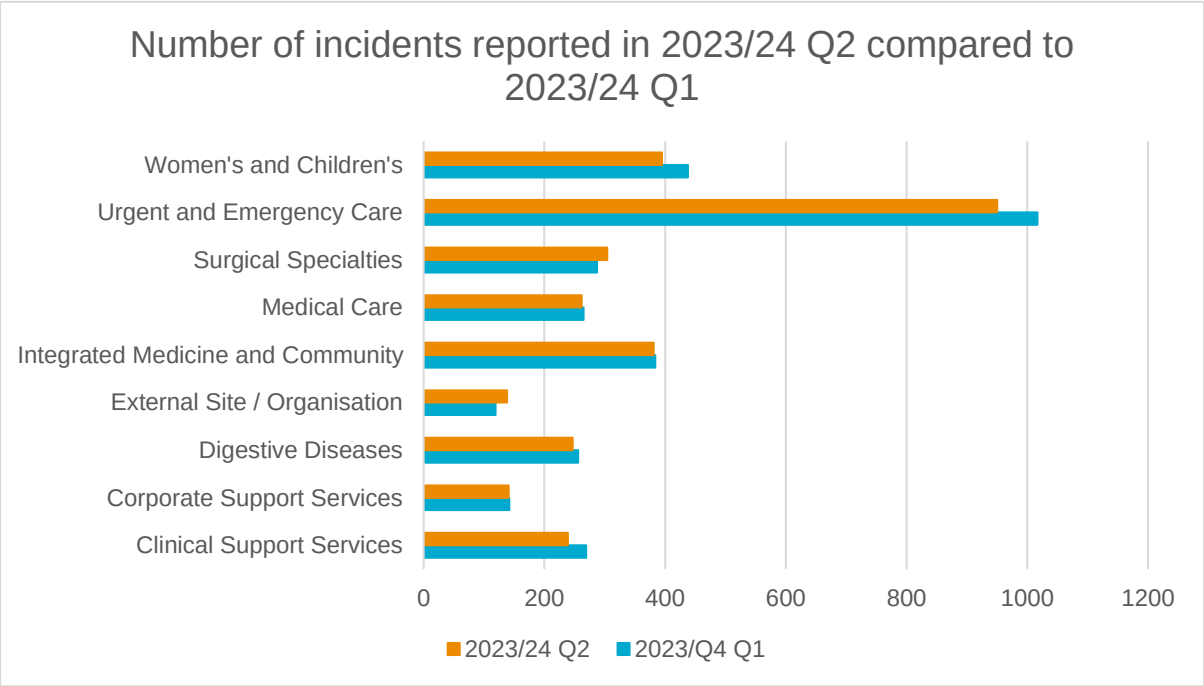
Graph 1



2.2 Incident Reporting Position per Clinical Business Unit (CBU).

In Quarter 2, a total of 2778 incidents were reported across the CBUs and Clinical Support Services as shown in graph 2 below. The remaining 138 were reported as external incidents and 141 were reported within corporate services. Corporate Services incidents include the following areas: Digital Services, Education and Organisational Development and Estates and Facilities.

Graph 2



Increases in reporting are noted in Surgical Specialties (17) (6%). Themes and learning relating to the Virtual Fracture Clinic are detailed below in the report.

2.2.1 Urgent and Emergency Care

The largest decreases in reporting in Urgent and Emergency Care relates to access, transfer and discharge and assessment, diagnosis, and investigation.

At the ED management away day, on 5th October 2023, the governance manager attended and presented an overview of incident reporting and management. A reminder on the importance of incident reporting has been shared with agencies (NHS Professionals) and via the ED team safety huddle on 30.10.23. The Care Group are aware of the decrease and the incident reporting position will be monitored. This is also monitored through Care Group Governance meetings.

The largest increases in reporting in Urgent and Emergency Care mainly relate to safeguarding, assessment, diagnosis and investigation and clinical care. Additional safeguarding support is being offered to the department to support new starters in understanding the referral process and support staff knowledge. Training is being incorporated into the induction for new staff and training trajectories are being monitored by the Care Group.

For Safeguarding incidents relating to patients with mental health concerns, the Associate Chief Nurse for Unplanned Care is currently working with Core 24 to explore the introduction of observer posts within the ED department. The Director of Governance, Deputy Chief Nurse has also had an initial meeting with Arbury Court who have agreed to support the delivery of mental health observational training for staff given the increased number and complexity of mental health attends. The ED department are running a test of change and have implemented an absconding patient checklist, to ensure that robust processes are in place should a patient abscond.

2.2.2 Women's and Children's

The largest decreases in Women's and Children's relates to assessment, diagnosis and investigation, appointment issues and antisocial, abusive, and violent behaviour. The Maternity team have been working with the digital midwife and continuity team leaders to improve pathways for women into Maternity services. The paediatric teams continue to work collaboratively with stakeholders to support the safe discharge of children with mental health or additional needs. During November 2023, incident reporting and management training will be provided to staff via the maternity training train.

Themes within Women's and Childrens include term admissions to the neonatal unit, staffing levels, and PPH. Within Maternity/Neonatal category there were 26 incidents related to PPH reported in Q2, compared to 47 in Q1, this is a decrease of 45%. All PPH's are reviewed by the senior clinical teams at the weekly review group. WHH is not an outlier (regionally) for PPH rates. The action plan which continues to be implemented involves the introduction of a new medication regime for those undergoing elective caesarean section and further simulation training to support management of cases. PPH >1500mls will continue to be reviewed on an individual basis via governance processes and will also be subject to additional review through the Intrapartum Incident Review Group which meet regularly to review patterns and themes from incidents of PPH >1500ml. Rates of PPH >1500mls are also reported via the Maternity dashboard to CBU Governance meetings.

2.2.3 Themes and learning from incidents by CBU:

Urgent Emergency Care (UEC).

1 Never Event was reported in Q2 2023/24.

- Wrong site block in the Emergency Department

Learning and actions taken from this Never Event were:

- The importance and the location of LOCSIPs within the Emergency Department, has been reiterated.
- To ensure there is an order of skin markers within the Emergency Department, these are located within the block packs. An additional supply has been received within the Emergency Department areas and staff educated of their purpose.
- This has been declared as a PSII and further learning will be shared upon completion.
- Following the Never Event staff on all 3 sites received a safety brief regarding the incident, each day for the remainder of the week.
- CQC and PLACE were informed as per governance processes.

2.2.4 Medical Care. Tracheostomy Care (ICU).

There have been two incidents relating to tracheostomy care reported in Quarter 2. The Associate Director of Governance has reviewed the tracheostomy incidents over the last 12 months. There have been 5 incidents, the main theme of these incidents was that they have occurred when rolling patients. ICU have implemented new guidance for staff that need to be present when rolling patients and produced a new Standard Operating Procedure (SOP) for manual handling of patients with artificial airways. This SOP has been ratified at both the ICU Governance Meeting and Unplanned Care Team Meeting. The displacement of tracheostomies will be an agenda item as a deep dive at QAC.

2.2.5 Surgical Specialities. Virtual Fracture Clinic.

Three incidents occurred in Quarter 2 related to delays in referral to Virtual Fracture Clinic

One referral had been closed before the patient was seen. There were two incidents from Urgent and Emergency Care where the Virtual Fracture Clinic appointment was not created as requested within Lorenzo. No harm was identified when Initial Safety Reviews were completed, however highlighted the below learning and actions.

- Trauma and Orthopaedics have requested that all referrals are completed on Pathpoint (electronic referral system), this has been shared with Clinical Business Units for awareness and audits are being undertaken to ensure that this is occurring and improving.
- The Service manager provided additional training on 4th July 2023, relating to the use of Pathpoint to reduce the risk of human error.
- The patient information leaflet has been updated to give additional information regarding who to contact, should the patient have any queries.

2.2.6 Integrated Medicine and Community (IMC) Falls.

In Quarter 2 of 2023/2024 there were 43 falls compared to 63 in Quarter 1 2023/2024. One of these was confirmed as moderate harm and occurred on the discharge lounge. There was also a moderate harm fall on Ward A8. These occurred in 2021 but were not reported as an incident through DATIX. These were brought to the attention of the Trust through the Claims process. Once the Trust was made aware, the incidents were submitted, and Initial Safety Reviews commenced. The value of timely incident reporting was reiterated at the ISR.

Themes for learning relating to falls relate to:

- Communication between ward areas and ambulance services
- Timely risk assessment on admission
- Unclear documentation

Actions are in place for learning to ensure improvement. This has been discussed with the ward team and included on the ward safety brief. The patient safety nurses now review all data to ensure falls are recorded accurately within the Trust. Plans are in place, during quarter 3, to amend the ward handover sheet to include patient mobility information (which will be shared with the next care providers, including transport services).

2.2.7 Digestive Diseases. Endoscopy equipment.

In Quarter 2, 2023/2024 there were 5 incidents submitted in relation to equipment issues within Endoscopy from new equipment sourced by Pentax. As part of the procurement process, testing took place as they were latest version of scopes to the market. There was a requirement for compatibility testing /sign off with the decontamination provider of which assurance was given that this would be completed, however this was not completed prior to delivery. All prerequisite work will now be checked and confirmed before delivery is accepted.

Issues identified:

- Inability to decontaminate the scopes due to the machine rejecting / high flow.
- Scopes have started to significantly leak.
- Cystoscopes, the new stackers were not compatible with the new scopes. Endoscopy informed the software of compatibility challenges and as a temporary measure Pentax have provided a dual processor.
- Duodenoscope failure.
- New Processor failed to work.
- IG29 OGD scopes – hook ups not available
- Halton have had to return the new colonoscopes for repair.

All five incidents had an Initial Safety Review completed which have not identified any harm to patients. The Trust has been working closely alongside Pentax to ensure equipment issues are reported and rectified in a timely manner to minimise disruption to the service. This is being discussed at the Medical Devices Safety Group on 3rd November 2023.

2.2.8 Women's and Childrens. Safeguarding.

In Quarter 2 of 2023/2024 there were 10 incidents reported relating to Mental Health Concerns on Ward B11 all of which have had an Initial Safety review. 7 of these related to one child, who remained an inpatient due to their being no appropriate placement for discharge. Parallel planning took place with external partners to support safe discharge.

Actions and learning include:

- Urgent meetings took place with external partners regarding further assessment and placement update. These circumstances remain challenging and have been discussed with PLACE and ICB colleagues intermittently and as part of the Clinical Quality Focus Group.
- Safety Actions were discussed with Ward B11 team whilst patients remained on the Ward.
- Development of a passport to support communication and triggers specific to the individual child, this communication tool will support future cases.
- Mental Health forms part of the Trust local priorities within the new Patient Safety Incident Response Framework (PSIRF).

2.2.9 Learning overview from individual incidents across the CBUs.

The following section provides a sample of learning from individual incidents across each CBU.

Women's and Childrens

We learnt that….
Medication for the third stage of labour was administered to a woman and Vitamin K administered to her baby without her knowledge or consent, despite consent being documented in the maternity record. Apologies were given, a debrief was offered and was declined. The woman was upset with this and would like this to be shared for learning.
We acted upon …
➢ Gap Analysis of training requirements was undertaken between NHSP/WHH on 19th September 2023, to align training requirements/competencies with external partners.

Medical Care.

We learnt that ….
A patient was discharged with incorrect medication. The incident was investigated with the support of pharmacy.
We acted upon …
Actions taken: ➢ The patient was given advice regarding possible effects of incorrect medication and advised as to what actions to take if there were any concerns. ➢ Learning was identified regarding ensuring the patient pod lockers are checked and emptied when a patient is discharged. ➢ Guidance has been shared on the safety brief for wider learning.

Integrated Medicine and Community

We learnt that….
Two incidents occurred in with regards to maintaining, monitoring, and supplementing potassium levels.
We acted upon….
An initial safety review was undertaken:

- Both incidents indicated a lack of appreciation regarding potassium levels and a greater need for education,
- The learning from these incidents was shared via the ward rounds, to ensure all grades of medical staff were aware of the concerns and learning.
- The Foundation programme director is providing a learning session on the training programme relating to good practice, providing supplements, and monitoring the use of them for high or low potassium levels.

Urgent and Emergency Care.

We learnt that …

A patient suffered a seizure and subsequent cardiac arrest in the ED waiting room. Emergency help was summoned immediately but there was a delay in obtaining the appropriate defibrillator and oxygen delivery device required. Two cycles of CPR were completed without a defibrillator being present.

We acted upon …

An initial safety review was undertaken:

- ED Matron and Department manager identified a location within Triage to attach an oxygen port for a portable oxygen cylinder to be used for emergency situations.
- ED matron and department manager reiterated the guidance of scoop and run within the department, meaning if a patient becomes critically unwell or unresponsive the patient is transferred to a trolley and taken to a more appropriate bedspace.
- ED Clinical Director is to provide simulation training to the ED teams to ensure awareness of management and escalation of patients. This will be completed during quarter 3.
- ED Matron and Department Manager created signs to be displayed noting the location of the nearest emergency/resus equipment.
- The floor plan review group are to evaluate contents and location of resus equipment. Initial meetings have been undertaken and this piece of work will be monitored through the governance meetings.

Digestive Diseases- Theatre

We learnt that….

Peri operative blood samples were taken for a patient in Theatre and sent to the laboratory. On checking of the results, it was discovered that the laboratory had not received the blood samples and that the samples were still on the reception desk. This resulted in a delay in blood results and the patient was anaesthetised for longer than necessary.

We acted upon….

An initial safety review was conducted and developed the following actions:

- Red bags are being utilised for urgent blood samples from theatre.
- Amendmentto the standard operative procedure specifying that blood samples need to be handed over to a member of staff.

- Theatre book bloods are now written in a book and signed by the laboratory when received.
- Consultant reviewed potential harm, this being no harm.
- The case was discussed at the patient safety meeting, and it was agreed that this should remain as an initial safety review with the above actions.

Surgical Specialities

We learnt that….
A patient had a bladder procedure and should have been booked for a further scan in three months' time. This was not booked, and the patient was later found to have extensive bladder cancer. Missed cancers are now investigated under the PSII framework.
We acted upon….

- An Initial Safety Review was undertaken which identified there was no evidence that this patient was on a waiting list at the time.
- Following the cystodiathermy in March 2021 there was no ICE requesting a repeat flexi- sigmoidoscopy and therefore no access plan the correct process should be an ICE for further flexi requests- no referral was made so patient was not on any list and got referred back in by the GP when passing blood.
- Patients do not now leave their appointments until all necessary treatments are booked.
- As this met one of the trust local priorities a PSII investigation was launched in response to this event.
- Duty of Candour was completed with the family.
- Further information with be available in Q3.

2.3 Learning from Incidents and Assurance.

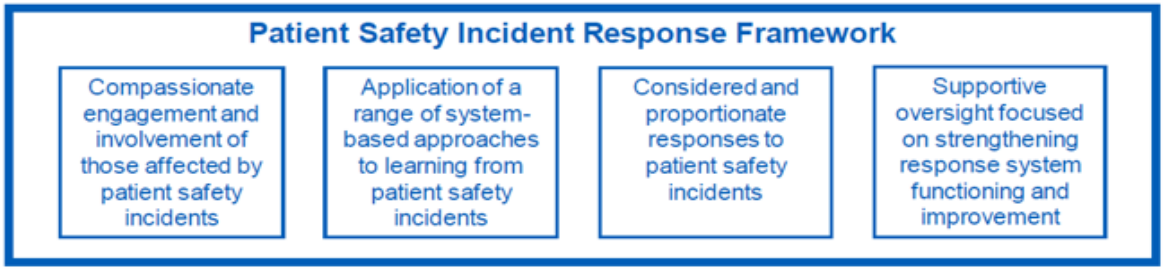
The Patient Safety Manager continues to attend the PLACE (previous CCG) meetings to present Serious Incidents alongside the Investigating Officer. This ensures that learning is shared externally as well as internally. Incidents and complaints are also discussed at the Clinical Quality Focus Group (PLACE) by the Director of Governance. Learning is shared within governance and speciality meetings with wider learning shared through other modalities such as safety alerts and other relevant meetings such as the Nursing and Midwifery Forum, Mortality Review Group, and the Medical Cabinet.

2.4 Patient Safety Incident Response Framework (PSIRF) - learning and improving patient safety.

The PSIRF was introduced in September 2022 and is mandated for any organisation who provide funded NHS care.

- PSIRF replaces the Serious Incident Framework but in itself is not an investigation framework.

- PSIRF aims to support organisations to change culture in order to improve patient safety.
- PSIRF does not mandate investigations as the only method of learning from patient safety incidents or prescribe what to investigate.
- PSIRF aims to move away from targets attached to incident investigations and instead focus on learning and improvement.
- PSIRF supports the development and maintenance of an effective patient safety incident response system with four main aims:



Via the PSIRF Task and Finish Group and the PSIRF Executive Oversight Group the implementation schedule has been worked through to ensure that appropriate plans and processes are in place to achieve successful implementation.

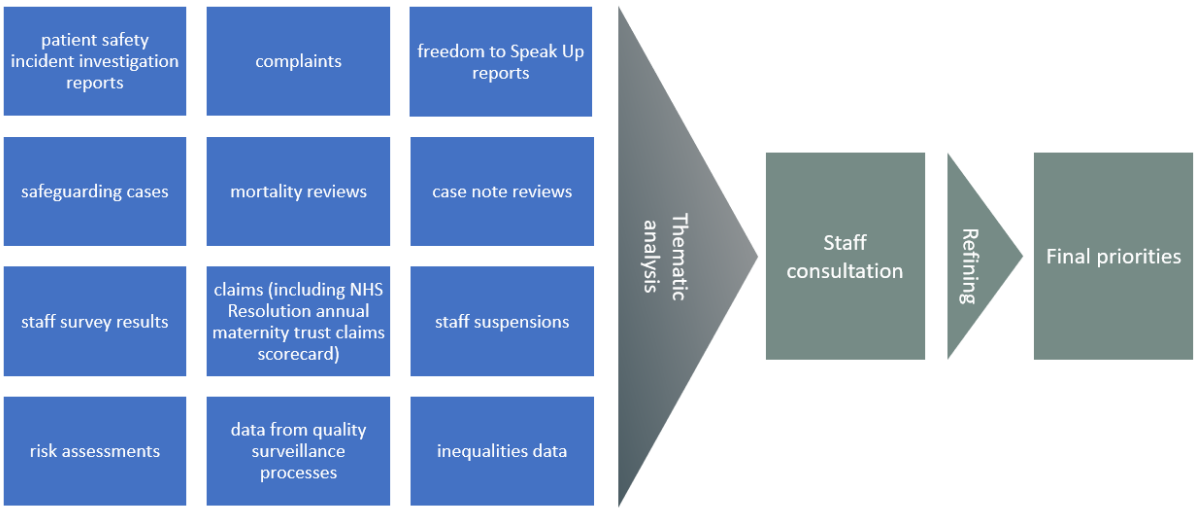
The various tools, and types of investigations and reviews that can be used for learning and improving patient safety include:

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how.
- Multidisciplinary Team Review – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care.
- Swarm Huddle – initiated as soon as possible after an event and involves and MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence.
- After Action Review (ARR) – structured facilitated discussion of an event, based around four questions.

In addition, a move away from the use of Root Cause Analysis (RCA) to a more systems-based learning approach including system engineering and human factors will bring about enhanced learning from incidents and support harm reduction.

WHH has been using the new learning response methodologies (to support incident investigations) and confidence is growing with the different approaches. These are supporting compassionate engagement with patients, families and staff through direct engagement and involvement where appropriate. And are also enabling proportionate responding to safety events.

The development of Local Priorities has taken place following extensive review of WHH data in order to identify issues which have been enduring and impact across a range of data sources in order to ensure opportunities for triangulation and maximise learning opportunities.



**Process for developing WHH local priorities.*

This exercise has resulted in the development of 3 local priorities which will be investigated using PSII methodology.

- Missed or delayed diagnosis of a cancer
- Delay in the identification, recognition and response to a patient's deterioration resulting in delayed escalation and treatment.
- Delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)

The PSIRF policy and plan have been developed based on the national templates and been approved by the appropriate governance processes with sign off at Trust Board, Place and ICB. These have both been made available to members of the public on the Trust website. WHH were able to go live with PSIRF on the 1st September 2023.

Training is being provided to staff to support the PSIRF requirements, and the Patient Safety Training Syllabus has been mandated and is available through the Electronic Staff Record.

Training compliance is currently:

Patient Safety Essentials for boards and senior leadership - Level 1: 84.21%

Patient Safety Essentials - Level 1: 82.37%

Patient Safety - Level 2: 59.90%

The fostering of a culture which support staff to feel psychologically safe is imperative to the success of PSIRF and a programme is in development to support this important work.

Alongside the implementation of PSIRF is the requirement to move towards using the new national learning and reporting system Learn from Patient Safety Events (LFPSE) this will replace both the current National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS). The new system is built on modern architecture and will include machine learning, which will support health care wide improvements and enable improvement efforts to be targeted to support organisations. Following an extensive programme of work to support the safe transfer to the new national system, WHH went live with LFPSE on the 1st September.

WHH continues to participate with PLACE and ICB partners across Cheshire and Mersey to share learning to further support embedding of PSIRF and LFPSE.

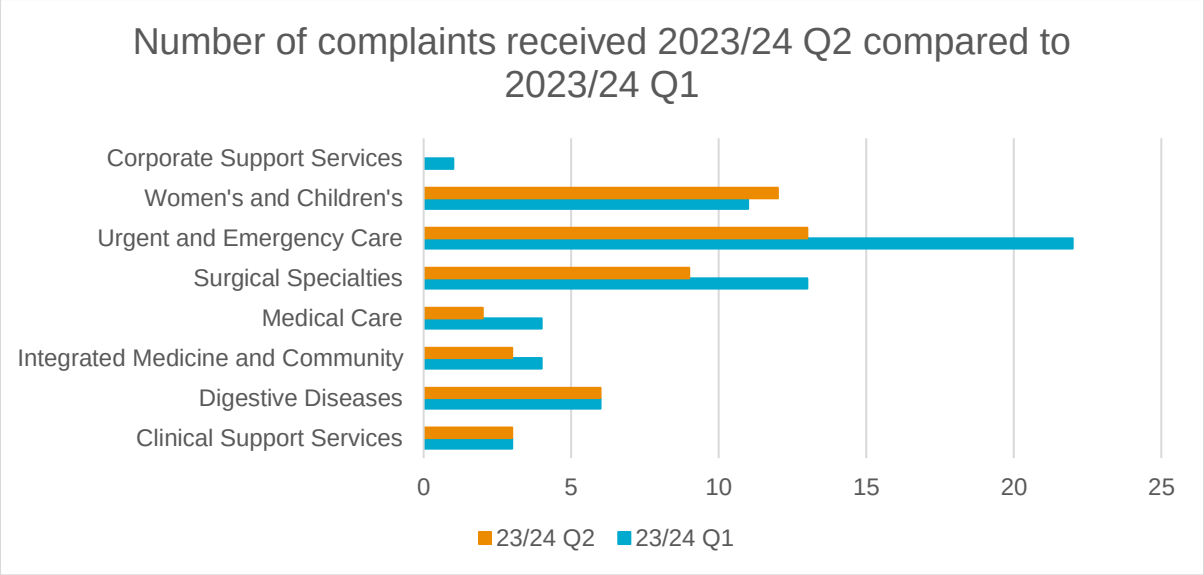
3. Learning From Complaints and PALS

3.1 Complaints.

3.1.1 Complaints received.

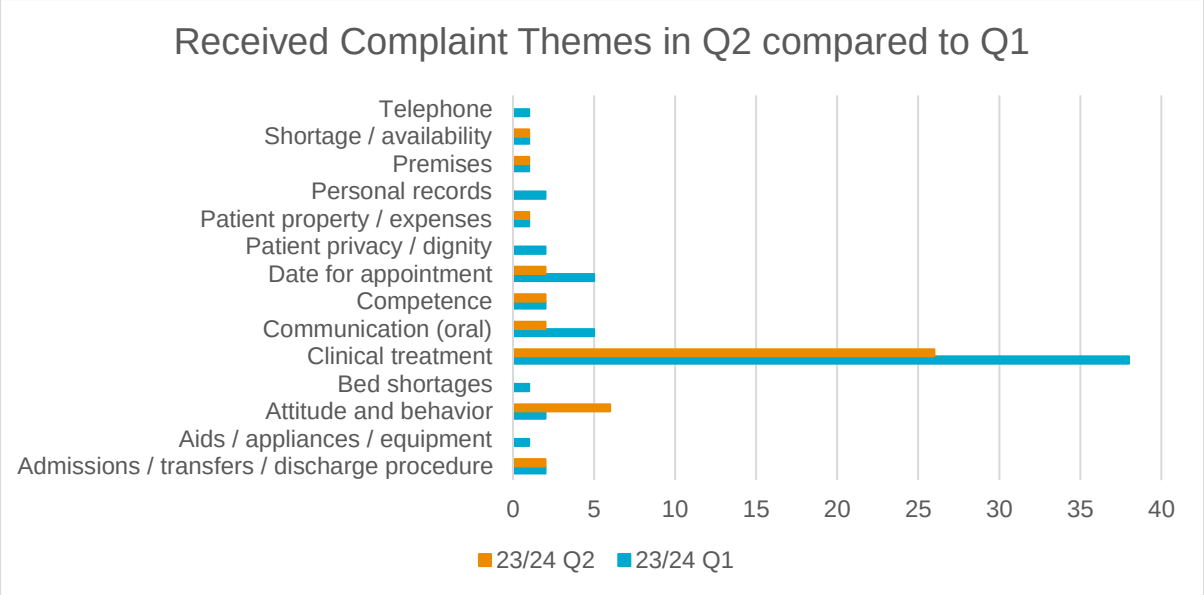
In 2023/24 Q2, there were 48 complaints received in which is a decrease of 16 compared to 2023/24 Q1. Women's and Children's have seen an increase of 1 complaint received **(Graph 3**).

Graph 3



The themes of complaints received in Q2 compared to Q1 are outlined within **Graph 4.** Clinical treatment remains the most common theme of complaints received. This category of complaints includes perceived delays in treatment, waiting times and/ or misdiagnosis. This is triangulated with the themes noted within incidents. The number of complaints relating to this theme has decreased from 38 in Q1 to 26 in Q2. The complaints received with a subject of 'clinical treatment' are spread across CBU's and a variety of specialties.

