WHH Board of Directors Meeting Part 1

Wednesday 25 January 2023
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 25th January 2023, 10.00am – 12.30pm
Trust Conference Room/Via MS Teams

AGENDA ITEM	TIME	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
BM/23/01/01	**10:00**	Engagement Story – Meeting the needs of the unexpected.	***To Note***	**Presentation**	Jen McCartney Head of Patient Experience & Inclusion & Emma Painter, Associate Chief of Nursing – Unplanned Care
BM/23/01/02	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chairman
BM/23/01/03 PAGE 6	**10:17**	Minutes and Action Log of the previous meeting held on 30 November 2022	***For decision***	***Minutes***	Steve McGuirk, Chairman
BM/23/01/04	**10:20**	Matters Arising • Charity Annual Report & Accounts	***For assurance***	***Verbal***	Steve McGuirk, Chairman
BM/23/01/05 PAGE 22	**10:25**	Maternity Incentive Scheme	***For approval***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO & Simon Constable, Chief Executive
BM/23/01/06 PAGE 53	**10:35**	Chief Executive's Report	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/23/01/07 PAGE 72	**10:40**	Chair's Report	***For info/update***	***Report & Verbal***	Steve McGuirk, Chairman
BM/23/01/08 PAGE 78	**10:45**	Board Assurance Framework	***For approval***	***Report***	John Culshaw, Company Secretary

Quality People Sustainability

BM/23/01/09 PAGE 108	**10:50**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a) PAGE 179		**Quality Dashboard** **Including** Assurance Reports – Quality and Assurance Committee (QAC) – 6.12.22 & 10.01.23	***For assurance***	***Report & Presentation***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO; Dan Moore, Chief Operating Officer; Paul Fitzsimmons, Exec Medical Director Cliff Richards, Committee Chair
(b) PAGE 186		**People Dashboard** **Including** Assurance Report - Strategic People Committee (SPC) – 18.01.23	***For assurance***	***Report & Presentation***	Michelle Cloney, Chief People Officer Julie Jarman, Committee Chair
(c) PAGE 187 (d) PAGE 193		**Sustainability Dashboard** **Including** Assurance Report – Finance and Sustainability Committee (FSC) – 21.12.23 & 18.01.23 Clinical Recovery Oversight Committee (CROC) – 17.01.23	***For assurance***	***Report & Presentation***	Andrea McGee, Chief Finance Officer & Deputy CEO John Somers, FSC Chair Jayne Downey, CROC Chair

Quality

BM/23/01/10 **PAGE 196**	**11:45**	Maternity Update including; I. Ockenden Review Updates December 2022, January 2023 **PAGE 210** II. Avoiding Term Admission into Neonatal Unit (ATAIN) Q2 **PAGE 218** III. Maternity Incentive Schemes – December 2022 **PAGE 224** IV. East Kent Review **PAGE 230** V. Perinatal Mortality	***To note for assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

People

BM/23/01/11 **PAGE 245**	**11:55**	Engagement Dashboard Q3 Update	***To note for assurance***	***Report***	Kate Henry, Director of Communications & Engagement

Sustainability

BM/23/01/12 **PAGE 255**	**12:00**	Strategy Update • Bi-monthly update	***To note for assurance***	***Presentation***	Lucy Gardner, Director of Strategy & Partnerships
BM/23/01/13 **PAGE 277**	**12:05**	Operational Planning Guidance	***To note for assurance***	***Report***	Andrea McGee, Chief Finance Officer & Deputy CEO

GOVERNANCE					
BM/23/01/14 **PAGE 287**	**12:15**	Risk Appetite Statement	***For approval***	***Report***	John Culshaw, Company Secretary

FOR APPROVAL					
BM/23/01/15 **PAGE 291**	**12:20**	Cycle of Business – Quality Assurance Committee	***For approval***	***Report***	John Culshaw, Company Secretary
BM/23/01/16 **PAGE 294**		Cycle of Business & Terms of Reference – Strategic People Committee	***For approval***	***Report***	John Culshaw, Company Secretary

SUPPLEMENTARY PAPERS (see Supplementary Pack for page numbers)

TO NOTE FOR ASSURANCE					
BM/23/01/17	Infection Prevention and Control - Board Assurance Framework	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 10.01.23 Agenda Ref: QAC/23/01/14 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/01/18	Digital Strategy Group Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 21.12.2022 & 18.01.2023 Agenda Ref: FSC/22/12/214 & FSC/23/01/15 Outcome: Noted	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/23/01/19	Trust Organisational Chart	***To note for assurance***	Committee: Executive Management Team	***Paper***	John Culshaw, Company Secretary
BM/23/01/20	Handover and Ward Round Standard Operating Procedure (SOP)	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 13.01.2023 Agenda Ref: Virtual approval Outcome: Approved	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/23/01/21	Any other Business		***To note***	***Verbal***	Chair

Date and Time of next meeting – Wednesday 29th March 2023

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.

GLOSSARY OF TERMS

CEO	Chief Executive	QIPP	Quality, Innovation, Productivity + Prevention
ANP	Advanced Nurse Practitioner	**RTT**	Referral To Treatment
AQP	Any Qualified Provider		
BAF	Board Assurance Framework		
BCF	Better Care Fund	**StH&KHT**	St Helens & Knowsley Hospitals Trust
CBU	Clinical Business Unit	SFIs	Standing Financial Instructions
CCG	Clinical Commissioning Group	SLR	Service Line Reporting
CHC	Continuing Health Care	SORD	Scheme of Reservation and Delegation
CIP	Cost Improvement Plan	SIs	Serious Incidences
COO	Chief Operating Officer	SJRs	Structured Judgement Reviews
COI	Conflicts of Interest ***(or Register of Interest)***	STF	Sustainability Transformation Fund
CNST	Clinical Negligence Scheme for Trusts		
CNO	Chief Nursing Officer		
CRR	Corporate Risk Register	**WDES**	Workforce Disability Equality Standard
CQC	Care Quality Commission	WEAR	Workforce Employment Assurance Report
CQUIN	Commissioning for Quality and Innovation	WRES	Workforce Race Quality Standard
DIPC	Director Infection Prevention + Control		
DoH	Department of Health	AC	Audit Committee
DTOC	Delayed Transfers of Care	CFC	Charitable Funds Committee
ED+I	Equality, Diversity + Inclusion	FSC	Finance + Sustainability Committee
EoL	End of Life	SPC	Strategic People Committee
ESD	Early Supported Discharge	QAC	Quality Assurance Committee
EDs	Executive Directors	COG	Council of Governors
FTSU	Freedom To Speak Up		
FT	Foundation Trust		
GoSW	Guarding of Safe Working	SEOG	Strategic Executive Oversight Group
HCAIs	Health Care Acquired Infections	CPG	Capital Planning Group
HEE	Health Education England	FRG	Finance Resources Group
HWBB	Health + WellBeing Board	PSCEC	Patient Safety + Clinical Effectiveness Cttee
IAPT	Integrated Access Point to Treatment	PEC	Patient Experience Committee
JSNA	Joint Strategic Needs Assessment	PPSRG	Premium Pay Spend Review Group
KLOE	Key Line of Enquiry	RRG	Risk Review Group
KPI	Key Performance Indicators	OP	Operational People Committee
MIAA	Mersey Internal Audit Agency	SDDG	Strategic Development + Delivery Group
NCA	Non-Contracted Activity	GEG	Governors Engagement Group
NED	Non Executive Director	QiC	Quality in Care
NEL	Non Elective	CQAG	Complaints Quality Assurance Group
NHSE/I	NHS England/NHS Improvement	H&SSC	Health + Safety Sub Committee
OSC	Overview and Scrutiny Committee	EoLSG	End of Life Steering Group
PbR	Payment by Results	MRG	Mortality Review Group
PHE	Public Health England		
PPA	PPA Prescription Pricing Authority		

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 30 November 2022 Halton Education Centre/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Simon Constable (SC)	Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Andrea McGee	Chief Finance Officer & Deputy Chief Executive
Kimberley Salmon-Jamieson	Chief Nurse & Deputy Chief Executive
Michelle Cloney (MC)	Chief People Officer
Dan Moore (DM)	Chief Operating Officer
Paul Fitzsimmons (PF)	Executive Medical Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
Liz Walker (LW)	Secretary to the Trust Board (minute taking)
Karen Mason (KM)	Cancer Nurse, Transformation Manager (*in attendance for Agenda Item BM/22/11/137 Patient Story)*
Laura Hilton (LH)	Associate Chief People Officer (*in attendance for Agenda Item BM/22/11/144)*
Rachel Clint (RC)	EPRR Manager (*in attendance for Agenda Item BM/22/11/144)*
Observing Governors	
Norman Holding	Lead Governor
Staff Observers	
Debbie Hatton	Lead Nurse
Debbi Howard	Head of Clinical Education
Harry Vlasman	Liverpool Heart & Chest Hospital

Agenda Ref	Agenda Item
BM/22/11/137	**ENGAGEMENT STORY – SIMON'S EXPERIENCE OF CANCER CARE** Karen Mason, Cancer Nurse, Transformation Manager was in attendance to

	present the Patient Story on behalf of Simon Caulfied, who had asked for his experience of his Cancer Care within the Trust, and also the work he had done and the work in the pipeline, to be shared with the Board. This demonstrated the improvements made by working together to make a difference to the people of Warrington who have been diagnosed with Cancer and to ensure they receive the support they need and deserve. The presentation highlighted the diagnosis and treatment of the patient who had been diagnosed with pancreatic cancer and was given a very low chance of survival. Notwithstanding that, he underwent surgery which was followed by 6 months of chemotherapy. The aftereffects were explained during and after treatment. However, it was apparent that there was a disconnect between tertiary centres and local hospitals. Simon has subsequently trained as a Counsellor, as part of 'giving something back' and had since gone on to volunteer at the Delamere Centre, providing sessions for patients who had been diagnosed with Cancer. The lessons learnt during this process were highlighted, noting the importance of understanding the impact of a poor experience in a pathway; seeing *the person in the patient* to ensure a positive experience; and the importance of ensuring that patients treated in tertiary centres are referred into local support available via local trusts. SMcG asked about the Tertiary Centre and Macmillan's acceptance for responsibility for this. KM responded, MacMillan was not responsible, however they were supporting WHH and ensuring a connection between tertiary centres. SMcG added this could probably be done better, as part of the ICB. DT noted it was wider than just cancer and there was a lack of connectivity between speciality centres and core services of local trusts which, hopefully, should form a part of the work of the ICB. ACD asked about social prescribing and KM did not know the answer to this as did not sit within her remit. **The Trust Board discussed and noted the Patient Story and thanked KM for attending the meeting to present.**
BM/22/11/138	**WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST** The Chair welcomed everyone to the meeting, and no apologies of absence were received for the meeting. It was noted that a landmark had been reached as the new range of services at Runcorn Shopping City were open as from today. (LG Had attended on the first day instead of participating in a leadership observation visit.) SMcG went on to remind everyone. – given a larger than usual number of

	observers - that the Trust Board meetings were meetings held in public rather than public meetings and therefore any questions to be raised should be tabled in advance of the meeting. It was noted that SMcG declared an interest in relation to Agenda Item BM/22/11/140 - amendment to the constitution. **The Trust Board noted the welcome.**
BM/22/11/139	**MINUTES AND ACTION LOG FROM THE PREVIOUS MEETING HELD ON 28 SEPTEMBER 2022** The minutes of the meeting held on 28 September 2022 were agreed as an accurate record and approved subject to minor amendments. The Action Log was reviewed and noted. **The Trust Board approved the minutes of the meeting held on 28 September 2022 and noted the Action Log.**
BM/22/11/140	**MATTERS ARISING** *Verbal Update in relation to Adaptive Reserve Fund* AMcG noted that meetings were taking place with partners in Warrington to review requests for use of the Adaptive Reserve Fund, along with DM, and also looking at how collective pots of money would be utilised. There were a host of schemes, and there was a need to look at the impact on "No Criteria to Reside" (NCTR) ahead of winter. DM added that the announcement around funding only just happened, and the list of schemes was due to be signed off within the next few days. There would be a process internally and externally to scrutinise the agreed schemes and the board would be updated as appropriate. *Amendment to Constitution* JC noted approval had been sought at CoG and GNARC, for a third term of office for the Chair, from 1 April 2023 – 30 March 2026, however, in order to facilitate this, there was a requirement to amend the Constitution, and, accordingly, formal approval was required from the Trust Board in addition to the approval of the CoG. *Governor Elections* JC noted the results of the recent Governor Elections and noted that Anne Robinson, Colin McKenzie and Keith Bland had been re-elected, and there were a number of new Governors who had been elected. **1. Trust Board noted the verbal update in relation to the Adaptive Reserve.** **2. The Trust Board approved the amendment to the Constitution.** **3. The Trust Board noted the results of the Governor Elections.**
BM/22/11/141	**CHIEF EXECUTIVES REPORT**

	SC presented his briefing report which provided the Trust Board with an overview of matters on a range of strategic and operational issues since the last meeting on 28th September 2022, some of which were not covered elsewhere on the agenda. The report was taken as read; however, items were highlighted in relation to section 2.3 regarding Industrial Action. It was noted that there would be no immediate strikes at WHH, and notification had been received within the last 24 hours that Unison will not be striking at WHH, the threshold not having been achieved A question was raised in relation to waiting times in A&E and the declaration of OPEL 4, along with the issues around super-stranded patients and when does the Trust become worried and what was the capacity. SC responded that OPEL 4 had been declared twice already this year; there were set criteria. DM added there had been conversation with the ICB as this was set when COVID was first an operational issue and is based on when the organisation becomes in distress but those around were operating satisfactorily. However, all organisations were in the same situation and therefore this was a challenge and the metrics relating to OPEL 4 were probably now not fit for purpose. There had been some revision to metrics and triggers as we get closer to Christmas. In terms of capacity, B3 had been opened and the numbers of patients were constantly being tracked in order to get ahead of the curve. It was not just about estate options but also the workforce challenge; it was positive there was a system that works together and also this was where the Adaptive Reserve Fund was conceived; however, it needed to move capacity faster before there is appoint where the hospital cannot operate. KSJ added that internally there was an escalation plan this had been reviewed for Winter and January capacity and the numbers to take on corridors were known, as well as any additional risk that might need to be managed. ACD asked about Freedom to Speak Up and if there were trends of behaviour and any lessons learnt from this. KSJ responded there overall were low number, however they had increased, with the majority around communication, behavioural and relationship issues but were still low numbers. CR asked about the COVID-19 Public Inquiry and the non-mandatory questionnaire to gather information, and what the thoughts of the Trust were and was there a strong detailed narrative in response. SC responded it had been included as an alert; it was due to be received, but as yet did not know how the Trust would respond and await further guidance. SMcG noted this thanks to CR for his attendance as representative for Armistice Day and also welcomed the new Chaplain. **The Trust Board noted the Chief Executive's Report.**
BM/22/11/142	**CHAIR'S UPDATE** The report was taken as read and no further comments were noted.

	The Trust Board noted the Chair's update
BM/22/11/143	**BOARD ASSURANCE FRAMEWORK (BAF)** SMcG reminded Board members of the change to the order of the agenda and consideration of the BAF would now take place at the start of the meeting to ensure that any subsequent discussions reflected the key risks facing the Trust, and that any feedback about whether this was being achieved was welcomed. JC went on to present the Board Assurance Framework update and noted there had been no new risks added, the rating for two risks had been amended and the description of four risks had been amended. It was also proposed to deescalate one further risk to the CBU Risk Register and close one risk. **Risk #114** had been reduced from a score of 20 to 16, and details were included in the report. Description amendments to **Risks #1114, #224, #1215 and #134** had been made and full details were included in the report Risk **#1579** was proposed to be deescalated to the CBU Risk Register. Risk **#1273** has been closed and gaps merged with **#224**. The top two risks on the BAF related to capacity, and the remainder of risks were around staff and nosocomial infection. JD asked about the rating for Risk **#1215** and whether it needs to be reduced from 2. It was discussed and it was agreed this would be reviewed. MOC referred to industrial action and asked if this would be escalated to the BAF once further work on milestones etc had been undertaken. It was confirmed that this would be discussed at the next Risk Review Group meeting and subsequently has been added to the BAF. DT asked about Risk #115, relating to vacancies and staff sickness and it was noted this would be raised in the IPR discussion. **1. The Trust Board discussed and noted the report and supported the proposed changes to the risks highlighted.** **2. It was agreed that Risk #1215 be reviewed.**
BM/22/11/144	**INTEGRATED PERFORMANCE REPORT** SC presented IPR summary and dashboard, alongside nurse safe staffing report and committee assurance reports. ***Quality*** *Nurse Staffing Report* KSJ provided an overview of Month 7 vacancies, noting there were 154 WTE registered nurse vacancies. However, if the nurses already recruited or coming into the Trust over a period of time were 'counted', this left 23 WTE vacancies remaining to be filled.

Staff will of course also leave over this period of time, and there is a constant rolling programme of recruitment, with the use of more specialised recruitment for those more challenging areas, i.e., Midwifery and A&E.
International recruitment would also be taking place, with significant staff movement across the NHS, and with the intention to fill gaps whilst supporting ongoing retention and recruitment.

A review of other types of support across Cheshire & Merseyside were being looked at to see if there was anything that could be replicated at WHH.

Daily Management of staffing takes place, with meetings three times a day to manage this in real time.

MOC added the recruitment team facilitates the pace and volume described, but it also impacts on the workload of the recruiting managers in trying to incorporate this into the daily workload of the People Directorate.

Work was also taking place to look at how we can attract from local communities using HWB hubs, apprenticeships and converting long term locum posts to substantive contracts, which would also result in a reduction in agency costs).

There had been some issues in relation to the newest version of NHS Jobs, which had led to some delays and discussions had taken place to look at ways to make it much for efficient. However, the system does not have some of the functionality it previously had, so eventually would change over to using a new system called TRAC.

"Stay" conversations were taking place with those who were thinking of leaving, alongside use of supporting attendance policy in relation to attendance management and impact had been seen by the implementation of the policy.

ACD then asked about agency and bank staff and the financial risk and impact in relation to covering the gaps we had.

KSJ responded that locum staff were booked through NHSP; and although we use our own substantive staff where possible (around 60%), this was variable, and the rest were the rest came through the *Cascade* system. It was noted that costs are negotiated and set through NHSP for all agencies.
SMcG added that reassurance was provided regarding this, along with the use of other methods of recruitment, and it was also good to see the move away from NHS Jobs website as his experience had been poor

Elective Restoration and Recovery
DM noted the following in relation to restoration and recovery;

- 104 week waits – patients had been offered a date for treatment, however some had declined or deferred. There is a finite number of times that someone can do this without triggering and move to re-categorisation of the level of urgency.
- Delivery of 78 week target to be achieved by end of March - this was being

tracked at weekly meetings.

- There were four trusts flagged in Cheshire & Merseyside that would not achieve by year end. Liverpool, Chester, St Helens & Knowsley and WHH, and this would be considered when forecasting at the end of the year.
- Patients fall into 4 specialities and modelling was underway and would look at best practice nationally, where efficiencies can be increased.
- In terms of general surgery this has been massively impacted and was reported as a national issue.
- There continues to be a high referral rate of cancer patients and there was a need to explore external support and the WLI budget could be used to pay for this.
- There was a lot of work underway in relation to efficiency and reduction of DNAs short notice cancellations in order to achieve the target.
- It was noted there would be a high number of risks leading into Winter and there would be a plan drawn up over the next weeks.

JD asked about the plans in place and if this would mean the target would not be met for those patients waiting over 78 weeks. DM responded that it was expected the target would be met.

AMcG noted it was important for productivity metrics to be clear on using resources as effectively as possible before occurring any external costs, and there was discussion about the plans in place to meet the relevant targets.

SMcG asked where the targets had come from in relation to acute kidney and impact (AKI) on mortality and also in relation to remote outpatients.

DM responded that in terms of 12 hours breaches, these numbers have continued to rise, as has every other organisation nationally and regionally, but access to benchmark data has started to become available, albeit intermittent, which can now be shared. Outpatient metrics had been set twice this year and WHH was currently on a journey to achieve this. 25% of appointments were virtual with the aim of creating outpatient capacity for restoration and recovery, and everyone is currently tracking slightly behind target.

Medicines Reconciliation

PF noted work was underway to identify AKI patients with the team up to full strength which had seen an immediate reduction in mortality, however there would be an impact during winter pressures.

Medicines reconciliation related to demand and capacity with an increase in complexity and patients in the wrong place. However, the picture had shifted slightly and was more around capacity, with plans in place to make improvements. In particular there had been an issue in relation to Band 6 staff which was likely to deteriorate further over the next few months. Bank staff were being utilised and people were being encouraged to take on additional bank shifts.

Committee Assurance Reports

Quality Assurance Committee

CR highlighted the key issues to the Trust Board from the Quality Assurance Committee meetings held on 4 October and 1 November 2022. These included :

- IPR data was being presented in relation to Quality updates.
- LPS and DoLs were discussed, in particular in relation to taking over legal responsibility which would be the responsibility of the Trust, and there were concerns in relation to training, as would take over the responsibility of the patient at the door, which would mean a huge amount of work.
- Missed fractures in ED, with 15 missed fractures identified, with no consistent issues, apart from 5 being rib fractures in older patients.
- Maternity update regarding Ockenden which was on track, and a second issue relating to Maternity Voices Partnership and where this should sit within the governance structure, which had now been formalised
- Training issues regarding de-escalation was a concern at only 15%.
- Histopathology issues were noted in relation to staff retirement and shortage of histopathologists, resulting in delays in prostate and colorectal.
- Hip fractures were discussed and agreed it was better to treat sooner, as this resulted in a better outcome, however it was noted that the Trust does not have an Orthogeriatrician.
- Complaints – there had been an increase in complaints relating to pressure ulcers.
- Enabling Strategies were discussed in detail and questioned whether some they were all strategies. It was agreed that the Strategy team would work through to understand the requirements of those that were needed and those that were not and agree timelines.

LG added that following a report by the CQC, a number of enabling strategies needed to be produced both departmental and some mandated. Therefore, it was important to ensure alignment with the overall Trust Strategy. A review would be undertaken to look at possible consolidation, and an update would be provided at the meeting in March 2023.

Strategic People Committee

MC noted the following issues from the Strategic People Committee held on 23 November 2022 for highlighting;

- It had been agreed that the Committee would meet monthly going forward.
- IPR data would be presented to the committee.
- An in-depth discussion regarding Industrial Action took place.
- Agency Controls were discussed with assurance around control on the process and review of the causes.
- On call harmonisation.
- Recognised an Apprenticeship levy and growing our own is one of the solutions.

ACD asked whether we knew about any staff members *in poverty*?

JJ responded there was a substantive offer for those struggling and MOC added this was a complex issue as assumptions cannot be made around personal circumstances, however information had been made available to staff.

SMcG noted that while it was important to support staff it was also necessary not to overreach, even with good intentions. He illustrated that some Chairs had recently commented on making the resources of their hospitals' available to staff to help them save money. One example quoted was, allowing staff to use hospital equipment to do their personal laundry. There were several issues with this, not least from a health and safety point of view. But also, the fact these resources were paid for by the tax paying public, many who are themselves struggling as much as, if not more than, employed staff. It was therefore important to be supportive but to signal and signpost help and assistance and be cautious of overstepping into areas that, in effect, subsidise income at the potential cost of patients.

Finance

AMcG provided the context around being slightly off plan for most of the year and to think about finances in conjunction with services and the recovery programme, along with capacity which would affect the financial forecast for the year. Nationally, forecast was the main focus and at meetings with Julian Kelly and the ICS Leads, there was discussion around risks and where this would likely land.

There was a new protocol to be completed by organisations if it was felt they would go off plan and the Trust was working on this right now, making every attempt to achieve the plan if possible. It was highlighted that while slightly off plan, CIP was delivering year to date although mainly non recurrent, however the capital programme was behind plan and it was important to catch up as it was important to spend the capital as it would not be able to be transferred into next year, if not spent.

Movements in contingency were highlighted with £209k of emergency capital requests approved since the last meeting, and a request from CPG to utilise contingency and also to return £200k to contingency. This had been discussed at FSC and supported, so the Board was asked to note the approvals and the changes outlined in Table 4.

A question was raised in relation to blockages for spending the rest of the capital and AMcG responded that some of these blockages related to when we get behind with an estates scheme, late allocations and late receipt of decisions and ordering equipment in a timely manner, therefore it was important to look now at what is next year's list that we could go and buy now, or what could be reshuffled. There was assurance that the Trust was included when an opportunity to bid for monies became available and is recognised that the Trust was in need of a fair share of any pots of money available either nationally or regionally.