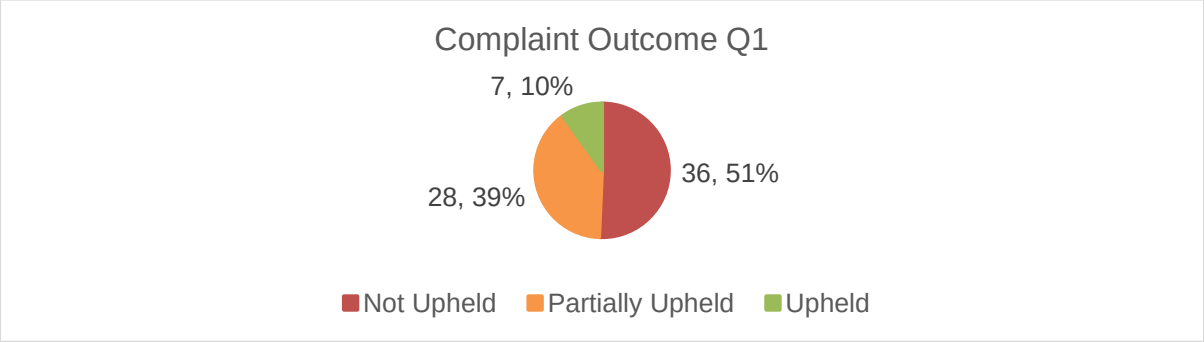
Graph 4

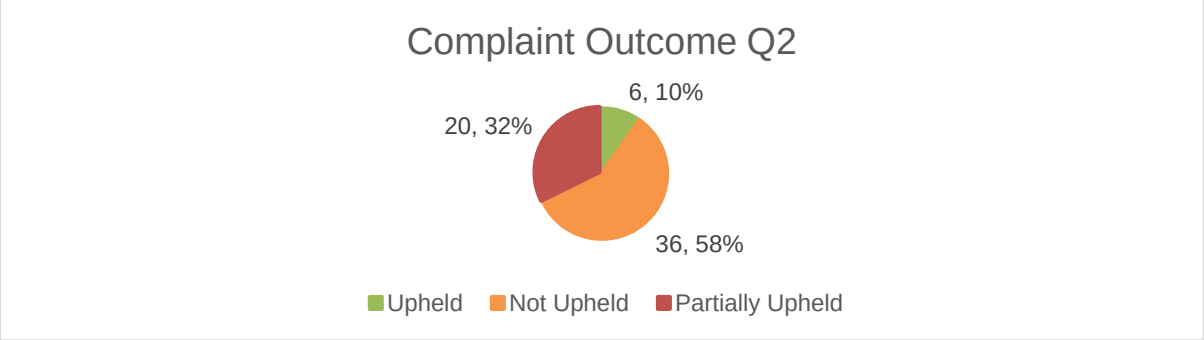


3.1.2 Complaints closed.

All complaints were closed in Q2 within timeframe. The below pie charts demonstrate the outcomes for complaints closed in Q2 compared to Q1. In Q2, a greater percentage of complaints were not upheld (51% in Q1 vs 58% in Q2). There has been a smaller percentage of complaints that were partially upheld (39% in Q1 vs 32% in Q2). The percentage of upheld complaints in Q2 has remained the same as Q1 (10% in Q1 vs 10% in Q2). There are no breached complaints or any complaints over 6 months old.

***Partially upheld complaints are those where aspects of the complaint are upheld, but the main issues are not.





3.1.3 Actions resulting from Complaint investigations.

The following table provides examples of complaints raised in Q2, and the actions taken to address the concerns raised as well as improvement processes. The Chairman holds a monthly complaint assurance meeting where a CBU or speciality will present a complaint, the lessons learnt, and the actions implemented.

You Said….	We Did….
Urgent and Emergency Care: A patient attended the Emergency Department with a nosebleed that would not stop. The patient attended triage and was then discharged without being examined /receiving treatment, as the nosebleed had stopped.	Upon investigation of this concern, a one-to-one meeting was undertaken with the triage practitioner involved. The importance of thorough triage to check for potential complications in relation to nose bleeds was discussed. To help promote wider learning, the concern was shared with the practice-based educator who has incorporated learning for all nursing staff regarding potential complications of nose bleeds, to highlight the importance of a thorough triage.
Digestive Diseases: A patient had concerns relating to a 13 month wait to have a ph Manometry test. The patient had a Gastroscopy in 2021 and was later referred for a ph Manometry test in 2022. However, because their Gastroscopy was performed over 1 year prior, the ph Manometry test couldn't be performed. This led to delays in treatment as the patient needed a further Gastroscopy procedure prior to the ph Manometry test.	This complaint was resolved locally by the clinical team. The clinical team spoke with the patient directly to address their concerns, to arrange a new appointment, and to advise that the patient's experience will be shared as a patient story at the Gastroenterology Governance meeting. The complainant was happy with the quick response and reassurance provided. Complaint was able to be closed without the need for a written response.
Digestive Diseases: Patient raised concerns around their discharge feeling rushed with poor communication. Patient felt that they were not actively involved in decisions around their discharge.	Complaint was anonymised and concerns raised in relation to patient's discharge was shared with all staff on Ward A5 (Elective) via the ward safety brief. The Ward Manager has reminded staff of the importance of enquiring whether patients have support at home upon discharge, and that this is documented in their electronic medical notes. Staff have also been asked to reflect upon how they communicate and support patients during discharge.
Corporate Support Services: Patient raised concerns that there is a patient with the same name and similar date of birth in hospital and at appointments they had received	An alert has now been added to patient's paper record and Lorenzo to ensure staff are aware and cautious when recording and sharing data that there is another patient with same name / Date of Birth (DoB) in hospital.

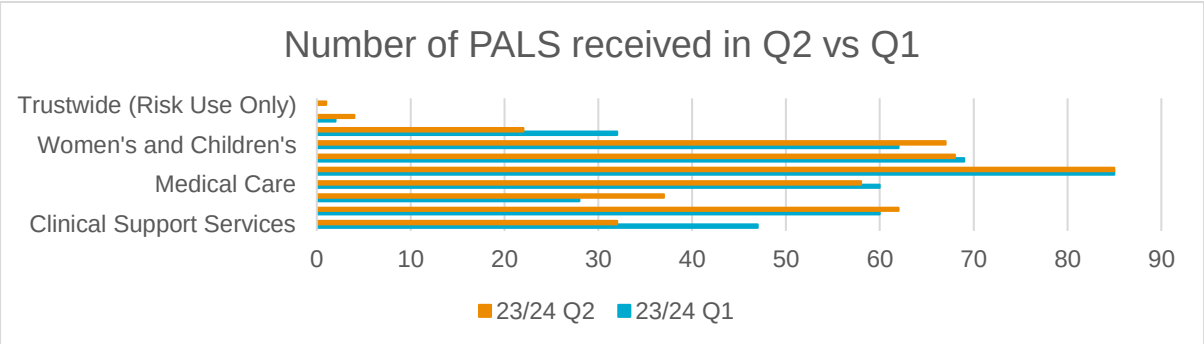
misinformation or been asked irrelevant questions.	
Women's and Childrens: Patient was unhappy with their appointment at the EPAU and felt that they were made to feel like an inconvenience.	The Matron for EPAU called the patient to apologise and discuss the concern. The patient felt reassured and was provided with a direct contact number for future. The concern has also been shared at the Early Pregnancy team meeting to remind staff of the importance of compassionate conversations.
Integrated Medicine and Community (IMC) Patients' daughter raised concern that their mother was discharged with another patient's medication alongside her own medications.	Upon learning of this concern, apologies were given on behalf of the ward for the error. The Ward Manager has confirmed that discussions have taken place within the team to highlight the importance of maintaining medication safety prior to a patient being discharged. A reminder has been given to all staff on the ward via the ward safety huddle that medications must be checked by two registered nurses prior to a patient being discharged. The clinical teams have also been provided with a further copy of the Trust's medication policy.

3.2 Patient Advice and Liaison Service (PALS).

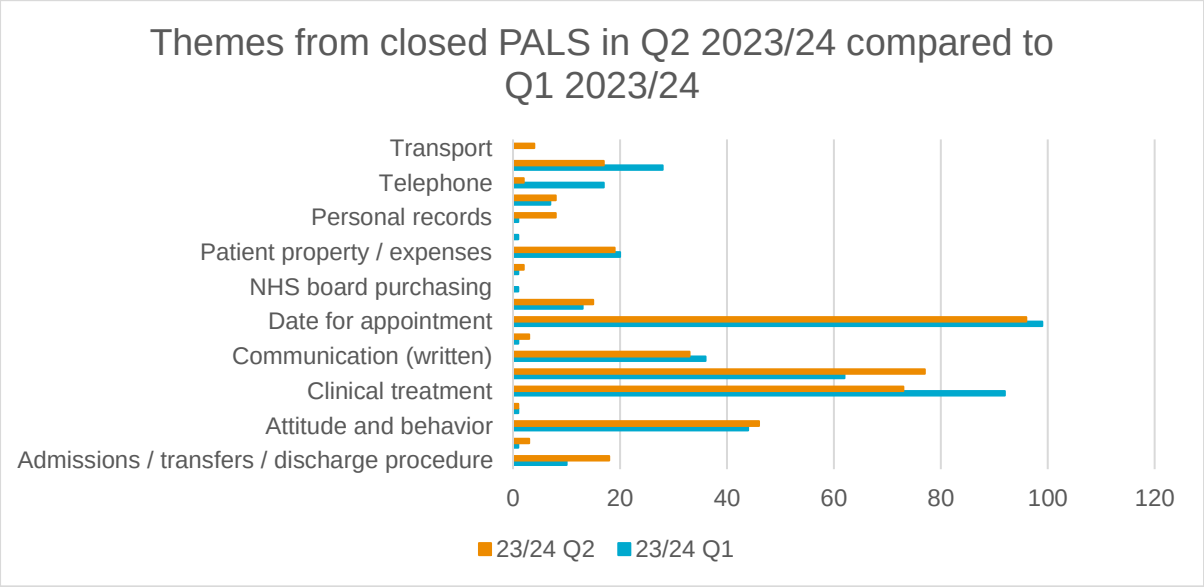
3.2.1 PALS received.

There were 436 new PALS referrals received in Q2, a decrease of 9 when compared to Q1. **Graph 5** demonstrates the breakdown of PALS received for each service.

Graph 5



Graph 6



4. Learning From Quality Improvement

4.1 Learning from QI training evaluation

NHS IMPACT (Improving Patient Care Together) has been launched to support NHS organisations and systems to have the skills and techniques to deliver continuous improvement. It should allow our Trust to identify our strengths and opportunities for development in our strategic plan to apply an organisational/system wide approach to improvement. We are utilising NHS Impact self-assessment as one of our mechanisms to establish a developmental plan with Executive Leads to achieve one of our Quality Priorities for CQC's QI maturity assessment and embedding PSIRF improvement programmes within the Trust in our next refresh of Quality Strategy.

We collect and review feedback following each training session delivered to ensure that we continuously learn and improve the training we provide to ensure we meet the needs and expectations of participants. Overall, QI training evaluates very well; both QI Foundation and QI practitioner training sessions were rated an average of 9.1 out of 10 during quarters 1 and 2.

- 72.7% of Practitioner respondents reported that they would "very likely" recommend the course to colleagues, with the remainder reporting that they were "somewhat likely" to recommend it.
- Two thirds of participants reported that the practitioner course exceeded their expectations, with the remainder saying it met their expectations.

Positive Feedback

Particularly positive aspects of training highlighted in feedback include the interactive nature and use of videos, games and practical examples to demonstrate theory, and the opportunities to interact with colleagues across different areas of the trust to share knowledge and bounce ideas for improvements between one another. One to one support and coaching as part of the practitioner programme was also highlighted as beneficial.

Opportunities for Improvement

Feedback from QI practitioners highlighted a need for greater support and awareness from team and line managers to ensure time and support to progress projects between training sessions. To address this, we have updated the information provided ahead of the course and begun to involved line managers/project sponsors from the outset.

Further ongoing support for QI practitioners' participants post-training completion was also highlighted as an area for further development. Additional one to one coaching sessions and support are offered, and we are currently exploring the development of a peer network or forum to provide ongoing support.

In addition to changes based on participant feedback, we have also made a number of changes to our training materials, incorporating learning around the revised CQC framework, for example, including greater emphasis on the use of patient stories, a focus on incorporating prevention as part of our definition of quality, and further alignment of training content with the Making Data Count programme.

4.2 Learning from registered QIPs completed within July-September 2023

Project Aim	Project Lead	Start Date	Completion Date	Lessons learnt/next steps
To reduce the amount of hospital acquired pressure ulcers by 60% by 31st December 2022 for inpatients on Ward B18	Peter Phillips & Tracy Travers	09/09/2022	24/07/2023	Use of a traffic light system visual alert to highlight patients at risk of developing pressure ulcers and identify appropriate intervention
To reduce the time duration whilst administering medications on A9 by 30 - 10 minutes by 30th June 2023	Vineetha Manu	22/03/2023	27/07/2023	Reduction in time taken from average 30 minutes to average 15 minutes with no increase in administration incidents.
To stop all inappropriate requests to GPs on FAU discharge summaries by March 2023	Elizabeth Nolan	31/01/2023	08/08/2023	Outcome data not collected directly, however, changes implemented based on analysis of data included: • Introduction of internal referral process to metabolic bone clinic to reduce GP requests

4.3 Learning from the application of knowledge and evidence

Evidence into practice - Online neurorehabilitation for stroke patients with an upper limb deficit

Learning Outcomes

Two evidence reviews requested by a Clinical Lead Physiotherapist identified good quality evidence that more therapy leads to improved recovery and outcomes in the first six months post-stroke; and revealed a growing body of research to attest that telerehabilitation is not inferior to in-person therapy.

This evidence was utilised to underpin a virtual neurorehabilitation pilot group, and quality improvement project, aimed at stroke patients with an upper limb deficit.

Impact

- **Frequency of therapy maintained -** Despite low staff levels over the summer due to maternity leave, the 'frequency of therapy' audit revealed that the number of sessions provided did not decrease as would have been expected.
- **Earlier Access to therapy -** Virtual sessions also allowed staff to manage their waiting list. It meant that patients who were triaged from referrals, and were identified as having an upper limb deficit, could start therapy online rather than waiting for therapists to go out and see them face to face.
- **Improved patient experience and empowerment** - Informal feedback demonstrated that patients understood that the service was under pressure, and they were glad to have contact and be able to start doing some therapy. They were motivated to help themselves and just needed to know what to do. Patients also fed back that they enjoyed the sessions.

Next steps:

- **Regional collaborative to provide increase access-** The team will be part of a wider regional project that would offer virtual rehab sessions to stroke patients across Cheshire and Merseyside. This collaborative scheme would allow a WHH therapist to see several of our patients in an hour, rather than just 1 patient face to face, and would also allow our patients to sign up to additional sessions led by therapists from other trusts.

4.4 What works well in reducing pressure ulcers? – WHH Interviews

Following a meeting with the Deputy Chief Nurse in June, and with Associate Chief Nurse, Corporate Nursing and the Quality Improvement team the KES have carried out interviews with lead Nursing staff and AHPs on AMU and A2 to capture their insight on what has worked well locally in reducing pressure ulcers. This work complements that of 2 successful workshops already carried out by Associate Chief Nurse, Corporate Nursing and the Quality Improvement team and finding have been added to this work.

Key learning from AMU and A2

Interviewed: Matron for AMU / A2, the Ward Managers of AMU and A2, and Advanced Practitioner Occupational Therapy.

Those interviewed identified several actions which had been taken, along with attitudes and culture fostered on the wards which they felt contributed to low levels of pressure ulcers on these wards.

- Audit tool designed by AMU and QI.

- Heel Checks.
- Mattress ‘opt-out’ (in progress).
- Amended version of the skin bundle.
- Multiple audits at different levels.
- Ownership and accountability lies with registered nurse.
- Body mapping as soon as admitted.
- Celebrating / sharing what is going well.
- Staff engagement.
- Staff mentality and encouraging patients to get up and get out of bed.
- HCA lead and team working brilliantly together.
- Sending a positive, enabling message to patients.
- The ‘Fit to Sit’ conversation; being mindful of the language used when talking with patients.
- Effective, inclusive morning huddle structure.
- The nature of the ward – faster pace and turnaround.

The full report ‘What works well on AMU and A2 in reducing Pressure Ulcers PU Interviews’ is available to read here https://bit.ly/3LGRd3D

The KES are working with the Associate Chief Nurse, Corporate Nursing to arrange interviews with A9 and HCAS.

> “*For the most part I can't say enough good things about it. I would say A1 for me is definitely setting the bar as a ward and encouraging people to get out and being proactive about it. The awareness of deconditioning and the impact it can have on patients. And there's definitely some lessons that people could learn from the way that they work on there.”*
>
> Advanced Practitioner Occupational Therapy.

4.5 Finding Evidence Fast Training – how learning is applied by WHH Staff

The KES offer all staff training in Finding Evidence Fast, equipping staff with the skills to confidently pinpoint research evidence to support them I their decision making improvement planning or continual professional development.

How WHH staff say they are applying learning from our training

- **Before training**:
  - **43%** of staff stated that they were ‘**not at all confident’** in carrying out an evidence search
  - **57%** stating that they were only ‘**a little confident**.’

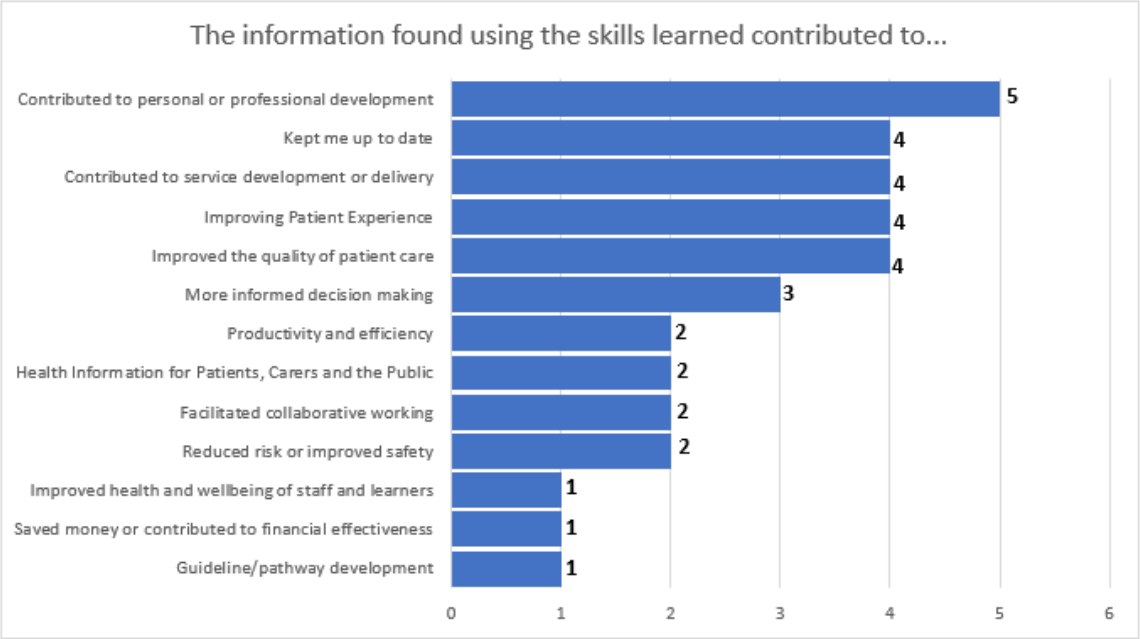
- **After training**:
  - **85%** of staff reported that they were ‘**very confident**.’
  - **15%** stated they were ‘**extremely confident**.’

- **100%** of staff have **applied the skills learned** in the session to find the information they needed.

- **57%** of staff say that the skills learnt in the training session **improved the quality of patient care/improved patient experience/contributed to service development**.

- **71%** said the skills **contributed to personal or professional development**.

Staff highlighted a number of key areas which were positively impacted by applying the skills they had learned in our training, with dominant areas being Improved Patient Care (4), Improved Patient Experience (4), Contributed to service development (4) and contributed to personal or professional development (5).



4.6 Patient Safety Incident Response Framework (PSIRF)

At the request of the Project Director for Patient Safety, the KES have produced guidance on writing effective SMART action plans specifically for PSIRF. This was based on a comprehensive evidence review and consultation with early adopters of PSIRF and includes:

- Creating blame free actions

- Using the hierarchy of controls to create effective systems focused actions.

- How to ensure that actions are monitored and evaluated for impact.

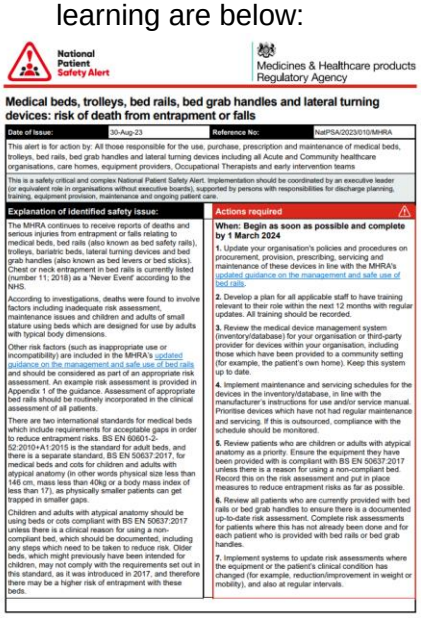
- Quick reference 'Do's and Don'ts' guide to writing SMART actions, with examples taken from real SMART plans.

The slides, with voiceover commentary, can be found on the trust's Extranet pages here.

The guidance will be used to inform WHH staff on writing SMART actions as part of their patient safety incident investigation (PSII).

5 Learning From Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily brief with 11 alerts being issued through Q2. When alerts are issued, some will be shared over a number of days, giving staff an opportunity to see the alert. National patient safety alerts are also shared widely and can provide learning from incidents that have occurred. Examples of learning are below:



National Patient Safety Alert

Medicines & Healthcare products Regulatory Agency

Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls

Date of issue:	30-Aug-23	Reference No:	NatPSA/2023/010/MHRA

This alert is for action by: All those responsible for the use, purchase, prescription and maintenance of medical beds, trolleys, bed rails, bed grab handles and lateral turning devices including all Acute and Community healthcare organisations, care homes, equipment providers, Occupational Therapists and early intervention teams

This is a safety critical and complex National Patient Safety Alert. Implementation should be coordinated by an executive leader (or equivalent role in organisations without executive boards), supported by persons with responsibilities for discharge planning, training, equipment provision, maintenance and ongoing patient care.

Explanation of identified safety issue:

The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS.

According to investigations, deaths were found to involve factors including inadequate risk assessment, maintenance issues and children and adults of small stature using beds which are designed for use by adults with typical body dimensions.

Other risk factors (such as inappropriate use or incompatibility) are included in the MHRA's updated guidance on the management and safe use of bed rails and should be considered as part of an appropriate risk assessment. An example risk assessment is provided in Appendix 1 of the guidance. Assessment of appropriate bed rails should be routinely incorporated in the clinical assessment of all patients.

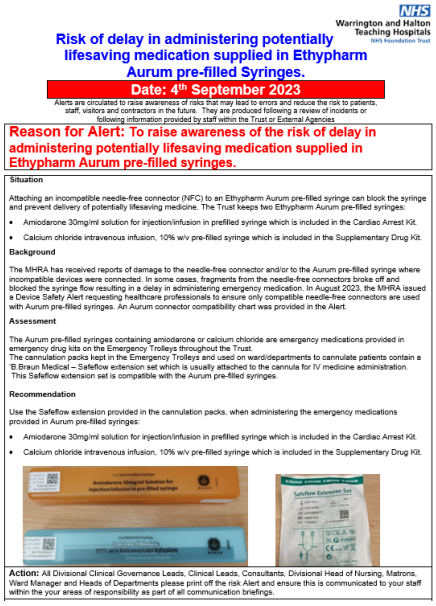
There are two international standards for medical beds which include requirements for acceptable gaps in order to reduce entrapment risks. BS EN 60601-2-52:2010+A1:2015 is the standard for adult beds, and there is a separate standard, BS EN 50637:2017, for medical beds and cots for children and adults with atypical anatomy (in other words physical size less than 146 cm, mass less than 40kg or a body mass index of less than 17), as physically smaller patients can get trapped in smaller gaps.

Children and adults with atypical anatomy should be using beds or cots compliant with BS EN 50637:2017 unless there is a clinical reason for using a non-compliant bed, which should be documented, including any steps which need to be taken to reduce risk. Older beds, which might previously have been intended for children, may not comply with the requirements set out in this standard, as it was introduced in 2017, and therefore there may be a higher risk of entrapment with these beds.

Actions required

When: Begin as soon as possible and complete by 1 March 2024

1. Update your organisation's policies and procedures on procurement, provision, prescribing, servicing and maintenance of these devices in line with the MHRA's updated guidance on the management and safe use of bed rails.
2. Develop a plan for all applicable staff to have training relevant to their role within the next 12 months with regular updates. All training should be recorded.
3. Review the medical device management system (inventory/database) for your organisation or third-party provider for devices within your organisation, including those which have been provided to a community setting (for example, the patient's own home). Keep this system up to date.
4. Implement maintenance and servicing schedules for the devices in the inventory/database, in line with the manufacturer's instructions for use and/or service manual. Prioritise devices which have not had regular maintenance and servicing. If this is outsourced, compliance with the schedule should be monitored.
5. Review patients who are children or adults with atypical anatomy as a priority. Ensure the equipment they have been provided with is compliant with BS EN 50637:2017 unless there is a reason for using a non-compliant bed. Record this on the risk assessment and put in place measures to reduce entrapment risks as far as possible.
6. Review all patients who are currently provided with bed rails or bed grab handles to ensure there is a documented up-to-date risk assessment. Complete risk assessments for patients where this has not already been done and for each patient who is provided with bed rails or bed grab handles.
7. Implement systems to update risk assessments where the equipment or the patient's clinical condition has changed (for example, reduction/improvement in weight or mobility), and also at regular intervals.



NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk of delay in administering potentially lifesaving medication supplied in Ethypharm Aurum pre-filled Syringes.

Date: 4th September 2023

Alerts are circulated to raise awareness of risks that may lead to errors and reduce the risk to patients, staff, visitors and contractors in the future. They are produced following a review of incidents or following information provided by staff within the Trust or External Agencies

Reason for Alert: To raise awareness of the risk of delay in administering potentially lifesaving medication supplied in Ethypharm Aurum pre-filled syringes.

Situation

Attaching an incompatible needle-free connector (NFC) to an Ethypharm Aurum pre-filled syringe can block the syringe and prevent delivery of potentially lifesaving medicine. The Trust keeps two Ethypharm Aurum pre-filled syringes:

- Amiodarone 30mg/ml solution for injection/infusion in prefilled syringe which is included in the Cardiac Arrest Kit.
- Calcium chloride intravenous infusion, 10% w/v pre-filled syringe which is included in the Supplementary Drug Kit.