Finance and Sustainability Committee

JS presented the key issues from the Finance and Sustainability Committee meetings held on 19 October and 23 November 2022;

- Pay Assurance update was provided on clarification of agency use and spend, with a presentation at the November meeting.
- CIP & GIRFT were discussed and the non-recurrent risk
- Finance report highlighted the likely forecast outturn at October meeting of

	£6m. • Capital – underspend and update on overspend on Urology & Paeds discussed at November meeting. • New protocol if off plan. • High turnover of nursing staff and improving sickness level but overall cost of sickness. • Presentation on Agency spend. • Exit strategy relating to additional bed capacity as non-recurrent funding until year end and pressures emerging • Further update on Urology & Paeds with a figure of overspend and commission internal review for lessons learnt and legal situation reviewed. • CQUIN with the assumption all CQUIN income is received. *Clinical Recovery Oversight Committee* JD provided an update on the key issues from the Clinical Recovery Oversight Committees held on 18 October and 15 November 2022. • Outlier for infections joint replacements and work to ringfence beds • Cancer alliance trajectory not deemed as risk for 62 week trajectory • Echo issues with sickness and member of staff left *Audit Committee* MOC noted the key issues from the Audit Committee meeting held on 17 November 2022. • NED input at Audit is useful as also commented from GGI and remains important to continue • Internal audit reports up to date • Cost of wasted drugs can be expensive and asked for review of the reasons and the costs and whether they could be distributed elsewhere on the patch. **1. The Trust Board discussed and noted the updates on the Performance Dashboard and the assurance provided in response to the challenges and questions.** **2. The Trust Board noted the highlights from the Committee Assurance Reports.** **3. The Trust Board approved that the Finance and Sustainability Committee approve Capital Requests.** **4. The Trust Board approved the updated KPIs in relation to the Oversight Framework.**
BM/22/11/145	**MATERNITY UPDATE** KSJ provided the highlights in relation to the Maternity update and included the following; *Maternity Incentive Schemes (MIS)* This was on track; however, the 10 standards were very challenging, with one issue raised in relation to medical training which had been escalated.

	Ockenden There were a total of 250 actions in all 3 parts and were on track. Pt 2 has a completion date of June 2023 and there were a number of actions, in particular in 1B relating to foetal compliance surveillance lead. *Cheshire & Merseyside Perinatal Mortality Report (PMRT)* Work was taking place with EMBRACE and any concerns raised. The PMRT tool had been reviewed on a Cheshire & Merseyside wide basis with further assurance requested around data, with a further deep dive to take place at a future Quality Assurance Committee meeting. *ATAIN* This was in a good position with a target of 4.5 and this continues to improve and was well below national requirements. *Independent Investigation into East Kent Maternity & Neonatal Services* A letter had been received from NHSE/I following the latest 'Kirkup' Report in to East Kent which made it a requirement for the report to be reviewed by the Trust Board. SMcG expressed disappointment at the superficial nature of a national response to yet another 'maternity crisis'. The impression formed was one of 'the centre' just pushing such reports 'out there' with little thought to how 'exactly' it was foreseen that they would be used. In this context it was of little surprise that such tragic events re-occurred with depressing frequency. From a WHH point of view, a further paper would be presented at QAC with a number of clear actions to be taken forward that would be monitored for their implementation. CR added in relation to PMRT, the tool was out of date, and it was important to understand what the figures were saying; therefore, a deep dive will be undertaken covering the 5 year period, in order to receive appropriate assurance. It was asked if this should be added to the Risk Register. **The Trust Board noted the updates**
BM/22/11/146	**ENGAGEMENT DASHBOARD** KH highlighted the launch of the website accessibility tool and that it was important to increase inclusivity. Previously there had been the opportunity to use such a tool but it was 'buried' many pages in, making it unusable, rather than it being on the front page There had also been the launch of the staff app which would support expansion of communication channels and reach people in different ways. **The Trust Board noted the Engagement Dashboard update.**
BM/22/11/147	**STRATEGY UPDATE** **LG highlights** LG provided the highlight in relation to the Strategy Update, noting that the Runcorn Town Deal had been formally approved.

	The Halton Health Hub was now open, and the Health & Social Care Academy based at the College had also opened. In relation to the Health & Social Care Academy, there had been three new courses developed based on employer needs and had successfully implemented a tailored curriculum and students were enrolled for this year. **The Trust Board noted the report.**
BM/22/11/148	**Q3 USE OF RESOURCE UPDATE** The paper presented an update for Quarter 3 2022/23 and the performance against each UoRA KLOE was set out in **Appendix 1**, the full detail for each KLOE indicator was detailed at **Appendix 2**. The following movements had taken place on the UoR Dashboard since Quarter 2 2022/23: • Finance Costs per £100m turnover – The Trust has moved from Red to Green for this indicator (£604k against a national median of £637k in 2021/22 vs £657k against a national median of £636k in 2020/21). • Human Resources Costs per £100m turnover - The Trust has moved from Red to Green for this indicator (£925k against a national median of £1.1m in 2021/22 vs £980k against a national median of £936k in 2020/21). Further to a request from Trust Board, this paper has been updated to support the streamlining of information. A number of indicators have been removed from the dashboard as set out below, with signposting to alternative existing reporting routes where appropriate. The report will now be presented annually. **1. The Trust Board noted the update and approved the report to be presented on an annual basis.** **2. The report to be added to the Cycle of Business for 2023/24.**
BM/22/11/149	**WINTER RESILIENCE PLANS** Winter NHSE planning guidance was published on 12th August2022 and updated on 18th October 2022, and the report presented outlined the response from the Trust. The biggest risks highlighted came from demand, excessive ‘ no right to reside’ patients, industrial action, funding challenges in the event the trust was subject to the new protocol and energy resilience. CR asked if GPs were aware of the pathway for referral into SDEC and it was advised that GPs were aware of the process which had been communicated appropriately. *Industrial Action & Resilience Briefing* It was noted that a task and finish group was in place in order review what this would mean for the Trust, and ensure plans were in place.

	SMcG asked about legalities and what derogation meant, as it was unclear. It created the idea that there was something rigorous in place by the use of language whereas, his experience, in reality, was that it meant going 'cap in hand' to people on local picket lines and asking them to return to work in an emergency? MOC confirmed that the appearance pf something well-ordered and agreed by all parties – including the unions – was misleading, and it was a 'hope' that derogations could be applied on the basis set out, rather than anything certain. RC advised an exercise with the ICB took place and established that, essentially, it was a matter for respective Trusts to work with other organisations to develop the best business continuity arrangements possible. SMcG sought to stress that there was a need to recognise that during periods of industrial action, trusts would undertake their best endeavours to address all their statutory and licence obligations and would have plans in pace for this. But in the event, all that was possible was the best possible which would not be the same as 'normal' times. This was particularly the case with, for example, NWAS, which had a significant non-urgent patient care/ transport role unlikely to be covered by derogations. **The Trust Board noted the update in relation to Winter Resilience and Planning.**
BM/22/11/150	**RECONFIGURATION OF BREAST SERVICES – PHASE 2 CONSULTATION OUTCOMES REPORT** WHH is the lead provider of the Breast Screening Service for Warrington, Halton, St Helens and Knowsley which is commissioned by NHS Specialist Commissioning. In 2021, following formal public consultation, breast assessment and symptomatic services were consolidated at two centres for the region – Captain Sir Tom Moore at Halton Hospital and the Burney Centre at St Helens Hospital. In 2022 it became possible to reconfigure the screening service within Warrington only, with the proposal to consolidate the service at Bath St Health and Wellbeing Centre and discontinue the service at Kendrick Wing, Warrington Hospital. As this was a significant service change public consultation was required and was carried out in May-June 2022. The consultation supported the proposal, and the final outcomes report is now submitted for assurance and decision. **The Trust Board approved the reconfiguration of the Breast Service Screening at Bath Street and continue the service in Kendrick Wing.**
BM/22/11/152	**NHS ENFORCEMENT GUIDANCE CONSULTATION** LG advised that NHS England had commenced 2 consultations, the first was a consultation on changes to enforcement guidance and secondly, how to deal with breaches of the provider licence, the consultation closes on 9th December 2022. In relation to enforcement guidance, the proposal is to introduce a two-tier approach to enforcement that reflects ICB regulation in relation to patient choice and ensure parity with NHS provider organisations in terms of NHSE's approach to ICB enforcement.

	NHS PROVIDER LICENCE CONSULTATION The proposed changes to the provider licence would be a shift of emphasis from economic regulation and competition to system working and collaboration. The consultation proposed four types of changes to the licence which would i) support effective system working ii) enhance oversight of key services provided by the independent sector, iii) addressing climate change and lastly technical amendments which would support effective system working. **NHS CODE OF GOVERNANCE** JC noted the update in relation to the new Code of Governance which will replace the NHS Foundation Trust Code of Governance and would apply to all trusts, not just Foundation Trusts. The new Code of Governance will align with the proposed extension of the NHS Provider Licence, changes to the UK Corporate Governance Code and reflect the evolving NHS System Oversight Framework. Further work with company secretaries will take place to review how this will affect the Trust going forward as a system with the main theme being collaboration and working together. **The Trust Board noted the updates in relation to;** **1. Enforcement Guidance** **2. Provide Licence** **3. Code of Governance.**
SUPPLEMENTARY PAPERS	
BM/22/11/153 **BM/22/11/154** **BM/22/11/155** **BM/22/11/156** **BM/22/11/157** **BM/22/11/158** **BM/22/11/159** **BM/22/11/160**	**WHH GMC National Trainee Survey Results 2022 & GMC Enhances Monitoring Status Update** **Medical Appraisal & GMC Revalidation Annual Report: September 2022** **Infection Prevention and Control - BAF** **Safeguarding Bi-Annual Report** **Digital Strategy Group Reports (19.10.22 & 23.11.22)** **Learning from Experience Q2** **Guardian of Safe Working Q2** **Winter Planning.** Items BM/22/11/153 – 159 were presented for noting and assurance, there were no issues or concerns raised in respect to any of the agenda items. Agenda Item BM/22/11/160 was covered in more detail at Agenda Item BM/22/11/149, Winter Resilience Plans. **The Trust Board noted the papers presented for noting and assurance purposes.**
BM/22/11/162	**ANY OTHER BUSINESS** There was no other business raised. The meeting closed at 12.30 p.m.
The Date and Time of the next Trust Board Meeting is Wednesday 25 January 2022	

Approved …… Dated ……

CHAIRMAN S McGUIRK

AGENDA REFERENCE	BM/23/01/xx	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	25 January 2023

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/22/11/143	**30.11.22**	**BAF**	To review Risk #1215 & #115.	**John Culshaw/Dan Moore**	**Next RRG Meeting.**	**17.01.23**	**#1215 Presented to Clinical Recovery & Oversight Committee. #115 has been added to the BAF.**	
BM/22/09/117	**28.09.22**	**Move to Outstanding**	Execs to review what outstanding care means to WHH as part of informing the strategy refresh.	**Simon Constable**	**14.12.22**	**14.12.22**		

RAG Key

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/05**
SUBJECT:	**Maternity Update: Maternity Incentive Scheme**
DATE OF MEETING:	25th January 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy 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): **(*Please DELETE as appropriate)***	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	NHS Resolution (NHSR) is operating year four 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 have been released in October 2022 and advised Trusts must submit the completed Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023. This paper will update the Quality Assurance Committee of the current position and trajectory of the 10 safety actions as recommended by NHSR. • **Safety Action 1** WHH is 100% compliant in all elements of Perinatal Mortality Review Tool (PMRT) • **Safety Action 2** The Maternity Strategy has been approved at FSC and Board Committee on the 19 October 2022 • **Safety Action 3** WHH is compliant following submission of Quarter 1 Avoiding Term Admissions to Neonatal Unit (ATAIN) and Transitional Care (TC) reports for all requirements. • **Safety Action 4** WHH is 100% compliant for all medical and neonatal staffing. • **Safety Action 5** WHH will be 100% compliant in all elements of Maternity staffing specifications following bi-annual staffing review report which is submitted to Board on 25th January 2023. • **Safety Action 6** WHH is 100% compliant with delivering all elements of Saving Babies Lives Version 2 (SBLV2)

<table>
<tr><td></td><td colspan="4">

- **Safety Action 7** WHH is on compliant with all Maternity Voice Partnership (MVP) specifications.
- **Safety Action 8** WHH is complaint with training standards.
- **Safety Action 9** WHH is compliant for all requirements in relation to Maternity and Neonatal Safety Champions
- **Safety Action 10** WHH is compliant for all requirements related to Healthcare Safety Investigation Bureau (HSIB) reporting and investigations.

WHH is compliant with all Maternity Incentive Scheme (MIS) requirements. The MIS Year 4 Compliance presentation is included as Appendix One to this report.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval
X</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">Trust Board is asked to note the content of this report and associated presentation and approve completion of the Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">QAC/23/01/02</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">10/01/2023</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update: Maternity Incentive Scheme	AGENDA REF:	BM/23/01/xx

1. BACKGROUND/CONTEXT

NHS Resolution is operating year four 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. The Year 4 scheme paused in December 2021 due to the challenges placed on Trusts during the COVID pandemic.

Revised specifications and timelines were released in October 2022 and advised Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023.

In preparation of the submission deadline a monthly update report will be provided. This paper will update the Quality Assurance Committee of the current Warrington and Halton position for the month of October 2022.

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 4 Guidance relaunched in May 2022 and revised in October 2022.

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 100% compliant in all elements of SA1 MIS Year 4 specifications.

  SA1 PMRT was also audited externally by MIAA on 13th and 14th June and provided additional assurance of WHH PMRT pathway and processes.

  The W&C CBU present quarterly PMRT reports to QAC which are shared with the Trust Board. Quarter 1 (Q1.) was presented in September 2022 and Quarter 2 presented to QAC in November 2022. Each PMRT review has met 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 100% compliant in all elements of SA2 MIS Year 4 specifications.

- Safety action 3: Can you demonstrate that you have transitional care (TC) services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme?

  WHH is 100% compliant with all elements of SA3 MIS Year 4 specifications.

ATAIN and TC quarterly reports have been submitted to QAC and updates are included in to the quarterly Maternity Trust Board Report. Q1 ATAIN has been shared with QAC and Trust Board in November 2022, Q2 TC submitted December 2022.

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

  WHH is 100% compliant with all elements of SA4 MIS Year 4 specifications.

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

  WHH is 100% compliant with MIS SA5 specifications.

- Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2 (SBLV2)?

  WHH is 100% compliant with all 5 elements of SBLV2

- Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to co-produce local maternity services?

  WHH is 100% compliant with MIS SA7 specifications.

- Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

  WHH is 100% compliant with MIS SA8 specifications.

- 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?

  WHH is 100% compliant with all specification of SA9.

- Safety action 10: Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022

  WHH is 100% compliant with SA10 HSIB specification.

2.2 WHH MIS Next Steps and timeline:

Date	Action	Name	Complete
14th Dec 2022	Review with Chief Nurse / Deputy Chief Executive	Kimberley Salmon-Jamieson	✓
19th Dec 2022	Review and sign off with Chief Executive	Simon Constable	✓
23rd Dec 2022	Review and sign off with PLACE (Commissioners) Associate Director of Quality and Safety Improvement, NHS Cheshire and Merseyside	Denise Roberts	✓
10th Jan 2023	Review and sign off with QAC and LMNS Representatives	QAC Debby Gould, LMNS	✓
25th Jan 2023	Present MIS Evidence and presentation to Trust Board and Trust Board sign off	Trust Board	
25th Jan 2023	Final sign off by Chief Executive	Simon Constable	
27th Jan 2023	ICB sign off	Graham Irwin	
MIS compliance declaration is to be submitted no later than 12 noon on 2 February 2023			

2.3 Summary

WHH is 100% compliant with MIS Year 4 Safety Standards.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023.

4. MONITORING/REPORTING ROUTES

MIS safety actions are monitored at W&C CBU Governance meeting monthly and at Quality Assurance Committee.

5. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 10th January 2023.

6. RECOMMENDATIONS

Trust Board is asked to note the content of this report and associated presentation and approve completion of the Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Maternity Incentive Scheme Year 4

Compliance Report

Ailsa Gaskill-Jones, Deputy Head of Midwifery

Background

- The 10 safety actions for the year four MIS scheme were first published by NHSR on 6 May 2022
- The final revision of the scheme was published in October 2022
- NHSR reporting deadline for the Board declaration of compliance with all 10 standards has been **extended to 12 noon on Thursday 2 February 2023**
- Update reports describing compliance against the revised standards have been shared monthly with the Quality Assurance Committee

Review and Sign-off schedule

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Date	Action	Name	Complete
14th Dec 2022	Review with Chief Nurse / Deputy Chief Executive	Kimberley Salmon-Jamieson	✓
19th Dec 2022	Review and sign off with Chief Executive	Simon Constable	✓
23rd Dec 2022	Review and sign off with PLACE (Commissioners) Associate Director of Quality and Safety Improvement, NHS Cheshire and Merseyside	Denise Roberts	✓
10th Jan 2023	Review and sign off with QAC and LMNS Representatives	QAC Debby Gould, LMNS	✓
25th Jan 2023	Present MIS Evidence and presentation to Trust Board and Trust Board sign off	Trust Board	
25th Jan 2023	Final sign off by Chief Executive	Simon Constable	
27th Jan 2023	ICB sign off	Graham Irwin	
MIS compliance declaration is to be submitted no later than 12 noon on 2 February 2023			

The10 Maternity Safety Actions

- Safety Action 1: Use of the National Perinatal Mortality Review Tool
- Safety Action 2: Submitting data to the Maternity Services Data Set
- Safety Action 3: Transitional care services to support Avoiding Term Admissions Into Neonatal Units Programme
- Safety Action 4: Effective systems of clinical workforce planning
- Safety Action 5: Effective system of midwifery workforce planning
- Safety Action 6: Demonstrating compliance with Saving Babies Lives Care Bundle v2
- Safety Action 7: Gathering service user feedback and working with Maternity Voices Partnership to co produce local maternity services
- Safety Action 8: Multi professional maternity Core Competency Framework training
- Safety Action 9: Board Assurance for maternity and neonatal safety and quality issues.
- Safety Action 10: Reporting of qualifying cases to HSIB and NHS Resolution Early Notification Scheme

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1a.i.	From 06/05/22, all perinatal deaths to be notified to MBRRACE-UK within 7 working days and the surveillance information completed within 1 month.	Shadow validation by NHSR to cross reference data from MBRRACE-UK for standards a, b and c MIAA Audit Report of SA1 evidence compliance	100% of cases reported and surveillance completed within the timescales 1 late fetal loss, 5 stillbirths and 4 neonatal deaths occurred and were reported from 06/05/22 - 29/12/22.	*Compliant*
1a.ii.	PMRT review of 95% of all deaths of babies, using the PMRT, from 06/05/2022 will have been started within 2 months of each death.		100% of cases (7) have been reviewed within the 2 month timescale. A further 2 cases will be reviewed on 20 January 23, and 1 case on 10 March 23, which will also be within the timescale.	*Compliant*
1b	50% of all deaths of babies from 06/05/2022 will have been reviewed using PMRT by a multi professional team. A PMRT draft report will have been generated within 4 months and the report published within 6 months.		100% of all deaths of babies from 06/05/2022 have been reviewed using PMRT by a multi professional team. A PMRT draft report has been generated within 4 months and the report published within 6 months.	*Compliant*

Safety action 1: Continued…..

	Required Standard	Evidence	Comments	RAG
1c	For 95% of all deaths of babies from 06/05/2022, parents will have been told that a review will take place, and their perspectives about the care sought.	PMRT and DOC letters completed for 100% of cases.	Bereavement Midwife supports parents to submit questions and comments to the PMRT case review.	*Compliant*
1d	Quarterly reports will have been submitted to the Trust Board from 06/05/2022 onwards	Q1&Q2 2022/23 PMRT Reports reported to QAC and confirm that the required standards a), b) and c) have been met Evidence of parents comments is included in PMRT reports	Q1 2022/23 PMRT Report to QAC 06/09/2022 Q2 2022.23 PMRT Report to QAC 01/11/2022	*Compliant*

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1	Digital maternity strategy to align with Trust Digital Strategy and reflect 7 success measures within the What Good Looks Like Framework. Strategy to be shared with LMNS and signed off by ICB. Dedicated Digital Leadership required to have engaged with the NHSEI Digital Child Health and Maternity Programme	WHH Digital Maternity Strategy approved November 2022 and shared with LMNS and CIO Liverpool Women's Hospital MIAA Audit Report of SA2 18 July 2022	Digital Maternity Strategy signed off by Trust Digital Care Delivery Group November 2022 and Women's Health Governance Meeting on 22 November 2022 - includes 7 success measures within the What Good Looks Like Framework. Consultant Obstetrician, Associate CIO in place. Digital Midwife in post.	*Compliant*
2, 3, 4, 5, 6	This relates to the quality, completeness of the July 2022 submission to the Maternity Services Data Set (MSDS) for 9 out of 11 Clinical Quality Improvement Metrics (CQIMs). BMI, Complex Social Factors, Personalised Care Plan and Ethnicity are all individual pass criteria and are not included in 9/11 CQIMs	CNST July 2022 scorecard.	CNST July 2022 Scorecard achieved 6/6 criteria with 11/11 CQIM standards.	*Compliant*
7	Midwifery Continuity of carer (MCoC) i. Antenatal Care Plan recorded by 29 weeks. ii. Recording of women placed on CoC pathway. iii. MSD202 and MSD302 Care Activity have a valid Care Professional Local Identifier recorded.	CNST July 2022 scorecard	CNST July 2022 Scorecard achieved 6/6 including MCoC metrics i, ii and iii.	*Compliant*

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units (ATAIN) Programme?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
3 a	Transitional care pathway has been jointly approved by maternity and neonatal teams. With evidence of neonatal involvement in care planning by **16/06/22** Admission criteria meets Healthcare Resource Groups (HRG) XA04 activity. Describes staffing model in place Quarterly policy audits are in place.	TC Guideline updated and approved at W&C Child Health Governance meeting 9/12/22 Q1 2022/23 TC presented to QAC Q2 2022/23 TC complete, due to be presented to QAC in January 2023	The TC Guideline covers:- *evidence of neonatal involvement in care planning *admission criteria *staffing model *quarterly audits	*Compliant*
3 b	Quarterly TC audits using data from Q1 2022/23 onwards to be in place	Q1 2022/23 TC presented to QAC 02/08/2022 Q2 2022/23 TC complete, due to be presented to QAC in January 2023 Minutes available of TC meetings.	No concerns raised, no action plan required.	*Compliant*
3 c d e	Data capture for all term babies transferred or admitted to the neonatal unit by 18/07/2022 Data capture babies for between 34+0-36+6 weeks gestation at birth from 16/06/2022 Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available share with ODN	From 29/06/2022 Babies receiving TC are recorded on Infant BadgerNet system, Babies requiring additional care are captured on Maternity BadgerNet. Data available WHH contribute to Quarterly ODN Neonatal Dashboard. Q3 2021/22 report received 21/02/2022 - Q4 report not yet received.	Term admission rate is captured in BadgerNet and is below the national target of 6%, NW ODN rate is 5.6%, WHH rate is 4.9% for Q2 2022/23. WHH contribute to Quarterly ODN Neonatal Dashboard. Q3 2021/22 report received Q4 report not yet received.	*Compliant*

Safety action 3: Continued ……

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
3f	Findings from quarterly reviews are shared with the Board Level Safety Champion using data from Q1 2022/2. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. Reviews of babies transferred to NNU regardless of length of stay to commence from 18/07/2022	Updated ATAIN case note review proforma in use. Q1 ATAIN report to QAC 02/08/2022 Q2 ATAIN report to QAC 06/12/2022	Q1 ATAIN PPT and QAC report available Q2 ATAIN report available. Learning has been shared to Obstetric colleagues by the Obstetric ATAIN Lead, and cases are presented at the Perinatal Meetings.	*Compliant*
3 g & h	Evidence of the action plan to address findings from TC audits and Q1 2022/23 ATAIN reviews, (points b +f above) has been agreed with the maternity and neonatal safety champions and Board level champion by 29/07/2022	ATAIN action plan in progress and Q4 2021/22 action plan shared with LMNS. Quarterly reports have recommendations and are shared at Board.	ATAIN Action plan in place and is a standing agenda item on the Women's Health Governance Meeting	*Compliant*

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
4 a	**Obstetric Medical Workforce** Sign off at Trust Board level acknowledging engagement with the RCOG "Roles and Responsibilities" document 16/06/2022 Monthly monitoring of compliance of consultant attendance for the clinical situations should be shared with the Trust board, the board-level safety champions as well as LMNS by 29/07/2022**.**	Handover and Ward Round SOP, incorporating Responsibilities and Duties of the Consultant Covering Obstetrics and Gynaecology Service Audit of consultant attendance undertaken from July 2022 indicating 93.4% compliance (one case).	Guidance agreed and reviewed in Women's Governance meeting 20/03/2022 Consultant attendance continues to be monitored on a monthly basis and shared at Women's Governance Meeting/LMNS and Trust Board.	*Compliant*
4 b	**Anaesthetic Medical Workforce** Availability of duty anaesthetist to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)	ACSA Report and Certificate	ACSA accreditation inspection completed 22/03/22 Final compliance report confirming satisfactory evidence with standard 1.7.2.1 Anaesthetic staffing guideline in place Anaesthetic staffing rota available	*Compliant*

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
4c	**Neonatal Medical Workforce** Formally record in Trust Board minutes whether it meets BAPM recommendations for junior medical staffing.	Business Case and approval of funding for 2 x Paediatric Hybrid Consultant posts. Confirmation of Board Meeting minutes with approval of funding.	Tier 1: The North West ODN is aware that level 2 units within Cheshire and Merseyside have tier 1 doctors who comprise mainly of GP trainees. The Unit is senior clinician led with support from 2 Advanced Neonatal Nurse Practitioners (ANNP) who support the tier 2 rota. Tier 2: The action plan has progressed since MIS Year 3. 1 resident Consultant Paediatrician appointed, 1 vacancy to be advertised January 2023. Job description for this post will include a 1:6 tier 2 rota. This will result in Tier 2 being BAPM compliant. Tier 3 – BAPM compliant.	*Compliant as per NWODN agreement*
4d	**Neonatal Nursing Workforce** Formally record in Trust Board minutes whether it meets BAPM recommendations for neonatal nurse staffing	Bi-annual Staffing Board Paper to Board – January 2023 BAPM compliance noted in monthly staffing papers to Board		*Compliant*

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
5a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.	Birthrate Plus completed Feb 2022 Outcome of BR+ review included in QAC Midwifery Staffing Report 06/07/2022 and Board report 27/07/22 NWC Divert and Escalation Policy in place. Midwifery red flag report completed Jan 2022 – Dec 2022 Supernumerary status of labour ward coordinator included as part of Matron daily walkarounds 1:1 care in labour monitored as part of the internal dashboard. 100% compliance reported.	Elements a,b,e covered in Midwifery Staffing Report to QAC 06/07/2022 1:1 care in labour monitored as part of the internal dashboard and reporting 100% compliance Supernumerary status of midwifery coordinator in charge of labour ward is 98.9% compliant Safer Staffing Report to Board June 2022 review - second paper due to go to Board in January 2023 Midwifery Staffing action plan December 2022 submitted to LMNS 12/12/2022 HLBP for WRG detailing Maternity Staffing from June to December 2022	*Compliant*
5b	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.			*Compliant*
5c	The midwifery coordinator in charge of labour ward must have supernumerary status; to ensure there is an oversight of all birth activity within the service			*Compliant*
5d	All women in active labour receive one-to-one midwifery care			*Compliant*
5e	Submit a 6 monthly midwifery staffing oversight report that covers staffing/safety issues to the Board.			*Compliant*

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1-3	Trust Board consideration of how organisation is complying with SBLCBv2 published in April 2019.	Evidence available – MIS Report provided to QAC monthly.	Quarterly care bundle survey 6 and 7 returned to NHSE Chief Nurse and LMS April and October 2022 respectively. Quarterly Care Bundle reports included in Maternity Champions Report to QAC	*Compliant*
E1	Recording of carbon monoxide reading on Maternity Information System and inclusion in MSDS submission. Audit of percentage of Carbon Monoxide measurement at booking is recorded and percentage of CO measurement at 36 weeks is recorded over a 4 month period	BN data Sept-Dec 2022 showing CO measurement at booking compliance BN data Sept-Dec 2022 showing CO measurement at 36 weeks compliance Annual update CO measurement review 13 December 2022 - report contains SMART action plan to achieve 95% compliance for CO measurement at booking and 36 weeks, and referral to smoking pathway compliance. Smoking in Pregnancy SOP	Trust complies with data quality rating on the National Maternity Dashboard. Audit of 20 consecutive cases with CO measurement >4ppm 50% of women were referred, action plan in place, will reaudit in January 2023	*Compliant*

Safety action 6: Continued….

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
E2	Percentage of pregnancies where a risk status for fetal growth restriction is identified and recorded using a risk assessment pathway at booking and at the anomaly scan. Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation In high risk pregnancies uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	FGR risk status recorded on BadgerNet Booking History SGA pathway and algorithm in place for USS routines in complex pregnancy Risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance. Fetal Medicine Consultant and Multiple Pregnancy Clinic available.	Quarterly review of a minimum of 10 cases of babies born <3rd centile >37+6 weeks' gestation	*Compliant*
E3	Audit of percentage of women who had received fetal movement leaflet/information by 28+0 weeks. Audit of percentage of women who attend with RFM who have a CTG.	Fetal movements leaflet included in maternity hand held records. Audit of percentage of women who attend with RFM who have a CTG 90.5%		*Compliant*

Safety action 6: continued….

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
E4	Audit of percentage of staff training on intrapartum fetal monitoring Audit of percentage of staff who have completed mandatory annual competency assessment	WHH maternity team has achieved the 90% training and competency assessment threshold for intrapartum fetal monitoring.	K2 fetal monitoring training package in place which includes competency assessment Fetal Monitoring training included in both PROMPT and one day fetal monitoring training session. Competency assessment on using local CTG machines in place	*Compliant*

Safety action 6: continued…..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
E5	a)Audit percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within 7 days of birth. b)Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. c)Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. d)Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Trust has a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided.	a)12 (60%) women received a full course of antenatal corticosteroids, within seven days of birth. 5 (25%) women had an incomplete course due to the urgent need for birth. 3 (15%)unknown reasons for not receiving a course of antenatal corticosteroids. b) 1 woman (3.85%) gave birth 10 days after course of steroids was completed. c)3 cases in total, 2 received magnesium sulphate within 24 hours prior to birth, 1 did not receive due to clinical need to expediate birth. d)Audit undertaken of women who give birth in an appropriate care setting for gestation – 100% compliant. Dedicated Lead Consultant Obstetrician to champion preterm birth prevention in post. Access to specialist preterm birth clinic in place, launched 1 March 2022.	Audit of 40 cases of women booking to assess the risk of preterm birth and appropriate referral undertaken – 100% compliant.	*Compliant*

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
	Demonstrate a mechanism for gathering service user feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services? Evidence requirements *MVP Terms of Reference *MVP meeting minutes *Written confirmation from the service user Chair confirming they, and other service user members of the MVP committee, are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way *MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it.	MVP Terms of Reference MVP Minutes Written confirmation received from MVP Chair to confirm remuneration/expenses received and SLA signed and returned as agreed. MVP work programme in place. Feedback and suggestions of co-production of The Nest Birth Centre, using social media to consult with service users during the pandemic	Active recruitment plan commenced beginning of October to ensure the MVP includes members from minority/vulnerable groups. Roadshows commenced in 2022 and will continue in 2023 Plans are in place for MVP Chair to be invited to a section of the W&C Governance meeting via MSTeams link. The section will provide a documented thematic overview of maternity complaints and incidents, and this will be provided on a quarterly basis to the MVP for sharing with members. This is expected to be in place by the end of February 2023.	*Compliant*

Safety action 7: Continued…..

	Required Standard	Evidence	Comments	RAG
	*Evidence that the MVP is prioritising women from Black, Asian, Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of MBRRACE-UK *MVP Chair to be invited to maternity governance meetings actions and complaints responses etc shared with MVP	Active recruitment ongoing through: *Attendance at events that represent vulnerable groups. Eg Disability Awareness day, Silver Birch open events *Active recruitment within the vulnerable areas/clinics *MVP Chair attends River / Sunlight clinics in Halton *Consultant Midwife attends clinics in Halton and Daresbury *Plan for ongoing roadshows going forward for 2023 *Mobile advertising screens with QR code to recruit are present in Warrington clinic *Consultant Midwife referral from debrief Birth Talk clinics of women from vulnerable communities who display an interest in joining MVP	Active recruitment plan commenced beginning of October to ensure members of the MVP include members from minority/vulnerable groups. Roadshows commenced in 2022 and will continue in 2023 Plans are in place for MVP Chair to be invited to a section of the W&C Governance meeting via MSTeams link. The section will provide a documented thematic overview of maternity complaints and incidents, and this will be provided on a quarterly basis to the MVP for sharing with members. This is expected to be in place by the end of February 2023.	*Compliant*

Safety action 8: At least 90%* of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year 4

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	Required Standard	Evidence	Comments	RAG
8a	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in training programme over the next 3 years	TNA and supporting training plan in place. Training schedules, plan and materials have been shared with LMNS	PDM training report presented to Women's Health Governance Meeting with supporting trajectory plan to achieve 90% training compliance PROMPT training materials in place.	*Compliant*
8b	90% of each staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four	All staff receive individual invitations to attend training which have been scheduled over a 12 month period. PROMPT multi professional training sessions in place.	The neonatal team have been designated as an NLS training Centre. There are neonatal resuscitation updates in place.	*Compliant*
8c	90% of each staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four		Obs Consultants – 100% Other Obs doctors – 95.4% Obs Anaesthetic Consultants – 96.6% Midwives – 93.4% Maternity Support Workers – 92.3%	*Compliant*
8d	90% of staff involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended annual in-house neonatal life support training or Newborn Life Support (NLS)		Obs Consultants – 100% Other Obs doctors – 95.4% Midwives – 91%	*Compliant*

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

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	Required Standard	Evidence	Comments	RAG
a	A pathway has been developed to describe how frontline and Board safety champions share safety intelligence from floor to Board and through local LMNS/ICS and regional quality groups by than 16 June 2022.	Pathway completed 28/02/2022 Names of safety Champions are displayed in all clinical areas. Maternity safety Champions Report presented at QAC You said we did reported in safety Champions Newsletter CoC action plan presented in Report to QAC Claims scorecard has been reviewed and presented at QAC	Posters of Maternity, Board and Non-Executive Safety Champions Displayed within Maternity and Neonatal Units.	*Compliant*
b	Board level safety champions present a local dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level by 16 June 2022.		"You said we did" feedback shared with staff via Safety Champions Newsletter QI project to improve Maternity Triage in progress as a result of Safety Champion listening event.	*Compliant*

Safety action 9 continued

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	Required Standard	Evidence	Comments	RAG
c	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024	CoC action plan presented in Maternity Safety Champion Report to QAC	Compliant with national targets	*Compliant*
d	Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	WHH neonatal and maternity MDT participating in Neonatal Optimalisation MatNeo Sip Chief Nurse (Maternity Safety Champion) and Deputy Head of Midwifery working as part of AQUA led project to co-design a MatNeo Board Safety Champions Programme. First co-design session attended 14/12/2022, further sessions January 2023. Ambition is for WHH to be a pilot site for the new programme. Quarterly Safety Champions walkarounds and Safety Champions Newsletter.	WHH will commerce MatNeo escalation toolkit workstream January 2023 WHH will participate in the LMNS commissioned cultural survey planned for 2023. Active engagement including attendance and presenting with MatNeoSIPP events. Participation in the MatNeo NHS Futures Platform – plans in place to launch improvement projects in 2023. Attendance at 4th North West Coast Maternity Safety Summit	*Compliant*

Safety action 10: Have you reported 100% of qualifying cases to HSIB and reported to NHS Resolution's Early Notification (EN) scheme from 01/04/21-05/12/22

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
a	Reporting of all outstanding qualifying cases from 01/04/21 – 05/12/22 to NHS Resolution's EN scheme.	MIAA Audit Report of SA10 18 July 2022	Shadow validation by NHS Resolution to cross reference Trust reporting against HSIB database and the National Neonatal Research Database for the number of qualifying incidents recorded and externally verify that standard a) and b) have been met 2 HSIB cases accepted for investigation 2021 2 HSIB cases reported for investigation 2022 (as at 19/12/2022). Of these cases, one investigation ongoing and one rejected.	*Compliant*
b	Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) from 01/04/2021 – 05/12/2022.			
c	For qualifying cases which have occurred between 01/10/20 to 31/03/21 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance with duty of candour.	Copy of DoC letter to parents. Copy of HSIB information leaflet sent to parents		

List of Supporting Evidence

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action 1

- PMRT Quarterly Reports
- PMRT Letters to parents
- Maternity Safety Champion Quarterly PMRT Reports to QAC
- MIAA Audit Report 18/07/2022

Safety Action 2

- CNST Scorecard – December 2021 onwards
- WHH Digital Strategy 2020-2022
- Obstetric and Digital Maternity Leads in Place
  MIAA Audit Report 18/07/2022

Safety Action 3

- Transitional care of the Newborn Guideline updated and approved 09/12/2022
- Q1 ATAIN 2022/23 report presented to QAC 02/08/2022
- Q1 2022/23 TC presented to QAC 02/08/2022
- Q2 2022/23 TC complete, due to be presented to QAC in January 2023
- Minutes available of TC meetings

- Quarterly ODN Neonatal Dashboard. Q3 2021/22 report received 21/02/2022
- Q1 ATAIN report to QAC 02/08/2022
- Q2 ATAIN report to QAC 06/12/2022
  ATAIN action plan in progress and Q4 2021/22 action plan shared with LMNS

List of Supporting Evidence continued…..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action 4	
• Handover and Ward Round SOP, incorporating Responsibilities and Duties of the Consultant Covering Obstetrics and Gynaecology Service • Audit of consultant attendance undertaken from July 2022 indicating 93.4% compliance (one case). • ACSA Report and Certificate	• Business Case and approval of funding for 2 x Paediatric Hybrid Consultant posts Confirmation of Board Meeting minutes with approval of funding • Bi-annual Staffing Board Paper to Board – January 2023 • BAPM compliance noted in monthly staffing papers to Board

Safety Action 5
• Birthrate Plus completed Feb 2022 • Outcome of BR+ review included in QAC Midwifery Staffing Report 06/07/2022 and Board report 27/07/2022 • NWC Divert and Escalation Policy in place. • Midwifery red flag report completed Jan 2022 – Dec 2022

List of Supporting Evidence continued…..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action 6

1-3
- SBLCBv2 Quarterly Survey Report 7
- MIS Report provided to QAC monthly

Element 1
- BadgerNet compliance Sept-Dec 2022 for CO measurement at booking and 36 weeks
- Smoking in Pregnancy SOP

Element 2
- FGR risk status recorded on BadgerNet Booking History
- SGA pathway and algorithm in place for USS routines in complex pregnancy
- Risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance
- Fetal Medicine Consultant and Multiple Pregnancy Clinic available

Element 3
- Fetal movements leaflet included in maternity hand held records
- Audit of percentage of women who attend with RFM who have a CTG

Element 4
- Audit of percentage of staff trained on intrapartum fetal monitoring and competency assessment

Element 5
- Audit percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within 7 days of birth
- Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids
- Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth
- Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance)
- Trust has a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention
- Access to specialist preterm birth clinic in place, launched 1 March 2022

List of Supporting Evidence continued.....

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Safety Action 7	
• MVP Terms of Reference • MVP Minutes • Written confirmation received from MVP Chair to confirm remuneration/expenses received and SLA signed and returned as agreed	• MVP work programme in place • Feedback and suggestions of co-production of The Nest Birth Centre, using social media to consult with service users during the pandemic • Active recruitment events
Safety Action 8	
• PROMPT Training Materials • PDM training report	
Safety Action 9	
• Pathway completed 28/02/2022 • Names of safety Champions are displayed in all clinical areas • Maternity safety Champions Report presented at QAC • 'You said we did' reported in safety Champions Newsletter	• CoC action plan presented in Report to QAC • Claims scorecard reviewed and presented at QAC • Quarterly Safety Champions walkarounds and Safety Champions Newsletter
Safety Action 10	
• MIAA Audit Report 18/07/2022	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/01/06**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	25th January 2023			
AUTHOR(S):	Simon Constable, Chief Executive			
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 BAF RISK:	All			
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)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The 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			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/23/01/06

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 30th November 2022, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing (18th January 2023), we have a total of 41 COVID-19 positive inpatients (14 days or less since their first positive sample). In total, 71 of our inpatients have tested positive at any time during their admission. There has been a plateau in the number of our total COVID-19 inpatients over the last couple of weeks. Since November 2022, the number of cases of 'flu (Influenza A) has also been steadily increasing, although this appears to have peaked and there has been a significant reduction more recently. The current position is 3 cases active (within 7 days of a positive test).

We have discharged a total of 5000 patients with COVID-19 to continue their recovery at home. Sadly, a total of 805 patients testing positive for COVID-19 have died in our care.

Total staff absence is just over 6.4% (a headcount of 300), which is a little lower than it has been of late (peaking at over 8%).

Appendix 1 graphically represents the total number of patients with COVID-19 in our hospitals, including critical care, since the start of the pandemic. You will note the successive waves and the differential impact upon critical care versus our General & Acute bed-base since 2021.

2.2 Overview of Trust Performance

Appendix 2 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete datasets. In this case, this is month 9 - December 2022. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

Since my last Board report, urgent and emergency care has been under the most significant and sustained pressure ever, and certainly this has increased since Christmas. We invoke our Full Capacity Protocol every morning and, have now on several occasions declared the highest level within the NHS Operational Pressures Escalation Level (OPEL) Framework, so called OPEL 4.

On Tuesday 3rd January 2023 our operational position was the worst we have seen in all my 8 years within this Trust, with over 90 patients in our Emergency Department awaiting a bed for admission in the main bed-base. In fact, I think you would have to go back to the days

before the 4-hour emergency access standard was introduced and embedded (late nineties/early 2000s) to see that kind of pressure concentrated in the relatively confined space of any Emergency Department.

Our strategy in coping with that situation has been about spreading the risk wider than the traditional ED footprint, in the most planned and controlled way possible. Tactics such as accelerated admissions to 10 core wards at Warrington, technically before they are ready to accept an extra patient, is not what we would ideally like to be doing, and it is a point of last resort, but it does make a big difference quickly when we are able to do this in core working hours. Our estate, with relatively small bays, corridors, and wards, is a significant constraint in doing this more often. Health and safety considerations are paramount.

Although it is of little practical comfort, we know that we have not been alone in the above scenario, as the same is being seen across the region and up and down the country.

However, the whole organisation has responded magnificently to the challenge; there has been some slight improvement more recently. At the time of writing, we are escalated at OPEL level 3, which, unfortunately has become 'normal'.

Our total number of super stranded patients with a length of stay greater than 21 days remains extremely high at 172. The number of patients that do not meet the criteria to reside (NCTR) is similarly very high at 142. For Warrington Borough Council residents in hospital, this latter number is 88 (24.5%); for Halton Borough Council residents in hospital, it is 38 (29.9%); for residents of other local authorities, it is 17 (26.9%). These figures are over double the national average.

Although there are of course other factors, such levels of patients who have a long length of stay and who do not meet the criteria to reside in an acute hospital is the major contributory driver to our inability to maintain a normal operating capacity through the non-elective/urgent care pathway, starting at our Emergency Department.

In order that all system partners are aware of the situation and can take action accordingly, I provide a daily summary situation report to local health and social care leadership, including the chief executives of Warrington and Halton Borough Councils, and Bridgewater Community Healthcare NHS Foundation Trust. There are daily system calls about capacity. Our Warrington System Sustainability Group continues to do good work collaboratively on solutions for the short, medium, and longer term; we are in the process of jointly working through our plans and trajectories for this coming financial year (2023/24). There will be a forensic focus and attention to detail on our NCTR numbers.

The Trust continues to undertake an elective recovery programme with minimal interruption despite urgent and emergency care pressure. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality & Assurance and the Finance & Sustainability Committees. Furthermore, given our financial position and plan, the Executive Team receive additional reporting regarding activity and cost improvement plans from the Care Group and Corporate Team leadership every Wednesday. The Clinical Services Oversight

group (CSOG) continues to oversee the waiting lists as well as the safety of patients on those waiting lists.

2.3 2023/24 Priorities and Operational Planning Guidance

We know and expect that 2023/24 will also be challenging. The Operational Planning Guidance from NHS England was circulated just before Christmas and our teams are now working their way through the implications locally; we need to ensure that all our plans align. The focus is on new ways of working, as recently articulated in the NHS Operating Framework, and an acknowledgement of the continuing complexity and pressures upon systems.

Our three key tasks over the coming year are (i) recover our core services and productivity; (ii) as we recover, make progress in delivering the key ambitions in the Long-Term Plan (LTP), and; (iii) continue transforming the NHS for the future.

To assist in meeting these objectives, we have been set the most critical, evidence-based actions that will support delivery - based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety. For example, in order to improve patient safety, outcomes and experience it is imperative that we improve ambulance response and A&E waiting times, reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard. Recovering productivity and improving whole system flow are critical to achieving these objectives.

We are working with our Cheshire & Merseyside Integrated Care Board and system partners to develop plans to meet the national objectives set out in the guidance and the local priorities set by systems. System plans will be triangulated across activity, workforce and finance, and signed off by the ICB and by Trust Board before the end of March 2023.

2.4 Cheshire & Merseyside Acute and Specialist Trust Provider Collaborative Update

As I have stated previously, the reporting of the Cheshire & Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) will evolve over time. As a CMAST forward plan is developed this should describe anticipated milestones from programmes and support formal engagement and reporting to Boards on any expected system decision making. The following is therefore the summary content developed by CMAST for Board reports.

The CMAST Leadership Board met on an informal basis in both December and January.

On 2nd December 2022 the group considered the current facts and planned responses to the then proposed strike action in a discussion led by the ICB workforce team. Further business considered by the CMAST Leadership Board included:

- A review and proposed refresh of the ongoing work on pathology hubs being led by the Diagnostics Programme Board – we expect this refresh to result in an updated timetable for delivery that may, in time, require Trust decision making.
- Outcomes and conclusions of the Clinical Pathways Programmes, to date, on orthopaedics. This included a number of collaborative and improvement initiatives that did not require significant service change. Clinically and operationally led

collaborative recommendations for optimising current system capacity were commended by the Board.

- A discussion on the impact and imperatives in urgent and emergency care arising from recent system pressures.
- NHSE Provider Collaborative Innovator Scheme expressions of interest process.

The CMAST Leadership Board next met on 6th January 2023 as a shorter meeting in recognition of the ongoing significant operational pressures. The discussion was used to provide space for sharing and reflection covering the following areas:

- Current system pressures, hospital discharges and the ICB role as a system coordinator and convenor.
- Reflection from recent strike experiences and a look forward to proposed future industrial action.
- Cheshire and Merseyside orientation on the anticipated approach to responding to NHSE Planning requirements.

2.5 Preparedness for Industrial Action

We continue to prepare for ongoing industrial action, whether it affects us directly or indirectly.

The Industrial Action Task and Finish group is lead jointly by the Associate Chief People Officer (Human Resources) and the EPRR (Emergency Preparedness & Resilience Response) Manager who oversee a representative group, including operational, nursing, governance, medical, corporate teams and volunteers. The group have identified key priorities for preparing for strike action based on national guidance.

The Trust continues to assess and exercise preparedness for any future potential instances of industrial action. Notice of industrial action will be served 14 days in advance of any activity. A Tactical response plan has been devised for any confirmed days of industrial action, with the response covering the week leading to, and the recovery from, the incident.

An ICB-led exercise (Exercise Arctic Willow) was undertaken on 2nd December 2022. The Executive Team is receiving a weekly update on preparedness by Michelle Cloney, Chief People Officer.

Weekly meetings have been established with the Senior People Directorate Management Team and the Trust's Staff Side Chair and Deputy Staff Side Chair. This meeting will be utilised to progress any negotiations and consultation related to Industrial Action, and to maintain good partnership relationships throughout this period.

Industrial Action is on the corporate risk register and mitigation is being monitored. The HR and EPRR lead for industrial action continue to engage with the ICB for further direction and communications.

2.6 WHH Thank You Awards 2022/23

I am very much looking forward to our next *Thank You Awards* being the biggest and best yet, in recognition of all the outstanding achievements that have been made over the past year or so. Our multi-professional *Thank You Awards* Organising Committee has been established, chaired by our Chief Nurse & Deputy Chief Executive, Kimberley Salmon-Jamieson.

The 2023 *Thank You Awards* are now open for ticket reservations, and this will take place on Friday 17th March 2023. As voted for by staff, the event will be held at the Concorde Arena, Manchester Airport. We have outgrown our previous venues.

Through sponsorship we are seeking the support of our suppliers and partners.

There are 12 award categories, nine of which can be nominated for directly:

- Star of the future
- Wingman team care and support
- Inclusion advocate
- Innovation and quality improvement
- Excellence in patient care
- Supporting excellence award
- Leadership award
- Volunteer of the year
- Student / trainee of the year
- Patients' choice award (selected by our patients)
- You Made A Difference Award (selected from all of our previous winners since we started this award in August 2021)
- Outstanding contribution award (selected by myself)

I would like this to be the biggest, best, most inclusive WHH *Thank You Awards* event ever, with every corner of the Trust represented on the night, in a very 'different' venue.

2.7 Armed Forces Update

As well as having an active Veterans' and Armed Forces Staff Network, WHH has an Armed Forces Advocate – Amanda Jordan. The role is dedicated to developing services that better support the healthcare experiences of our Armed Forces Community.

For the first time, the 2021 Census included questions to gather data about our Armed Forces communities. Initial census data reveals that 4% of the Warrington population and 4.7% of the Halton population are veterans, and many of these will have families. This gives a useful benchmark to understand how many veterans and their families we are likely to see using our services at WHH and to enable us to tailor care to specific health needs.

On 22nd November 2022, the Armed Forces Act 2021 legally came into force. This means that all public bodies, such as the NHS, have a legal duty to demonstrate 'due regard' to veterans and their families in the provision of services. This may include consideration of prioritisation of care in relation to assessment, treatment, and appliances. It is important to

note that prioritisation is not guaranteed and is dependent on an assessment of clinical needs of veterans and other patients.