Background

The MHRA has received reports of damage to the needle-free connector and/or to the Aurum pre-filled syringe where incompatible devices were connected. In some cases, fragments from the needle-free connectors broke off and blocked the syringe flow resulting in a delay in administering emergency medication. In August 2023, the MHRA issued a Device Safety Alert requesting healthcare professionals to ensure only compatible needle-free connectors are used with Aurum pre-filled syringes. An Aurum connector compatibility chart was provided in the Alert.

Assessment

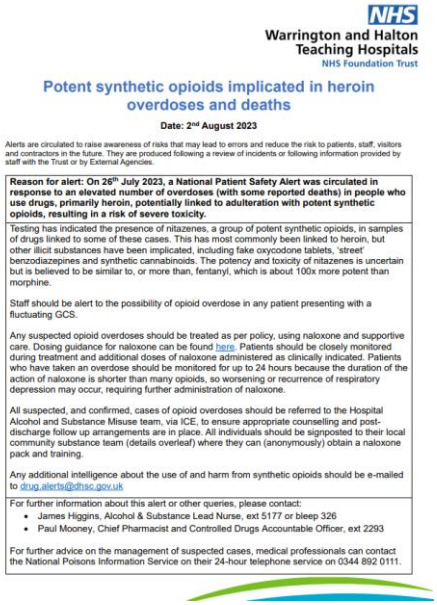
The Aurum pre-filled syringes containing amiodarone or calcium chloride are emergency medications provided in emergency drug kits on the Emergency Trolleys throughout the Trust.
The cannulation packs kept in the Emergency Trolleys and used on ward/departments to cannulate patients contain a B.Braun Medical – Safeflow extension set which is usually attached to the cannula for IV medicine administration. This Safeflow extension set is compatible with the Aurum pre-filled syringes.

Recommendation

Use the Safeflow extension provided in the cannulation packs, when administering the emergency medications provided in Aurum pre-filled syringes:

- Amiodarone 30mg/ml solution for injection/infusion in prefilled syringe which is included in the Cardiac Arrest Kit.
- Calcium chloride intravenous infusion, 10% w/v pre-filled syringe which is included in the Supplementary Drug Kit.

Action: All Divisional Clinical Governance Leads, Clinical Leads, Consultants, Divisional Head of Nursing, Matrons, Ward Manager and Heads of Departments please print off the risk Alert and ensure this is communicated to your staff within the your areas of responsibility as part of all communication briefings.



NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Potent synthetic opioids implicated in heroin overdoses and deaths

Date: 2nd August 2023

Alerts are circulated to raise awareness of risks that may lead to errors and reduce the risk to patients, staff, visitors and contractors in the future. They are produced following a review of incidents or following information provided by staff with the Trust or by External Agencies.

Reason for alert: On 26th July 2023, a National Patient Safety Alert was circulated in response to an elevated number of overdoses (with some reported deaths) in people who use drugs, primarily heroin, potentially linked to adulteration with potent synthetic opioids, resulting in a risk of severe toxicity.

Testing has indicated the presence of nitazenes, a group of potent synthetic opioids, in samples of drugs linked to some of these cases. This has most commonly been linked to heroin, but other illicit substances have been implicated, including fake oxycodone tablets, 'street' benzodiazepines and synthetic cannabinoids. The potency and toxicity of nitazenes is uncertain but is believed to be similar to, or more than, fentanyl, which is about 100x more potent than morphine.

Staff should be alert to the possibility of opioid overdose in any patient presenting with a fluctuating GCS.

Any suspected opioid overdoses should be treated as per policy, using naloxone and supportive care. Dosing guidance for naloxone can be found here. Patients should be closely monitored during treatment and additional doses of naloxone administered as clinically indicated. Patients who have taken an overdose should be monitored for up to 24 hours because the duration of the action of naloxone is shorter than many opioids, so worsening or recurrence of respiratory depression may occur, requiring further administration of naloxone.

All suspected, and confirmed, cases of opioid overdoses should be referred to the Hospital Alcohol and Substance Misuse team, via ICE, to ensure appropriate counselling and post-discharge follow up arrangements are in place. All individuals should be signposted to their local community substance team (details overleaf) where they can (anonymously) obtain a naloxone pack and training.

Any additional intelligence about the use of and harm from synthetic opioids should be e-mailed to drug.alerts@dhsc.gov.uk

For further information about this alert or other queries, please contact:

- James Higgins, Alcohol & Substance Lead Nurse, ext 5177 or bleep 326
- Paul Mooney, Chief Pharmacist and Controlled Drugs Accountable Officer, ext 2293

For further advice on the management of suspected cases, medical professionals can contact the National Poisons Information Service on their 24-hour telephone service on 0344 892 0111.

Potent synthetic opioids implicated in heroin overdoses and deaths. The reason for this alert was to highlight a National Patient Safety Alert in response to an elevated number of overdoses in people who use drugs.

Supply problem: Sodium Bicarbonate 1.26% Polyfusor. The reason for this alert was to inform of a supply chain problem and to provide information on what to do when Sodium Bicarbonate 1.26% Polyfusor is not available.

Cannula used on Resuscitation Trolly. On recent checks of resuscitation trollies, it had been found that the wrong cannula was being put on the trollies. It was recommended that all resuscitation trollies were checked for the correct cannula and restocked appropriately.

6 Learning from Clinical Claims

6.1 Clinical Claims Received.

There were 35 clinical claims received in Q2, 32 were received in the previous quarter.

6.2 Clinical Claims Closed.

There were 32 ongoing Clinical Claims closed in Q2, 13 with damages (totalling £1,224,236.28 (excluding costs of instructing Trust solicitors), 1 Periodic payments (totalling £5,429,250.21 (excluding costs), 2 Successfully repudiated and 16 withdrawn including closed due to lack of further correspondence from the claimant.

Specialty	Damages Paid	No of Claims
Radiology	£630,000.00	1
General Surgery	£244,824.00	1
Spinal Surgery	£135,162.28	1
Trauma & Orthopaedics	£7,500.00	2
Acute Medicine	£15,000.00	1
Emergency Medicine	£21,750.00	2
Gynaecology	£25,000.00	1
Obstetrics	£5,574,250.21	5
Grand Total	**£6,653,486.49**	**14**

6.3 Non-Clinical Claims (Employee Liability/Public Liability)

6.3.1 Non-Clinical Claims Received.

There were 2 employer liability claims and no public liability claims received in Q2 in comparison to 7 claims received in Q1, 6 of those being Employer Liability and 1 Public Liability.

Quarter 2

Employer Liability	2
Abuse etc of Staff by patients	1
Exposure to infection, hazardous substance, electricity	1
Public Liability	**0**
Grand Total	**2**

6.3.2 Non-Clinical Claims Closed.

There were 5 Employer Liability Claims closed in Quarter 2, 3 with damages paid. There was 2 Public Liability Claims closed, both with damages paid. The total damages paid is £17,552.00 excluding costs.

6.3.3 Claims Learning and Actions.

Following claims investigations for claims closed in Quarter 2, the following themes were identified, and actions implemented. The clinical claims review group continues to monitor themes and trends. All claims had previously been investigated through the incident process.

Claims Learning	
Closed: 24/08/2023 – 1962 **Delay in diagnosing and treating pancreatitis and**	1. An internal audit was undertaken which found a number of subtotal cholecystectomies linked to this clinician. This clinician is no longer employed by the Trust.

Claims Learning	
subsequent negligent removal of gallbladder.	
Closed: 18/08/2023 – 6713 **Delay in diagnosing tendon in hand**	1. Teaching on hand and tendon injuries was added to the junior doctor induction. 2. Emergency Department Nurse practitioners attended a teaching session on hand injuries. This included recommendation's regarding tendon assessments and washouts.
Closed: 29/08/2023 -894 – 10/07/W26 **Mismanagement of pre-eclampsia**	1. The Maternity team have updated their guidelines for the Management of Hypertension in Pregnancy to reflect best practice NICE recommendations. 2. An audit regarding the management of severe pre-eclampsia in pregnancy was completed and identified a specific group of women where aspirin could help to reduce the risk of pre-eclampsia in pregnancy. As an action, the maternity team have introduced an antenatal risk assessment proforma, completed at booking, to identify women who will benefit from prophylactic aspirin in pregnancy.
Closed: 19/07/2023 **Fluid overload - 7135**	1. Obstetric doctors and midwives involved in this case have attended a multi-disciplinary training for care and management of obstetric HDU patients. 2. Midwives involved in incident have completed the AIMS course (Acute Illness Management) in recognising the deteriorating patient. 3. Doctors and midwives involved in incident have completed a Trust study day in IV drug administration. 4. A Lessons learned document was completed and shared at the Women's and Children's governance meeting. 5. The case was discussed at the Birth Suite Forum meeting and a review of HDU charts used in maternity was undertaken.

7. Learning from Inquests

17 inquests were heard in Quarter 2, 9 with narrative verdicts, 3 with natural causes, 1 with drug related concluded, 1 with misadventure concluded, and 3 with accidental death concluded. The Cheshire Coroner was satisfied with the learning implemented. There were no Regulation 28 (prevention of future deaths) concerns.

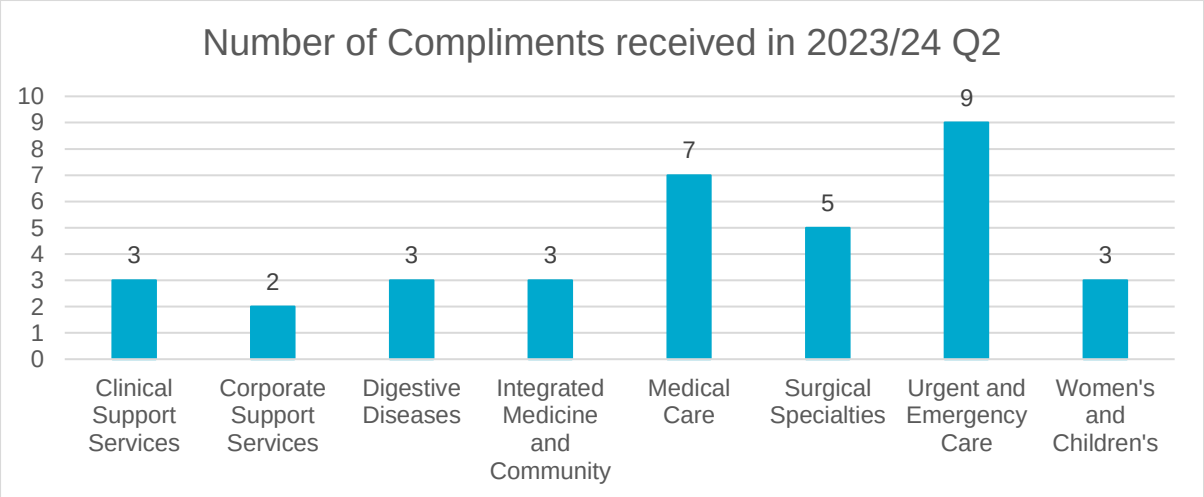
Two of the inquests had legal representation. 1 was a narrative verdict. The coroner confirmed she had heard the Trust have learned lessons from this death and was satisfied with the learning put in place since. The other was an accidental death verdict. There was no learning identified.

The Trust is in the process of liaising with the Trust solicitors to arrange a Mock Inquest event. This being a good learning opportunity for teams to understand the inquest process at coroners court.

8. Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a very useful tool for the Trust to be able to identify what areas are working well. In Q1, the Trust received 35 compliments which has decreased compared with 44 compliments received in Q1.

Graph 7



It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. When investigating a formal complaint, another learning consideration is to share the positive messages contained within these. For example, although an experience can provoke a formal complaint, this does not been that all elements of care were negative.

9. Learning from Patient Experience

The Patient Experience and Inclusion team continue to develop monthly patient stories with senior nursing colleagues. These patient stories are shared across multiple committees such as Patient Experience Sub Committee, Patient EDI Sub Committee, Quality Assurance Committee, Trust Board and with the learning and development team. The purpose is to highlight areas of improvement required and identify good practice for shared learning.

The Patient Experience and Inclusion team use several methods to gain valuable qualitative data from patients. Again, this allows the celebration of good practice and to initiate improvements required that are identified via patient feedback. Methods used include:

- The national Friends and Family Test.
- Local departmental surveys.
- National audits.
- Monthly Patient Experience and Inclusion team observation rounds.
- Monthly First Impression observation rounds.
- Monthly Governors observation rounds.
- Feedback from complaints / PALS.
- Feedback from Community Partners and Advocacy Groups.
- Knowledge and Evidence resource for best practice.

As a result of feedback received from these various methods, examples of improvements are as follows:

- Improving our communication with the d/Deaf community; including:
    - The Launch in August 2023 of monthly d/Deaf awareness training sessions, running until March 2024, open to all Trust colleagues.
    - The introduction on Lorenzo of a d/Deaf alert for patients in July 2023.
    - Commenced in September with an interpretation compliance audit.
    - Focused meetings and ward visits to ensure compliance with the interpretation policy.
- Addressing comments around communal areas by:
    - The Launch in September 2023 of First Impression observational rounds in communal areas. Represented by Patient Experience and Inclusion, Volunteer Team, Governors, Estates and Facilities.
    - Initial focus on keeping areas clutter free and tidy, with clear signage in place.
    - Actions noted and will be reported through Patient Experience Sub Committee for updates.
- Information regarding waiting times with ED, developing better communications:
    - Designed single poster to explain key messages:
        - prioritisation based on medical need.
        - types of communication support available
        - available pain relief
        - assistance to bathroom facilities
        - food/drink available
        - alerting staff

10.Learning from Clinical Audit

10.1 Learning from National Audits

National Paediatric Diabetes Audit (NPDA).

Summary:

NPDA was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. This report covers the health checks (care processes) and outcomes for children and young people with diabetes aged 0-24 on the first day of the audit period. The latest data published relates to 1st April 2020- 31st March 2021.
The report aims to address a series of questions relating to paediatric diabetes care, which include:

- What proportion of children and young people with diabetes are reported to be receiving key age-specific processes of diabetes care, as recommended by NICE?
- How many achieve outcomes within specified treatment targets?
- Are children and young people with diabetes demonstrating evidence of small vessel (microvascular) disease and/or abnormal risk factors associated with large vessel (macrovascular) disease prior to transition into adult services?

Key Findings:

- The Clinical outcomes continued to be good with HbA1c levels in the cohort of patients and were better than regional average and sustained at 61 mmols/mol despite COVID pandemic and patients seen virtually.
- The percentage of patients receiving sick day rules and flu vaccinations were significantly high and better than national average.
- The patients with poor control were consistently lower comparable to national rates and there is improvement with a greater number of patients with good control despite COVID pandemic pressures.
- The patients with newly diagnosed patients had lower coeliac screen and thyroid tests performed at diagnosis as patients were seen virtual post diagnosis.
- The data on abnormal eye screening were inappropriate as we do not receive eye reports from the community regional screening team consistently. The eye screening during COVID pandemic were done once in 2 years instead of annually and thus not appropriately reflecting the data.
- We have lower than national average patients with kidney disease.

Improvement Action Plan:

- Raise awareness among patients for regular annual eye checks (Digibete APP communication).
- Ensure communication to regional eye screening team to obtain annual screen reports.
- Training plus raising awareness for junior doctors at induction to ensure completion of Thyroid and coeliac screening completed and chased at diagnosis.

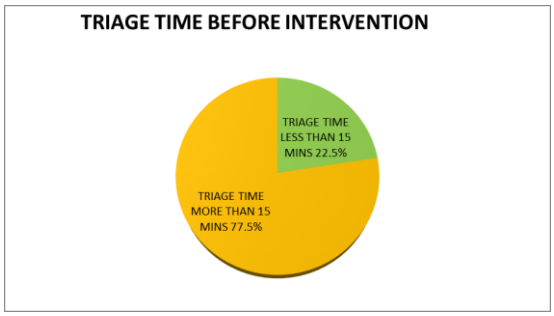
Assurance rating (using Trust assurance rating matrix): Significant.

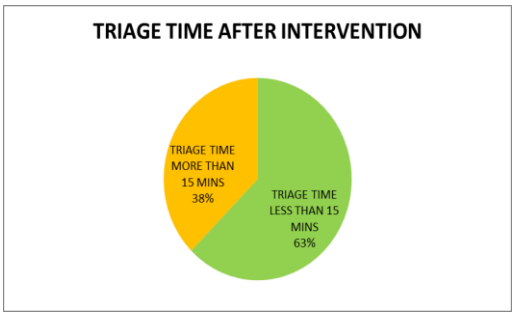
10.2 Learning from Local Audits

Summary:
The triage process plays a crucial role in emergency and acute medicine departments, including the SDEC (Same Day Emergency Care), by prioritizing patient care based on the severity of their condition. Timely triage is essential for patient safety ensuring prompt medical assessment and appropriate allocation of resources. Implementing triage stickers in the SDEC unit is one approach aimed at improving triage efficiency and reducing overall triage time.

Furthermore, there is a need to evaluate the effectiveness of the triage sticker implementation in achieving the desired outcomes. Assessing the percentage of patients who are triaged within the target time frame of 15 minutes after the introduction of triage stickers provides a quantitative measure of the intervention's success.

Key Findings:





Observations from the audit indicate significant improvements in triage time after the implementation of triage stickers.

After the intervention, there was a significant improvement. The percentage of patients with a triage time less than or equal to 15 minutes increased to 62.5%, indicating that a larger portion of patients received a faster triage process. Conversely, the percentage of patients with a triage time exceeding 15 minutes decreased to 37.5%, suggesting a reduction in the number of patients experiencing longer waiting times for triage.

Improvement Action Plan:

- Incorporating training sessions for new staff to highlight the importance of the stickers.
- Emphasize the importance of triage timings during MDT meetings.
- Review the staffing between 12-5pm, to improve compliance.

Assurance rating (using Trust assurance rating matrix): Moderate Assurance

11.Compliance

11.1 Learning from Mock CQC Inspection

Following the ED Mock Inspection which took place in June 2023, ED action plans are in place with focus upon remaining regulatory breaches following the 2019 inspection: Over crowding, staffing, deterioration and escalation, good governance. Triage is also an area of focus for improvement utilising the Manchester Trage tool. A programme of continuous flow has also been introduced Trustwide with initial positive outcomes. There is a weekly ED Quality Improvement Meeting where progress against actions is monitored and reviewed.

11.2 Learning from the recent Maternity CQC Inspection

A formal Maternity Inspection took place on 14th September 2023, the feedback report is expected in early November.

No specific risks or concerns were escalated by the CQC inspection team on the day of inspection. A letter was received from the CQC on 22nd September 2023, detailing the following as significant concerns:

- Enhanced Care
- Transitional Care
- Postpartum haemorrhage rates

Additional evidence was submitted at the request of the CQC within timeframe. A further meeting was held with the CQC on 29th September 2023 to discuss the content of the Trust letter of response which has been submitted, the CQC were satisfied with the Trust response.

A programme of Mock inspections remains in place as detailed in the M20 report.

12. Learning from Research and Development Activity

12.1 Learning from Research and Development

Learning from Experience

The RD&I team and wider research workforce have reached some significant research landmarks over recent months, from global first recruit into a study, to first paediatric vaccine study on the HCRU, to highest recruiter for another vaccine trial. Amongst these achievements, many opportunities for learning to identify areas for improvement have arisen, to further enhance the performance of research, as well as the participant experience. Some learning opportunities are highlighted below.

Learning from Lived Experience

An example is the experience of working with the Trust engagement team to embark on some patient and public engagement activities. The R&D&I team had pleasure of spending time at Halton Clinical Research Unit with a group of young adults who are part of Halton Research Ready Community Champions. Supported by National Institute for Health and Care Research Clinical Research Network (NIHR CRN) and Power In Partnerships (PIP) these young people, who are all care leavers, are part of a national programme to help build better relationships with communities that are currently under-served by health and care research, to increase access to health and care research opportunities.

This was the first conversation of its kind for the RD&I team and provided a valuable learning experience for all involved. With the support of the Engagement team, plans are in place to have further discussions with the group regarding their lived experience as young Care Leavers and how we can work together co -productively to tackle health inequalities in the communities where they live. Topics that the group want to see prioritised were diabetes, heart conditions, drug and alcohol addiction, contraception, housing complications, loneliness and isolation.

Research Awareness and Education

The RD&I team are also focusing on the learning and education of others though a specific programme of engagement with Nurses, Midwives and Allied Health professionals, thus opening the dialogue for conversations about research and evidence-based practice. Examples include delivery of research sessions on the preceptorship programme for Occupational therapists and Physiotherapists, the AHP Research lead delivering bite size seminars with 45 delegates attending 1 or both sessions. The RD&I team are learning, through surveys, discussions and evaluation forms, about the research training needs of WHH staff and how best to address those needs. The outcomes will be improved awareness and increased capacity and capability to undertake and develop research for the benefit of patients.

13. Quarterly Learning Opportunities Section

13.1 Falls Awareness Week 18th- 21st September 2023 and #WorldPatientSafetyDay

A series of events showcasing falls awareness was delivered by the Patient Safety Team across WHH.



As part of the promotion of the patient safety theme a #WorldPatientSafetyDay video featured our Chief Nurse and Deputy CEO Kimberley Salmon- Jamieson talking about the importance of involving patients and the benefits that this brings for patient safety. Kimberley was joined with videos from our Patient Safety Partners Sue and Gemma in talking about how it is important for patients to be given a voice.





13.2 September is Sepsis Awareness Month

This initiative aimed to raise vital funds for research and promote awareness of the key symptoms of sepsis, helping to save lives and improve outcomes for sepsis patients. The patient safety team hosted a series of learning events to higlight sepsis awareness and prevention.







13.3 Your Future Your Way Celebratory Event September 2023

Your Future Your Way (YFYW) celebratory event for internationally educated nurses, midwives and AHPs on took place on Friday 8th September.

YFYW was designed to develop aspiring nursing, midwifery and AHP leaders from multi-ethnic backgrounds (the global majority) reach equity, further recognising their talent and skills as well as helping to remove any barriers to professional career development. The Trust won an outstanding contribution to EDI award from the North West Royal College of Nursing (RCN).



13.4 First C.difficile learning events September 2023



The WHH Infection Control and Prevention Team launched a series of interactive learning events including two study days focussed on leaning about C.difficle infection. Great feedback was received from these fun and informative events from the clinical support workers and students that attended.



13.5 Quality Academy Showcase July 2023

The annual Quality Academy Showcase took place in July as a fantastic learning event celebrating teamworking and coming together to make a difference. Outstanding examples of work to demonstrate how we deliver safe, effective and compassionate care were showcased through oral and poster presentations and a series of breakout sessions offered more opportunities to share learning and network. The day was highlighted by expert presentations from Professor Michael West on compassionate leadership and Julia Wood on Joy in Work and was attended by over one hundred colleagues.





14. Recommendations

The Quality Assurance Committee is asked to note the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/11/240**			
SUBJECT:	**Infection Prevention and Control Report Quarter 2**			
DATE OF MEETING:	14 November 2023			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		N/A	N/A	N/A
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	N/A	N/A	N/A
	Further Information/Comments: Nil			
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 2 (Q2) of the 2023/24 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators. Healthcare Associated Infection (HCAI) cases at end of Q2 are: - • E. coli bacteraemia 42 cases against an annual threshold of 54 • Klebsiella Spp. bacteraemia 6 cases against an annual threshold of 18 cases • P. aeruginosa bacteraemia 3 cases against an annual threshold of 2 cases • C. difficile 19 cases against an annual threshold of 36 cases			

<table>
<tr><td></td><td colspan="4">

- MRSA bacteraemia 0 cases and rolling 12 months MRSA bacteraemia free
- MSSA bacteraemia 16 cases (no threshold)

Inpatient Covid-19 cases at end of Q2 are: -

- 258 (0-2 days)
- 42 (3-7 days)
- 58 (8-14 days – probable healthcare associated)
- 89 (15+ days – definite healthcare associated)

There were 9 inpatient Covid-19 outbreaks at the end of Q2: -

- 6 were mixed inpatient and staff outbreaks and 3 were inpatient only outbreaks. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups

Research undertaken in relation to healthcare associated infection incidents and alignment with the Patient Safety Incident Response Framework has been shared with the regional NHS England IPC network and will be presented at an NHS England PSIRF national webinar in November.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note √</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Quality Assurance Committee is asked to receive and note the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Infection Control Sub-Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">ICSC/23/10/163</td></tr>
<tr><td>Date of meeting</td><td colspan="3">19th October 2023</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Submit to Quality Assurance Committee</td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="4">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 2	AGENDA REF:	QAC/23/11/240

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control (IPC) activity for Quarters 1& 2 of the 2023/24 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, continued response to Covid-19 cases and progress towards achieving the Infection Prevention Strategy.

There is a national ambition to halve Gram-negative bloodstream infections (GNBSI) by 2024. GNBSI include: - Escherichia coli (E. coli); Klebsiella species (Klebsiella spp.) and Pseudomonas aeruginosa (P. aeruginosa). NHSE set annual thresholds to minimise rates of *Clostridioides difficile* (*C. difficile*) and Gram-negative bloodstream infections (GNBSI). The thresholds set for WHH for 2023/24 are shown in table 1.

Table 1: WHH HCAI Thresholds for 2023/2024

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

GNBSI and C. difficile cases meeting the definitions below are apportioned to acute trusts:

- **Hospital-onset healthcare-associated (HOHA) =** Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- **Community-onset healthcare-associated (COHA) =** is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

NHSE also set annual thresholds for all sub-Integrated Care Boards (ICB) geographical areas and these thresholds include all cases (comprising of the acute Trust and community cases). The Cheshire and Merseyside ICB thresholds for 2023 2024 are shown in table 2.

Table 2: Local ICB Sub-Group HCAI Thresholds for 2023/2024

C&M ICB	*C. difficile*	*E. coli*	*P. aeruginosa*	*Klebsiella spp.*
01X Halton	47	137	10	28
02E Warrington	45	130	5	37

The zero-tolerance threshold for avoidable cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia remains in place. There is no threshold for Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases.

NHSE case definitions for Covid-19 are as follows with date of admission equalling day 1:

- Hospital-Onset Indeterminate Healthcare-Associated - First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission to Trust

A cluster of Covid-19 cases is defined as 2 cases arising within the same ward/department over a 14-day period. Further investigation is undertaken to assess if cases are linked, and if linked this is considered an outbreak and reporting is carried out in line with NHSE guidance.