In the last quarter, our interventions have included:

- Improved waiting list times for surgical interventions.
- Referral to specialist military mental health services.
- Referral to specialist charities to support with physical aids and appliances.
- Referral of veterans to local veteran clubs and societies to improve social isolation.

2.8 SIREN – Winter Pressure Sub-Study.

The SARS-CoV2 Immunity and Reinfection EvaluatioN (SIREN) study is a unique, large-scale study providing valuable evidence on immunity following SARS-CoV-2 infection and COVID-19 vaccination. This evidence has played a critical role in informing the national COVID-19 response. WHHFT joined the UKHSA led SIREN study back in September 2020 with over 250 participants. The study was initially planned for one year but later extended in August 2021 until March 2023.

Now SIREN has proposed to extend the scope of this study (with a 'sub-study') to understand the asymptomatic carriage of other respiratory viruses in healthcare workers (HCWs). In this winter, coupled with the reduction in social distancing measures and universal masking, it is likely to be the first time that we see the impact of both COVID-19 and other respiratory pathogens together in the UK. Our experience thus far is consistent with this expectation. It is for this reason that SIREN is expanding the testing this winter to include influenza and some other respiratory viruses. This expanded testing will help to understand the incidence of influenza infection (symptomatic and asymptomatic) in HCWs, effectiveness of influenza vaccine, incidence of co-infection (influenza and SARS-CoV-2) in HCW etc.

WHH has formally agreed to support this sub-study from 5th December 2022. There will be no change in the current process except that the PCR testing will be done using a Quadplex PCR which in addition to COVID-19, will also detect Influenza A/B and RSV. SIREN has estimated that only between 0.5%-1.5% of participants may be tested positive for influenza per week whilst asymptomatic.

SIREN has sought guidance from UK Health Security Agency (UKHSA) on what to do if a HCW was found to be positive for influenza but otherwise asymptomatic. A risk assessment will be performed by the line manager/Occupational Health for each influenza positive but asymptomatic HCW. Typically, if working in a low-risk area and asymptomatic, HCWs may continue to work, carefully wearing face masks at the time of staff and patient interactions (for 3 days), whilst being vigilant for symptoms. Only in a case of working with a known high risk (immunocompromised) patient, staff may need to be redeployed for 3 days. Treatment for Influenza (with oseltamivir) is not indicated for staff who are otherwise healthy and not at risk of getting complicated influenza.

2.9 Halton Health Hub

November quietly marked an important milestone for the Trust as we saw the 'soft-launch' of the Halton Health Hub in Runcorn Shopping City. This was the opening of a stand-alone

outpatient facility off a main hospital site, putting hospital diagnosis and treatment in the community and placing it where patients and service users visit for other reasons, arguably making healthcare more part of daily life. I hope we will do even more of this in the future, consistent with our New Hospitals Programme aspirations.

Halton Health Hub has been designed from the outset to provide a fabulous patient experience, allowing our patients easier access to their appointments, as well to assist the Trust in furthering our ambitions in improving the health, wealth and prosperity of our boroughs. We hope the hub will encourage further use of the facilities within Shopping City, boosting the local economy as well as improving local health outcomes. The hub consists of:

- 5 clinical examination rooms
- 2 diagnostic imaging rooms
- Adult and paediatric waiting rooms
- A full complement of staff support spaces, including a kitchen and a shower

On 30th November 2022 we started offering optometry and orthoptics, audiology and dietetic appointments from this location. Throughout the development of the designs, the delivery of the unit and the application of the finishing touches, the main driver from all concerned has been maximising the quality of the patient (and staff) experience. The project exemplifies our Trust priorities of Quality, People and Sustainability: the quality of the unit is self-evident and will improve access and reduce waiting times in the above specialties; our people will enjoy working from a first-class facility with all mod cons; and the unit itself is a result of our sustainability priorities – working in partnership with organisations across our boroughs and enhancing our commitment to our resident population.

This project has touched nearly all parts of our Trust and would not have been possible without the involvement of so many extremely talented individuals and teams across three years. It has been a massive accomplishment.

The formal opening of the new facility will take place on 3rd February 2023.

2.10 Pathway to Research

January has seen the official launch of our new Pathway to Research. The aim of the Pathway is both to widen involvement in research among patients and healthy volunteers and also serve as a prospective pool of potential research participants to be approached for clinical trials thus improving recruitment.

The Trust recognises that participation in clinical research demonstrates our commitment to improving the quality of care we offer, both by helping ensure our clinical staff stay abreast of the latest possible treatment options and because there is evidence that active participation in research leads to successful patient outcomes.

Pathway to Research forms a route for individuals to register their interest in taking part in future research. The pathway can be accessed via a QR code or by clicking on the Pathway to Research logo wherever it is seen on our website.

2.11 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.

2.12 Employee Recognition

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

You Made a Difference Award (November 2022): Joanne McGlashan

Joanne McGlashan, Matron (Gynaecology, Women's & Children's Health) was given this award in recognition of the excellent support and care provided to patients.

The example provided in the nomination tells of how Jo went above and beyond to ensure a patient and their family had the best possible experience. This was from the initial referral to contacting the family and working with the multi-disciplinary teams, adjusting and looking at different ways of working. In February 2020, Jo was contacted by the Learning Disability Specialist Nurse from a community learning centre asking for help and support for a young girl with severe autism who was waiting for a hospital appointment after having been referred by her GP. Jo contacted her parents to introduce herself and gain some background of the challenges that their daughter was facing, and then followed her care all the way through appointments and procedures, ensuring that all adjustments were made over a 2-year period. A good outcome was achieved for the patient and her family.

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

Chief Executive Award (December 2022): Tissue Viability Team

I was very pleased to present to present this award to our Tissue Viability Team to acknowledge their commitment and hard work in support front line clinical teams, as well as driving improvement. They are a group of truly committed, diligent and helpful individuals who work hard as a team to support colleagues.

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

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

- Dr Jeff Little, Consultant Intensivist - Medical Care
- Lesley Howlett, Senior Sister, Critical Care - Medical Care
- Nathan Taylor-Thompson, Ward Manager - Ward A4, Digestive Diseases
- Millie Ratcliffe, Check-in Administrator – COVID-19 Vaccination Service
- Sheila Fields-Delaney, CBU Manager - Urgent & Emergency Care

- Ms Gemma Gossedge, Consultant Surgeon - Digestive Diseases
- Jo Moldoveanu, Staff Nurse - Urgent & Emergency Care
- Tracey Travers, Ward Sister - Ward B18, Medical Care
- Rebecca Patel, Associate Chief People Officer - HR/OD
- Linda Doherty, Senior Nurse - Urgent & Emergency Care
- Corinne Roe & Team, Ward Manager - Ward B11, Women's & Children's Health
- Christine Mulhall, Ward Clerk – CSTM, Surgical Specialities
- Susan McNevin, Clerical Officer - Cash Office, Finance & Procurement
- Carol Bent, Medical Secretary - Surgical Specialities
- Lauren Southern, Clerical Officer - Education Centre
- Toni Harris, Nurse Practitioner - Urgent & Emergency Care
- Janet Rouse and Ward B14, Ward Manager - Integrated Medicine & Community
- Mr Noaman Sarfraz & Team, Consultant Surgeon - Digestive Diseases

2.13 Signed under Seal

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

- Licence to Alter – Unit 42 Runcorn Shopping City

3 MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended in December 2022 and January 2023 since the last Trust Board Meeting.

- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)
- CMAST Clinical Pathways Programme (Various)
- Steve Broomhead, Chief Executive, Warrington 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)

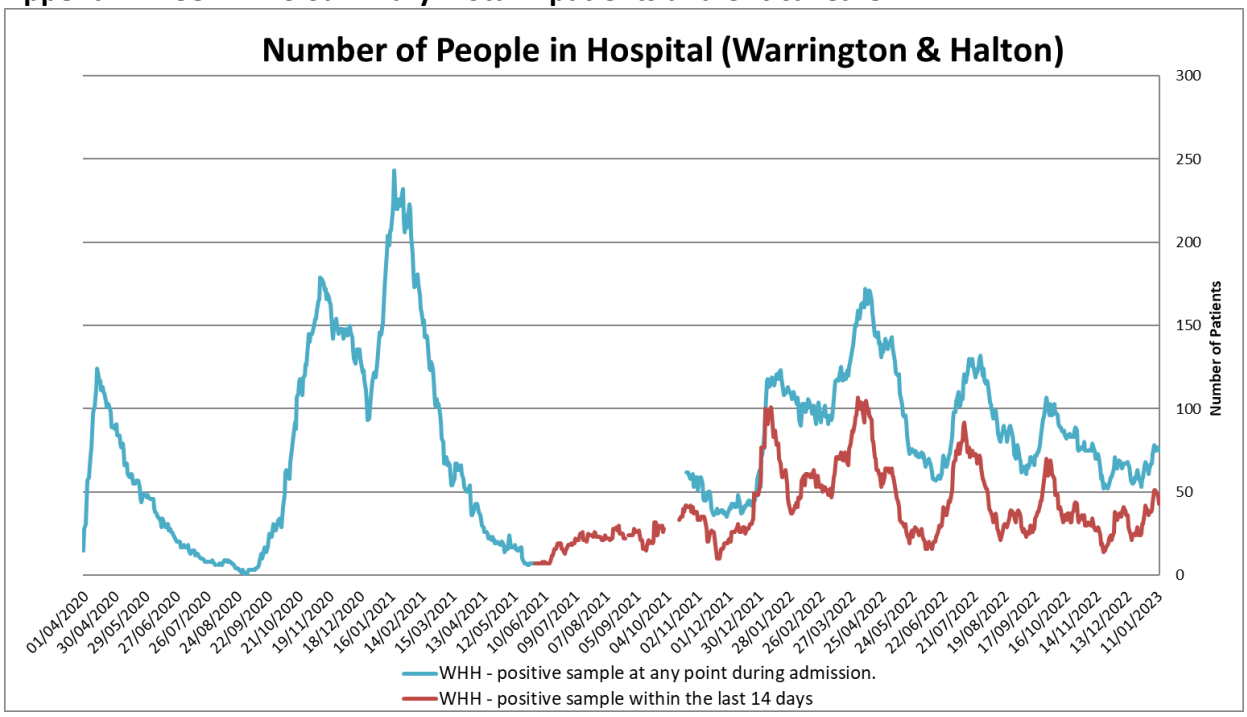
4) RECOMMENDATIONS

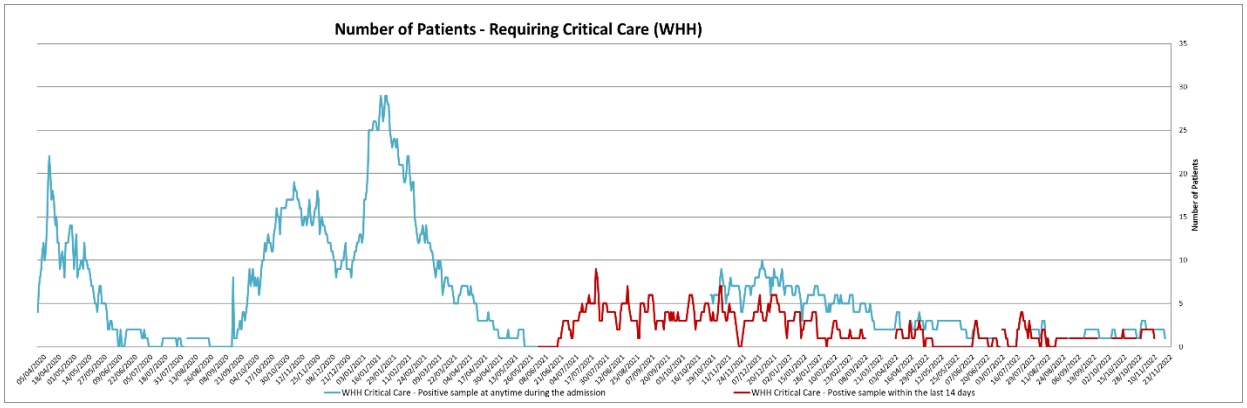
The Board is asked to note the content of this report.

5) APPENDICES

Appendix 1: COVID-19 Summary: total inpatients and critical care
Appendix 2: CEO Dashboard – Month 9 (December 2022)
Appendix 3: Cheshire and Merseyside Acute and Specialist Trust (CMAST) Briefing (November 2022)

Appendix 1: COVID-19 Summary: Total inpatients and Critical Care





CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

November 2022

First meeting of new-look Cheshire and Merseyside Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership – our new statutory Integrated Care Partnership – met for the first time on November 8th 2022.

Consisting of representatives across the NHS, local authorities, voluntary sector, housing, police and fire and rescue, the Partnership Board provides a multi-agency forum to assess the health, public health and social care needs of people across Cheshire and Merseyside – and develop a combined strategy to address them.

Councillor Louise Gittins, the leader of Cheshire West and Chester Council, was unanimously confirmed as Chair, with Raj Jain – the Chair of NHS Cheshire and Merseyside – confirmed as vice-chair. A process to appoint a second vice-chair, to represent the voluntary sector, is already underway.

Councillor Gittins described her appointment as "an honour" and the inception of the multi-agency partnership as "a once in a lifetime opportunity to make a real difference across our communities". As a "Marmot community", she said the Partnership must come together to help tackle health inequalities across Cheshire and Merseyside.

Dame Jo Williams, Chair of Alder Hey Children's NHS FT, is the CMAST representative on the C&M Health and Care Partnership.

NHS Cheshire and Merseyside Integrated Care Board

NHS Cheshire and Merseyside's final Board meeting of 2022 was held on Monday, November 28th.

Attended by more than 20 members of the public, with dozens more accessing a live stream of the meeting via YouTube, Chief Executive Graham Urwin noted that the Royal College of Nursing (RCN) has now confirmed two planned strike dates – on December 15th and 20th – with detailed local planning around how to maintain emergency care on both days underway.

He added that several other trade unions are either out to ballot their members or have held indicative ballots, so this is unlikely to be the end of industrial action in the coming months.

Separately, Graham confirmed that Cheshire and Merseyside would receive an extra £500m national funding for care this winter (£19.2m) and said the money would be used to help reduce the number of people who remain in hospital despite being medically fit for discharge. The recurring nature of the funding will enable NHS Cheshire and Merseyside to make better decisions for the long-term.

Director of Nursing and Care, Chris Douglas MBE, joined forces with Chief People Officer Chris Samosa, to update on work to maintain safety in urgent and emergency care and efforts to recruit and retain staff amid cross-system workforce challenges.

Director of Planning and Performance Anthony Middleton described the current challenges in urgent and emergency care, elective care, and cancer, with Trust Board member Ann Marr OBE noting that, while cancer referrals are up, the conversion rate is the same. This means more cancers are being found and more people are entering treatment.

In month CMAST Leadership discussions

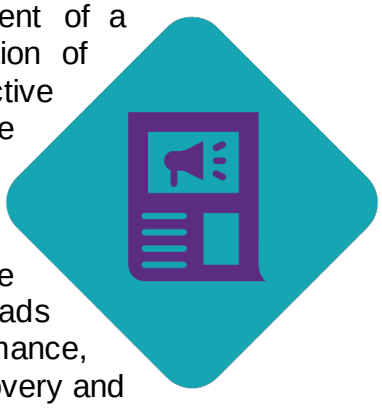
CMAST Leadership Board met on 2nd December and received an update on the current facts with regards to proposed strike action from the ICB workforce team.

Further business considered by the Leadership Board included:

- A review and refresh of the work on pathology hubs being led by the Diagnostics Programme Board
- The outcomes and conclusions of the clinical pathways programmes, specifically on orthopaedics. The recommendations for optimising current system capacity were commended to the Board
- A discussion on the impact and imperatives on urgent and emergency care were discussed with NWAS' contribution particularly noted
- Provider Collaborative Innovator Scheme

Elective Recovery and Transformation Programme

Outpatients



Stakeholders from across the system have contributed to the development of a Specialist Advice Policy document which aims to support increased utilisation of advice & guidance, improved recording and a potential increase in Elective Recovery Funding opportunity. This will benefit the system in terms of only the most appropriate patients being referred into secondary care and supporting the management of patients within primary care.

The first C&M Outpatient Transformation Operational delivery group will take place on 12th December. This group will bring together senior operational leads from all acute providers to provide oversight of non-admitted performance, agreement of system action plans for outpatient (OP) transformation and recovery and to lead implementation of key system interventions at trust level.

The newly published clinically led GIRFT Outpatient Transformation guidance has been published and will be used to support transformational efforts in C&M. The guidance describes clinical best practice across a range of interventions and will be invaluable in the delivery of the Outpatient Transformation ambitions at system and trust level. https://www.gettingitrightfirsttime.co.uk/bpl-outpatients/

We have also identified a Primary Care Clinical lead for OP (Hilary Flett) who will be supporting with primary care engagement and working with PCN colleagues.

Elective hubs update

Good progress with the elective hubs:

- The Broadgreen Hub on track to open in January.
- We have appointed a programme manager to develop the business case for the North Mersey hub. The first steering group is scheduled for next week.
- The Cheshire Hub is in the operational phase.
- The Wirral Clatterbridge hub is up and running, and COCH have undertaken lists there too. The hub has been put forward as a GIRFT Hub Accreditation pilot.

Theatres update

Theatre utilisation in C&M remains in the upper quartile for uncapped and capped utilisation. This compares favorably with our NW partners who are in the lower two quartiles.

We have launched a booking pilot programme with 5 trusts in November. This is a 12-week programme aimed at supporting the booking and scheduling processes for theatres.

We are still working with trusts to focus on the top 10 consultant opportunities in each trust. The team have undertaken exec team briefings on these opportunities. In depth support is being offered to the theatre teams.

Waiting list targets

The trusts are working hard to clear the 78-week waiting lists and ensure no patients will be waiting over 78 weeks by the end of March. Calculations earlier in the year showed that we need to clear approximately 1,000 patients per week to achieve this. Over the last 11 weeks we have cleared 18,801 patients, we are therefore ahead of trajectory at present which provides some mitigation to the risks such as the proposed BMA rate for waiting lists, potential industrial action, and winter pressures (including Christmas).

We have established a "mutual aid hub" which will combine the existing resource with a new function to facilitate and track mutual aid. This will ensure we have one central point for mutual aid requests (including those from out of area), and that we support trusts in reducing variation of waiting times across our geography.

Clinical Pathways

Orthopaedics

The orthopaedics report is in final draft and is being shared with medical directors, CEOs, and clinical directors for orthopaedics. The key themes within the report are around improving performance against national standards such as GIRFT KPIs, and the utilisation of cold sites wherever possible for elective orthopaedic surgery. An orthopaedics dashboard is in development, combining data from different sources including GIRFT KPIs and Model Health System metrics.

Dermatology and ENT

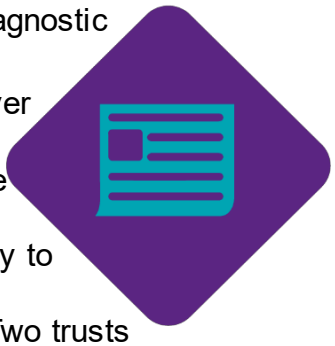
Engagement meetings are well underway with trust medical, nursing, and operational leads, commissioners, and other key stakeholders.

Clinical network meetings are taking place to provide collaborative clinical, operational, and quality focused speciality discussion and solutions.

Work on the current state pack and case for change is underway and the first workshops are scheduled for January (ENT) and February (Dermatology), bringing stakeholders together to gain consensus on the current challenges facing the speciality across C&M, agree what good looks like and establish principles we will adhere to going forward.

Diagnostics Programme

September performance headlines



- C&M ICS has maintained its ranked position of 12th out of 42 ICSs for diagnostic waiting time performance. C&M was ranked 16th in April 2022.
- The total number of patients waiting for a test has remained static at just over 70,000 patients.
- In the following tests, we are continuing to deliver more activity than we were before the pandemic – CT, MRI, Colonoscopy.
- For Gastroscopy and Non obstetric ultrasound we have increased activity to match pre pandemic levels.
- 5610 patients (7.8% of the waiting list) have waited 13 weeks or longer. Two trusts have contributed to significantly improve this position in month, Countess of Chester have ensured that those waiting 13wks+for an echocardiography reduced by 193 patients and Southport and Ormskirk have reduced their 13wk+ waiters by 354.
- Key performance data on pathology turnaround times are now included in diagnostic reports. Work to support trusts with improved histopathology and cytology turnaround times has begun.

Performance improvement plans

C&M have been reporting some very long wait patients on the Waiting List Minimum Data Set return. LUFHT has taken action to ensure that all data quality issues are resolved, and all patients have a booked date before the end of November 2022. Work with COCH continues to ensure that numbers are validated urgently.

Echocardiography recovery plan

We are seeing positive developments in Echo's. 69% of patients have received their test within 6 weeks which is the highest rate since March 2020 and the number of patients waiting has reduced by 3470 or 33%.

Cardio – collaborative cardiology digital imaging system

A proposal (jointly led by LHCT and the Imaging Network) for a unified system across C&M has been sent to all Chief Operating Officers. All providers are asked to sign up to a single direction of travel to enable image sharing (and therefore reduce duplication) for many tests including: Cardiac MR, ECG and Echocardiograms. For some trusts this could represent a cost improvement opportunity, as well as a quality improvement opportunity.

Imaging – overseas recruitment

During November staff from across the Northwest flew to India to conduct hundreds of face to face radiographer interviews. A high proportion of staff supporting this initiative were from C&M. 81 candidates have been offered positions with 31 due to be employed in 8 trusts in C&M.

Imaging – medical physicist support linked to MRI advance technology

The November C&M Diagnostics Board received a compelling presentation on the above topic which was backed up by case studies from other regions. C&M has received funding from NHSEI to implement the acceleration technology on 19 MRI scanners. The technology requires Medical

Physicist support in order for the benefits to be realised. C&M falls short of other ICSs for Medical Physicist input. The conservative estimate for C&M is that the acceleration technology would provide in excess of 10,000 additional scans each year, which would cost £1.8m if procured from the Independent Sector. Using an allocation based on scanner number, the cost per trust is between £9k and £24k per annum. C&M Trusts are asked to support this invest to save plan.

Imaging – collaborative contracts for picture archiving communication system (PACS)

Some ICS regions have 4 different PACS providers. We are very pleased to be an ICS which can image share across all sites and have a strong collective contracting voice which should lead to enhanced service provision. Information has been sent to key executives within each provider organisation which requires action, so that the collaborative contract can be signed on 28 December 2022. Without this there are operational and financial risks. All trusts are asked to ensure that they have contributed to the schedule construction by 16 December 2022 and taken the governance papers through appropriate channels by 12 December 2022. The C&M Directors of Finance agreed that LUFHT should host this contract on behalf of all other providers.

Endoscopy – NorthWest Tonight

Well done to the LUFHT and the C&M Endoscopy Network for the piece on Northwest Tonight which showcased the Transnasal Gastroscopy Service. This has been established thanks to NHSEI funding to see 4000 patients across C&M. The innovation has helped to reduce the number of patients waiting for a Gastroscopy by 40% (2897 patients) since December 2021. BBC report of Broadgreen Transnasal Gastroscopy service – YouTube

Digital diagnostics

Bids for £10.8m submitted this year. C&M is leading the way as the only ICS to be pushing forward plans that will connect pathology and imaging. Letters of Agreement have been sent out to key contacts with each trust to be signed off by 28 November 2022.

Pathology – non-urgent 3 hub model

A 'Readiness Assessment' has been completed to assess if C&M is ready to proceed from Outline Business Case to Full Business Case stage in relation the 3-hub model. The work has concluded that C&M is not yet ready to proceed and that in order to do so, critical action is required both from the C&M Pathology Network and each of the provider organisations who form part of the network. A Reset Plan has been drawn up. All providers are asked to support the Reset Plan and understand what is required of them.

Diagnostics programme budget

The November C&M Diagnostic Delivery Board has agreed to move all elements of programme budget that relate to diagnostics to Clatterbridge from 1 April 2023. This will allow greater oversight, consistency, transparency, and efficiency across networks.

Urgent and Emergency Care – Gold Command

- Acute Trusts remain pressured in terms of continued high occupancy. C&M G&A occupancy average for November was 96%-97%. Most weeks 4-6 Trusts are commonly reporting between 98-100% over several days.

- Long length of patient stays over 21 days 27%-30% for previous 4 weeks, 28% across C&M on 27.11.2022 (consistently highest over month at WUTH 35%, followed by LUHFT 33% and S&O 32%). Also, a continuously high number of patients continuing to occupy beds who are medically fit for discharge and no longer meet criteria to reside across the system, WUTH currently highest at 33% (C&M average 26%) as of 27.11.2022.

- Overall COVID occupancy and COVID G&A occupancy reduced week on week from the beginning of November, however, this now appears to be increasing slightly from the previous week.

- C&M Acute Trust COVID related staff absence has reduced to 9% of all sickness absences and remained so for the previous 2 weeks, as of 29.11.2022.