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

RAG rating of Trust performance for HCAI by month is shown in Table 3.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	J	A	S	Total	In year status
C. difficile	≤ 36	1	1	2	5	4	6	19	Over trajectory
MRSA BSI	Zero	0	0	0	0	0	0	0	On trajectory
MSSA BSI	No target	1	2	3	4	1	5	16	No threshold
E. coli BSI	≤ 54	8	8	6	5	8	7	42	Over trajectory
Klebsiella spp. BSI	≤ 18	0	3	0	1	1	1	6	On trajectory
P. aeruginosa BSI	≤ 2	0	2	0	0	0	1	3	Over threshold

C. difficile: 15 cases reported in Q2 and over trajectory at the mid-year point. Ribotyping of Trust apportioned cases continues and during September, identified 2 cases on ward B19 with 078 ribotype. This ribotype accounts for approximately 5% of C. difficile infections in England. Additional genetic testing has been requested to identify if the cases are linked, with results awaited at the time of writing. Review of the ward identified 100% compliance with the Antibiotic Formulary and high standards of environmental cleaning. An audit of infection prevention and control practices identified areas for improvement with equipment decontamination. C. difficile specific training with the ward team has been implemented.

MRSA Bacteraemia: Nil cases in Q2 and no Trust apportioned cases for a rolling twelve months.

MSSA Bacteraemia: 10 cases in Q2 and 16 cases YTD. The likely primary sources include: 3 skin and soft tissue infection; 3 central line associated; 1 endocarditis, 1 possible surgical site infection, 1 osteomyelitis, 2 other including discitis and psoas abscess and an infected haematoma and 5 with source unknown. Further review of the cases with unknown sources will take place to identify any areas for learning and improvement.

GNBSI: E. coli 20 cases, Klebsiella spp. 3 cases and P. aeruginosa 1 case reported in Q2. E. coli cases are over trajectory and the P. aeruginosa annual threshold has been breached by 1 case. The GNBSI Prevention Group has been reformed and the GNBSI prevention action plan updated. Workstreams include : -

- Review findings from the audit of hepatobiliary cases
- Identify system level learning
- Continue work with the Quality Academy to introduce a nurse led protocol for urinary catheter removal
- Launch the Oral Care Policy to support prevention of hospital acquired pneumonia

Policy/Guideline/SOP Updates

The IPC Team have included a schedule of documents for review in the annual workplan and work has commenced to review and update these documents alongside the National IPC manual for England. The following documents have been updated and approved by the IPC Sub-Committee (ICSC): -

- SOP for COVID Self-Isolation and Routine Testing V12
- SOP for COVID Self-Isolation and Routine Testing V13

Audit

During Q2, 45 audits were completed with results shown by Clinical Business Unit (CBU) in appendix 2. The audit tool is aligned to the NHS England National Infection Prevention and Control Manual and includes standard precautions. A summary of areas for improvement (list is not intended to be exhaustive) are included in table 4.

Table 4: Audit Findings

Element	Areas for improvement
Environment	General tidiness, high/low level dust, dust build up on extraction vents, dusty IT equipment, storage of cleaning equipment and lack of handwashing only signage
Ward Kitchens	General tidiness, perishable items not stored in pest proof containers, labelling of staff food, recording of fridge temperatures, microwave cleanliness

Element	Areas for improvement
Handling/Disposal of Linen	Linen bags overfilled, used linen not being placed in a linen skip at the bedside, used linen on the floor, incorrect personal protective equipment for handing used linen
Departmental Waste	Availability of correctly colour coded bins, waste carte left unlocked, incorrect waste stream disposal
Safe Handling/Disposal of Sharps	Temporary closure system not activated, sharps bin not secured on a bracket, closed bin not labelled
Patient Equipment (General)	Missing I am clean labels, some items required cleaning
Personal Protective Equipment (PPE)	Overuse of gloves, not changing PPE between patients, removal of PPE prior to leaving an isolation room
Short Term Catheter Management	Completion of on-going care documentation, securing the device to the patients leg
Care of Peripheral Intravenous Lines	Ongoing indication for cannula not documented and completion of monitoring charts
Isolation Precautions	Door signage, timely removal of used linen
Hand Hygiene	Handwashing after PPE removal

Concerns and issues requiring immediate action are reported to the nurse in charge at the time of the audit. Full audit findings are emailed to Ward Managers and an action plan to address findings is requested.

The re-audit schedule is set according to findings. For areas with lower scoring results, re-audit is completed sooner. All areas are monitored by an IPC and CBU Matron monthly visit and if concerns about IPC standards are identified, a repeat audit is completed.

Several actions are in place including: -

- Project to improve standards of environmental hygiene and equipment cleaning including standards for cleaners cupboards
- Awareness raising to improve use of PPE and gloves off campaign in October
- Audit tool education and action planning support for Ward Managers
- Implementation of the NHS Waste Strategy and education on waste segregation

Antimicrobial Stewardship

The Point Prevalence Audit conducted in August 2023 showed 87% compliance with the Trust Antibiotic Formulary which is a decrease from the previous audit in April 2023 where compliance was 91%. The 87% compliance is below the Trust's internal minimum compliance target of 90%.

Table 5: Antibiotic Compliance with Formulary by Ward

Ward	Compliance Sept 2022	Compliance Jan 2023	Compliance April 2023	Compliance August 2023
AMU	**95.8%** (23/24)	**69.2%** (18/26)	**80.8%** (21/26)	**75%** (18/24)
A2	**100%** (13/13)	**71.4%** (10/14)	**96%** (24/25)	**90%** (9/10)
ACCU Ward	**87.5%** (7/8)	**80%** (4/5)	**100%** (5/5)	**100%** (5/5)
ACCU HC	**100%** (6/6)	**75%** (3/4)	**100%** (3/3)	**66.6%** (2/3)
A4	**85%** (17/20)	**95.5%** (21/22)	**86.7%** (13/15)	**76.5%** (26/34)
A5 Elective	**100%** (2/2)	**100%** (6/6)	**100%** (3/3)	**100%** (3/3)
A5 Gastro	**100%** (3/3)	**90.9%** (10/11)	**92.3%** (12/13)	**100%** (6/6)
A6	**100%** (10/10)	**100%** (9/9)	**100%** (9/9)	**100%** (9/9)
A7	**88.9%** (8/9)	**100%** (7/7)	**100%** (16/16)	**100%** (12/12)
A8	**100%** (8/8)	**90.9%** (20/22)	**84.6%** (11/13)	**92.9%** (13/14)
A9	**100%** (13/13)	**75%** (6/8)	**76.9%** (10/13)	**94.4%** (17/18)
A10		**0%** (0/2)	**100%** (1/1)	
B12	**100%** (1/1)	**75%** (3/4)	**100%** (2/2)	**100%** (4/4)
B14	**100%** (6/6)	**100%** (6/6)	**100%** (9/9)	**88.9%** (8/9)
B18	**95%** (20/21)	**85.7%** (12/14)	**92.3%** (24/26)	**87%** (20/23)
B19	**100%** (9/9)	**87.5%** (7/8)	**100%** (6/6)	**100%** (7/7)
C20	**100%** (8/8)	**88.9%** (8/9)	**90.9%** (10/11)	**0%** (0/2)
C21	**100%** (11/11)	**85.7%** (6/7)	**66.7%** (2/3)	**100%** (7/7)
C23	**66.7%** (2/3)	**100%** (2/2)	**100%** (4/4)	**71.4%** (5/7)
K25	**100%** (2/2)	**91.7%** (11/12)	**100%** (7/7)	**100%** (5/5)
Cath Lab		**50%** (1/2)		
SDEC		**100%** (3/3)	**75%** (3/4)	**100%** (7/7)
ITU	**100%** (18/18)	**94.7%** (18/19)	**100%** (15/15)	**100%** (20/20)
CSTM PACU	**0%** (0/1)			
Halton B3	**100%** (1/1)	**100%** (2/2)	**66.7%** (2/3)	**80%** (4/5)
Halton B4		**100%** (2/2)		
CSTM		**0%** (0/1)		**0%** (0/4)
B11	**90%** (9/10)	**87.5%** (7/8)	**100%** (4/4)	**100%** (8/8)
NNU				

Overall, across the two sites 194 (35.4%) patients were prescribed a total of 246 antibiotics, This is similar to the previous quarter (April 2023) where a total of 185 (32.7%) of patients were prescribed a total of 252 antimicrobials.

Of the **246** antimicrobials prescribed, **139 (57%)** were being administered intravenously. This is an increase on the previous audit results which showed that 52.3% of all antimicrobials prescribed in April 2023 were prescribed for IV administration.

Of the **139** IV antibiotic prescriptions, **66** had been prescribed for longer than 72 hours at the time of the audit. Of these, **40 (61%)** had a documented review within 72 hours and **26 (39%)** did not. This compares with 76% having had a documented review within 72 hours and 24% not in April 2023.

The Trust is participating in the national Commissioning for Quality and Innovation (CQUIN) CCG3 which is concerned with prompt switching of intravenous (IV) antimicrobial to oral route of administration (IVOS) as soon as patients meet switching criteria, which supports the antimicrobial stewardship objective in the IPC Strategy. A digital IVOS decision tool is being implemented to ensure IV antibiotics are not continued without clinical justification.

Key issues to address from the Point Prevalence Audit include:

- Ongoing assurance with Trust antibiotic guidelines and the need for clear documentation of an appropriate reason for deviation in the EPR
- Achieve and sustain 100% indication documented in the EPR by mandating documentation of indication on EPMA
- Improvement of documentation of course length or review date and evidence of review of all antibiotics between 24-72 hours
- Consider amending criteria to include mandatory review of IV antibiotics within 48 hours of initiation and every 24 hours thereafter as per new CQUIN
- Implementation of IVOS algorithm to aid prompt IV to oral switch in line with CQUIN
- CMM advice should be sought for patients who have received a prolonged course of broad-spectrum antibiotic therapy to ensure appropriate investigations and microbiological sampling is undertaken at point of antibiotic escalation
- Continual action to be taken to reduce Tazocin prescribing in line with National Targets
- AMS weekly ward rounds to focus on areas with high antibiotic use where compliance is < 90% (AMU, A4, B18) and potential patients who meet criteria for IVOS
- Develop a specific action plan to improve compliance within the surgical speciality

CQUIN03 IV Oral Switch

This CQUIN is concerned with prompt switching of IV to oral antibiotics and includes an ambition to achieve 40% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria. The results for Q1 and Q2 (not finalised) are shown in table 6.

Table 6 IVOS CQUIN results

Q1	Q2
28%	**22.86%**

The IVOS decision aid tool was launched on medical wards with good feedback of usability and next steps include extending the use of the IVOS tool to the planned care division and surgical specialties (who do not currently use CDC forms for their ward round documentation).

Education and Training

Overall compliance with infection control mandatory training was 91% at the end of September 2023 (table 7). Mandatory training is available via eLearning, 2 taught sessions are provided each week and the training session is included at corporate induction.

Table 7 Mandatory training Compliance

IPC Mandatory Training	A	M	J	J	A	S
Level 1 – Non-Clinical	94%	96%	94%	95%	95%	96%
Level 2 - Clinical	83%	84%	85%	86%	86%	86%
Overall compliance	**84%**	**90%**	**90%**	**91%**	**91%**	**91%**

The Infection Prevention and Control Team have offered additional sessions to support compliance improvements, including evening training sessions. The training package is being shared with Practice Based Educators for local delivery.

Environmental Hygiene

A programme of cleanliness monitoring is in place with frequency of auditing carried out according to the NHS Standards of Healthcare Cleanliness (2021). Audit results are emailed to ward/departmental managers and star ratings awarded according to scoring.

All areas are scoring 4-star or 5-star ratings (out of a 5-star rating). Areas with reduced scores are given a 2-to-4-hour timescale to rectify concerns in functional risk 1 (highest risk areas) and functional risk 2 categories.

The Infection Prevention and Control Nurses will be shadowing the Cleanliness Monitoring Team in Q3 to collaborate on auditing standards and work continues to establish a programme of cleaning efficacy audits, which will take a multidisciplinary approach.

Incidents

Covid-19

Covid-19 continued to impact the Trust with details of all cases as shown in Table 8.

Table 8 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	44	14	14	21	93
May	51	6	13	18	88
Jun	58	6	8	11	83
Jul	32	0	3	0	35
Aug	26	6	6	14	52
Sep	47	10	14	25	96
Total	**258**	**42**	**58**	**89**	**447**

Covid-19 Outbreaks

Four Covid-19 outbreaks were reported in Q2, two of which affected both patients and staff. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups with additional oversight of infection prevention and control precautions.

Chickenpox Exposure Neonatal Unit

In July, a sibling visitor to the Neonatal Unit (NNU) was clinically confirmed to have chickenpox, by a Consultant Paediatrician. Review identified the sibling visited during the infectious period and length of time on the NNU was significant for transmission to have occurred.

Five contacts were identified and immunity testing undertaken and post exposure prophylaxis given to two contacts who were non-immune. Both contacts were isolated from day 8 of exposure until day 21 (incubation period) and neither infant developed chickenpox.

Collaboration with Estates

Joint working with the Senior members of the Estates Team to review ventilation and put plans in place to align to the latest building standards. The Ventilation Group has reviewed the trust-wide ventilation survey results and plans are in place to upgrade ventilation systems starting with the system in Warrington theatre recovery.

Patient Safety Incident Response Framework (PSIRF)

Work is in progress to align review of infection prevention and control events with PSIRF.

Qualitative research was undertaken, which involved staff interviews to gain insight into their experience of investigating, reviewing, and learning from healthcare associated infection incidents. This provided rich contextual data and also gave a voice to staff to inform the transition to PSIRF, system thinking and sharing learning.

The research undertaken has been shared with the NW NHS England IPC Network Group and will be shared on a national NHS England webinar in November.

Collaboration with the Patient Safety Incident Director has led to the development of a matrix approach for reviewing infection prevention and control and/or healthcare associated infection events. This will be safety huddles, with the addition of external cross partner working element, using the Safety Engineering in Patient Safety Model (SEIPS) and multidisciplinary team reviews in psychologically safe settings.

One of the findings of the research related to feedback of learning and taking this directly to those involved by interactive learning events rather than just local safety

brief. Work on this has commenced in relation to C. difficile and timely sampling and isolation which was a recurring theme from root cause analysis investigations.

Awareness Raising Activity

C. difficile Learning Events for Care Support Workers

During September the IPC Nurses facilitated 3 study sessions for Care Support Workers, focussing on sharing learning from key themes arising from previous C. difficile investigations.

The approach incorporated interactive games and humour to communicate key themes included timely sampling, isolation, cleaning standards and hand hygiene.

All the sessions evaluated well with positive feedback from all attendees that the sessions surpassed their expectations and a request for more sessions for learning developed in this style.



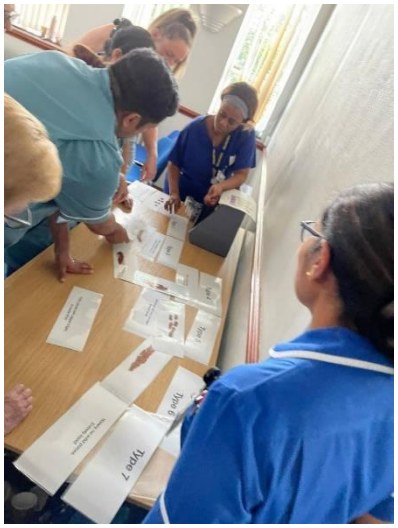














3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies recovery plan
- Delivery of the Infection Prevention Strategy
- Provision of infection prevention and control expert advice to colleagues
- Review of escalations in infections jointly with the associated Care Group

4. IMPACT ON QPS?

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Improved attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability and the green plan

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to UK Health Security Agency
- Surveillance of nosocomial Covid-19 cases/reporting Covid-19 outbreaks
- The Infection Prevention and Control Team monitor HCAI. Action is implemented in response to increased incidences of HCAI and infection control related incidents
- The Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents

- Review of HCAI incident investigation reports and audits and agree actions to support care improvements
- Healthcare Associated Infection data is included in the ward dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy Objectives

- Prevention of healthcare associated infections

Table 8 HCAI Thresholds 2023/24

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

- Strengthening Antimicrobial Stewardship – Participation in the IV Oral Switch CQUIN CCG3
- Improving standards of environmental cleanliness
- Implementing action in line with the NHS Waste Strategy

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:-

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Infection Control Sub-Committee, Quality Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

Monitoring by the Senior Executive Oversight Group.

8. TIMELINES

2023 – 2024 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

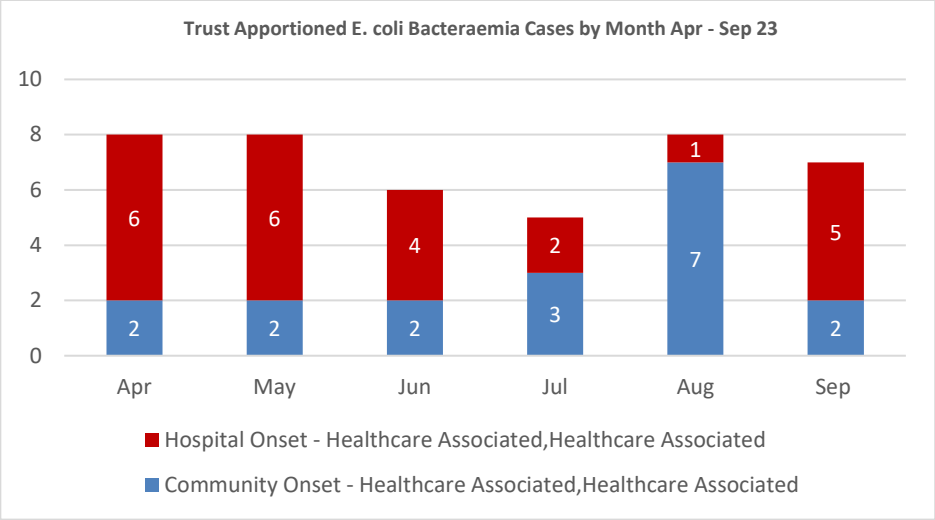
10. RECOMMENDATIONS

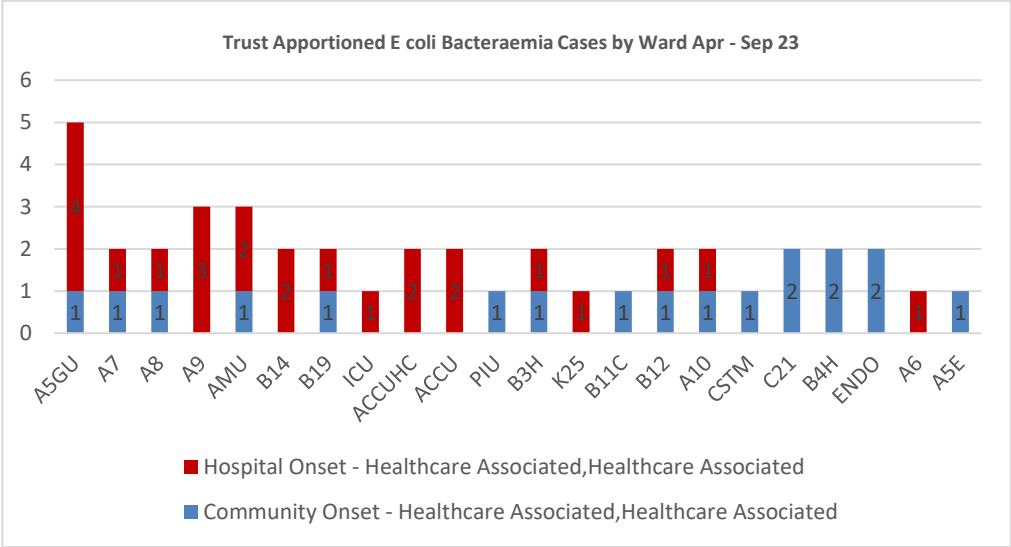
The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported and progress made.

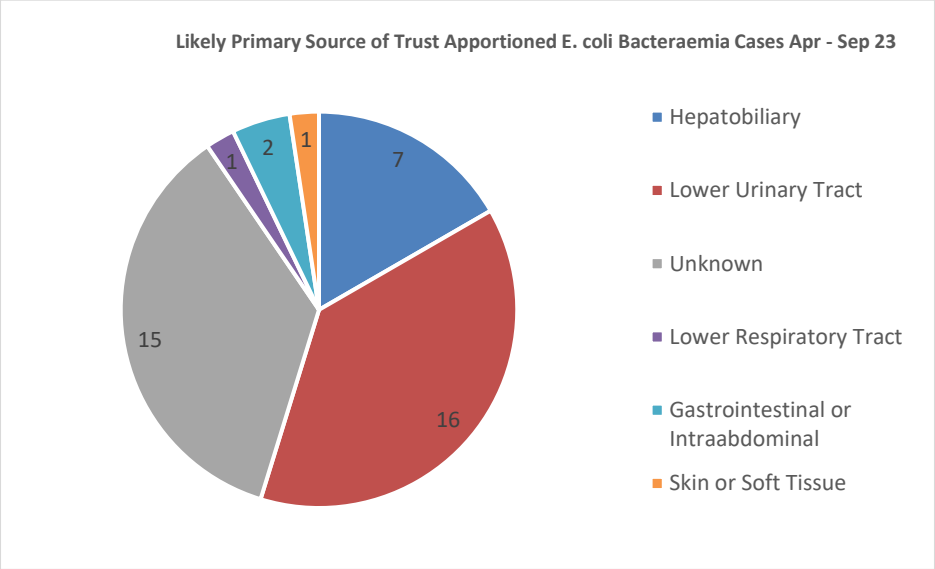
Appendix 1

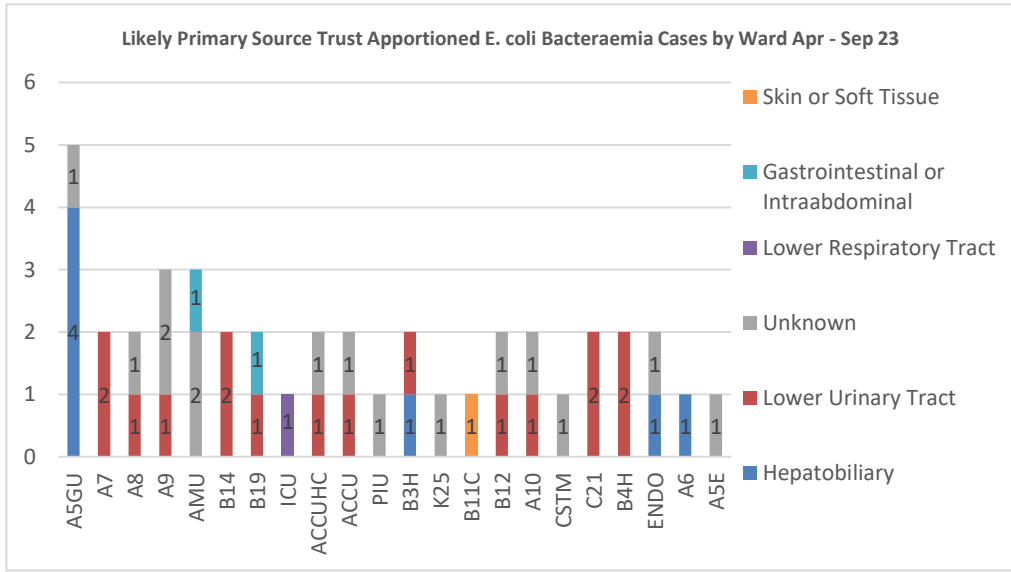
Gram Negative Bloodstream Infection: E. coli Apr – Sep 23