- High front door demand continues to impact on flow through/from Emergency Departments. Trusts reporting large numbers of A&E attendances and high patient acuity leading to high admission conversion rates, crowding in EDs leading to episodes of corridor care. Trusts continue to report nursing and medical staffing gaps. These issues have contributed to most of the Adult Acute Trusts reporting at OPEL 3 daily throughout the last 4 weeks, despite all possible mitigations in place.

- A&E Performance remains challenged, with very high numbers of both ambulance handover delays over 60 minutes and patients waiting over 12 hours from decision to admit to admission/spending 12 hours in ED from time of arrival.

- Focus continues on winter planning, with monitoring of progress of plans via weekly C&M ICB Winter Planning Group, chaired by the ICB Director of Planning & Performance/Associate Director of Planning.

Finance, efficiency and value workstream

Month 7	Plan(£m)	Actual(£m)	Variance(£m)	FYE Plan (£m)	FYE Forecast (£m)
CMAST (deficit)	41.0	62.3	21.3	59.3	59.3
CMHCD (surplus)	4.6	4.6	-	9.3	9.3
Total provider (deficit)	36.4	57.7	21.3	50.0	50.0
Total system (deficit)	25.0	56.8	31.9	30.3	30.3

The combined financial position of CMAST Trusts continues to worsen with six providers now reporting an adverse position against plan. At this stage no provider is reforecasting, but delivery of plans will require some significant cost reduction/CIP delivery in the final quarter of the year, a challenging task given likely pressures. ICBs submitting a refreshed deteriorating forecast will be subject to restrictive actions including:

- Sign off by provider/ ICB for revenue investments >£50k
- Sign off by provider/ICB/NHSE for investments >£100k
- A review of capital allocations by NHSE
- Increased oversight and workforce controls, particularly on bank and agency spend

These constraints are regarded as 'last resort' and providers will be deemed to have breached their statutory duty.

Assurance and regulation

CMAST providers are cumulatively missing I&E, CIP and BPPL targets. The ICB CFO is in discussion with individual organisations on recovery and re-forecasting plans. The finance workshop of 18th November explored issues around accountability, incentives and blockers to progress and the actions and next steps following this will be shared via the ICB CFO with a follow up workshop planned.

Governance and risk

Opportunities to improve the financial bottom line will be explored and linked to incentives and risk and reward principles. This will be incorporated into the financial planning and sustainability exercise. Further discussion on the impact of known and forecast risk will be incorporated into the regular CMAST PB.

Strategy and planning

Specialised commissioning will remain at NHSE regional level until April 2024 for those service deemed suitable for delegation. Revised allocations based on population will be notified in December alongside a phasing trajectory. At this point modelling will be undertaken on the impact at organisational/CMAST/ICB level.

Value and Efficiency

The collaboration at scale workstream was launched at the ICB finance workshop on 18th November. The first meeting of the CaS Board chaired by Ged Murphy is planned for January 2023, where target efficiencies will be discussed, linked to the four themes of procurement, financial services, pharmacy, and workforce.

Workforce

The Workforce Programme led by Kathryn Thompson is holding a workshop for Chief People Officers on Friday 9th December, the purpose of the session is to review project initiation documents and identify a number of priority programmes which the workstream focus on.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/07**			
SUBJECT:	**Chair's Briefing**			
DATE OF MEETING:	25th January 2023			
AUTHOR(S):	Steve McGuirk, Trust 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): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the external activity of the Chair of the Trust, as well as drawing attention to matters the Chair believes are of significance to the Board of Directors. Two key aspects related to: • Heightened Activity update/ comment • The need to 'sign off' the Maternity Incentive Scheme			
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked: i) To note the meetings/engagement of the Chair over the reporting period (since the last Board meeting). ii) To note the sign off process for the Maternity Incentive Scheme iii) To make any comments or ask any questions arising from the report.			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chair's Briefing	AGENDA REF:	BM/23/01/07

1. BACKGROUND/CONTEXT

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

2. MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

The period covered runs from 30th November 2022 to 24th January 2023 and only outlines 'formal' meetings for information and does not encompass day to day business in the hospitals.

DATE	ACTIVITY
30 November 2022	Trust Board Day - Warrington
6 December 2022	Chairs and Chief Execs Meeting; Aiming for Success Seminar (Manchester); Workforce Programme Update Meeting
7 December 2022	Welcome Event – new governors
8 December	Charitable Funds Committee meeting
12 December 2022	Meeting with CMAST Management Team and Chair
13 December	Complaints Assurance Meeting; Chair's briefing with Governors
14 December	Board development session with the Good Governance Institute (GGI); NHS Carol Concert Liverpool (evening)
15 December	Christmas Hamper Raffle; December Team Brief
16 December	Shadowing Discharge Team
21 December	Meet new Chaplain; Extraordinary Board Meeting (re extraordinary activity levels – risk review)
22 December	Halton chocolate distribution; Regional Roadshow with NHS CEO and her team
5 Jan 2023	New governors 'meet and greet' and ED Walk round; Forecast Outturn Extraordinary Meeting
10 Jan 2023	Meeting and walk round with Chester University NED; 121 with Associate NED
11 Jan 2023	Freedom to speak up meeting

12 Jan 2023	Chair's briefing with Governors;121 with Lead Governor
16 Jan 2023	Workforce programmes update meetings
18 Jan 2023	CMAST Chairs meeting;
19 Jan 2023	Clinical Entrepreneur Programme (CEP) Appraisal; 121 NED Associate
24 Jan 2023	Combined NW System Leaders Update

3. KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

The period on the run-in to Christmas was marked by a level of demand that has never been seen before at the Warrington site, in particular, and that has continued unabated.

In this respect, I mentioned in my last update how frequent the activation of the Operational Pressures Escalation Levels (OPEL) protocol had become (NHS Escalation Framework), but, in this last period, it would be easier to record the occasions when the Trust has not been in OPEL 4, than when it has been. There has been huge media coverage of the images of people waiting in emergency departments (EDs) and their corridors and that has very much reflected the reality here, as I have seen for myself having attended the department on several occasions. (In fact, we held a new governor 'meet and greet' session early in January, and to ensure they had a good grasp of the issues being faced, we organised a visit to the Emergency Department.)

I must also continue to draw attention to the significance of the issue of patients who no longer meet the clinical criteria to *reside for inpatient care in an acute hospital*, and that we have continued to see up to 170 people - (effectively) 8 wards of people – in this situation. There are no simple or quick answers to this issue, but it is readily apparent that the existing model of health and social care requires a radical rethink.

Once more, though, it is impossible to overstate just how hard colleagues across and at every level of the Trust have worked and the stress they are under. As a Board, we have recognised the need to ensure that we manage the heightened level of risk being faced, but to do so in a proportionate manner and, in support of this, it is worth drawing attention to the fact that the Chief Executive called an urgent board meeting in December.

The other specific matters that I wish to draw the Board's attention are as follows:

3.1 National Industrial Action

The Chief Executive will cover this issue more comprehensively in his report.

3.2 Maternity Incentive Scheme

In 2017, the then Health Secretary of State, Jeremy Hunt announced that the Government were bringing forward to 2025, the target of halving the numbers of stillbirths, neonatal and maternal deaths and severe birth-related brain injuries that was originally set for 2035. In

support of this, ten maternity safety actions were agreed with National Maternity Safety Champions and in partnership with NHS Digital, NHS England, NHS Improvement, the Royal College of Obstetricians and Gynaecology, the Royal College of Midwives, MBRRACE and the CQC. These actions formed the basis of the following ten questions that trusts needed to respond to:

1. *Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths?*
2. *Are you submitting data to the Maternity Services Data Set to the required standard?*
3. *Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?*
4. *Can you demonstrate an effective system of medical workforce planning?*
5. *Can you demonstrate an effective system of midwifery workforce planning?*
6. *Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?*
7. *Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?*
8. *Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?*
9. *Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?*
10. *Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification Scheme?*

In support of this, and to incentivise the adoption of best practice, a **Maternity Incentive Scheme** (MIS) was introduced which meant that all members of the NHS Resolution's Clinical Negligence Scheme for Trusts (CNST)[1] qualified for a financial rebate (up to 10%) for making progress against these actions.

The responsibility for monitoring progress has sat with trust boards over the four years since its introduction, and there has been a well-ordered process in place at WHH with which Directors will be familiar.

Over the last few months, however, because of further and wider issues associated with maternity services (for example the Ockenden report) new monitoring and oversight arrangements have been introduced. These are intended to provide public reassurance by the application of additional assurance mechanisms out with the trust, but within which sits the issue of MIS. As a result, this year, there has been added layer of assurance from the Local Maternity and Neonatal Service (LMNS) (at the ICS level) as well as assurance from the 'Place Partnership'.

[1] NHS Resolution is an arm's length body of the Department of Health and Social Care and provides expertise to the NHS on resolving concerns and disputes fairly and sharing learning for improvement and, for information, WHH is a member of CNST.

And, as part of this, the LMNS has stipulated a requirement for their executives to attend the Board at which the MIS approach is signed off, thus, colleagues from the LMNS will attend the Board today.

These matters are recognised by the Board as being of huge importance and, accordingly, have been on every Board agenda for the last few months, as well as the years before that; but, by way of summarising the 'sign-off arrangements and governance' this year, our approach has been 'signed off' by:

- The Chief Executive (by way of initiating the sign off process)
- Relevant Executives
- Place Partnership Leads
- Quality Assurance Committee (on which sits our Maternity Champion)
- ICB on or before 02/03/23 (awaiting 'process' for this)
- And once again the Chief Executive's final 'signature' at today's Board

For the sake of completeness (notwithstanding all the previous board and governance papers mentioned), it should be understood that we are 99% compliant with the ten actions (awaiting one individual to complete training (likely to be complete by the time of this Board) following which we will be fully compliant in all areas. The only 'risk' with this one aspect may be a slight delay because of the unprecedented operational pressures being faced.

This is a positive achievement, and it is fair to say, has necessitated a relentless effort and focus over an extended period.

It is my understanding that there remain some outstanding financial issues and delays to the payment of the full rebate being made to the Trust.

3.3 CMAST Update

CMAST stands for the Cheshire and Merseyside Acute and Specialist Trusts and is one of the two Provider Collaboratives - the other being mental health and community services' trusts – that form part of the Cheshire and Merseyside ICS architecture.

In the spirit of sharing information related to the wider agenda, the latest CMAST briefing is included in the Chief Executive's Briefing and, equally, in the spirit of not making comment for the sake of it, I do not propose to repeat that update in my report.

3.4 ICS Update

The ICS has now established another formal regional body – the Integrated Care Partnership (ICP). The ICP is a statutory committee jointly formed between the NHS Integrated Care Board (ICB) and all (upper tier) local authorities (councils) that fall within the ICS area. The Cheshire and Merseyside region encompasses nine local authorities and is therefore the second largest in the country. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population and will be chaired by Councillor Louise Gittins. It is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area and is in the process of developing its

first strategy, albeit that first version will be an interim strategy to reflect the relative 'newness' of the ICP.

3.5 Council of Governors

I referred to the election of governors in my last update. Just before Christmas we held a 'welcome' Christmas Lunch, and I would want to say thank you to our partners at the Warrington and Vale Royal College Catering School for hosting us.

Just after Christmas we held a meet and greet session for new governors as a precursor to getting the various checks undertaken and in anticipation of an induction session once those checks have been approved.

Governors are now back in to a regular pattern of observation visits and these are now channelled through respective governance committees.

3.6 Governors Q and A Sessions and Working Group

Governors have held two, Q and A sessions with the Chair since the last meeting (see list of activity above).

10. RECOMMENDATIONS

The Trust Board is asked:

i) To note the meetings/ engagement of the Chair over the reporting period.
ii) To make any comments or ask any questions arising from the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/01/08**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	25th January 2023	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • One new risk has been added; • There have been no amendments to the ratings of any risk • The description of one risk on the BAF has been amended • No risks have been closed or de-escalated Notable updates to existing risks are also included in the paper.	
PURPOSE: ***(please select as appropriate)***	Information | 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
	Agenda Ref.	QAC 22/12/ 307 & QAC 23/01/07
	Date of meeting	06.12.2022 & 10.01.2023
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/23/01/07

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, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

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

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting one new risk has been added to the BAF

Following discussions at the Strategic People Committee and the Trust Board it was agreed to escalate **Risk #1757** in relation to Industrial Action at a rating of 16.

ID	Risk description	Rating	Executive Lead
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	16	Michelle Cloney

2.2 Amendment to Risk Ratings

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

2.3 Amendments to descriptions

Since the last meeting there have been amendments to the descriptions of one risk:

1. **Risk #1215**

Following discussion at the Clinical Recovery Oversight Committee (CROC) it was agreed to update the description of risk #1215 as described below.

Previous: *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.*

Current: *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.*

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 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.	• Ward A10 opened as winter escalation capacity funded by the ICB. • 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.	25	No impact on risk rating
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	• 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	25	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	<u>Controls & Assurances</u> • 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 • 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 • Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews, over recruitment plans to commence 1st January 2023 • Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust • Retention – Internal Transfer process in place for staff • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team • 2 wte Matrons commencing 3/4/2023. • 10.97 wte awaiting clearance/induction date (of these 6.01fte have start dates before the end of February) <u>Gaps</u> • 7.63 WE Band 6 midwife vacancies & 2 Matron Vacancies	20	No impact on risk rating
1275	If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.	• Concern relating to an emerging strain in China and triaging implemented to identify returning travellers for isolation and further national laboratory-based testing • Clear curtains in bays have been removed • Attention focussed on isolation of immunosuppressed patients • Asymptomatic staff testing has ceased	20	No impact on risk rating
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact	<u>Controls & Assurances</u> • TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m over 3 years) • CDC phase 1 has now been approved (£10.5m over 3 years)	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 ability to provide local services for the residents of Warrington & Halton	• CDC phase 2 application has been submitted but we are still awaiting an outcome (£14.9m over 2 years) • Undertaken a review of a number of mitigations to support delivery of the Trust's Control Total and engaged with system partners to seek support. • Daily review of Non-Pay requests to reduce Non-Pay spend in the last quarter • Annual Planning timetable established for 2023/24 • Additional income from Commissioners & Adaptive Reserve agreed which will support delivery of £6.1m deficit plan • Annual Planning timetable established for 2023/24 <u>Gaps</u> • Unidentified CIP of £0.7m and non-recurrent CIP of £13m presents a challenge to the delivery of the control total and financial sustainability • Assuming £8m ERF; however, this is not guaranteed as the Trust is not chieving planned activity levels. • Current level of risk is £2m-£4m from the control total with risk of entering in t a double lock scenario • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability should the capacity remain open and funding withdrawn at 1st April 2023. • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan		
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	<u>Gaps</u> • ITHealth Assurance Dashboard license expires this financial year • 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 • Although got the licenses for SQL migration, some 2012 servers still need a migration plan/support to migrate them	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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	Gaps Due to Partnership working delay in programme timetable will put the project outside of the national funding window, and the business case will become untenable due to restrictions on Trust expenditure e.g. CDEL	16	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

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	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight 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	1	25 (5x5)	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
1275	Kimberley Salmon-Jamieson	If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
134	Andrea McGee	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and	1	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee

Board Assurance Framework

		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	Paul Fitzsimmons	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1757	Michelle Cloney	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	16 (4x4)	8 (4x2)	TBC	Strategic People Committee
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)	4 (4x1)	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, 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.	3	12 (3x4)	8 (4x2)	TBC	Executive Management Team

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

Board Assurance Framework

Risk 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:	25(5x5)
				Target:	8 (2 x 4)

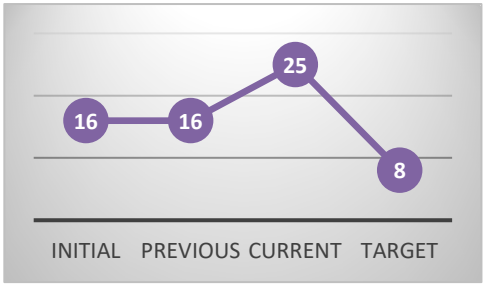
Assurance Details:

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 Lilycross site
- 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
- Command & Control initiative in place since 8th December 2021 and ongoing to support pathway 0 and pathway 1 discharges.
- Ward B4 at Halton converted to provide additional G&A capacity (additional 27 beds) and flow in ED
- 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 has commenced to identify additional community and Trust based capacity to support expected activity levels for winter

Assurances

- Systemwide relationships including social care, community, mental health and CCGs
- System actions agreed supporting the Winter Plan



Board Assurance Framework

	• The Trust participates at the system & regional UEC improvement meeting on each Wednesday • 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	
Assurance Gaps:	**<u>Gaps in Controls</u>** • Staffing pressure created as a direct result of COVID-19 Global pandemic. **<u>Gaps in Assurances</u>** Confirmed exponential growth in types 1 & 3 as a result of population need and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/03/2023	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/03/2023	

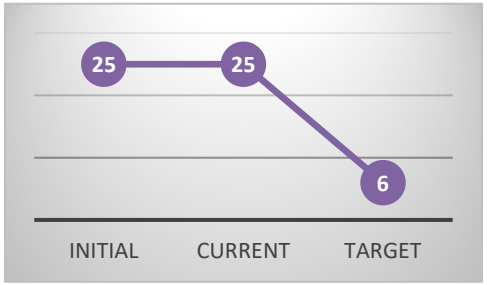
Board Assurance Framework

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			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 6 (3x2)

Assurance Details:

Controls

- Clinical Services Oversight Group (CSOG) established
- Clinical Recovery Oversight Committee (CROC) 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.
- Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists.
- 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



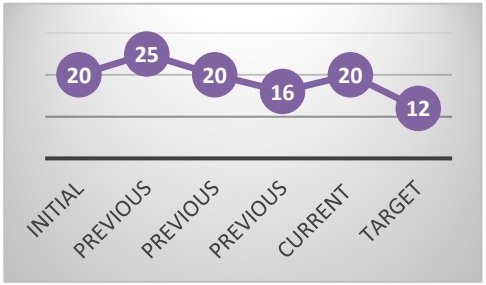
Assurances

Board Assurance Framework

	• Operational planning monitored by Cheshire & Merseyside on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity. • 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 to start 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.	
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	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/03/2023	

Board Assurance Framework

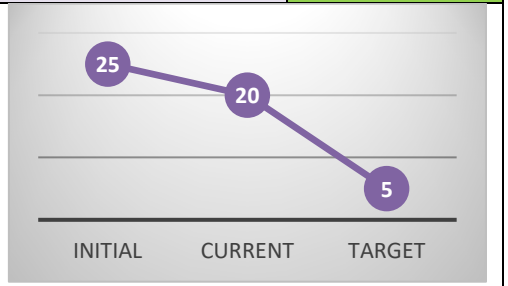
Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If we cannot provide minimal staffing levels in some clinical 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:	• 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 • 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 • 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 • 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, over recruitment plans to commence 1st January 2023 • Part of National Recruitment Programme and Care Support Worker Development Programme for HCAs • Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust • Retention – Internal Transfer process in place for staff • Workforce plan/ strategy in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team • Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead • International Nurse recruitment in place • 2 wte Matrons commencing 3/4/2023. • 10.97 wte awaiting clearance/induction date (of these 6.01fte have start dates before the end of February)			
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. B3, B4, A10, Catheter Laboratory) • Increased staffing pressures anticipated due to winter surge • Time to post when recruiting new staff • Increased turnover by 6% over last 12 months • Predicted 30 WTE Vacancies in Emergency Department • Predicted 60%-80% Band 6/7 Pharmacy vacancies • 7.63 WE Band 6 midwife vacancies & 2 Matron Vacancies			

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	Kennah, Ali	31/01/2023	

Board Assurance Framework

		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.			

Board Assurance Framework

Risk ID:	1275	**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 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.			**Initial:** 25 (5x5) **Current:** **Target:** 5 (5x1)
Assurance Details:	Triage and testing on emergency admission using molecular and PCR testing; to pause for asymptomatic patients from 1/09/2022 Planned procedure testing SOP Guidance for staff returning to on-site working (previously considered extremely vulnerable) COVID-19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms and have been revised as per hierarchies of control. Mask stations and santiser remain in place at all entrances and designated points throughout the Trust. Agile working policy is in place. Information technology infrastructure is in place to support remote working. Risk assessment in place to support safe visiting. Providing and maintaining a clean environment that facilitates the prevention and control of infections. Communications through TWSB to staff reinforcing updates to Covid-19 SOPs. Environmental Safety Action plan in place reported by exception to Silver Infection Control; Silver Infection Control Group meeting paused from September 2022 Outbreak meetings held with lessons learned shared across the Trust. PPE audits completed weekly on wards and increased frequency during outbreaks. PPE & swabbing champions identified. Clear curtains are in place in all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place; to pause from 1/09/2022 Bioquell Pods now in place in ICU, ED and B18. Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place. Cohorting of COVID-19 positive patients in place. Surveillance of patient in bays for 7 days following Covid-19 exposure; early release plan from 1/09/2022 (5 days) Risk assessment in place for use of beds in Covid-19 exposed bays to protect immunosuppressed and unvaccinated patients. Asymptomatic staff testing using Lateral Flow Device testing is encouraged. Revised guidance in place for respiratory and non-respiratory pathway. Testing amended to included Influenza A&B & RSV. Agreed patient flow pathways based on results of screening. IPC Team liaison with clinical teams on AGP precautions IPC Team liaise with Patient Flow Team on patient placement FFP3 fit testing programme in place. Staff training in safe donning and doffing of PPE is included in mandatory training Updated IPC measures in place including the relaxation of mask wearing in certain areas of the Trust, a return to pre pandemic visiting arrangements and 1 relative/carer to accompany patients in the Emergency Department. Updates to Trust Guidance/SOPs in line with publication of national guidance and upload to the Hub Updated National Guidance in place from 1st September 2022			

Board Assurance Framework

	09/01/2023 concern relating to an emerging strain in China and triaging implemented to identify returning travellers for isolation and further national laboratory-based testing Clear curtains in bays have been removed Attention focussed on isolation of immunosuppressed patients from 01/09/2022 Asymptomatic staff testing has ceased	
Assurance Gaps:	Increased risk from return to pre-pandemic standards with removal of social distancing requirements, removal of universal masking and opening up visiting Non-compliance with PPE Non-adherence to Trust Staff isolation policy Mask station not present at all entrances Cleanliness score (on small number of ward items) sit just below 95% Site-wide assessment of ventilation (mechanical and manual) – action plan required to ensure all areas with mechanical ventilation are compliant with standards Unknown uptake of asymptomatic staff testing – LFD testing as this is not centrally reported	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Review Nurse cleaning roles & responsibilities	Reviewed as part of a Task & Finish Group to implement revised cleanliness standards (published April2021) within an 18-month timescale	Agree roles and responsibilities	McGreal, Julie	30/12/2022	

Board Assurance Framework

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)

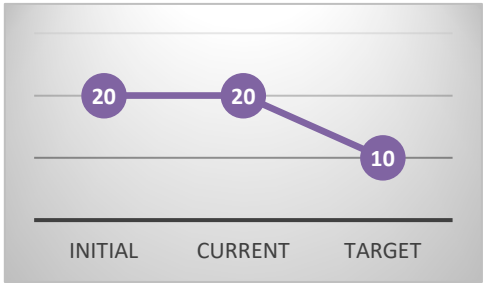
Assurance Details:

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 review at extended Executive team meeting
• Workshop undertaken with - Exec, CBU, Corporate to review 2022/23 cost pressures
• Workshops undertaken 2022/2023 budget setting
• Capital Plan 2022/23 approved by Trust Board on 30th March 2022
• Procurement/tender waiver training in place
• Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M
• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m over 3 years)
• CDC phase 2 application has been submitted but we are still awaiting an outcome (£14.9m over 2 years)
• Latest guidance from MIAA Counter Fraud Team circulated
• Counter Fraud campaign took place for national anti-fraud week in November 2022
• Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance.
• Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced.
• Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022
• ICS executive peer to peer review June 2022, and September 2022.
• B3 exit strategy requested as funding until 31.03.2023
• Appointed GIRFT Finance Lead and 3 Clinical Leads
• Undertaken a review of a number of mitigations to support delivery of the Trust's Control Total and engaged with system partners to seek support
• Daily review of Non-Pay requests to reduce Non-Pay spend in the last quarter
• Annual Planning timetable established for 2023/24

Assurances

• Achieved Break Even in 2021/22
• Delivered 2021/22 Capital Plan
• Unqualified audit opinion (2021/22)
• 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.