Threshold	54
YTD Total	42



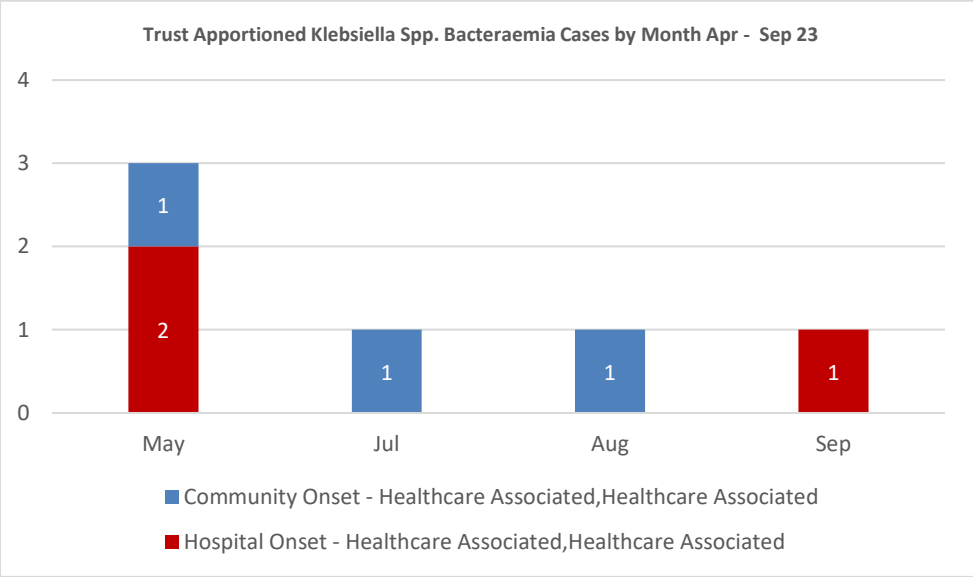


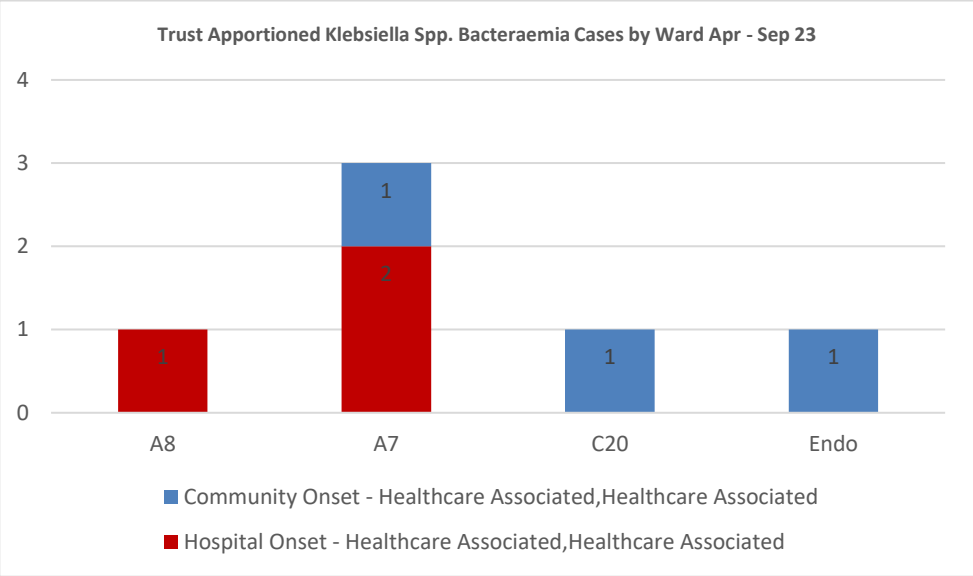


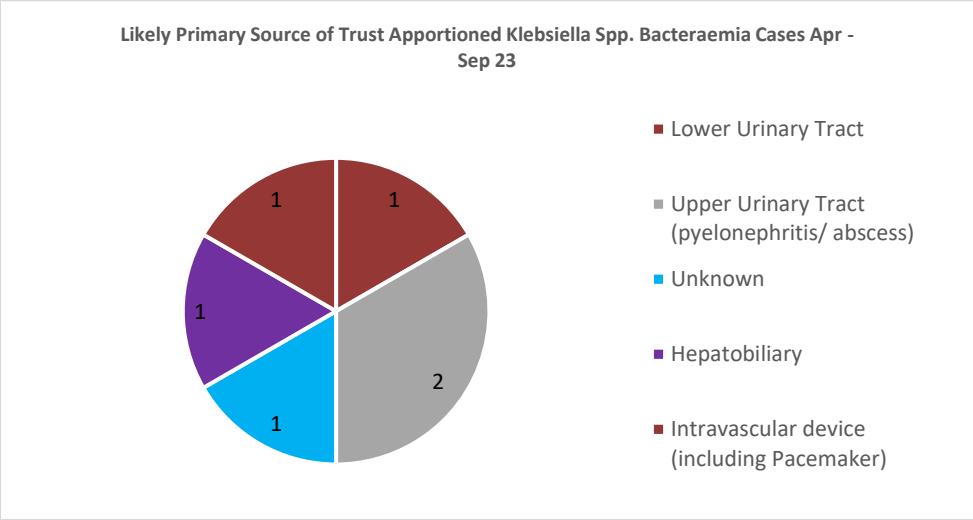


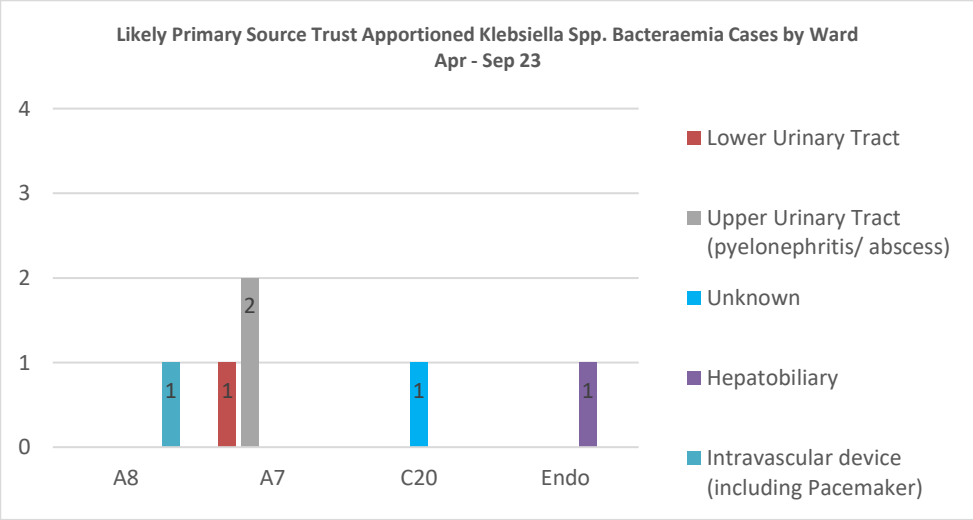
Gram Negative Bloodstream Infection: Klebsiella spp. Apr – Sep 23

Threshold	18
YTD Total	6



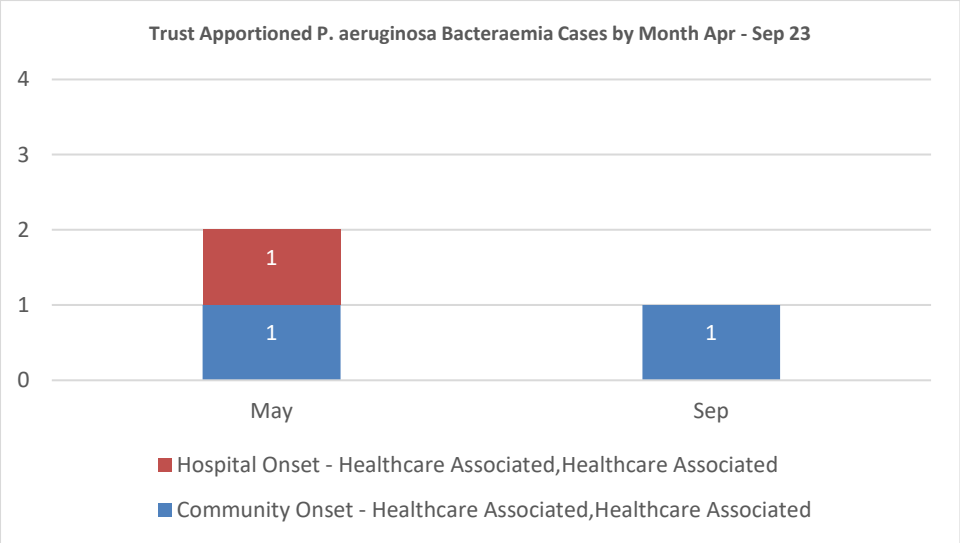


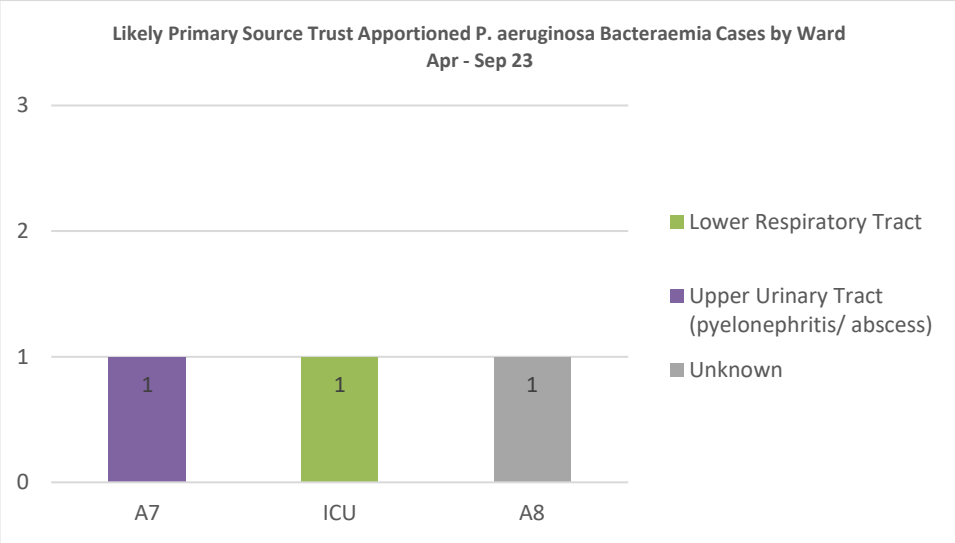


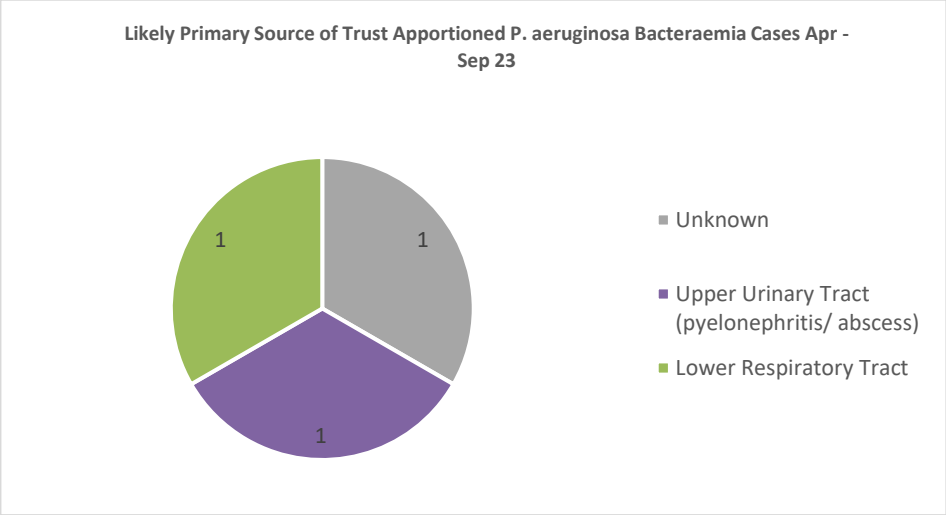


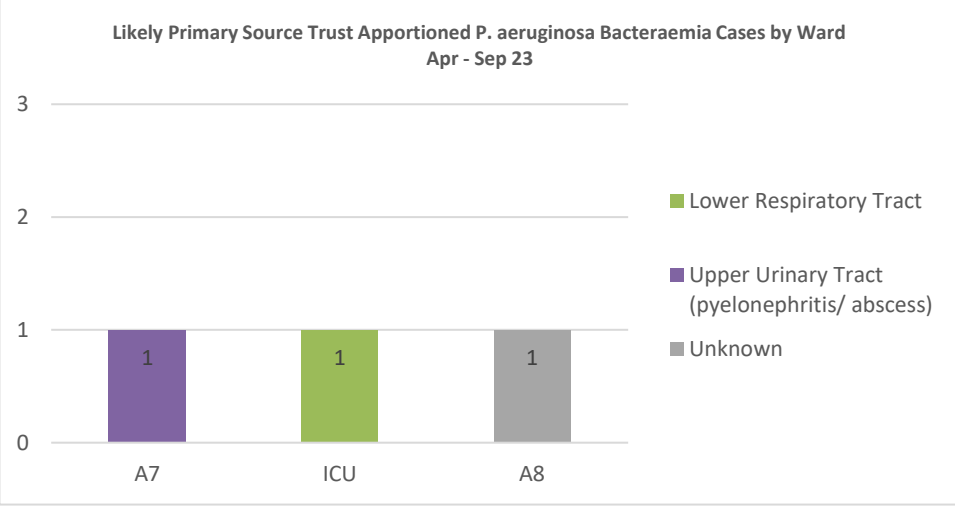
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr - Sep 23

Threshold	2
YTD Total	3









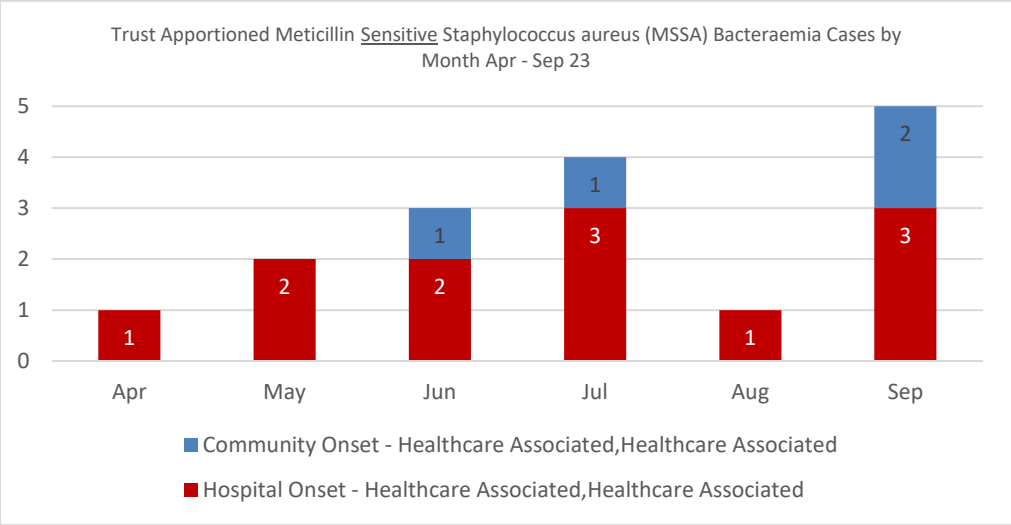
Threshold	0
YTD Total	0

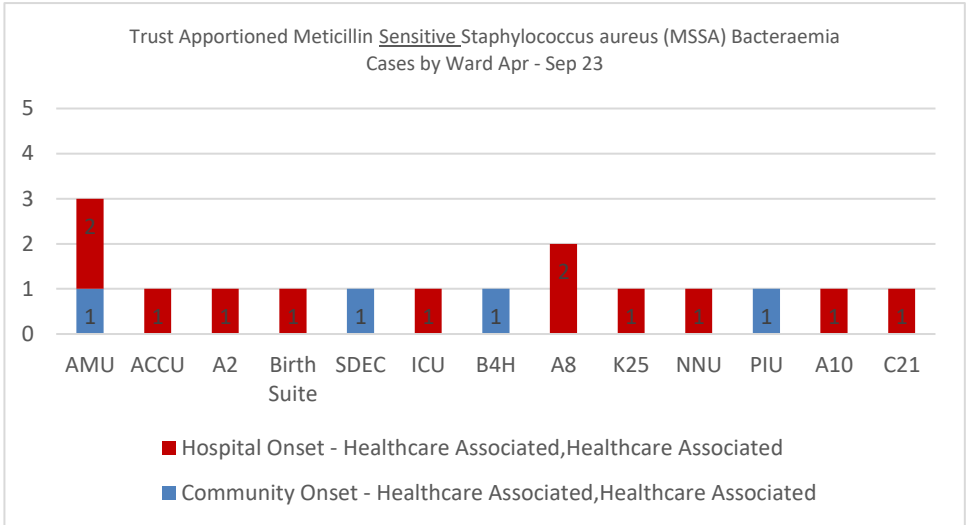
Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr – Sep 23

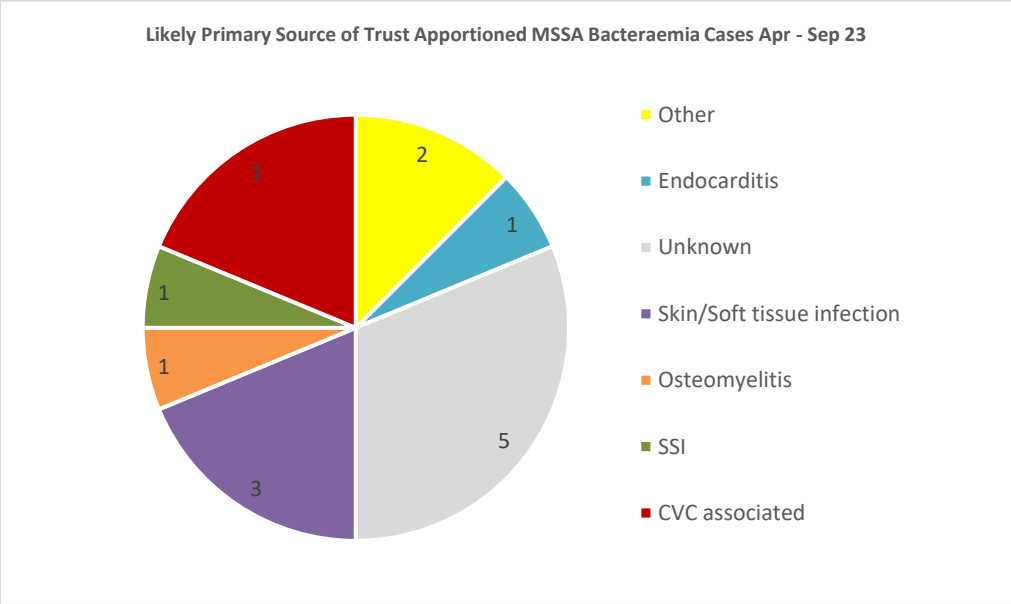
Rolling 12 Months MRSA bacteraemia free

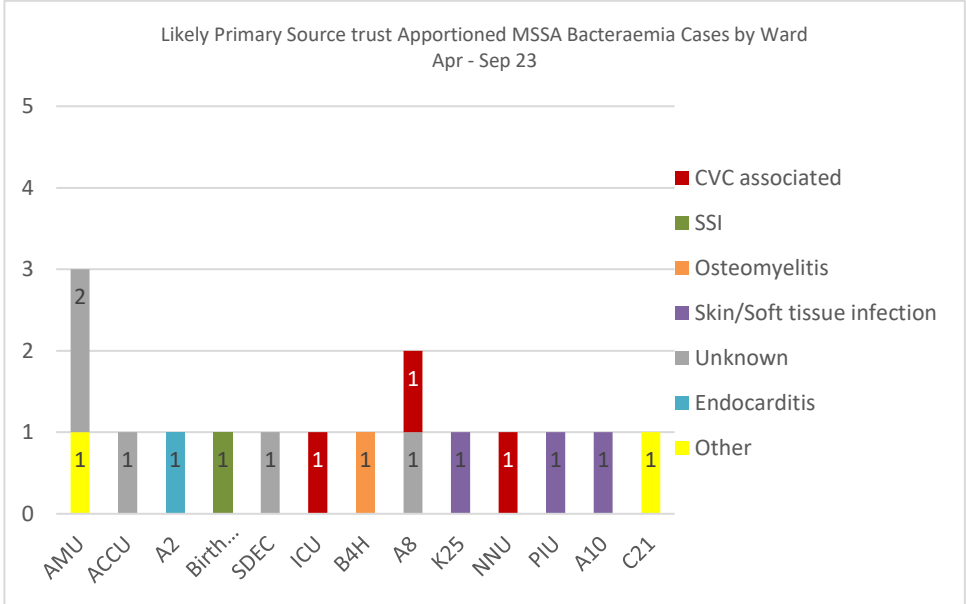
Gram Positive Bloodstream Infection: Staphylococcus aureus Apr - Sep 23

No Threshold	
YTD Total	16



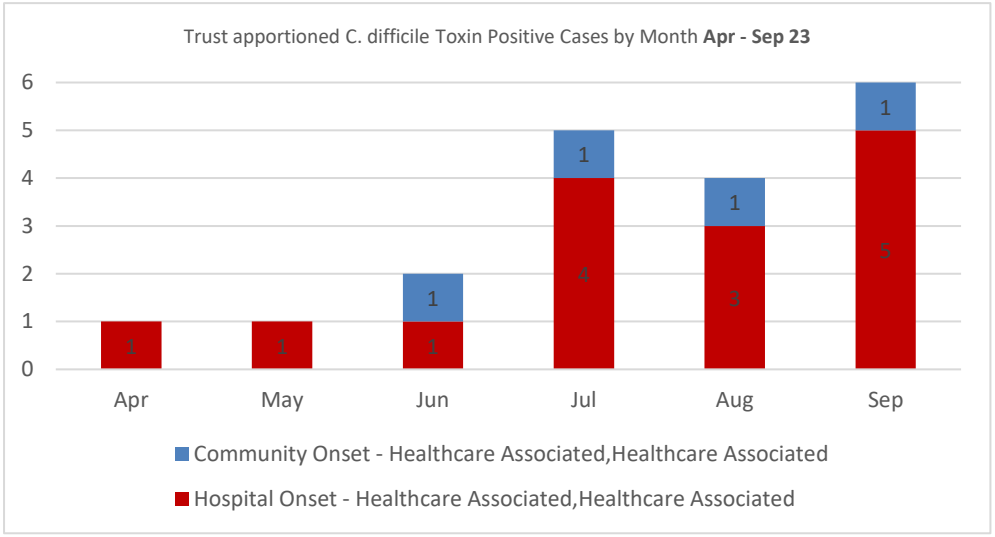


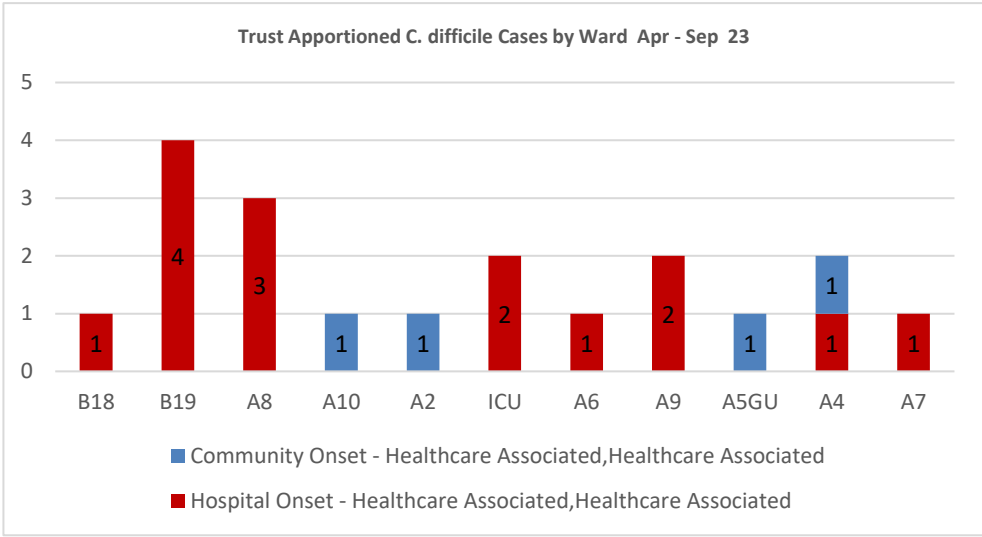


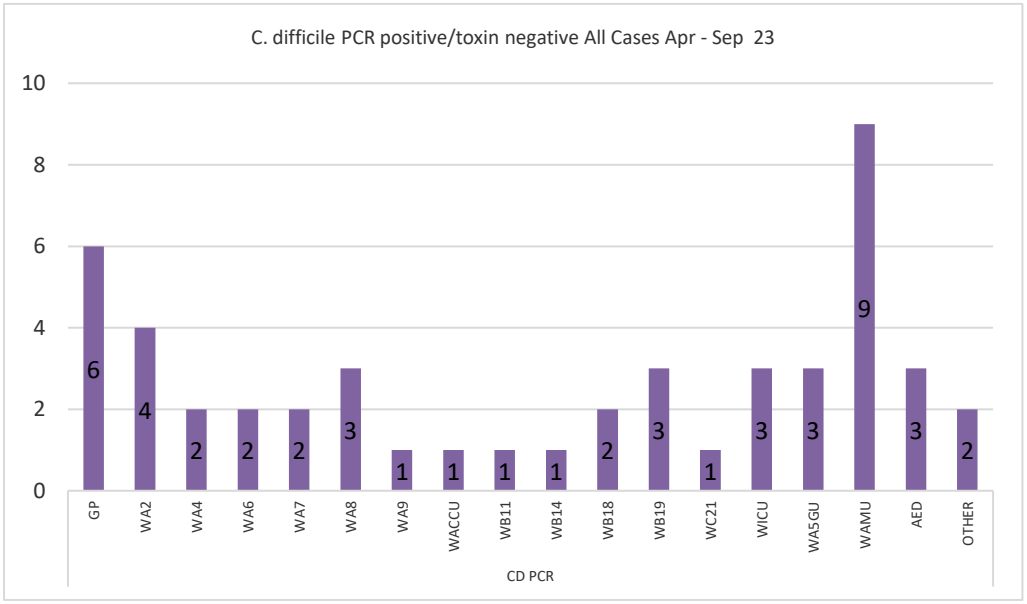


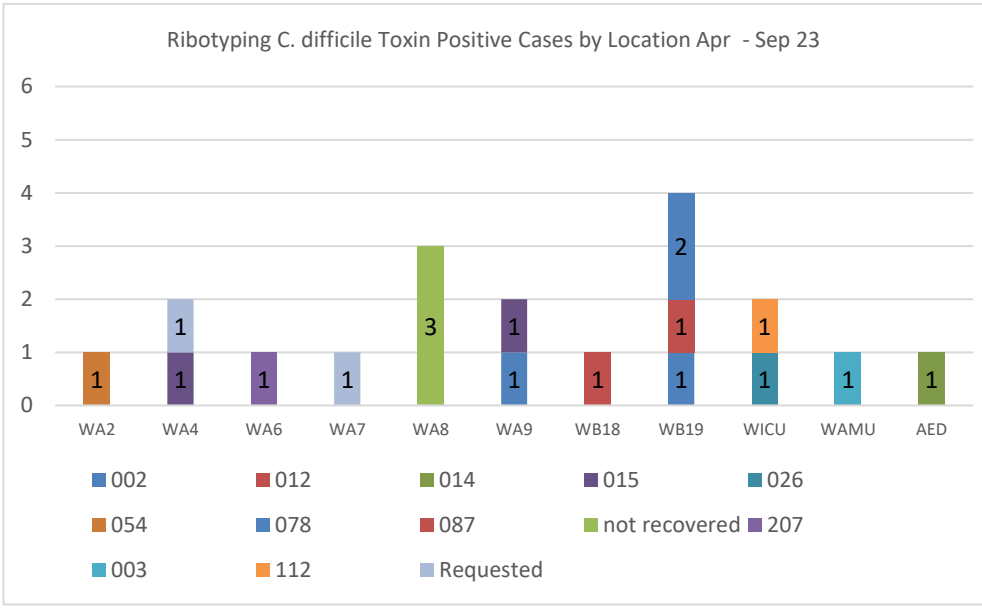
Clostridioides difficile (C. difficile) Toxin Apr - Sep 23

Threshold	36
YTD Total	19

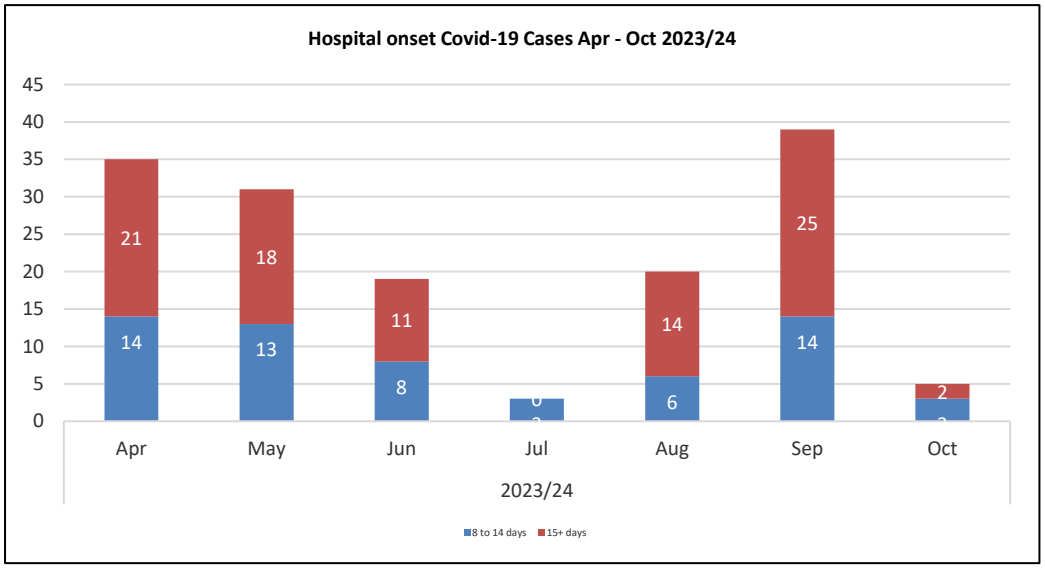


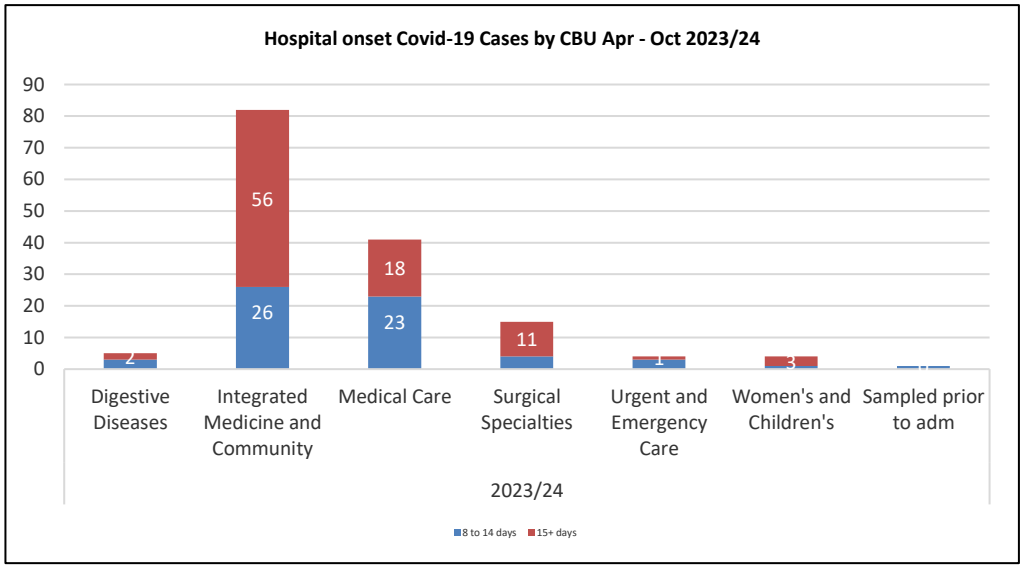


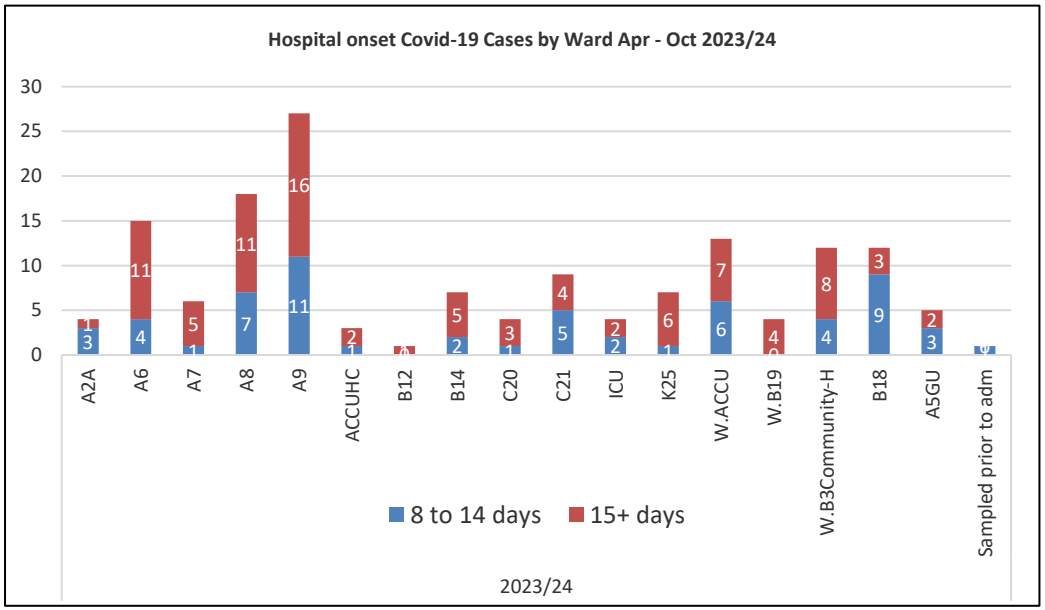


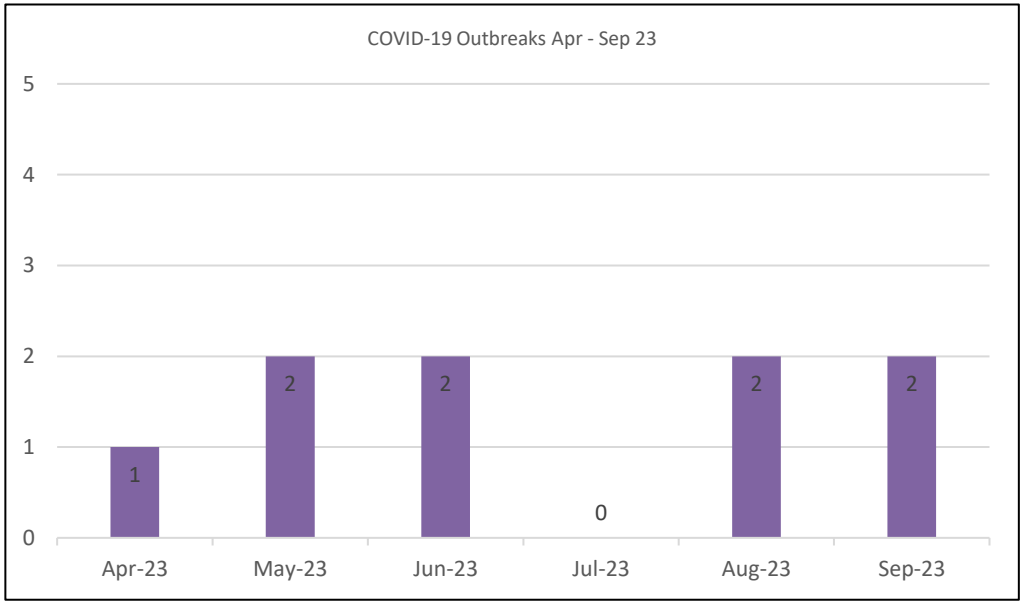


Covid-19 Surveillance Data Apr - Sep 23









Appendix 2 IPC Audits by CBU

UEC CBU

Ward/Department	AMU	A2	PAEDS ED	TROLLEY TRIAGE	RESUS HIGH CARE	AMB CARE	RESP LOW CARE	TRIAGE	MAJORS 2	MAJORS	MINORS
Environment	89%	92%	76%	81%	71%	86%	87%	74%	89%	88%	79%
Ward Kitchens	79%	88%	100%	100%	100%	N/A	N/A	N/A	87%	N/A	N/A
Handling/Disposal of Linen	82%	82%	90%	100%	100%	100%	78%	N/A	82%	100%	N/A
Departmental Waste	92%	100%	100%	100%	100%	100%	92%	100%	83%	100%	100%
Safe Handling Disposal of Sharps	100%	89%	94%	80%	81%	80%	88%	75%	88%	88%	77%
Patient Equipment (General)	91%	86%	88%	88%	73%	93%	94%	82%	70%	71%	85%
Personal Protective Equipment	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	N/A
Short Term Catheter Management	100%	88%	100%	100%	88%	100%	100%	N/A	100%	100%	N/A
Care of Peripheral Intravenous Lines	50%	67%	100%	100%	60%	80%	67%	N/A	N/A	60%	N/A
Isolation Precautions	100%	100%	75%	100%	100%	100%	91%	N/A	N/A	N/A	N/A
Hand Hygiene	96%	96%	95%	90%	90%	100%	91%	95%	86%	87%	95%
Overall Compliance	89%	90%	93%	94%	88%	94%	89%	88%	86%	88%	87%

IMC CBU

Ward	A7	A8	K25	A9	B12	B14
Environment	88%	90%	88%	90%	92%	87%
Ward Kitchens	96%	83%	100%	78%	88%	96%
Handling/Disposal of Linen	100%	91%	91%	82%	82%	91%
Departmental Waste	92%	92%	100%	100%	92%	92%
Safe Handling Disposal of Sharps	89%	94%	100%	89%	100%	94%
Patient Equipment (General)	100%	91%	82%	95%	95%	100%
Personal Protective Equipment	92%	83%	93%	93%	100%	100%
Short Term Catheter Management	100%	100%	100%	93%	94%	88%
Care of Peripheral Intravenous Lines	83%	83%	67%	100%	83%	83%
Isolation Precautions	92%	100%	N/A	92%	100%	100%
Hand Hygiene	95%	91%	100%	91%	95%	87%
Overall Compliance	93%	91%	92%	91%	93%	93%

MC CBU

Ward	ACCU	B18	ICU	C21
Environment	92%	93%	92%	92%
Ward Kitchens	100%	96%	92%	96%
Handling/Disposal of Linen	100%	91%	91%	100%
Departmental Waste	100%	83%	100%	100%
Safe Handling Disposal of Sharps	89%	83%	100%	100%
Patient Equipment (General)	100%	95%	86%	100%
Personal Protective Equipment	100%	100%	93%	100%
Short Term Catheter Management	100%	94%	88%	88%
Care of Peripheral Intravenous Lines	100%	83%	83%	83%
Isolation Precautions	100%	100%	100%	100%
Hand Hygiene	96%	96%	96%	96%
Overall Compliance	98%	92%	93%	96%

W&C CBU

Ward	C23	NNU	BIRTH SUITE	B10	B11	C20	ANTE NATAL CLINIC	CHILDREN OPD	NEST	ANDU	C23
Environment	79%	90%	87%	84%	80%	87%	82%	89%	82%	95%	82%
Ward Kitchens	75%	92%	83%	96%	78%	75%	92%	96%	92%	91%	92%
Handling/Disposal of Linen	63%	94%	57%	83%	67%	89%	100%	100%	80%	98%	90%
Departmental Waste	100%	100%	100%	83%	100%	100%	100%	100%	100%	83%	75%
Safe Handling Disposal of Sharps	78%	100%	89%	100%	94%	94%	78%	100%	100%	100%	89%
Patient Equipment (General)	81%	87%	94%	84%	85%	82%	77%	93%	89%	80%	69%
Personal Protective Equipment	91%	100%	100%	100%	100%	100%	93%	100%	100%	100%	88%
Short Term Catheter Management	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Care of Peripheral Intravenous Lines	67%	83%	100%	100%	100%	83%	100%	100%	100%	100%	100%
Isolation Precautions	86%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%
Hand Hygiene	80%	91%	100%	95%	95%	89%	89%	90%	80%	94%	95%
Overall Compliance	82%	94%	92%	93%	91%	89%	92%	97%	93%	95%	89%

DD CBU

Ward	OBS THEATRE	CSTM THEATRE	A4	HALTON THEATRES	A5GU	A5E	WARR THEATRES
Environment	82%	90%	66%	88%	77%	70%	86%
Ward Kitchens	100%	100%	46%	100%	78%	96%	79%
Handling/Disposal of Linen	90%	100%	90%	100%	91%	67%	70%
Departmental Waste	92%	92%	83%	92%	92%	92%	92%
Safe Handling Disposal of Sharps	82%	100%	78%	88%	100%	83%	78%
Patient Equipment (General)	86%	88%	64%	93%	86%	73%	55%
Personal Protective Equipment	100%	100%	64%	100%	75%	83%	100%
Short Term Catheter Management	100%	100%	100%	100%	79%	100%	91%
Care of Peripheral Intravenous Lines	100%	100%	67%	67%	83%	83%	83%
Isolation Precautions	100%	100%	75%	100%	100%	100%	100%
Hand Hygiene	95%	100%	74%	100%	90%	86%	90%
Overall Compliance	93%	95%	73%	93%	86%	85%	85%

SS CBU

Ward	CSTM WARD	ORTHO DEPT CSTM	UIU	A6
Environment	88%	88%	74%	88%
Ward Kitchens	92%	N/A	90%	91%
Handling/Disposal of Linen	100%	N/A	75%	82%
Departmental Waste	100%	92%	67%	92%
Safe Handling Disposal of Sharps	100%	94%	76%	88%
Patient Equipment (General)	86%	86%	89%	94%
Personal Protective Equipment	100%	100%	100%	75%
Short Term Catheter Management	100%	N/A	100%	100%
Care of Peripheral Intravenous Lines	83%	N/A	N/A	83%
Isolation Precautions	100%	N/A	N/A	100%
Hand Hygiene	96%	100%	93%	90%
Overall Compliance	95%	93%	85%	89%

Clinical Support Services

Ward	BREAST CARE CSTM	MRI /CT CSTM
Environment	81%	78%
Ward Kitchens	N/A	74%
Handling/Disposal of Linen	N/A	80%
Departmental Waste	92%	100%
Safe Handling Disposal of Sharps	100%	100%
Patient Equipment (General)	0%	92%
Personal Protective Equipment	100%	100%
Short Term Catheter Management	N/A	N/A
Care of Peripheral Intravenous Lines	N/A	N/A
Isolation Precautions	N/A	N/A
Hand Hygiene	100%	93%
Overall Compliance	79%	90%

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/11/241**			
SUBJECT:	Violence Prevention and Reduction Strategy – Bi-Annual Update			
DATE OF MEETING:	14 November 2023			
ACTION REQUIRED:	**To note the content of the paper and the progress made against the Violence Prevention and Reduction Strategy**			
AUTHOR(S):	Ian Wright			
EXECUTIVE DIRECTOR SPONSOR:	Dan Moore			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Violence Prevention and Reduction Standard provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence. All NHS commissioners and all providers of NHS-funded services operating under the NHS Standard Contract should have regard to the violence prevention and reduction standard and are required to review their status against it. A Violence Prevention and Reduction Strategy is a requirement of the standards, and this paper reviews the status of the strategy.			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The committee is asked to note the content of the paper and the progress made against the Violence Prevention and Reduction Strategy			
PREVIOUSLY CONSIDERED BY:	**Committee**	n/a		
	Agenda Ref.			

	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

QUALITY ASSURANCE COMMITTEE

SUBJECT	Violence Prevention and Reduction Strategy – Bi-Annual Update	AGENDA REF	QAC/23/11/241

1. BACKGROUND/CONTEXT

The violence prevention and reduction standard provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence.

The violence prevention and reduction standard employs the Plan, Do Check, Act (PDCA) approach,
an iterative four-step management method to validate, control and achieve continuous improvement
of processes.

- **Plan**

The NHS organisation must review their status against the violence prevention and reduction standard and identify their future requirements, to understand what needs to be completed and how, who will be responsible for what, and what measures will be used to judge success. This phase of the process includes developing or updating strategies, policies and plans to deliver the aims.

- **Do**

The NHS organisation must:

• assess and manage risks

• organise and implement processes, and communicate plans to, and involve NHS staff and key stakeholders in their delivery

• provide adequate resources and training.

- **Check**

The NHS organisation must ensure that the plans are implemented successfully, assess how well the
risks are controlled and determine if the aims have been achieved, ie via audit measures. As part of the process, the NHS organisation should routinely assess any gaps and ensure swift corrective action.
Credible, accurate and unambiguous data will assist in checking incidents of violence have fallen.

- **Act**

The NHS organisations must review its performance to enable the senior management team to direct and inform changes to policies or plans, in response to any localised lessons learnt, and incident data collected in respect of violence prevention and reduction. The NHS organisation should share critical findings with internal and external stakeholders.

2. Violence Prevention Strategy

The Violence Prevention and Reduction Strategy is a guide for all colleagues to ensure that measures are put in place to better protect staff against deliberate violence and aggression from patients, their families, and the public, and to prosecute offenders more easily. Experiencing violence and aggression does not form any part of any role within the Trust, as such, it is the mission of WHH to prevent and reduce incidents of violence and aggression towards its staff by raising awareness and improving corporate arrangements to address areas of concern. The aim of this Violence Prevention and Reduction Strategy is to set out a plan for WHH to address this significant and ever-increasing risk to staff from violence and aggression.
This supports staff to work in a safer and more secure environment, to safeguard against abuse, aggression, and violence. Work is ongoing to achieve the objectives of the strategy.

Below demonstrates what has been achieved to date of the Violence Prevention & Reduction Strategy:

Improved staff safety:

- Undertaken a self-assessment on compliance with the Violence Prevention and Reduction Standard using the Plan, Do, Check, Act model.
- Ward/Department Risk Assessments undertaken.
- Reduction in the number of incidents in key areas and the level of harm regarding violence and aggression.
- Strengthened the monitoring of incidents reported regarding violence, identifying any trends, and escalating to the Corporate Risk Register if required.
- Provided appropriate training in Conflict Resolution Training and De-escalation Training commensurate to roles and risks posed following a training needs analysis (TNA)

Improved staff experience by:

- Continually ensuring all individuals who have been affected by or exposed to violence and aggression will be offered appropriate individualised support.

- Raised awareness and communicate the ‘Staff Support violence aggression support protocol’.
- Initiated a poster campaign and security newsletter to prevent violence and aggression and respect our staff.
- Annual Security Awareness month held in February 2023.

3. Risk Assessments

The standards relay the importance for all areas to have relevant and current risk assessments in place to mitigate against violence and aggression towards staff. The Trust Local Security Management Specialist (LSMS) provides template security risk assessments to all CBU managers and equips them with completion guides. Risk assessments are completed by ‘area’ of the Trust with mitigations and actions allocated.

4. Audit

To ensure all areas have current risk assessments, the Trust LSMS audits the completion of security risk assessments in relation to violence and aggression by asking CBUs to report on a template audit form. Those areas that are faced with challenges to the completion of risk assessments or audits are supported by the security department. 99 Audits were sent out in October 2023 with 22 audits returned to date. Since May 2023, an additional 11 audits have been returned to date.

In circumstances where there is a low return of audits, the security management team have commenced visits to areas outstanding to assist in their completion this commenced in August 2023.

5. Training

As part of the Violence Prevention & Reduction Strategy the Trust has:

- Provided a robust training plan for all staff groups within the Trust.
- Ensured staff attend regular update training.
- Evaluated the effectiveness of current training provisions.

Conflict Resolution Training

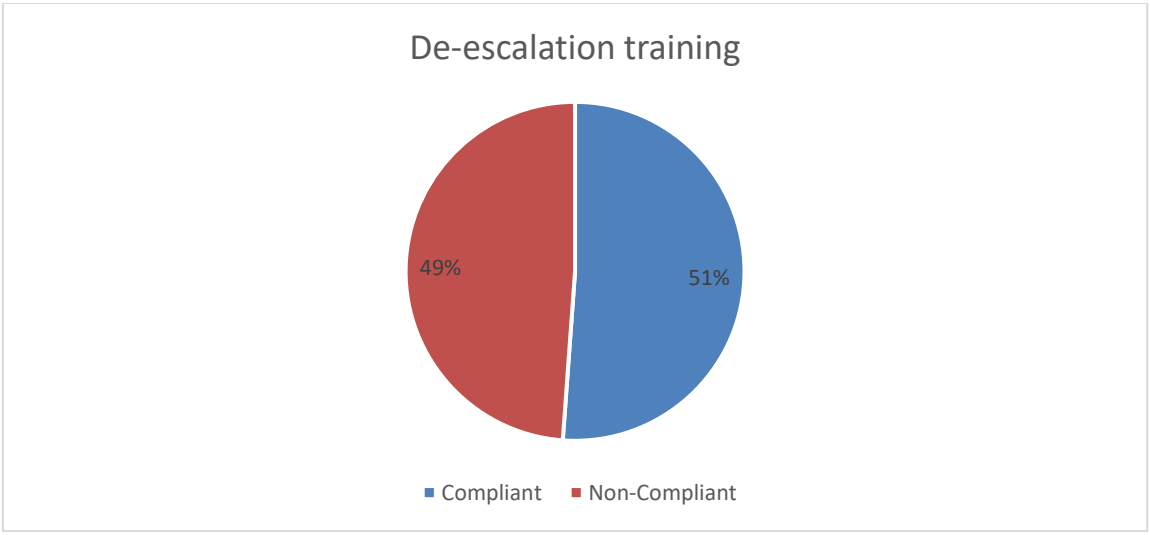
Chart 1 below shows a 91.48% compliance rate in Conflict resolution training. This is monitored monthly.



De-Escalation Training

De-escalation training was first mentioned in the managing clinically challenging behaviour group back in 2019. The group was set up to review incidents within the trust and to support staff in dealing with incidents. Clinical Education along with the LSMS developed a TNA to identify staff groups that require training. Once the TNA was finalised funding was provided for a trainer to deliver De-escalation Training for the staff groups identified in the TNA.

Chart 2 below shows a 51% compliance rate in De-escalation training. Since November 2022. At last reporting period this was **26%**



This is how we are achieving this.

- Training Needs Analysis (TNA) has been developed based on incident data from high-risk areas.

- Training requirements and incident data has now been added to ESR/ Business Intelligence (BI) Workforce and will be monitored monthly and presented at the Violence and Reduction Group.

- Evaluating the effectiveness of training delivered will be carried out by course evaluation questionnaires.

- The de-escalation Trainer will be invited to the Violence and Reduction Group Bi-monthly to highlight any issues.

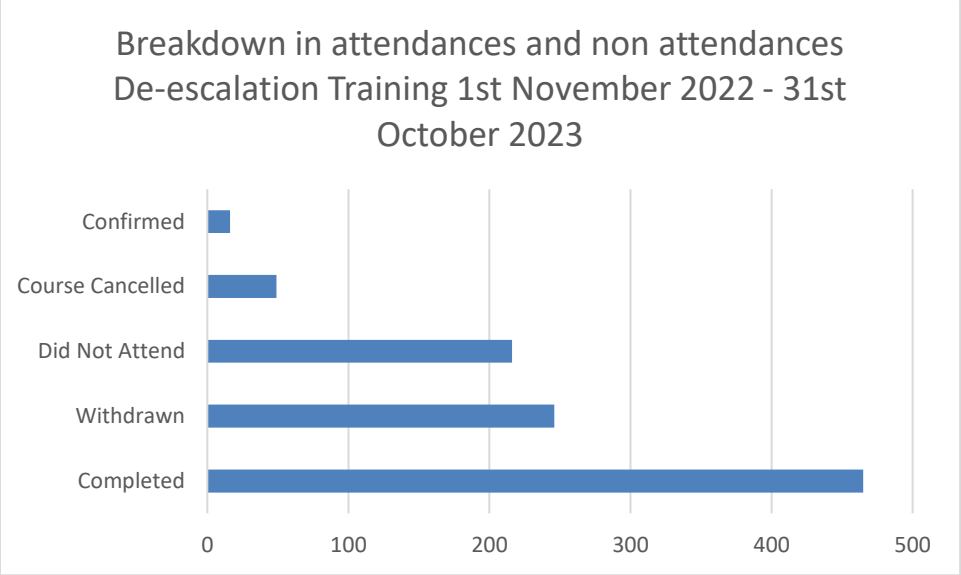


Chart 3 above demonstrates a breakdown in attendances. In line with the current training needs analysis, 909 staff are required to complete the training.

The chart show's 992 staff booked onto training with a 511 non-attendance. This could be due to operational issues within departments i.e., recent strike actions, increase patient capacity, sickness, or annual leave.

The figures show over 50% non-attendance. This is escalated via the Learning and Development department to forward onto the departmental managers to investigate and action.

Chart 4 demonstrates Between 1st November 2022 – 31st October 2023 Radiology noticeably higher **withdrawn** figures compared with other departments within the trust.

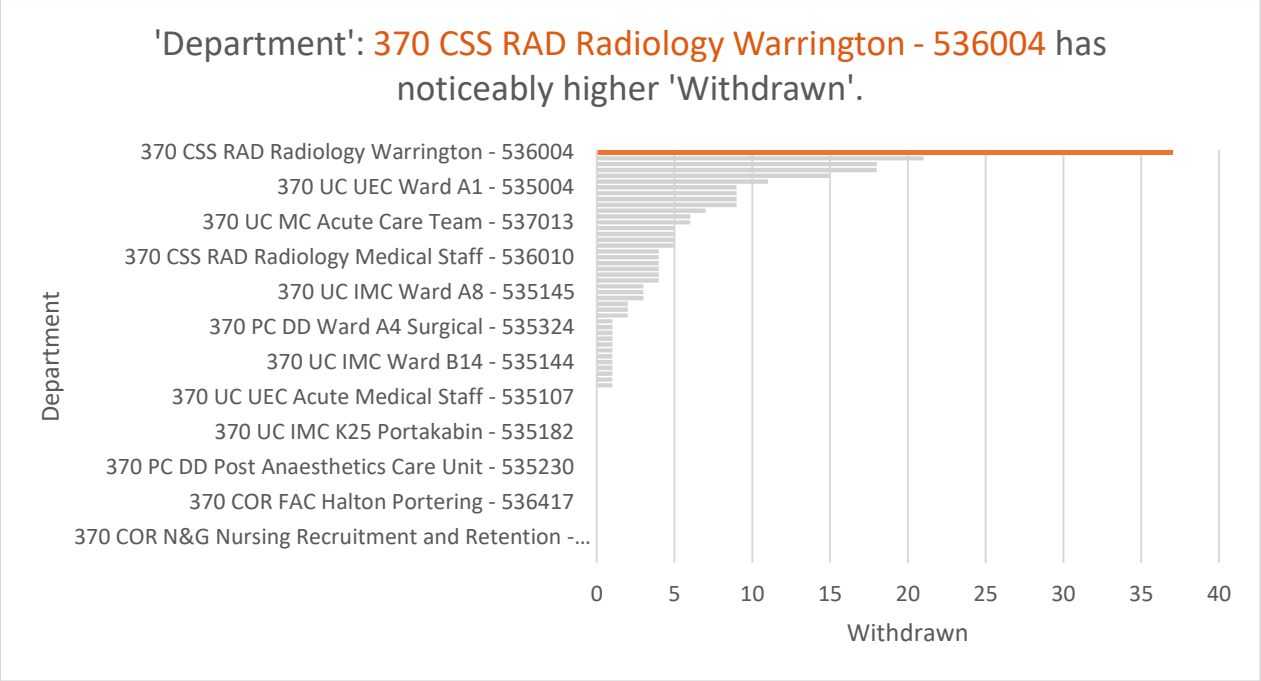


Chart 5 demonstrates Between 1st November 2022 – 31st October 2023 ED and Radiology has a noticeably higher **did not attend** figures compared with other departments within the trust.