Board Assurance Framework

	• ICS review undertaken of increases in WTE and pay run rates which are less than C&M ICS. Increases relate to Clinical Staffing in the main. • CDC phase 1 has now been approved (£10.5m over 3 years) • HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • Funding to support B3 confirmed for 2022/23 • Additional income from Commissioners & Adaptive Reserve agreed which will support delivery of £6.1m deficit plan • Annual Planning timetable established for 2023/24	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Assuming £8m ERF; however, this is not guaranteed as the Trust is not achieving planned activity levels. • 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 due to further COVID-19 / Flu surge • Availability of social care to support the current super stranded position (currently c25% of bed base). Estimated annual cost of at least £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 should the capacity remain open and funding withdrawn at 1st April 2023. • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identify CIP to support delivery of the overall financial plan	Identify CIP	Establish Leadership and oversight with the Executive Medical Director and meeting with Care Groups. Joint reporting to F&SC	McGee, Andrea & Fitzsimmons, Paul	30.03.2023	
Develop Financial Plan for 2023/24	Develop Plan	Trust Board to approval 2023/24 Financial plan	McGee, Andrea	31.03.2023	

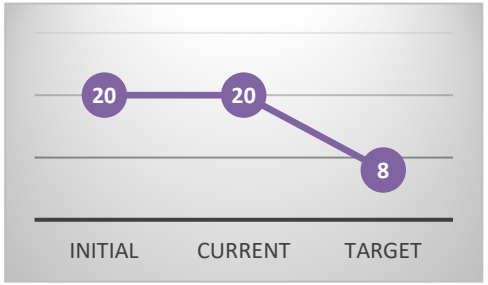
Board Assurance Framework

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)

Assurance Details:

Sickness Absence

- Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. North West Acute Trusts make up 45% of quartile 4 - Highest 25% for sickness absence nationally. WHH currently sit in quartile 3 nationally and rank 10th out of 20 for North West Trusts as at September 2022 (no further updates available in Model Hospital at this time).
- Overall absence rate was 5.97% for October 2022 against a target of 4.25%.
- New Supporting Attendance Policy has been live since February 2022. There is currenlty a post implementation review being undertaken to inform further enhancements to the policy and supporting porcesses.
- Supporting Attendance bitesize briefings on the new policy continue to be offered, these include a focus on Welcome Back Conversations.
- Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and potential bespoke interventions to support managers.
- Full training sessions have been implemented with the offer communicated via informal and formal channels.
- In order to support accessible learning and development bitesize sessions continue to be offered via a hybrid format.
- Specific support continues within areas of high sickness and low compliance WBC figures.
- Occupational Health and Wellbeing continue to hold triangulation meetings with HR colleagues to review individuals who are under the formal stages Supporting Attendance Management, to progress the case through enhancing support and/or developing interventions.
- The Supporting Attendance Steering Group, has been refreshed and reset to the 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'. This will enable the Trust to identify patterns and implement support interventions to assist prevent absences and support staff wellbeing. In September, the group focused on the data for stress / anxiety /depression, which has shown an ongoing decrease since April 2022, and interventions to support staff absent for these reasons. This will also inform the work regarding the Winter Well campaign to ensure the necessary targted support for the workforce.
- The team held a Supporting Attendance Month, whereby there has been a number of roadshows, drop-in sessions, comms and events to showcase the Trust's commitment to Supporting Attendance. The team plans to produce a flipping book of the Supporting Attendance Policy once the interim policy review has taken place and any subsequent actions actioned.
- The HR team are supporting improvements in welcome back conversation recording through the introduction of a coaching focused welcome back conversation internal audit
- 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.



Turnover and Attraction

- Turnover in October 2022 is above the target of 13% at 16.5%. Turnover of permanent staff is 15.48%.
- Work-life balance continues to be the number one known reason people leave WHH, followed by retirement.
- A new Exit Interview process has been implemented to further understand the details as to why people are leaving. Collation and analysis of this data enables themes to be identified and targeted action to be taken to address these areas. This information is now available on the Trust Workforce Information Dashboard.

Board Assurance Framework

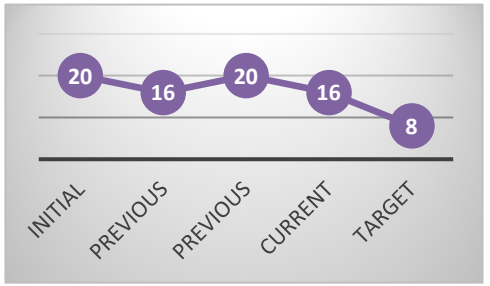
	• To support with the development of an Agile/Flexible Working Toolkit, views of the staff are being sought on the current agile working culture, barriers, opportunities and best practice. Once developed the toolkit will be promoted with Line Managers and drop in sessions will be setup to support managers to understand the principles of Agile/Flexible working and how it can be best implemented within their teams. • A significant number of people delayed their retirement plans in 2020 and 2021, and we have now seen a significant increase in the number of individuals choosing to retire. It is worth noting a number of retirees do return to the workplace (retire and return) and are supported to do so, however these still count as a leaver for the purposes of retention and turnover. • Rugby League Cares have been supporting WHH since July 2021, providing a range of physical and mental fitness offers to our workforce. • Grief and Menopause cafes continue to be delivered to offer guided support sessions both virtually and face to face. • A Resourcing T&F group is being established to support retention, recruitment and temporary staffing actions • The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH. From 1st April – 31st August, the Mental Wellbeing Team have been able to deliver: • 162 referrals • Over 700 counselling hours for individuals • 1004 telephone interactions • 1724 email interactions • Interventions to 885 participants • Social media accounts have been created to support recruitment attraction across a number of social media platforms • A recruitment marketing approach is being developed to support attraction to WHH • Financial wellbeing resources have been implmented to support the workforce and retention including Wagestream **Temporary Staffing & Agency spend** • Reliance on bank and agency staff increased was 15.67% in October 2022. • The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: • ECF process for non-clinical vacancies approval • ECF process for bank and agency temporary staffing pay spend approval • Medical Rate Escalations approved by Medical Director • Through the Finance and Sustainability Committee, compliance against our processes and rate cards continues to be monitored. • There is currently work underway to establish clear actions that the Trust needs to undertake to reduce agency expenditure. This includes: • Assessment by Deputy Medical Director and Deputy Chief Nurse against a combined NHSE and East Lancs Best Practice Toolkit for controlling agency spend • Development of recommendations and approaches to bring down agency costs including: • Reduction in commission for long line bookings • Walk down Medical and Dental agencies over a period of time; firstly, to within the 50% cap and then to close to the rate cap • Implementation of tiering of agencies, offering priorities to agencies who are within rate cap • Implementation of check and challenge around agency use • Review of the Frameworks being used to ensure best service and value for money • Upon completion of the best practice assessment tool, a Task and Finish group will be setup to review any gaps identified through the tool, support with the plans to hold the agencies to account and improve the use of the Trusts banks.	

Board Assurance Framework

	• To support tighter agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group. This report will be updated accordingly.	
Assurance Gaps:	• Turnover continuing to be above target, review of actions to reduce and make impact • Agency spend above previous years, definitive actions to be identified to reduce agency spend • Compliance with NHSE Agency Rate card very low, need identified actions to support increase in compliance • 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
Establishment of Resourcing Task and Finish Group	Establishment of Resourcing Task and Finish group to review: agency cap, agency spend reduction, agency controls, retention and recruitment marketing	• Establish group and ToR • Establish governance structure for group to support reporting Establish action plan	Carl Roberts	30.11.2022	
Develop Trust approach to agile working	Establish a best practice toolkit, processes and policies to support agile working at WHH	• Establishment of T&F group • Survey of organisation to identify best practice • Review of national best practice recommendations • Development of toolkit	Carl Roberts	31.01.2023	
Design and implementation of 'Winter Well' campaign to support staff wellness in work	Develop and implement a 'Winter Well' campaign that supports staff to stay well and in work including OH and wellbeing support, face to face, online and via ward visits	• Work with Care Groups to understand support for workforce needed • Develop 'Winter Well' campaign including online platform, face to face events and ward visits • Robust communications plan to ensure staff, managers and organisation aware of support available from the Winter Well campaign	Rebecca Patel	30.11.2022	
Post implementation review of Supporting Attendance policy	Review the new Supporting Attendance policy with the workforce to understand and identify any further policy or process enhancements required	• Gather feedback from different staff groups and managers, face to face and online surveys to inform policy and process review	Laura Hilton	30.11.2022	

Board Assurance Framework

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 Digital • **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). • 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. (March 2021) • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital (December 21) • WHHT return for assurance re cyber security to NHS England (March 22) • Cisco Phase 2 business case being approved (for financial year 22/23). Providing the procurement mini tender is done on time and the orders are place in advance and there are no other world-wide changes happen impacting on supplies, kit will be delivered and installed within 22/23. **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 membership of the **Sustainability Transformation Partnership Cyber 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. • **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. • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved).				

Board Assurance Framework

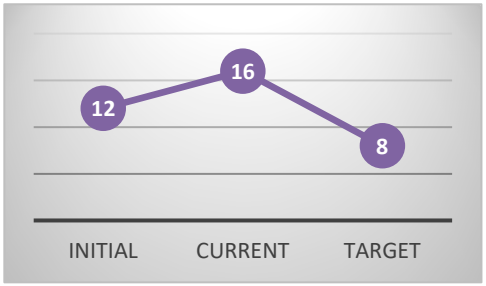
	• Office 2010 being used while end of life due to the N365 deployment plan (100% migrated) • Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second 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	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving 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) • ITHealth Assurance Dashboard license expires this financial year **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • 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 SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • 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. • The extension of the mainstream support for SQL Server 2012 will end on 12 July 2022 • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS • Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server • MFA on limited number of systems • 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 • Although got the licenses for SQL migration, some 2012 servers still need a migration plan/support to migrate them	

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	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital	Deacon, Stephen	30/06/2023	

Board Assurance Framework

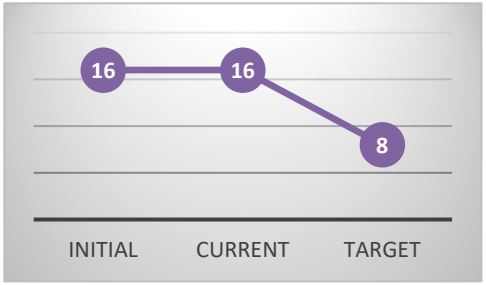
Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]		Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Cisco Phase 2 upgrade to replace aging network equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	Waterfield, Tracie	31/03/2023	
Mitigations to be put in for ORMIS security issue	Mitigations to be put in for ORMIS security issue	To set up security groups to stop unauthorised access to the SQL database.	Deacon, Stephen	31/10/2022	
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommsion Server 2012 servers	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to the latest Windows Server operating system or decommission them.	Waterfield, Tracie	31/10/2023	
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	Upgrade and enable DLP	Waterfield, Tracie	31/12/2022	
Renew ITHealth Assurance Dashboard	Renew ITHealth Assurance Dashboard as this provides NHSD, Trust and ICB assurance regarding out Cyber Stance including NHS Digital's Cyber Security Bulletins	Obtain capital and renew the license	Deacon, Stephen	31/03/2023	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Paul Fitzsimmons	**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:** • A revised OBC is being progressed for August 2022 Trust Board approval in line with emerging guidance on managed convergence. • Trust Board approved ceasing procurement process a relaunch complying with Managed Convergence is being planned to start November 2022 • EPR Project Board (and escalation/assurance through Digital and Trust Boards) • Regular, documented conference calls with the ICS NHSE and NHSD – external partners supportive of managed convergence relaunch. **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 includes 3-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 in development • Procurement relaunch to start November 2022 • Senior Programme Manager assigned. • Financial modelling of realistic collaboration 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:** • Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC • ICS strategic approach to delivering managed convergence remains unclear **Gaps In Controls:** • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Due to Partnership working delay in programme timetable will put the project outside of the national funding window, and the business case will become untenable due to restrictions on Trust expenditure e.g. CDEL				

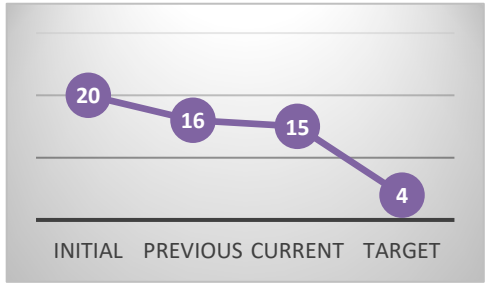
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Presentation of OBC v3 to Executive Team	Presentation of OBC v3 to Executive Team	Review the contents of OBC v3 Presentation of OBC v3 to Executive Team in May 22	Caisley, Sue	31/01/2023	

Board Assurance Framework

Risk ID:	1757	**Executive Lead:**	Michelle Cloney	**Rating**
Strategic Objective:	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
Risk 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:** 16 (4 x 4) **Target:** 8 (4 x 2)
Assurance Details:	• Weekly IA Task and Finish group established from 28th October 2022 requiring representatives from across all depts. 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 • IA tactical meetings to be established for the days of strike action • Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice • Review of policies for absence during IA in progress Results received so far: • RCN ballot - WHH did not meet the 50% threshold • Unison ballot - WHH did not meet the 50% threshold • Regionally Trust's within C&M have been named as sites participating in RCN IA on the 15th and 20th December 2022 - the Trust anticipates that it will have an impact upon the operations of the Trust and is stepping down Trust meetings where possible and deploying an incident control room response. NW Ambulance IA on 21st and 28th December			
Assurance Gaps:	• Uncertain whether IA will be national or regional approach and potential impact for different unions. RCN approach is based on individual Trusts. • Lack of clarity from the ICB regarding mutual aid • Lack of MOU from ICB			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Weekly meeting with staff side chair and deputy	Weekly meeting with staff side chair and deputy to take place with People Directorate in order to plan and update regarding Industrial Action	Weekly meeting to take place	Hilton, Laura	31/01/2023	
Weekly Industrial Action Update to Execs	Executive Management Team to receive weekly updates on Industrial Action	Executive Management Team to receive weekly updates on Industrial Action	Hilton, Laura	31/01/2023	
Set up Industrial Action task and finish group	To set up a Trust wide Industrial Action Task and Finish group to prepare for industrial action	Identify key stakeholders Set terms of reference and frequency of meeting Set work plan	Hilton, Laura	31/01/2023	
Participate in regional ICB Workforce Industrial Action preparedness group	Participate in regional ICB Workforce Industrial Action preparedness group	Attending and participating in regional ICB Workforce Industrial Action preparedness group	Hilton, Laura	31/01/2023	

Board Assurance Framework

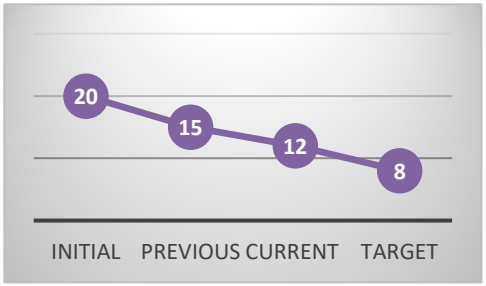
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns			**Initial:** 20 (5x4) **Current:** 15 (3x5) **Target:** 3 (3x1)
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 Targetted Investment Fund (TIF) for delivery of elective recovery at the Halton site have both been approved. The capital builds in these cases will substantially increase diagnostic & 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			
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 pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.			

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	30/06/2022	

Board Assurance Framework

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	31/03/2023	

Board Assurance Framework

Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
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, 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.			**Initial:**	20 (5x4)
				Current:	12 (3x4)
				Target:	8 (4x2)
Assurance Details:	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. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single. - 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 - 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. - Regular Strategy updates are provided to the Council of Governors & Trust Board - Clinical strategies at Specialty level have been refreshed - Breast Centre of Excellence opened. Bid for targettied 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. - Bid for Community Diagnostics Centre (CDC) at Halton site submitted. Phase 1 approved Pathology OBC supported by the 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 to commence from Autumn 2022. Opening planned for end of November 2022 - 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 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 - 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 developed for approval and submitted with a response expected in November 2022 - Strategy refresh completed and approved at Trust Board to confirm 2022/23 priorities.				

Board Assurance Framework

	- Full refresh of the Trust 5-year strategy in progress and due to complete in April 2023 - 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. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Drafts of both reviews complete. - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. - Consistent Trust representation within Cheshire & Merseyside ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative. - Trust representation on newly established place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. - Discussions with neighbouring Trusts to accelerate collaboration taking place - Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities.	
Assurance Gaps:	Risk to securing capital funding to progress new hospitals 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.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue to progress plans for new hospitals to be best placed to secure funding when available	Further develop SOCs and participate in competitive process for HIP funding	Further develop SOCs and participate in competitive process for HIP funding	Lucy Gardner	31/03/2023	SOCs – March 2020
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	31/03/2023	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/01/09**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	January 2023	
AUTHOR(S):	Marie Garnett – Head of Contracts, Performance and Commercial Development	
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 Andrea McGee - Chief Finance Officer and Deputy Chief Executive 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.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#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. **#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. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer, and ED Performance.	

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 82 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" principles and performance over the last 6 months: Consistently passes the target: 16 Consistently fails the target: 26 Inconsistently passes/fails the target: 11 No SPC/Not enough datapoints: 29 There is special cause variation of a concerning nature, as the Trust has consistently failed to meet the following indicator targets in the last 6 months: Medicines Reconciliation within 24 hours, RTT 18 Weeks, A&E 4 Hour Standard, Super Stranded Patients, Outpatient Appointments Delivered Remotely, Welcome Back Conversations, Vacancy Rates and Retention. SPC assurance cannot be determined for the following indicators that have not achieved their target in the last 6 months: Friends and Family – ED and UCC, Sepsis Screening for all emergency patients within 1 hour, Sepsis within an emergency setting receiving antibiotics with 1 hour and Sepsis within an inpatient setting receiving antibiotics with 1 hours. The Trust has submitted a £6.1m deficit plan for 2022/23 At month 9 the Trust has indicated that although there are risks, the forecast is achievement of this plan. The month 9 position is a £8.2m deficit year to date which is on plan.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive 2. Note the changes approved by the Finance and Sustainability Committee on behalf of the Trust Board as per the delegated authority set out in Section 2.5 3. Note the amendments to the KPIs set out in section 2.6 4. Note the contents of this report			

PREVIOUSLY CONSIDERED BY:	**Committee**	Clinical Recovery Oversight Group Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	• Capital Requests Supported • Changes to include new KPIs and update existing KPIs supported
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/23/01/09**

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

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

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

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

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

1.2 NHSE Oversight Framework Changes to KPIs

In June 2022, NHSE published a new Oversight Framework which included a new set of oversight metrics. Section 2.6 of this paper sets out the amendments to the Trust IPR to provide assurance in relation to the performance of these metrics.

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" category. **Table 2** contains the number of IPR indicators in each Making Data Count "Variation" category.

Table 1: Assurance Categories*

		Quality	Access & Performance	People	Finance & Sustainability
	**Consistently Passes the Target (based on the last 6 months)**	8	4	3	1
	**Consistently Fails the Target (based on the last 6 months)**	6	12	7	1
	**Inconsistently Passes/Fails the Target**	3	4	2	2
	**No SPC/Not Enough Datapoints/Not Applicable**	10	15	1	3
Total		**27**	**35**	**13**	**7**

*based on the last 6 months performance.

Table 2: Variation Categories

		Quality	Access & Performance	People	Finance & Sustainability
	**Common Cause Variation**	11	16	6	2
	**Special Variation of an Improving Nature**	2	1	1	1
	**Special Variation of a Concerning Nature**	1	4	3	0
	**No SPC/Not Enough Datapoints/Not Applicable**	13	14	3	4
Total		**27**	**35**	**13**	**7**

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

2.2 QUALITY

Assurance

There are 6 Quality indicators which are consistently failing the target in December, these are:

- 10. Medication Reconciliation within 24 hours – the Trust achieved 49%, against a target of 80%
- 12. Care Hours Per Patient Day (CHPPD) – the Trust achieved 6.8 hours against a target of 7.9 hours.
- 18. Friends & Family Test (Urgent & Emergency Care) – the Trust achieved 66%, against a target of 87%
- 21. Sepsis Screening (Emergency Patients) – the Trust achieved 61%, against a target of 90%
- 23. Sepsis Antibiotics Administration (Emergency Patients) – the Trust achieved 76%, against a target of 90%
- 24. Sepsis Patients receive antibiotics administered within 1 hour of diagnosis– the Trust achieved 88%, against a target of 90%

There are 3 Quality indicators which are inconsistently passing/failing the target in December, these are:

- 3. Healthcare Acquired Infections – MRSA – the Trust reported 0 cases of MRSA, against a target of 0. Therefore, this target was achieved in December.
- 7. VTE Assessment – the Trust achieved 95.31%, against a target of 95%. Therefore, this target was achieved in December.
- 22. Sepsis Screening (Inpatients) – the Trust achieved 84%, against a target of 90%. Therefore, this target was not achieved in December.

SPC Assurance cannot be determined for the following indicator which has failed to meet the target in December:

- 11. Staffing Average Fill Rate – the average staffing fill rate for all four groups combined was 85.35%, against a target of 90%

Variation

There is 1 Quality indicator which is indicating special cause variation of a concerning nature in December, this is:

- 10. Medicines Reconciliation within 24 hours

2.3 ACCESS AND PERFORMANCE

Assurance

There are 12 Access & Performance indicators which are consistently failing the target in December, these are:

- 28. Diagnostics 6 Week Waiting Times – the Trust achieved 71.07%, against a target of 99%
- 29. Referral to Treatment – 18 Weeks – the Trust achieved 57.30%, against a target of 92%

- 30. Referral to Treatment – 104 Week Waits – there were 2 patients waiting over 104 weeks, against a target of 0. Whilst this indicator doesn't comply with the target, this is in line with the Trusts 2022/23 plan
- 31. A&E Waiting Times – 4 hours – the Trust achieved 55.34%, against a target of 95%
- 35. Cancer 14 Days – the Trust achieved 88.44% in November, against a target of 93%
- 41. Cancer 62 Day Urgent – the Trust achieved 69.57% in November, against a target of 85.00%
- 43. Ambulance Handovers within 15 minutes – the Trust achieved 12.91%, against a target of 65%
- 44. Ambulance Handovers within 30 minutes – the Trust achieved 33.66%, against a target of 95%
- 45. Ambulance Handovers within 60 minutes – the Trust achieved 50.95% in December, against a target of 100%
- 46. Discharge Summaries (24 Hours) – the Trust achieved 85.72%, against a target of 95%
- 55. % Outpatient Activity Delivered Remotely – the Trust achieved 11.34%, against a target of 25%
- 56. % Patients seen in the Fracture Clinic within 72 hours – the Trust achieved 8.16%, against a target of 95%

There are 4 Access & Performance indicators which are inconsistently passing/failing the target in the last 6 months, these are:

- 36. Breast Symptoms 14 Days – the Trust achieved 100% in November, against a target of 93%. Therefore, this target was achieved in November.
- 37. Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 70.69% in November, against a target of 75%. Therefore, this target was not achieved in November.
- 42. Cancer 62 Days Screening – the Trust achieved 100% in November against a target of 90%. Therefore, this target was achieved in November.
- 47. Discharge Summaries (7 Days) – there were 156 discharge summaries not sent within 7 days to meet the requirement, against a target of 0. Therefore, this target was achieved in December.

SPC Assurance cannot be determined for the following indicators which have failed to meet the target in December:

- 33. A&E Waiting Times (12 Hours) – the Trust achieved 23.9%, against a target of 2% or less
- 52. COVID-19 Recovery (Inpatient/Daycase) – the Trust achieved an average of 85.07% for inpatient/daycases combined, against a target of 104%
- 54. COVID-19 Recovery (Outpatients) – the Trust achieved 87.68% of outpatient activity, against a target of 104%

Variation

There are 4 Access & Performance indicators which are indicating special cause variation of a concerning nature, these are:

- 29. Referral to Treatment – 18 Weeks

- 31. A&E Waiting Times – 4 Hours
- 51. Super Stranded Patients
- 55. % Outpatient Activity Delivered Remotely

2.4 PEOPLE

Assurance

There are 7 People indicators which are consistently failing the target in December, these are:

- 60. Supporting Attendance – the Trust achieved 7.29%, against a target of 4.20% or less
- 61. Welcome Back Conversations – the Trust achieved 69.55%, against a target of 85%
- 62. Recruitment Time to Hire – time to hire average days was 96, against a target of 65 days or less
- 63. Vacancy Rate – the Trust achieved 11.86%, against a target of 9% or less
- 64. Retention – the Trust achieved 83.59%, against a target of 86%
- 65. Turnover – the Trust achieved 15.78%, against a target of 13% or less
- 66. Bank & Agency Reliance – the Trust achieved 16.67%, against a target of 9% or less

There are 2 People indicators which are inconsistently passing/failing the target in December, these are:

- 67. Monthly Pay Spend – monthly pay spend was £18.3m, against a budget of £19.2m. Therefore, this target was achieved in December.
- 72. PDR Compliance – the Trust achieved 62.43%, against a target/trajectory of 79%. Therefore, this target was not achieved in December.

SPC Assurance cannot be determined for the following indicator which has failed to meet the target December:

- 70. Safeguarding Training – the Trust achieved 71.28%, against a target/trajectory of 83%

Variation

There are 3 People indicators which are indicating special cause variation of a concerning nature, these are:

- 61. Welcome Back Conversations
- 63. Vacancy Rates
- 64. Retention

2.5 FINANCE AND SUSTAINABILITY

Assurance

There is 1 Finance & Sustainability indicator which is consistently failing the target in December, this indicator is:

- 76. Better Practice Payment Code – the Trust achieved 92% (cumulative), against a target of 95%

There are 2 Finance & Sustainability indicators which are inconsistently passing/failing the target, these are:

- 73. Trust Financial Position – the Trust recorded a deficit position of -£8.2m against a plan of -£8.2m. Therefore, this target was achieved in December
- 75. Capital Spend – the Trust capital spend as at the end of December was £5.9m against a plan of £10.9m. Therefore, this target was not achieved in December

SPC Assurance cannot be determined for the following indicator which has failed to meet the target in month:

- 79. Cost Improvement Programme (Recurrent Forecast) – the Trust is forecasting a recurrent CIP achievement of £2.1m, against a full year target of a minimum of £6.5m

Variation

There are no Finance & Sustainability indicators which are indicating special cause variation of a concerning nature.

The Income and Activity Statement for December 2022 is attached in **Appendix 5**.

The Trust has agreed a control total of £6.1m deficit with Cheshire & Merseyside ICS. There are several risks to the achievement of the planned £6.1m deficit. The key risks to achievement of the plan are:

- CIP delivery
- Achievement of Elective Recovery Fund (ERF) - during December 2022 elective activity has underperformed against plan. The position also shows an under performance against all elective activity to date, however the income has been assumed in the forecast
- A&E staffing pressures
- Additional capacity

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

Cash

The cash balance at the end of December is £35m, which is £17.4m higher than plan (£17.6m). In the main this relates to timing differences in the payment of trade creditors.

CIP

At 31st December, the Trust has delivered a CIP of £9.1m against a target of £9.9m year to date. There remain several high-risk schemes to be delivered (circa £3.2m) and £0.7m remains unidentified. Only £2.1m recurrent CIP has been identified presenting a risk to future sustainability.

Capital Programme

The Trust has a capital programme of £23m (£12.5m CDEL and £10.5m externally funded). At 31st December 2022, the year-to-date capital spend is £5.9m, a variance of £5.0m compared to plan of £10.9m. The Capital Planning Group continues to monitor any underspends or slippage of schemes and looks to bring forward any mandatory schemes from 2023/24 as necessary.

Table 3 provides a breakdown of capital expenditure by category

Table 3: Capital Expenditure by category as at 31 December 2022

	Annual Plan	Plan YTD	Actual YTD	Variance against Plan YTD
	£'000	£'000	£'000	£'000
Estates	7,794	6,472	4,635	1,837
IM&T	2,175	1,783	665	1,118
Medical Equipment	2,525	782	711	71
Contingency	-	-	- 512	512
Sub total	12,494	9,037	5,499	3,538
External Funded	10,524	1,850	426	1,424
Total	23,018	10,887	5,925	4,962

Table 4 highlights the current contingency and **Appendix 6** contains the updated Capital Programme.

Table 4: Capital Contingency

DETAIL	£'000	£'000
Contingency as at end of month 8		**150**
Capital request approved by Trust Board 30th November 2022		
Bath Street Lease	- 305	
Sub Total		- **305**
Contingency balance start of month 9		- **155**
Emergency capital request approved by the CFO & Deputy CEO		
Breast Screening Mobile Replacement	- 18	
Sub Total		- **18**
Contingency as at end of month 9		- **173**
Emergency capital request approved by the CFO & Deputy CEO up to 13 Jan 2023		
Replacement of Myosure Fluid Management System	- 32	
Replacement of grid for Xray Room 3	- 8	
Sub Total		- **40**
Capital changes/requests approved by FSC 18/01/2023		
Capital request from the Capital Planning Group (13 Jan 2023)		
Addendum to Ultrasound doors	- 4	
Audiology ABR replacement	- 10	
Digital Analytics Staffing	- 20	
Sub Total		- **34**
Capital change to plan from the Capital Planning Group (13 Jan 2023)		
EPR EPCMS - no longer required as external funding approved	205	
ED Plaza further underspend	138	
Mammography Equipment Replacement underspend	38	
Security - NEST/neonatal unit underspend	25	
Sub Total		**406**
Contingency as at 13 Jan 2023		**159**

<u>Capital Requests</u>

The Trust Board is asked to:

- Note the Capital requests of £40k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive
- Note the changes approved by the Finance and Sustainability Committee on behalf of the Trust Board as per the delegated authority as follows: -

- Note the funds requested from the Capital Planning Group (CPG) and supported by the January FSC for £34k
- Note the return of the EPR (£205k now funded), ED Plaza (£138k further underspend), Mammography equipment underspend (£38k) and Security for Neonatal unit (£25k) to the capital plan totalling £406k

2.6 NHSE Oversight Framework Changes to KPIs

In the November IPR there were 3 amendments which were due to take effect from January. These amendments are now in place. Therefore, the IPR has increased from 79 to 82. The indicators are set out in Table 5**.**

Table 5: Amendments to the IPR

Amendment	Detail	Rationale
New KPI (Oversight Metric 101)	**KPI Name:** Reduction in Outpatient Follow Ups **Target:** N/A **Amendment:** To include a specific KPI to outline the reduction in Outpatient follow up activity. The purpose of this is to measure the reduction in outpatient follow up appointments as per the operational planning guidance. Target: 75% or less based on 2019/20 activity.	Included as a new KPI on the 2022/23 NHSE Oversight Framework.
New KPI (Oversight Metric 10a)	**KPI Name:** COVID-19 Recovery Cancer First Treatment **Target:** N/A **New KPI:** The number of people each month who receive their first treatment for cancer compared to the equivalent month in 2019/20 adjusted for number of working days. Target: 100%	Included as a new KPI on the 2022/23 NHSE Oversight Framework.
New KPI (Oversight Metric 105)	**KPI Name:** % patients discharged to their usual place of residence. **Target:** No current threshold agreed.	Included as a new KPI on the 2022/23 NHSE Oversight Framework.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPI's 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
- Clinical Recovery Oversight Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive
2. Note the changes approved by the Finance and Sustainability Committee on behalf of the Trust Board as per the delegated authority set out in Section 2.5
3. Note the amendments to the KPIs set out in section 2.6
4. Note the contents of this report

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	QUALITY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
1	Incidents (over 40 days old)	0	0	Dec-22		0	Nov-22	P
2	Duty of Candour (serious incidents)	100.00%	100.00%	Dec-22		100%	Nov-22	P
3	Healthcare Acquired Infections - MRSA	0	0	Dec-22		0	Nov-22	?
4	Healthcare Acquired Infections – CDI	Less than 37 for 2022/23	9	Dec-22		2	Nov-22	No SPC
5	Healthcare Acquired Infections – Gram Negative (E.coli)	Less than 57 for 2022/23	6	Dec-22		7	Nov-22	No SPC
6	Healthcare Acquired Infections - COVID-19 Outbreaks	N/A	2	Dec-22	No SPC	1	Nov-22	No SPC
7	VTE Assessment	95.00%	95.31%	Dec-22		92.78%	Nov-22	?
8	Inpatient Falls & Harm Levels	20.00% annual reduction based on 590 in 2021/22	53	Dec-22		39	Nov-22	No SPC
9	Pressure Ulcers (Total)	10.00% reduction based on 91 in 2021/22	12	Dec-22		7	Nov-22	No SPC
10	Medication Safety (24 Hours)	80.00%	49.00%	Dec-22		57.00%	Nov-22	F

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11	Staffing – Average Fill Rate (Combined)	90.00%	85.35%	Dec-22	No SPC	82.50%	Nov-22	No SPC
12	Staffing – Care Hours Per Patient Day	7.9	6.8	Dec-22		7.1	Nov-22	F
13	Mortality ratio - HSMR	N/A	93.04	Dec-22	No SPC	92.42	Nov-22	No SPC
14	Mortality ratio - SHMI	N/A	97.86	Dec-22	No SPC	97.86	Nov-22	No SPC
15	NICE Compliance	90.00%	92.61%	Dec-22	H	92.42%	Nov-22	P
16	Complaints (open over 6 months)	0	0	Dec-22		0	Nov-22	P
17	Friends & Family – Inpatients & Day cases	95.00%	95.00%	Dec-22	No SPC	96.00%	Nov-22	P
18	Friends & Family – ED and UCC	87.00%	66.00%	Dec-22	No SPC	71.00%	Nov-22	F
19	Mixed Sex Accommodation Breaches (Non ITU Breaches Only)	0	0	Dec-22	No SPC	0	Nov-22	P
20	Continuity of Carer	51.00%	81.30%	Dec-22	H	82.40%	Nov-22	P

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21	Sepsis - % screening for all emergency within 1 hour.	90.00%	61.00%	Dec-22	No SPC	64.00%	Nov-22	F
22	Sepsis - % screening for all inpatients within 1 hour.	90.00%	84.00%	Dec-22	No SPC	66.00%	Nov-22	?
23	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.	90.00%	76.00%	Dec-22	No SPC	58.00%	Nov-22	F
24	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.	90.00%	88.00%	Dec-22	No SPC	83.00%	Nov-22	F
25	Ward Moves between 10:00pm and 06:00am	N/A	91.00	Dec-22	No SPC	N/A	N/A	No SPC
26	Number of Hospital Acquired Acute Kidney Injuries	Less than previous month	221	Dec-22	No SPC	193	Nov-22	No SPC
27	Number of CAS Alerts Actions Breached	0	0	Dec-22		0	Nov-22	P

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
28	Diagnostic Waiting Times 6 Weeks	99.00%	71.07%	Dec-22	H	75.91%	Nov-22	F
29	RTT - Open Pathways (18 Weeks)	92.00%	57.30%	Dec-22	L	60.62%	Nov-22	F
58	RTT – Number of Patients Waiting 78+ Weeks	0	229.00	Dec-22	No SPC	199	Nov-22	No SPC
30	RTT – Number of Patients Waiting 104+ Weeks	0	2	Dec-22		0	Nov-22	F
31	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	95.00%	55.34%	Dec-22	L	63.80%	Nov-22	F
32	A&E Waiting Times – ICS Trajectory	Trajectory TBC for 2022/23			No SPC			No SPC
33	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2.00% or less	23.90%	Dec-22	No SPC	19.64%	Nov-22	No SPC
34	Average time in department ED (mins)	N/A	478	Dec-22	No SPC	387	Nov-22	No SPC
35	Cancer 14 Days*	93.00%	88.44%	Nov-22		89.20%	Oct-22	F
36	Breast Symptoms 14 Days*	93.00%	100.00%	Nov-22		97.92%	Oct-22	?

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37	Cancer 28 Day Faster Diagnostic*	75.00%	70.69%	Nov-22		71.72%	Oct-22	
38	Cancer 31 Days First Treatment*	96.00%	97.70%	Nov-22		98.53%	Oct-22	
39	Cancer 31 Days Subsequent Surgery*	94.00%	100.00%	Nov-22		100.00%	Oct-22	
40	Cancer 31 Days Subsequent Drug*	98.00%	100.00%	Nov-22		100.00%	Oct-22	
41	Cancer 62 Days Urgent*	85.00%	69.57%	Nov-22		70.43%	Oct-22	
42	Cancer 62 Days Screening*	90.00%	100.00%	Nov-22		100.00%	Oct-22	
43	Ambulance Handovers within 15 minutes	65.00%	12.91%	Dec-22		21.93%	Nov-22	
44	Ambulance Handovers within 30 minutes	95.00%	33.66%	Dec-22		42.52%	Nov-22	
45	Ambulance Handovers within 60 minutes	100%	50.95%	Dec-22		59.07%	Nov-22	
46	Discharge Summaries - % sent within 24hrs	95.00%	85.72%	Dec-22		87.03%	Nov-22	
47	Discharge Summaries – Number NOT sent within 7 days	0	156	Dec-22		214	Nov-22	

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48	Cancelled Operations on the day for a non-clinical reasons	Please note: Validation for this indicators was in progress at the time of reporting.						No SPC
49	Cancelled Operations– Not offered a date for readmission within 28 days							No SPC
50	Urgent Operations – Cancelled for a 2nd time	0	0	Dec-22		0	Nov-22	P
51	Super Stranded Patients	Trajectory TBC for 2022/23	145	Dec-22	H	138	Nov-22	No SPC
52	COVID-19 Recovery Elective (Inpatient/Daycase) - (Average)	104%	85.07%	Dec-22	No SPC	85.07%	Nov-22	No SPC
53	COVID-19 Recovery Diagnostic Activity - (Average)	104%	111.27%	Dec-22	No SPC	111.27%	Nov-22	No SPC
54	COVID-19 Recovery Outpatient Activity	104%	87.68%	Dec-22	No SPC	94.79%	Nov-22	No SPC
55	% Outpatient Appointments delivered remotely	25.00%	11.34%	Dec-22	L	12.45%	Nov-22	F
56	% of Patients seen in the fracture clinic within 72 hours	95.00%	8.16%	Dec-22		4.95%	Nov-22	F
57	% patients referred to long COVID service not assessed within 15 weeks	N/A	0	Dec-22	No SPC	0	Nov-22	No SPC
59	% of zero-day length of stay admissions (as a proportion of total)	N/A	85%	Dec-22	No SPC	83%	Nov-22	No SPC
80	Reduction in Outpatient Follow Ups	N/A	83%	Dec-22	No SPC	90%	Nov-22	No SPC

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81	COVID-19 Recovery Cancer First Treatment	N/A	0%	Dec-22	No SPC	0%	Nov-22	No SPC
82	% Patients discharged to their usual place of residence	N/A	96%	Dec-22	No SPC	94%	Nov-22	No SPC

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
60	Supporting Attendance	4.20%	7.29%	Dec-22		5.81%	Nov-22	F
61	Welcome Back Conversations	85.00%	69.55%	Dec-22	L	78.79%	Nov-22	F
62	Recruitment Time to Hire (Days)	65	96	Dec-22		86	Nov-22	F
63	Vacancy Rates	9.00%	11.86%	Dec-22	H	11.63%	Nov-22	F
64	Retention	86.00%	83.59%	Dec-22	L	83.43%	Nov-22	F
65	Turnover	13.00%	15.78%	Dec-22		15.97%	Nov-22	F
66	Bank & Agency Reliance	9.00%	16.67%	Dec-22		18.20%	Nov-22	F
67	Monthly Pay Spend (Contracted & Non-Contracted)	£19,273,413.00	£18,335,127.97	Dec-22		£19,671,138.31	Nov-22	?

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68	Core/Mandatory Training	85.00%	85.16%	Dec-22	H	84.68%	Nov-22	P
69	Role Specific Training	85.00%	86.45%	Dec-22	No SPC	88.16%	Nov-22	P
70	Safeguarding Training	83.00%	71.28%	Dec-22	No SPC	70.59%	Nov-22	No SPC
71	% Workforce carrying out an Apprenticeship Qualification	2.30%	3.08%	Dec-22	No SPC	2.93%	Nov-22	P
72	PDR Compliance	79.00%	62.43%	Dec-22		63.23%	Nov-22	?

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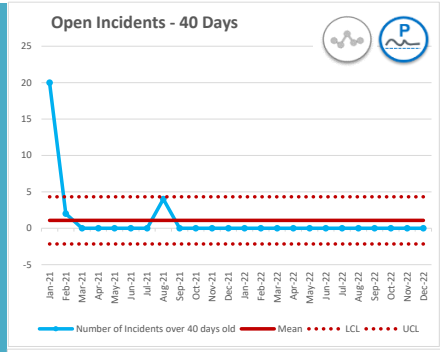
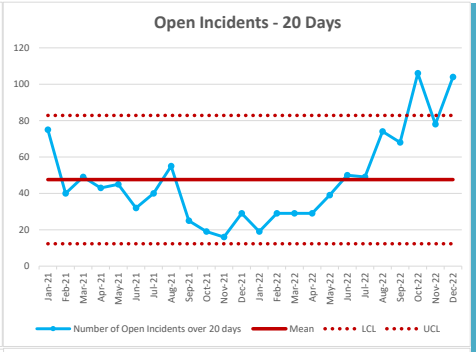
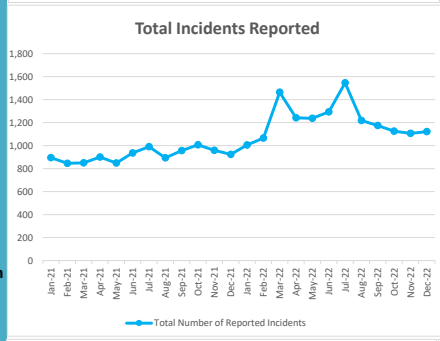
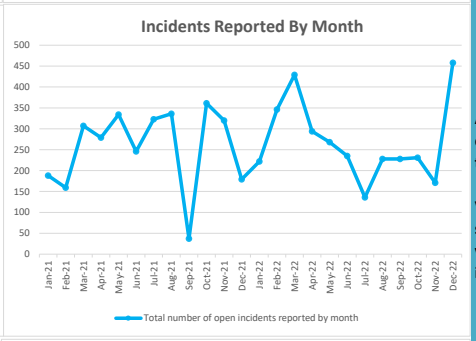
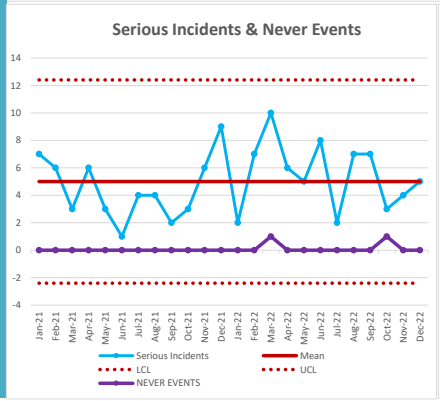
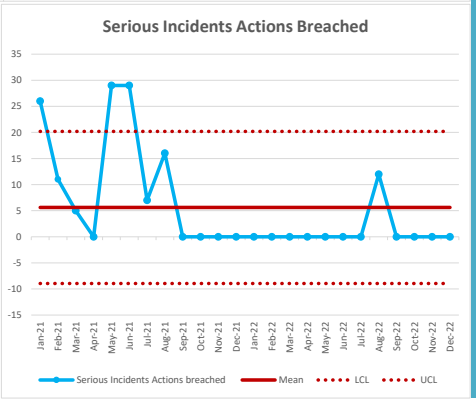
*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
73	Trust Financial Position £m (Cumulative)	-8.25	-8.25	Dec-22		-8.10	Nov-22	
74	Cash Balance £m	17.61	34.99	Dec-22		37.22	Nov-22	
75	Capital Programme Spend £m (Cumulative)	10.887	5.93	Dec-22	No SPC	5.48	Nov-22	
76	Better Payment Practice Code (Cumulative)	95%	92%	Dec-22		92%	Nov-22	
77	Use of Resources Rating	Please note: This indicator is currently suspended. The Trust is awaiting further guidance from NHSE/I.						No SPC
78	Cost Improvement Programme – Performance (Recurrent and Non-recurrent delivered) £m	2.10	2.10	Dec-22	No SPC	1.20	Nov-22	No SPC
79	Cost Improvement Programme – Forecast (Recurrent) £m	6.50	2.10	Dec-22	No SPC	N/A	N/A	No SPC

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 **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**				
There were 0 incidents over 40 days old and 104 incidents open over 20 days old. These have all had a first review and have been sent to the relevant department, no concerns noted with those over 20 days.		**Assurance: The Trust consistently passes the target.** **Variation: There is special cause variation of an improving nature.**	**Incident reporting remains within range with little variance .**	**Close weekly monitoring of incident reporting Trust wide, CBU and speciality specific continues. A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting with further assurances provided to Quality Assurance Committee and Patient Safety and Clinical Effectiveness Sub Committee.**
				
			**There are 0 overdue 40-day incidents.**	**Weekly CBU monitoring supports with timely escalation to the Associate Director of Governance to ensure the zero over 40 days is maintained.**
				
			**There were 5 serious incidents reported in December 2022 an increase of 1 compared to the previous month.**	**This is within statistical control**
			**There were 0 breached serious incident actions in December 2022.**	**Weekly monitoring continues with appropriate escalation to the CBU leads.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

System Oversight Framework (SOF)

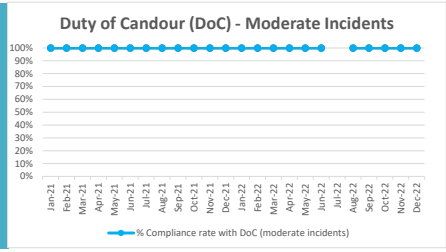
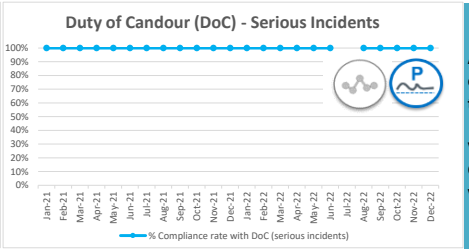
Care Quality Commission (CQC)

Risk Register (RR115)

Trust Strategy

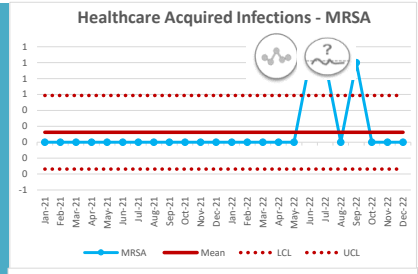
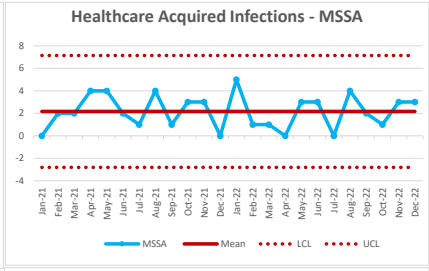
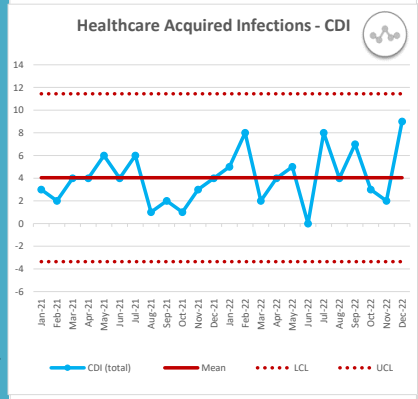
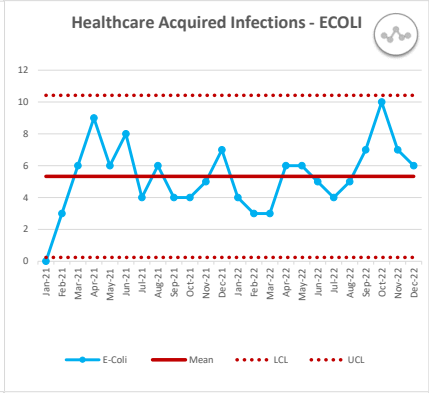
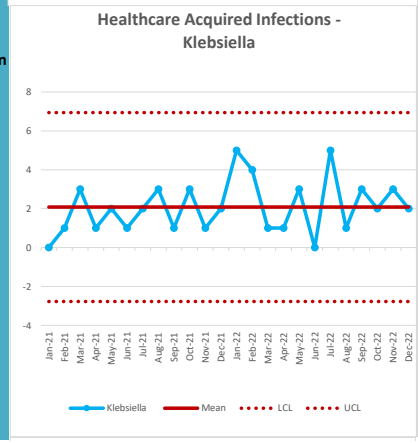
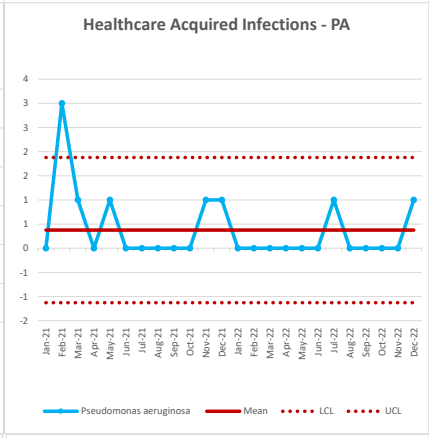
Quality Improvement - Trust Position

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)?
2. Duty of Candour **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.**	**Robust weekly monitoring is undertaken by the Patient Safety Manager to ensure compliance is maintained.**

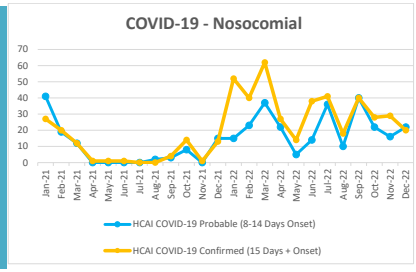
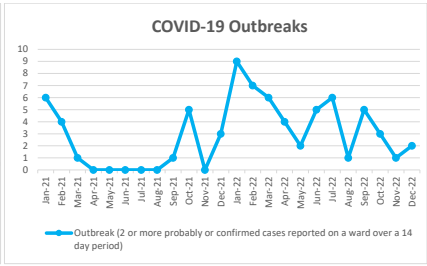
Quality Improvement - Trust Position