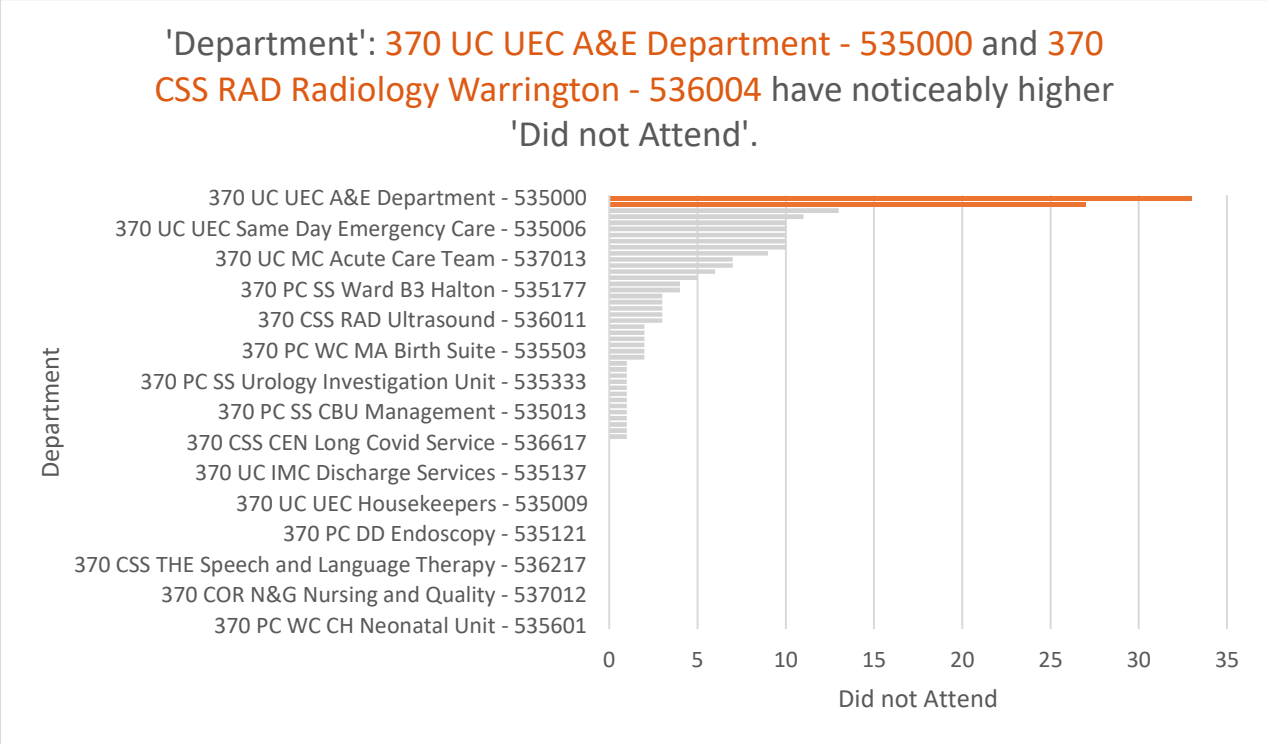


Chart 6 demonstrates Between 1st November 2022 – 31st October 2023 ED and Radiology has a noticeably higher **completed** rates compared with other departments within the trust, even though charts 4 & 5 shows higher rates in withdrawn & did not

attends for both departments, they are managing to getting staff numbers through training.

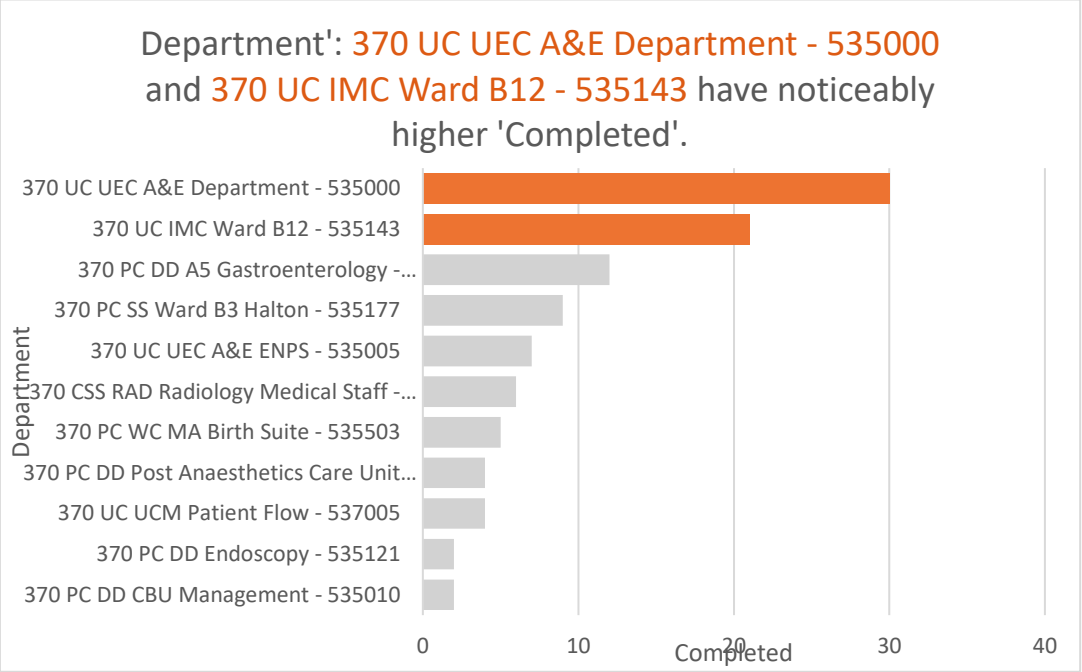


Chart 7 demonstrates Between 1st November 2022 – 31st October 2023 49 courses cancelled; this is due to non-attendances. The number cancelled reflects staff numbers, not courses, for example if the course had 20 staff book on and the course was cancelled then it would be classed as 20 cancelled courses.

Since November 2022 only 3 training sessions have been cancelled to lack of attendances.

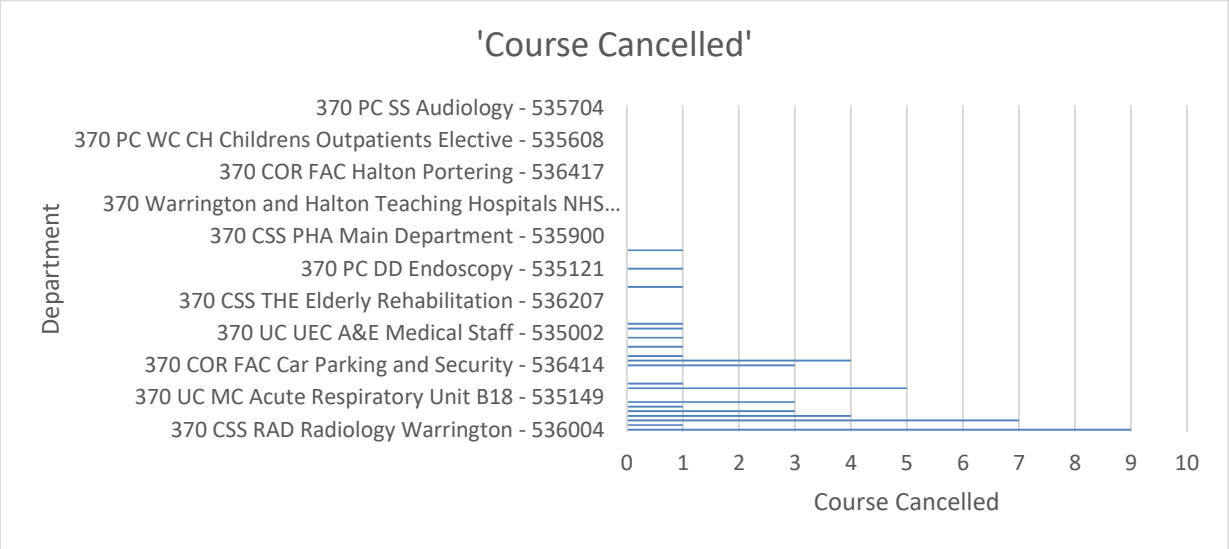
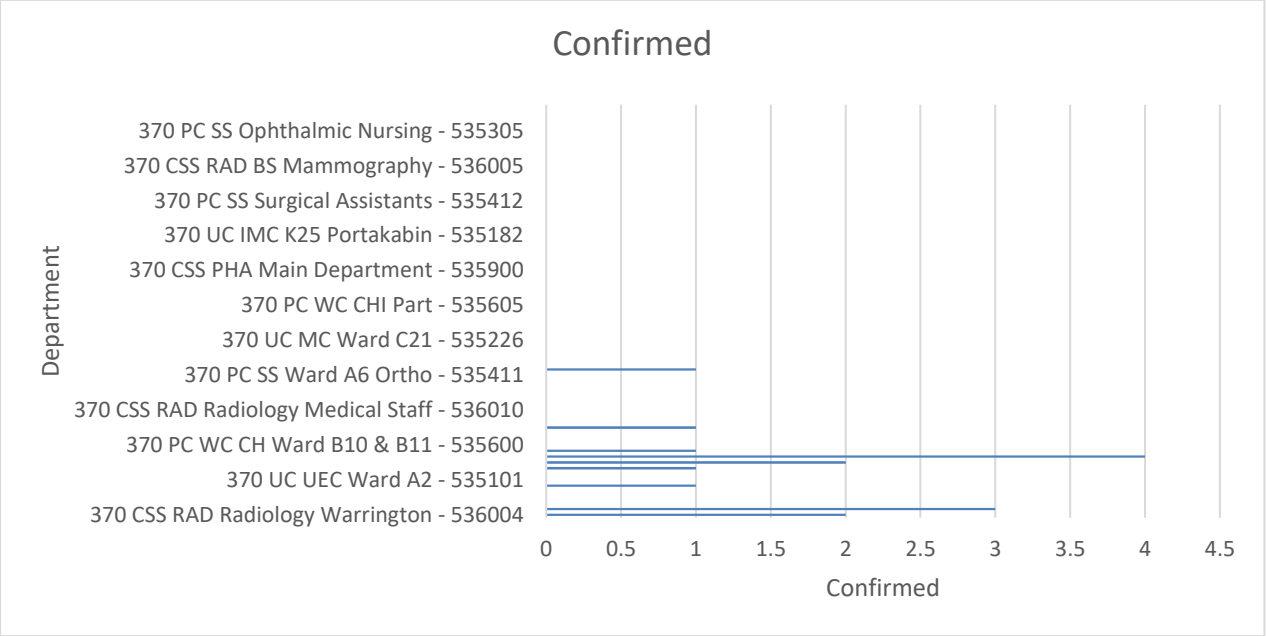


Chart 8 demonstrates Between 1st November 2022 – 31st October 2023 Confirmed this means staff that have attended and will be recorded in the following months figures.



Dates have now been booked for De-escalation training through to December 2024

Date	Location	Date	Location
08/01/24	A4, Halton	01/07/24	A4, Halton
19/01/24	A4, Halton	08/07/24	A4, Halton
22/01/24	A4, Halton	17/07/24	A4, Halton
01/02/24	A4, Halton	22/07/24	A4, Halton
08/02/24	A4, Halton	29/07/24	A4, Halton
12/02/24	A4, Halton	05/08/24	A4, Halton
21/02/24	A4, Halton	12/08/24	A4, Halton
26/02/24	A4, Halton	19/08/24	A4, Halton
08/03/24	A4, Halton	27/08/24	A4, Halton
14/03/24	A4, Halton	02/09/24	A4, Halton
18/03/24	A4, Halton	09/09/24	A4, Halton
25/03/24	A4, Halton	16/09/24	A4, Halton

03/04/24	A4, Halton	23/09/24	A4, Halton
15/04/24	A4, Halton	30/09/24	A4, Halton
24/04/24	A4, Halton	07/10/24	A4, Halton
29/04/24	A4, Halton	14/10/24	A4, Halton
10/05/24	A4, Halton	21/10/24	A4, Halton
15/05/24	A4, Halton	28/10/24	A4, Halton
20/05/24	A4, Halton	04/11/24	A4, Halton
29/05/24	A4, Halton	11/11/24	A4, Halton
05/06/24	A4, Halton	18/11/24	A4, Halton
10/06/24	A4, Halton	25/11/24	A4, Halton
17/06/24	A4, Halton	02/12/24	A4, Halton
24/06/24	A4, Halton	09/12/24	A4, Halton
		16/12/24	A4, Halton

6. Incidents

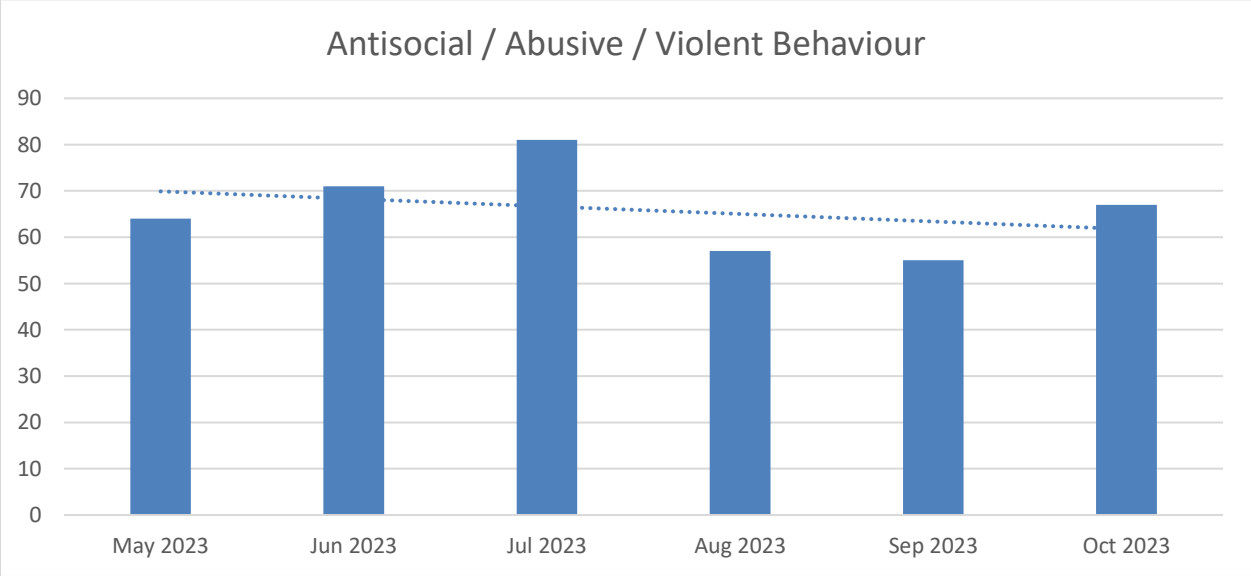


Chart 9 above shows an overall increase in incidents by month since 1st May 2023 compared to the previous year.
Staff record incidents of violence and aggression in line with the Trust inccident reporting policy via DATIX. The tables below indicate incidents recorded on DATIX.

The following charts demonstrates the recorded incidents of violence and aggression at WHH.

Between 1st May 2023 to the 31st October there were 398 incidents of Violence & Aggression recorded this is compared to 361 incidents of Violence & Aggression recorded between 1st May 2022 to the 31st October 2022

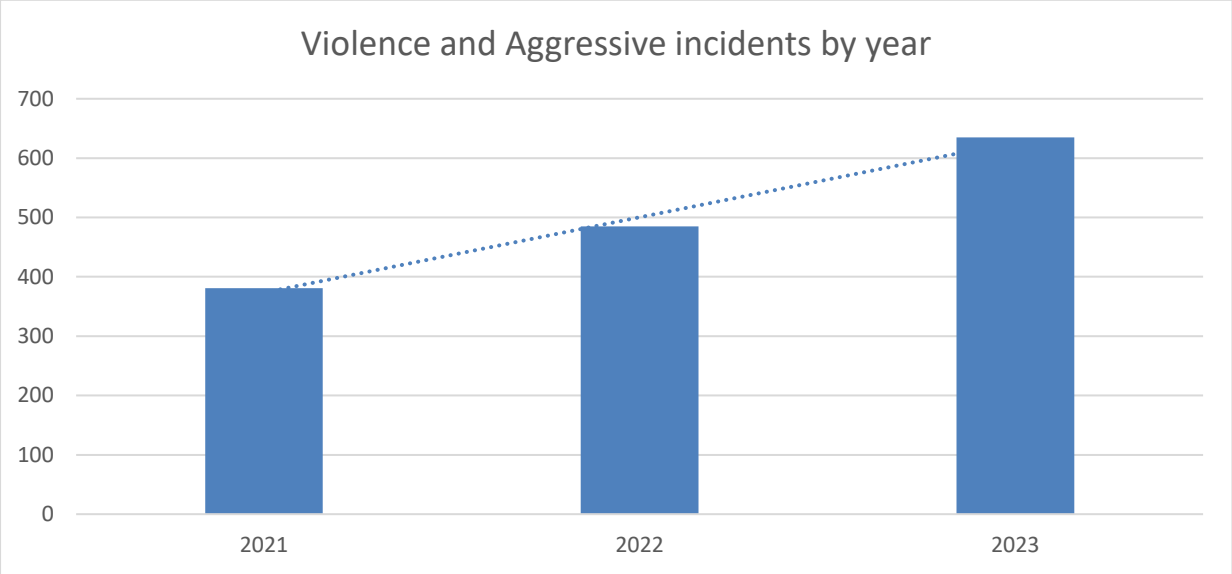
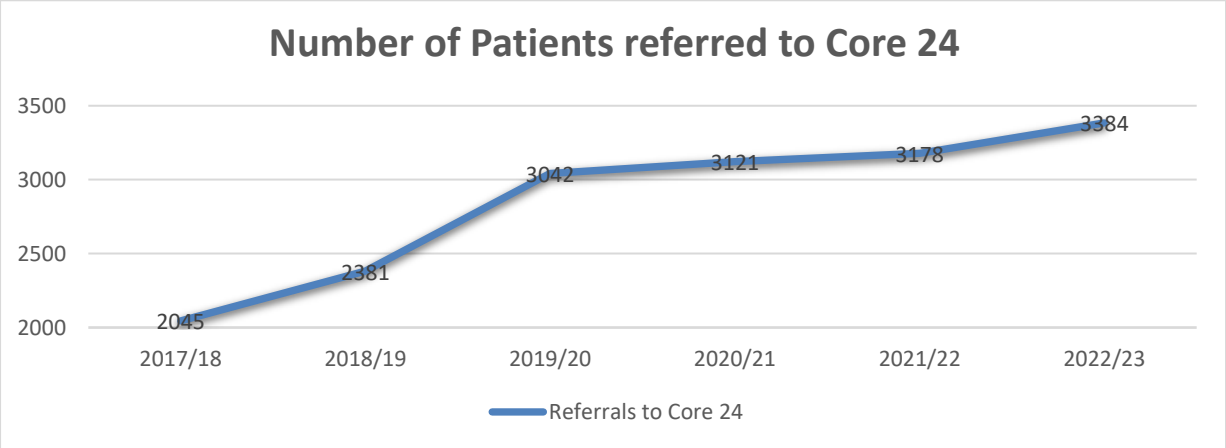


Chart 10 above shows an increase incident year on year. Increase in incidents **MAY** be due to several factors, mostly clinical including an increase in Mental Health referrals which are up by 65% over the last 5 years and a more robust reporting culture across the trust due to awareness of violence and aggression and the importance of recording all incidents.

Chart 11 shows several patients referred to core 24 from low/medium/high secure mental health inpatient units e.g., Arbury Court. These patients are often the highest risk patients, often requiring multiple members of staff to observe and support them and can often display challenging behaviours due to their clinical condition.



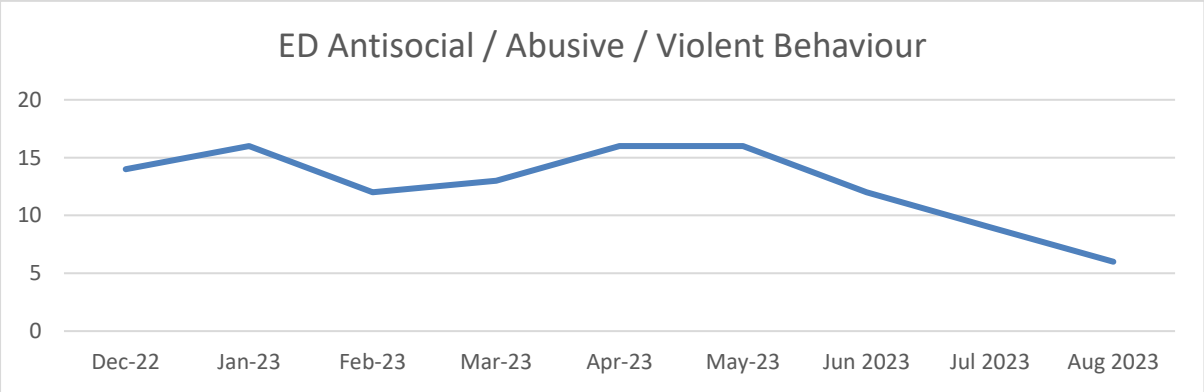
7. Violence Prevention and reduction initiatives

Over the last reporting period, several initiatives have neem explored and initiated collectively by the LSMS and key internal stakeholders.

Body worn CCTV (BWCCTV)

- A recent initiative at WHH was to support and implement the wearing of BWCCTV by reception and clinical staff. The initiative was supported by the Executive Team in December 2022 and implemented in January 2023. There are currently 8 BWCCTV units available for reception and clinical staff to use in ED. It anticipated their use will trigger a reduction in violent and aggressive incidents in ED and in sanctions imposed against those who are violent to staff.

  Since the start of the trial, it's had a positive effect on reducing incidents within ED and increasing staff morale. Chart 12 shown below show's a 57.1% decrease in incidents since December 2022.



After the Body worn CCTV trial, which ended in June 2023, an evaluation was carried out on the effectiveness of the trial. Questions and responses shown below:

- Q1 – Do staff feel safe when utilising Body Worn CCTV?
- A1 – **Staff came back with a positive outlook when wearing the BWCCTV. Staff stated that they had felt they were much safer. Also, it seems to stop any aggression just by wearing the devices.**
- Q2 – During the trial, it was identified via a monthly review that the incidents were increasing, after a conversation with the staff, we were informed that they had stopped wearing the devices. Emergency Department staff were asked, why did they stop wearing the devices?

- A2 - **Staff reported that they forgot to wear them. This was actioned by the Emergency Department Matrons to express to the staff the importance of wearing the BWCCTV.**
- Q3 – A question put to staff. Are there any recommendations they wish to add.
- A3 – **Emergency Department staff recommended that the BWCCTV would be useful in Outpatients, Minor Injuries, Ambulatory Care.**

Emergency Department staff embraced the BWCCTV. The trial was unable to demonstrate how many incidents have been avoided whilst using this technology. Based on staff feedback, it's believed this is significant

The BWCCTV trial has also demonstrated significant benefits in terms of crime reduction and evidence collection. The presence of these cameras has acted as a deterrent, enhanced staff, and patient safety, and provided valuable evidence for investigations. Overall, the trial has highlighted the potential of BWCCTV cameras as a valuable tool within WHH, paving the way for future adoption of this technology.

Poster Campaign

- There was a slight delay with regards to the Violence Prevention & Reduction Poster due to the Trust's rebranding. However, posters are in the process of being displayed within wards and departments across both sites. The posters have an emotive theme with real life photographs of Trust staff and family members.

Support

- LSMS has continued to attend areas with increased violence and aggression, offering support to staff and advice with positive feedback.

Awareness

- Security awareness session was held in February 2023 promoting the security department and the Violence Prevention and Reduction Strategy. Sessions were held across both sites with excellent staff participation.

CCTV

- The trust back in 2022 invested £60k in improving the CCTV infrastructure with future capabilities of facial recognition and health monitoring technology. The new system can be interfaced with the door access control system within the Trust.

Panic Alarms

- New panic alarm systems have been installed in various areas; B10/11, Pharmacy, PAL's, SDEC & ED mental health assessment suite. This system can be remotely

activated from a fob which a staff member carries and can be activated anywhere within the ward or department area to summon for security assistance.

Access Control

- As a result of reviewing and monitoring incidents, the Trust has made improvements in high-risk areas, investing in additional door access systems, and implementing swipe in and swipe out in high-risk areas. These areas include, Maternity, ED & B10/11

Policy

- Introduction of the Management of Unacceptable Behaviours by Patients, Visitors, and members of the Public has gone down well within the Trust as staff feel more supported as there is now a consequence if they are subject to abuse. As part of the policy the trust introduced sanctions against patient and visitors who abuse our staff. The Trust has currently issued 65 sanctions against person who have been physically or verbally abusive to staff members. Chart 13 below show a break down in sanctions applied:

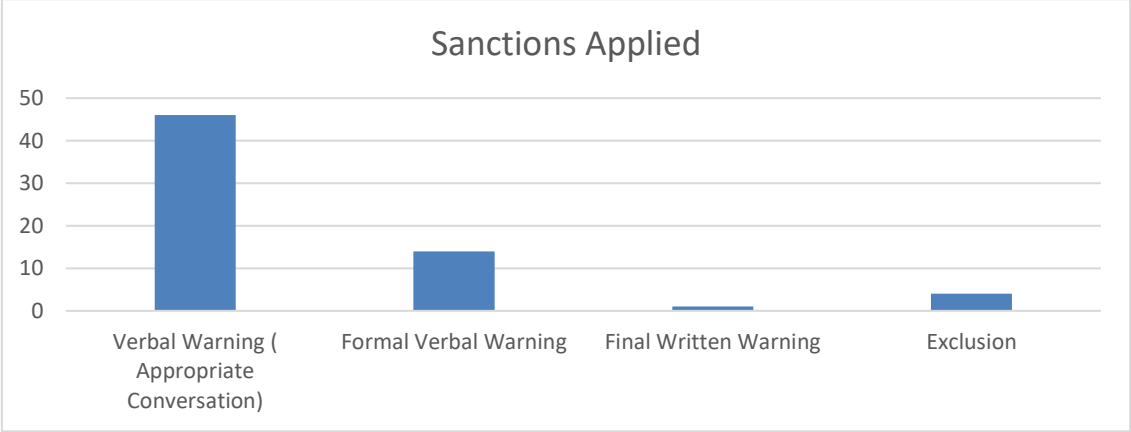
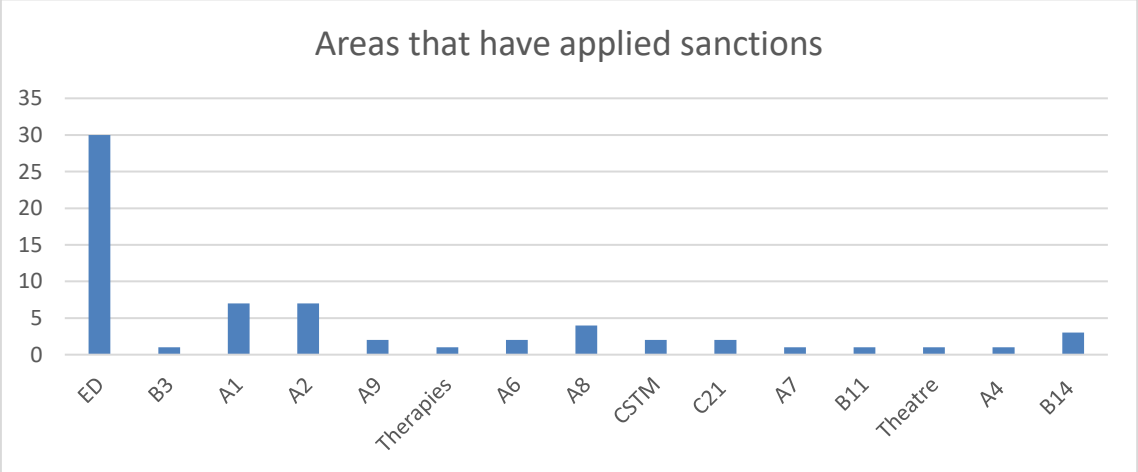


Chart 14 shows sanctions applied by departments.



In summary, the initiatives that have been achieved have increased staff confidence when faced with challenging behaviour from patients, visitors, and members of the public and more confident with the knowledge on how to deal with and to de-escalate incidents.

This can only prove to be positive, as staff will feel more supported. Better reporting structure within the organisation so that incidents can be investigated and actioned promptly is key. Staff are now safer with the introduction of the improved security systems that have been introduced.

8. Equality, Diversity & Inclusion

The Violence Prevention Reduction Strategy ensures that it meets the individual needs of all, considering the protected characteristics outlined in the Equality Act 2010: age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity. As well as this, we also explore how wider socioeconomic factors impact on specific groups of people.

This strategy ensures equity in access to our hospitals and the experience of all our workforce is reviewed whilst we create a culture of belonging in which everyone feels supported, safe and secure.

The local security management specialist has been working with the ED&I lead along with the trust DATIX administration team data sets within the incident reporting system. This will allow for better monitoring of incidents against protected characteristics. Please see below 3-year plan:

- In **year one** within the strategy, WHH will undertake a review of what information we record, how we utilise data related to equality, diversity and inclusion and our internal systems and processes. **- COMPLETED**
- In **year two**, we will focus on ensuring that inequality and disparity in the experience of staff groups with protected characteristics is addressed and monitored through systems and processes. We will work with our subject matter experts to ensure that our objectives and work plans apply due regard and meet our regulations under the Public Sector Equality Duty. - **ONGOING**
- In **year three**, WHH will focus on working with our staff networks and patient groups to embed learnings, principles, and findings from years one and two to ensure they are fully embedded in business as-usual organisational procedures.

Data is currently retrieved from the NHS staff survey results.

Summary

In summary the paper provides an overview of the initiatives undertaken and the progress made in deterring violence and promoting a safer environment within WHH. The paper highlights key strategies, programs, and outcomes achieved during the specified reporting period.

The paper also highlights the collective efforts made in preventing and reducing violence. It showcases the implementation of comprehensive strategies, policy, staff engagement, education, new technology, and data-driven approaches to achieve positive outcome.

It also acknowledges the challenges faced in violence prevention and reduction. It identifies areas that require further attention, such as addressing training, risk assessments and strengthening partnerships across the Trust. The Trust LSMS will continue to work to meet the objectives of the Violence Reduction and Prevention Strategy.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REF:	**FSC/23/11/163**			
SUBJECT:	**Digital Strategy Group (DSG) update**			
DATE OF MEETING:	29 November 2023			
ACTION REQUIRED:	**To note the contents of the report**			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on 13th November 2023. This report provides a summary of the updates received from the DSG feeder groups, providing the following assurance status for key delivery areas: ○ **Digital Transformation Highlight Report** Moderate Assurance ○ **Digital Service Delivery Highlight Report** Moderate Assurance ○ **Digital Analytics Highlight Report** Moderate Assurance ○ **Digital Care Delivery Highlight Report** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): ○ NHSE Initiative driven projects (PEP/eBCMS/EPCMS) all running at similar timeframes all with tight timelines and funding drawing down in 2023/24. ○ EPCMS ITT launched 2nd of November 2023. ○ Digital Strategy approved in September launch and engagement workshops delayed due to resource pressures and being planned for December. ○ PEP ITT reissued announcing preferred supplier is gateway NHSE releasing tranche 2 funding £675k			

<table>
<tr><td></td><td colspan="3">Results Acknowledgement paper switch off process significant backlog of unacknowledged results a report has been developed assure progress
Patient Entertainment project group stepped down 3-6 months
eOutcome 7th December cut over at risk
This disconnect for EBCMS and SHREWD tool which requires implementation and that we will be double running these both along with other trusts in Cheshire and Merseyside.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
√</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The FSC is asked to note the contents of the report, including assurance levels.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Not Applicable</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>NEXT STEPS: State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Share with Finance & Sustainability Committee</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Section 43 – prejudice to commercial interests</td></tr>
</table>

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF	FSC/23/11/163

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

Digital Strategy Update

The new Digital Strategy was presented to trust board at the board developments day on 6th September. The team is working with communications team to launch and hold engagement workshops in December 2023.

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- Paperless Care – Phlebotomy App Pilot involved several issues during the first two weeks of the pilot go live involving duplication of SMS messages, appointments, and cancellation messages. The Pilot has been extended 4 weeks.
- Warrington Place strategy was presented to Warrington together partnership board on 4th October and was well received by board – The area DEG will concentrate on is Digital inclusion – looking at tangible outputs for 24/25. Workshops will commence in the next month.
- EPCMS – V4 OBC and OBS was presented to NHSE Frontline Digitisation EPR Investment Board (EPRIB) on 11th October and approved with conditions. All pre-ITT conditions have been actioned.
- EPCMS Procurement launched on 2nd of November 2023 at 12 noon. Ongoing work with Communication lead to develop stakeholder map and a communication plan.
- Confirmation from Frontline Digitalisation WHH have secured funding for 2 Graduates to work on the EPCMS.
- Digital Infrastructure: Network refresh switches 23/25 involved challenges around procurement but have now signed the order with BT. eOutcome cyber security as part of migrate/decommsion Server 2012 servers is in exception with agreed mitigation plans. Go no Go decision end November the cutover scheduled 7th December is at risk and will be rescheduled for 25th January 2024.
- Electronic Bed Capacity Management System (eBCMS): business case being developed for December 2023 Trust Board approval.
- Digital Diagnostics: No update for Diagnostics. Unified comms will be on hold until Unified Limms is completed. Pacs Replacement - Arranging a date to

discuss technicalities for how we link our network up to theirs and these dates will be before Christmas.

- Patient Engagement Portal (PEP): The decision was made to re-issue the ITT and complete reprocurement with the preferred supplier notified by mid-December 2023. Announcing preferred supplier is gateway NHSE releasing tranche 2 funding £675k.
- Patient Entertainment: Following the research completed via the Project Group, Project Group are finding it difficult to present a solid proposal to execs without fully testing re negotiating a new contract with Hospedia. Doing a direct award against G Cloud Framework and renegotiating a new contract is still the preferred option (this would retain existing equipment and infrastructure on site, include a bring your own device into the contract, include additional TVs where none exist and replacing broken TVs) we need time to fully validate indicative costs and assumptions from procurement research. It has been agreed to step down the Project Group for 3-6 months until procurement in a position negotiate a new contract.

Items for escalation from the Digital Transformation Group

- EPCMS Procurement launched 2nd November 2023
- EBCMS business case December Trust Board for approval
- PEP ITT reissued announcing preferred supplier is gateway NHSE releasing tranche 2 funding £675k
- Patient Entertainment project group stepped down 3-6 months
- eOutcome 7th December cut over at risk

Digital Service Delivery Highlight Report (Moderate Assurance)

- Stats for October 2023: 2824 tickets opened in October 2669 closed within 85% SLA, 28 closed which missed SLA, 79 still open within SLA, 48 open that are breaching SLA. Hit 95% of SLA Trust Wide.
- Print server's stats - 9.5 million sheets of paper have been printed so far this year. From September to October, there has been an additional 1 million pages printed. This is the trend we are seeing month by month.
- Turned off GP printing in Radiology this month.
- Discussion to be held surrounding the Printer Reduction Policy to review draft and work through the issues and fill gaps. Ideally policies will have been approved and implemented before formal launch for SLAs in December.
- There are no new high cyber alerts reported last month by NHS England.
- Vendor Management routine meetings are taking place for Service reviews and outstanding issues.

Items for escalation from the Digital Service Delivery Group

- None.

Digital Analytics Highlight Report (Moderate Assurance)

- 13 deliverables have been achieved in October 2023. There are currently 11 deliverables for November 2023. In addition there is 3 delayed deliverables.

- The Fraxinus and Data Warehouse infrastructure project – with a revised plan for a decision on a “go” “no go” on the 23 November 2023. If it’s a “go” this phase of the project will complete 7 December 2023 which is the deadline on the current plan. If it’s a “no go” then the completion date will be the end January 2024. The revised deadline should it be required was agreed at a meeting with the project SRO 1 November 2023.
- Re write of Data Warehouse loads continues which supports the delivery of the Digital Analytics plan.
- The Digital Analytics Department have developed a three-year Target Operating Model to support the delivery of the Electronic Patient Care Management System.

Items for escalation

- This disconnect for EBCMS and SHREWD tool which requires implementation and that we will be double running these both along with other trusts in Cheshire and Merseyside.

Digital Care Delivery Highlight Report (Moderate Assurance)

- Clinical safety Update - 3 ongoing clinical safety cases. WASP has had no additions since going live. Then there is the Virtual ward and Point of Care testing.
- SDEC/ACC Type 5 – supported the SDEC and Ambulatory teams to transition from Inpatients to a Type 5 ED location. Built and configured the Type 5 locations in Lorenzo and all downstream systems, supported Ops Managers with process redesign and floorwalking support at Go-Live.
- Pharmacy – Outpatient prescribing now live. Taking a paper to Transformation and provide the recommendation that we can extend it out to the whole of outpatients. Phase 2 is the logical printing aspect of this.
- ACCIO Update - Cutting and pasting clarifies they are stopping cutting and pasting nationally which is stated in the current data standards. Due to the information being taken from a live record, when it is copied and pasted it can be outdated very quickly. Need to rely on up-to-date information hence the use of the live system.

Items for escalation

- Results Acknowledgement paper switch off process significant backlog of unacknowledged results a report has been developed assure progress

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only:

- NHSE Initiative driven projects (PEP/eBCMS/EPCMS) all running at similar timeframes all with tight timelines and funding drawing down in 2023/24.
- EPCMS ITT launched 2nd of November 2023.

- Digital Strategy approved in September launch and engagement workshops delayed due to resource pressures and being planned for December.
- gateway NHSE releasing tranche 2 funding £675k
- Results Acknowledgement paper switch off process significant backlog of unacknowledged results a report has been developed assure progress
- Patient Entertainment project group stepped down 3-6 months
- eOutcome 7th December cut over at risk
- This disconnect for EBCMS and SHREWD tool which requires implementation and that we will be double running these both along with other trusts in Cheshire and Merseyside.

4. MONITORING/REPORTING ROUTES

Monthly highlight reports from digital feed groups into Digital Strategy Group

5. TIMELINES

2023 to 2025 priorities set via Digital Strategy

6. RECOMMENDATIONS

The Finance and Sustainability Committee is asked to note the contents of the report, including internally assessed assurance levels.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/12/154**			
SUBJECT:	**WHH Influenza Vaccination Approach 2023-24**			
DATE OF MEETING:	6th December 2023			
AUTHOR(S):	Rebecca Patel, Associate Chief People Officer			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	☐		
	SO2 We will be the best place to work with a diverse and engaged workforce	☒		
	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)***	**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 and 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: The WHH influenza campaign approach as outlined in this paper details accessibility measures and considerations to ensure equality of opportunity.			
	3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A ✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the planning, implementation and delivery of the influenza vaccination programme for the workforce for 2023-24. The paper gives a			

	clear indication of the reporting and governance routes, identifies risks and mitigations which are being managed in line with the governance processes and procedures and outlines the communications and engagement approach deployed. In addition, the paper provides a baseline self-assessment against the national best practice management of influenza vaccination guidelines which has been used to prepare for the campaign.		
PURPOSE: ***(please select as appropriate)***	Approval ☐	To note ✓	Decision ☐
RECOMMENDATION:	Trust Board are asked to note the contents of the report and assurance regarding the implementation of the campaign for 2023-24.		
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A	
	Agenda Ref.	N/A	
	Date of meeting	N/A	
	Summary of Outcome	N/A	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	WHH Influenza Vaccination Approach 2023-24	AGENDA REF:	BM/23/12/154

1. BACKGROUND/CONTEXT

The organisation's Occupational Health and Wellbeing service leads on the delivery of the annual seasonal influenza vaccination campaign on behalf of the workforce. In the 2021-22 campaign, the vaccine was offered to 100% of staff and was administered to 76.4% of patient-facing staff. This year, the campaign has continued in this approach and be aligned to Winter Well Public Health messaging to support vaccination messaging during the autumn and winter period.

Following a letter sent to NHS Trusts on 30th August 2023, regarding the NHS vaccination response to the BA2.86 Covid variant risk, all NHS organisations were requested to accelerate the roll out of all autumn / winter vaccination deliver, including influenza which meant that that the WHH campaign started earlier than planned from the 25th September.

All organisations have an identified CQUIN target for the administration of the influenza vaccination to patient-facing staff, which is set at an ambitious minimum of 75% for 2023-24. The timeframe for the campaign is from the 25th September until March 2024 with the ambition for WHH to deliver the majority of the campaign by 31st December 2023.

The organisation are also required to send monthly reporting externally to the UK Health Security Agency (UKSHA) via ImmForm and CQUIN. Data will be publicly available approximately six weeks after each quarter in order to provide benchmarking information. In addition to external reporting, progress will be reported through to the executive team via the Chief People Officer on a weekly basis.

2. KEY ELEMENTS

2.1 Influenza Campaign Planning

In order to support the planning of the campaign, the Occupational Health and Wellbeing team met with key stakeholders to provide oversight on the planning and implementation of the programme.

In preparation for the campaign, the team has also undertaken a baseline assessment against the Flu Programme Best Practice Management Checklist[1], published in 2022 and available in **appendix one** which accompanies the robust communications and engagement plan which has been developed.

[1] Healthcare Worker Flu Vaccination Best Practice Management Checklist: www.gov.uk/publications/national-flu-immunisation-programme-plan/appendix-h-healthcare-worker-flu-vaccination-best-practice-management-checklist

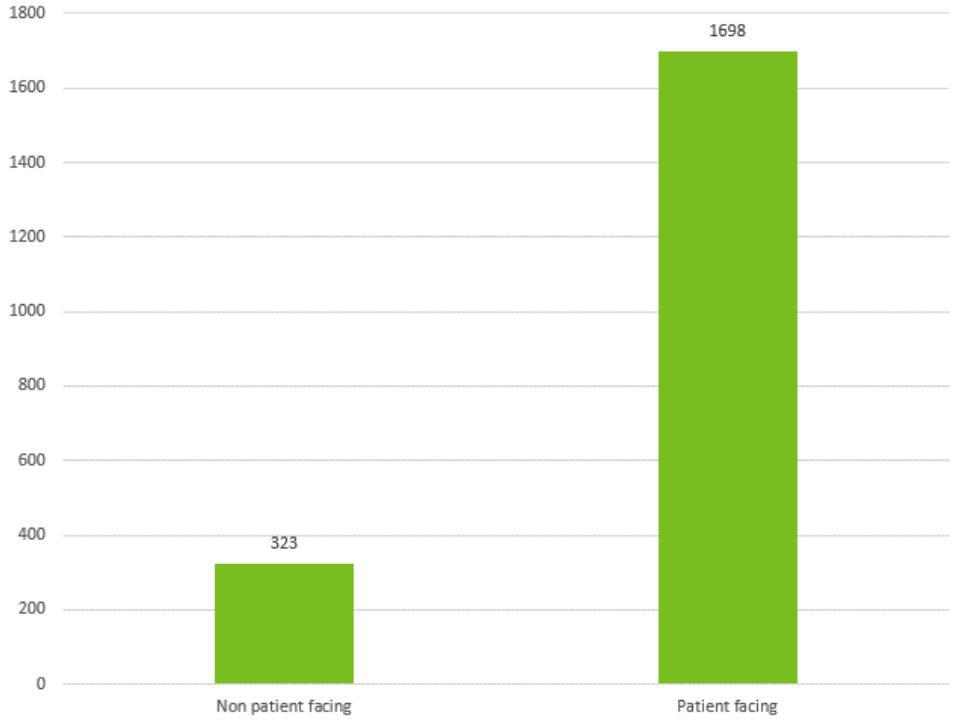
2.2 Governance and Reporting

There is a national requirement to report on participation rates for the programme, which will be reported externally utilising the ImmForm and CQUIN systems to the regional NHSE team and UKSHA.

From an internal reporting perspective, the campaign has utilised an electronic consent form which has enabled direct reporting into ESR and through executive governance routes via the Chief People Officer on a weekly basis at Execs and at Operational People Committee and Strategic People Committee as appropriate.

The latest data from 17th November demonstrates that the organisation has delivered 2,103 flu vaccinations, equating to approximately 48.6% of our CQUIN target as illustrated in **diagram one**, which is aligned to the action plans developed as part of the campaign.

Diagram One: Flu Vaccination Participation Overview



2.4 Clinic Locations

Learning from previous campaigns, it is imperative that a targeted approach in clinical areas is deployed to support the continued participation in the influenza campaign including out of hours provision to support individuals working nights and weekends.

The Occupational Health and Wellbeing team have and will continue to be visible across both sites with a roving model deployed across clinical areas as well as the following static locations on a rota basis:

- Main hospital reception area – Warrington site
- Occupational Health and Wellbeing offices – Warrington site
- George Lloyd Restaurant – Halton site

- Education Centre – Halton site.

The location of roaming and static clinics continue to be communicated via informal and formal communication channels across the organisation throughout the campaign.

2.5 Communications and Engagement approach

Both informal and formal communication mechanisms and channels continue to be fully utilised to deploy the campaign, as articulated in **table one** which is accompanied by a robust communications plan developed in partnership with the communications team.

Table One: Communication Channels

Formal Communication Channels	Informal Communication Channels
• Trust-wide communication • Safety Brief • Team Brief • Extranet pages / announcements • The Week • Specific meetings i.e., Housekeepers and Ward Managers amongst others	• People Champion Network • Staff Networks • People Directorate meetings • Staff Engagement noticeboards • WHH People Twitter and Facebook channels • Staff side colleagues

From an engagement perspective, existing stakeholder relationships continue to be maximised including the engagement of people Champions and Staff Network members to support key messaging across the organisation linked to Winter Well messaging.

2.6 Overview of Risks

For the 2023-24 campaign, it is recognised, similarly to the previous campaign that there continues to be elements of vaccine hesitancy due to vaccine fatigue and misinformation about efficacy of vaccination. In addition, there is likely to be a possibility of increased co-circulation of influenza, COVID-19 and other respiratory illnesses which is the rationale for accelerating the vaccination programme for 2023-24. Some of the key risks and mitigations to the programme are outlined in **table two**.

Risk	Mitigation
1. Staff may refuse the vaccination due to personal behaviours and belief in over-vaccination, which has an impact on the achievement of the CQUIN target which has a financial incentive attached.	Communications campaign includes Public Health messaging focusing on behaviour change. The utilisation of internal advocates have also been deployed to support decision making.

2. Internal reporting is reliant upon staff capacity which may be impacted by sickness absence rates	Administrative functions within the wider People Directorate are able to cross-cover and scale up to support as required to the Occupational Health and Wellbeing team.
3. Delayed delivery of the vaccine from the supplier or a shortage will delay the administration of the vaccine and therefore shorten the delivery timescale, impacting on the ability to administer the CQUIN.	Delivery plan developed to mitigate against delays, which includes the provision of increased activity within the first 2 weeks of the campaign.

2.7 Next Steps

The Occupational Health and Wellbeing team will continue to deliver the 2023-24 influenza campaign on behalf of the organisation, utilising the learning from previous campaigns and bespoke communications and engagement approaches as appropriate across the organisation.

3. RECOMMENDATIONS

Trust Board are asked to note the contents of the report and assurance regarding the ongoing delivery of the influenza campaign for 2023-24.

4. APPENDIX ONE: Baseline Assessment – Best Practice Management Checklist

Self-Assessment Key	
Purple	Action not initiated
Red	Action initiative but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete, assurance embedded but not received
Blue	Complete, assurance evidenced, embedded, received and passed to CBU for monitoring

	Overview	Evidence	Trust Self-Assessment	Timescales
Committed Leadership	**A1:** Board record commitment to achieving the ambition of vaccination of all frontline health care workers (both clinical and non-clinical staff who have contact with patients)	The WHH Board does support the campaign year on year. Acknowledgement of national documentation to encourage all frontline patient-facing staff to be vaccinated embedded into communication plans. As representatives of the Board, the Executive team receive weekly updates on participation rates and approach.		Ongoing
	A2: The Trust has ordered and provided a quadrivalent (QiV) influenza vaccine for healthcare workers	The Trust has ordered in total 3,100 vaccines split as follows: • 970 Sanofi priced at £14.85 each for those over the age of 65 (but also suitable for those aged 18 and over) • 2130 vaccines provided by Sequris which are priced at £9.94 each.		Q1 2023-24
	A3: Board receives evaluation of the influenza programme 2022-23 including data, successes, challenges and lessons learned	Executive briefing paper provided in Q4 2022-23 which highlighted the success of a hybrid model, including the use of targeting resources in clinical areas.		Q4 2022-23
	A4: Agree on Board Champion for Influenza campaign	As the Occupational Health and Wellbeing department are within the People Directorate, it was recommended and endorsed that the Board Champion for the campaign is the organisation's Chief People Officer		Q1 2023-24

	A5: All Board members receive influenza vaccination and publicise this	Board members have been offered the vaccination as part of the implementation of the campaign. Accompanying communications were via the trust-wide communications and utilisation of the WHHNHS and WHH People social media channels		Q3 2023-24
	A6: Influenza team formed with representatives from all Directorates, staff groups and trade union reps	A planning group was set-up with key stakeholders prior to the campaign to ascertain key messages, themes and also update any Trust-wide communications. Key stakeholders have also been engaged with throughout the campaign to support with key messages and to encourage further participation and uptake.		Q2 2023-24
	A7: Influenza team to meet regularly from September 2022	The Occupational Health and Wellbeing team lead on the workforce's vaccination programme. Key stakeholders will continue to be met with where appropriate to disseminate key communications and support any campaign implementation.		Ongoing
Communications Plan	**B1:** The rationale for the Influenza Vaccination programme and facts to be published – sponsored by senior clinical leaders and Trade Unions	The planning group have discussed communication approaches and updates in partnership with the communications team and aligned to clinical guidance and information form the UK Health Security Agency (UKHSA)		July 2022
	B2: Drop-in clinics and mobile vaccination schedule to be published electronically on social media, and on paper	The influenza administration in clinical areas will be supported by the roving Occupational Health and Wellbeing team through a targeted approach. In addition, the team will be visible across both sites offering mobile and pop-up clinics to support the campaign. Opportunities to be vaccinated have been published via mixed media and informal and formal communication mechanisms as		Ongoing for duration of campaign (September 2023 – March 2024)

		per the robust communications plan		
	B3: Board and senior managers having their vaccinations to be publicised	Photographs capturing senior management and the Board participating in the vaccination programme have been publicised by the Trust and with consent from the individual.		October 2023
	B4: Influenza vaccination programme and access to vaccination on induction programmes	The Occupational Health and Wellbeing team are scheduled to attend induction and capture all new starters for the duration of the campaign.		Ongoing for duration of campaign (September 2023 – March 2024)
	B5: Programme to be publicised on screensavers, posters and social media	The communications plan to support the 2023-24 campaign plan includes the use of desktop screensavers which have been implemented to garner interest. In addition, a raft of resources have been made available and deployed via formal and informal mechanisms for the duration of the campaign.		Ongoing for the duration of the campaign (September 2023 – March 2024)
	B6: Weekly feedback on percentage uptake for Directorates, teams and professional groups	Weekly figures are provided from the data submitted via the electronic consent form for use by the Chief People Officer to provide oversight and assurance with executive colleagues and for communications to promote participation rates.		Ongoing for the duration of the campaign (September 2023 – March 2024)
Flexible Accessibility	**C1:** Peer Vaccinator, ideally at least one in each clinical area to be identified, trained, release to vaccinate and empowered	Due to lessons learned from the previous campaign, the Peer Vaccinator model has not been implemented for 2023-24 and instead the OH team will be providing a targeted clinical approach utilising different shift patterns and opportunities for engagement.		Not required due to deployment of alternative method.
	C2: Schedule for easy access drop-in clinics as agreed	The influenza campaign has been delivered in visible and accessible areas with the first 4 weeks of the campaign having a static model based at the Warrington site and this is also supported by a roving Occupational Health team who		Ongoing for the duration of the campaign (September 2023 – March 2024)

		are targeting areas with lowest participation rates.		
	C3: Schedule for 24 hour mobile vaccinations to be agreed	Early morning and late evening roving model and clinics have been implemented to capture night staff and those working at weekends. These options have been communicated and advertised on a weekly basis.		Ongoing for duration of campaign (September 2023 – March 2024)
Incentives	**D1:** Board to agree on incentives and how to publicise this	Incentives to support the campaign, such as campaign pens and stickers have been deployed.		August 2023
	D2: Success to be celebrated weekly	The communications plan identified the areas that are celebrated as part of success stories to support participation rates. This includes key messages on social media utilising the WHH People channels.		Ongoing for the duration of the campaign (September 2023 – March 2024)