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 3 cases YTD, this is over threshold MSSA 19 cases YTD - no threshold set			(MRSA) Assurance: The Trust inconsistently passes/fails the target. (MRSA) Variation: Special Cause Variation of a concerning nature.	Case 1 (A8) - highly likely urinary tract infection associated and considered avoidable. Case 2 (C23) - household contact, considered unavoidable. Case 3 (A2) - considered unavoidable. All cases awaiting review meeting with the commissioning team.	Drive compliance with ANTT training and competency assessments, audit compliance with MRSA admission screening.
4. Healthcare Acquired Infections (CDI) Target: Less than 37 -annual	CDI 42 cases YTD, above in year trajectory.			(CDI) Assurance: N/A Annual Target (CDI) Variation: Common Cause (Normal) variation.	Higher incidence of C. difficile across the North West which NHSE are reviewing. Increase in antibiotic prescribing associated with respiratory infections following Covid-19/influenza	CDI prevention action plan in place. RCA investigations & review meetings will continue, approach will be aligned to PSIRF, SIGHT mnomonic education will continue, review of approach to auditing hand hygiene with NHSE
5. Healthcare Acquired Infections (Ecoli) Target: less than 57 - annual (Klebsiella) Target: Less than 19 - annual (PA) Target: Less than 6 - annual	E. coli 56 cases YTD 1 case under the annual thershold) Klebsiella spp. 20 cases YTD (1 case over annual threshold) P. aeruginosa 2 cases YTD (within trajectory).			(ECOLI) Assurance: N/A Annual Target (ECOLI) Variation: Common Cause (Normal) variation.	The change in the apportionment rule to include COHA cases has increased the number of GNBSI cases apportioned to the Trust.	Audit hepatobiliary cases, revise GNBSI RCA template and re-introduce RCA investigation of hospital onset cases - aligning approach to PSIRF, review urinary catheter use nd protocol for nurse led removal, focus support on wards with higher cases align to o Food and Drink Strategy
6. Healthcare	Covid-19: 188 day 8-14 cases probable healthcare associated cases YTD 255 day 15+ cases definite healthcare associated YTD 4 COVID-19 outbreak in month					

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)?
6. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)	RR1275			N/A - No target.	Implementation of revised national approach to testing. Admission, day 3 and day 5 testing paused.	Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients, staff and visitors. Respiratory infection (including influenza ward escalation plans for winter pressures in place). The national requirements to report Covid-19 outbreaks remains in place

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

System Oversight Framework — SOF

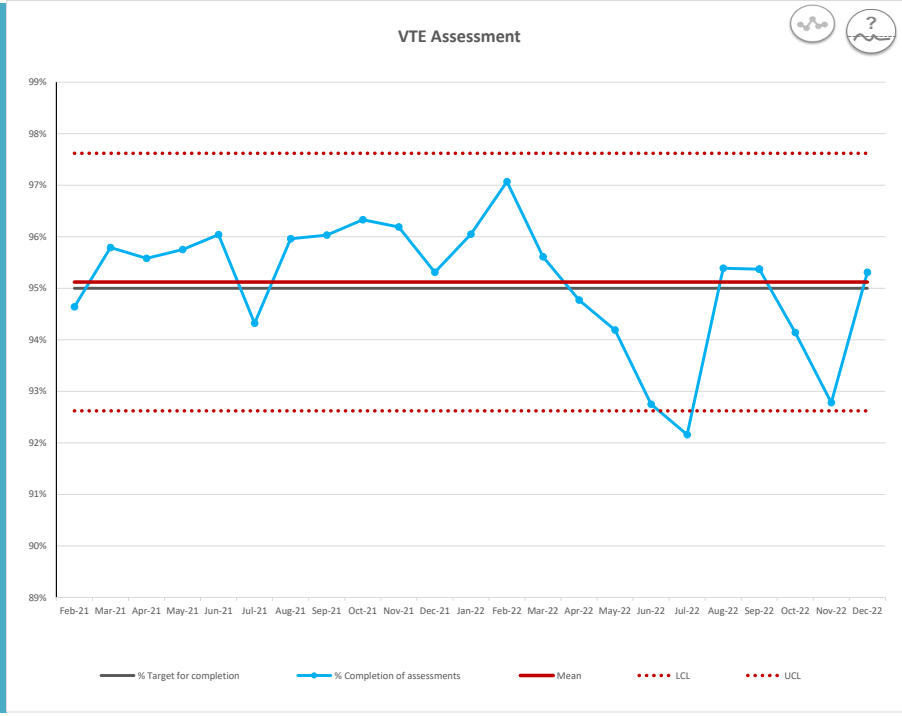
Care Quality Commission — CQC

Risk Register — RR11S

Trust Strategy — S

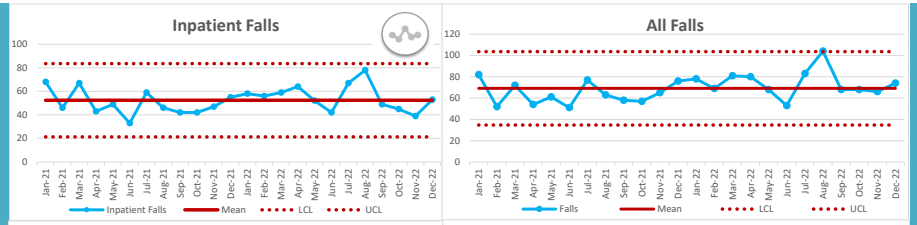
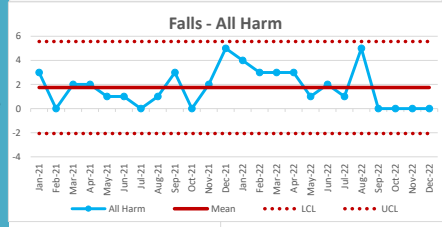
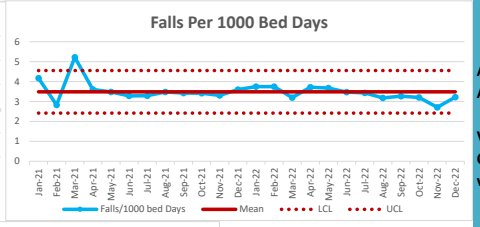
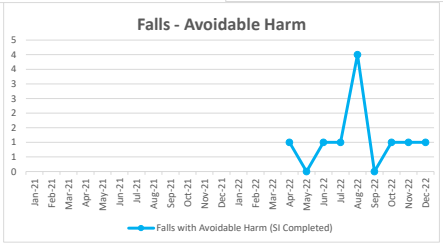
Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
7. VTE Assessment **Target: 95% (quarterly position)** SOF S **The Trust achieved the required target at 95.31% for VTE assessments in December 2022.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special cause variation of a concerning nature.**	**Year to date performance from April 2022 has been on track at 95.37 %.** **There was under reported VTE RA figures last month due to the change in data collection methods within WHH data warehouse which now has been rectified.**	**Current systems in place to improve VTE compliance:** **1. Inconsistent use of the standardised RWW CDC initial clinical assessment and ward round forms within the surgical specialties although the senior signed off before relaunch in August 2022.** **2. Monthly CBU VTE RA compliance data with the breakdown at ward level has been distributed to all CBU governance meetings with October compliance data for CBU to analyse the data for feedback with improvement plans** **3. Continue to raise awareness of the need for VTE completion with the changeover of junior doctors into 2nd 4 month placement.** **Future proactive approach/plan to improve VTE compliance within 14 hours of admission:** **1. To get the feedback from all CBUs how to improve future CBU VTE risk assessment compliance** **2. To add VTE risk assessment data to be visible at the ward level for ownership of overall VTE compliance. This was endorsed by PSCESC as an one of the improvement plans based on VTE report.**

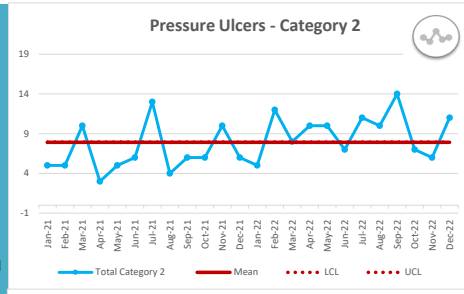
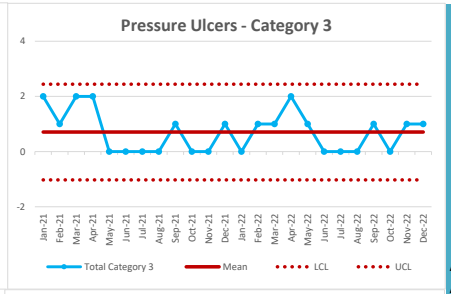
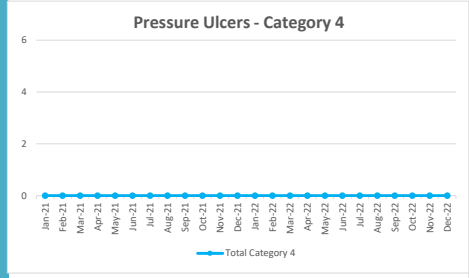
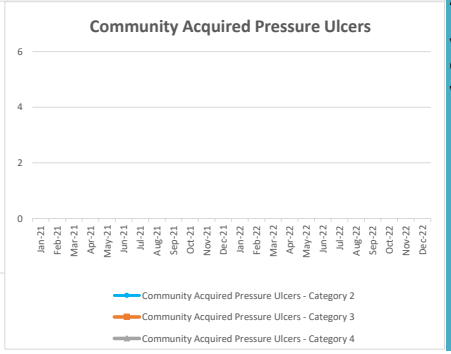
Quality Improvement - Trust Position

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)?
8. Inpatient Falls & harm levels **Target: 20% or more decrease from 21/22 (590 Inpatient Falls in 2021/22)** **74 total falls were reported in December 2022. 53 of these were inpatient falls. There were 0 inpatient falls with harm for December.**	   	**Assurance: N/A Annual Target.** **Variation: Common Cause (Normal) variation.**	**The number of inpatient falls for December remain within normal variation. The main contributory factor was reported to be the increase in the need to provide enhanced care, as a result of higher numbers of patients with 'no right to reside', increased escalation beds open and spike in sickness absence which challenged ward staffing.**	**Actions to improve the position include:** **1. Falls link nurse meetings will restart in early 2023** **2. Trust documentation for falls is all within the Lorenzo system to support the clinical teams with access** **3. Falls are discussed at the Weekly Harm Free Care meeting, with feedback and learning shared across the ward teams** **4. Quality Improvement work with the clinical teams continues** **5. Senior oversight from the Associate Chief Nurses is in place with individual action plans monitored for areas of higher risk**

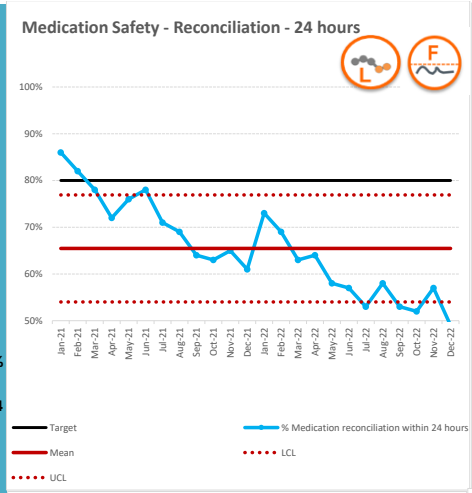
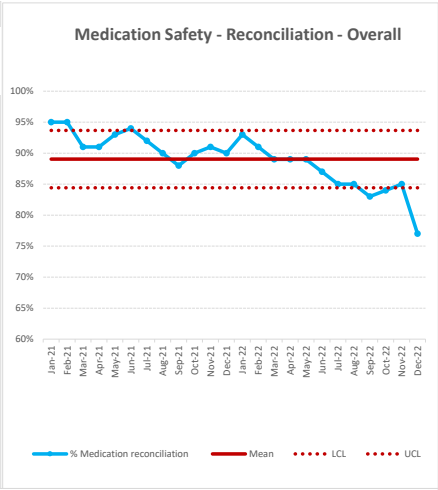
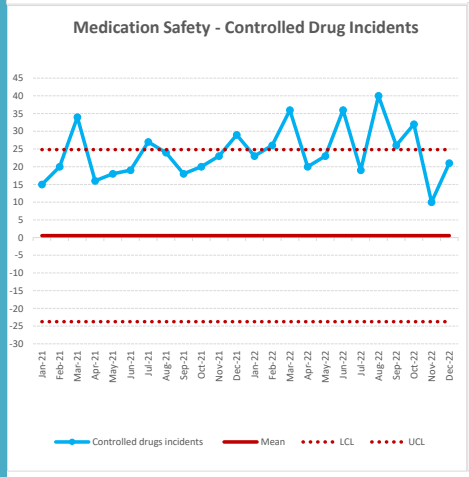
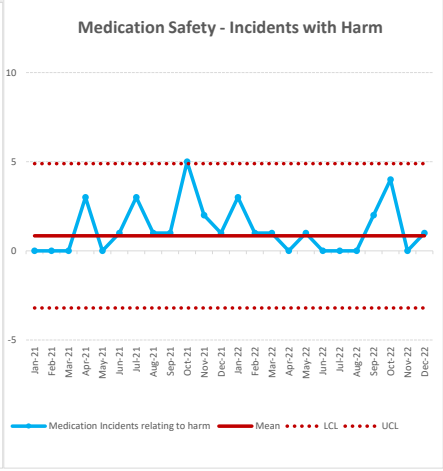
Quality Improvement - Trust Position

Appendix 2

Trust Performance	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)?
9. Pressure Ulcers Target: 10% reduction based on 91 in 2021/22 There were 11 hospital acquired category 2 pressure ulcers and 1 unstageable pressure ulcer in December 2022.	   	Assurance: N/A Annual Target. Variation: Common Cause (Normal) variation.	Prolonged length of time on trolleys in the Emergency Department continues to be a contributory factor. Delay in upgrading to pressure relieving mattresses and medical devices have also been identified as a reason for pressure ulcer development. The unstageable pressure ulcer was related to a plaster of paris cast.	Actions to improve performance include: 1. The Tissue Viability team have an increased presence in ED 2. The QI team have an engagement programme with the Matrons to follow up on actions from the pressure ulcer prevention study day 3. Senior clinical oversight is provided by the Associate Chief Nurses with action plans for areas of higher incidence 4. Face to face pressure ulcer prevention training is held monthly, the Tissue Viability Team also provide training on a monthly basis for preceptorship and international nurses.

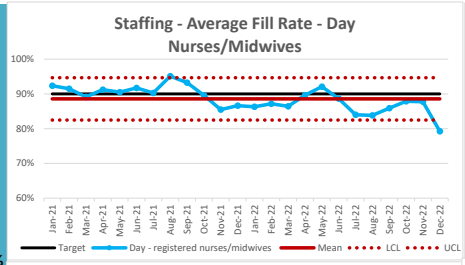
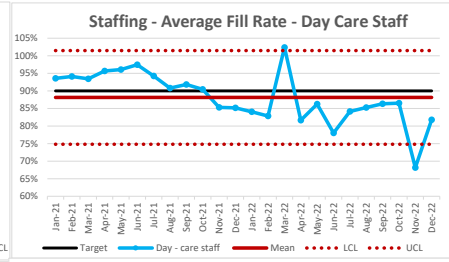
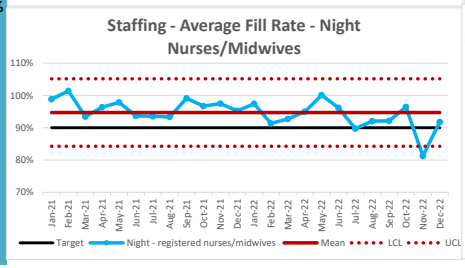
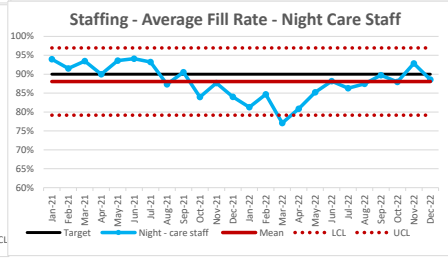
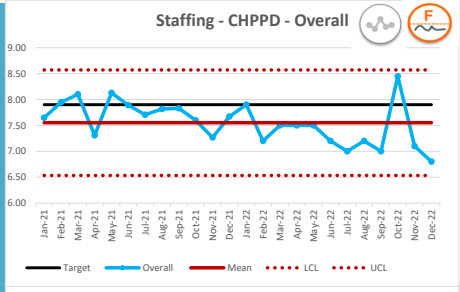
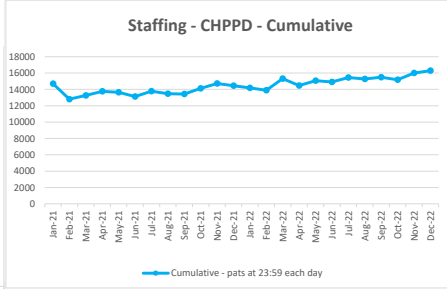
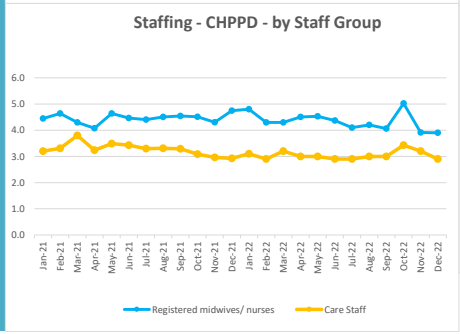
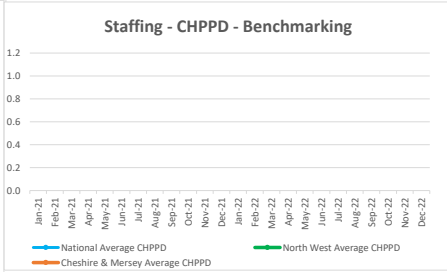
Quality Improvement - Trust Position

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. Medication Safety Reconciliation within 24 hours Target: 80%	**The Trust achieved 49% for medicines reconciliation within 24 hours and 77% for overall medicines reconciliation.** **There were 21 controlled drug incidents.** **There were 1 medication harm incidents reported in December.**	   	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**Performance outwith national targets continues to be adversely impacted by pharmacy workforce issues. Currently only 59% of established pharmacist posts filled.** **There is no target for this metric. The most common type of incident was administration error (n=4), followed by dispensing error (n=3), running balance error for liquids (n=3). No themes in the reported incidents were identified.** **There is no target for this metric.**	**Ongoing recruitment campaign and locum support.** **Monthly self-assessment and quarterly CD audits are undertaken. Themes identified and addressed with specific action plans. Support given to areas with poor compliance.** **All medication incidents reviewed by governance and pharmacy team and lessons learned shared within the organisation.**

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)?
11. Staffing - Average Fill Rate Target: 90%	**In December 2022, the average staffing fill rates were:** **Day (Nurses/Midwife) 79.25%** **Day (Care Staff) 81.78%** **Night (Nurses/Midwife) 91.77%** **Night (Care Staff) 88.59%** RR11s RR110s	   	**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**The reason for the reduction in fill rates for December is due to additional beds in use across the Trust as a result of increased demand in ED and higher numbers of patients with 'no right to reside'. In addition a spike in staff sickness absences was reported in December.**	**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. Vacancy trends are monitored through the Trust Workforce Review Group. Recruitment and retention plans are in place and overseas recruitment programmes continue. The Workforce Team work with the Trust Communication Team to create campaigns for hard to recruit areas. Bi-weekly shortlisting and interviews continue. Additional resource has been added to recruitment to reduce time to post and additional resource.**
12. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	**In December 2022, the average CHPPD were:** **Nurse/Midwife: 3.9 hours** **Care Staff: 2.9 hours** **Overall: 6.8 hours**	   	**Assurance: The Trust consistently fails to hit the target.** **Variation: Special Cause Variation of a Concerning Nature.**	**The decreased CHPPD data for December is due to the increase in escalation beds open as a result of higher numbers of patients in ED and the number of patients with 'no right to reside'. A spike in sickness absence is reported for December which has contributed to the overall reduction in total CHPPD.**	**Staff are moved across the Trust to areas of greater need which is reviewed twice daily by the senior nursing team. Vacancy trends are monitored through the Trust Workforce Review Group. Temporary staff are utilised when required. Recruitment and retention plans are in place and overseas recruitment programmes continue. The Workforce Team work with the Trust Communication Team to create campaigns for hard to recruit areas.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

System Oversight Framework (SOF)

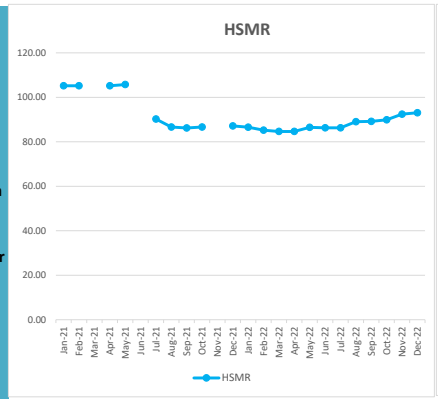
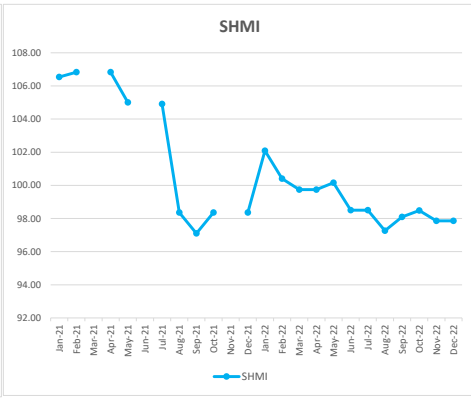
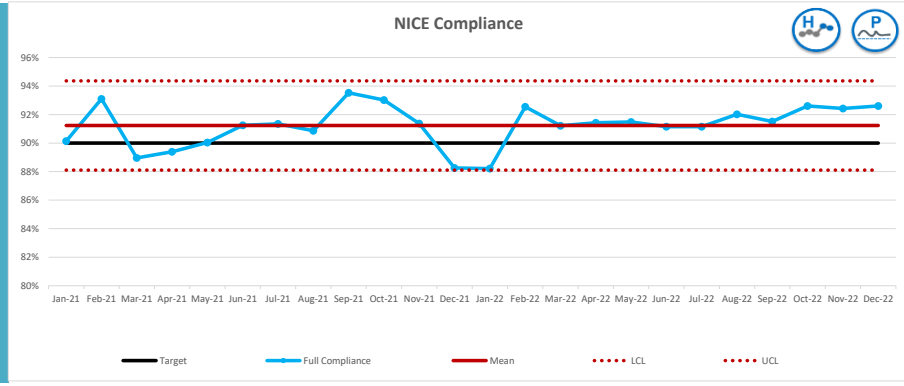
Care Quality Commission (CQC)

Risk Register (RR115)

Trust Strategy

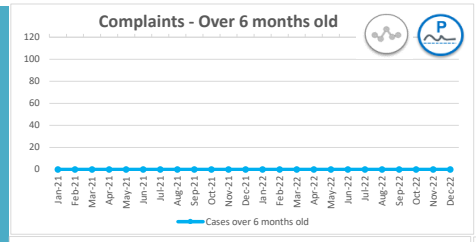
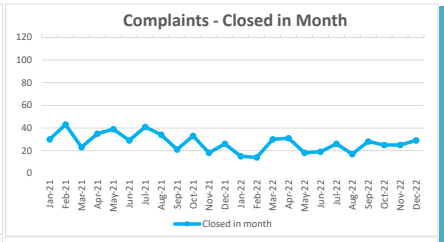
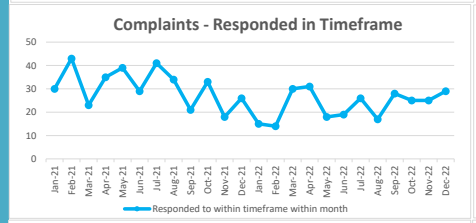
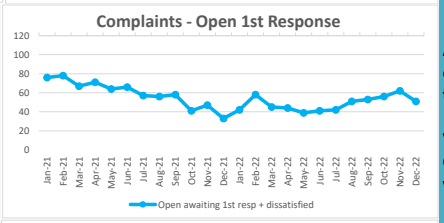
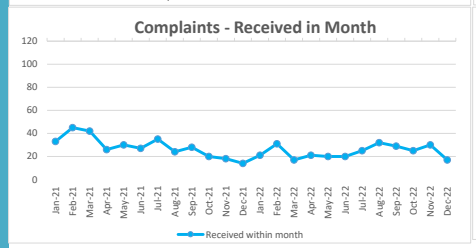
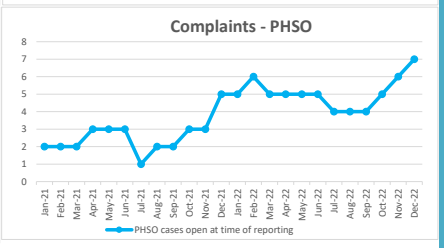
Quality Improvement - Trust Position

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)?
13. Mortality ratio - HSMR Target: Plan 14. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 93.04. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 97.86.	 	N/A - No SPC/Target	No variation. HSMR and SHMI remain within expected range. NB: The gaps in the SPC relate to the time peroids whereby our external provider (HED) did not produce a report with the HSMR/SHMI.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning.
15. NICE Compliance Target: 90%	The Trust achieved 92.61% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	The Trust has met the target of achieving over 90% compliance.	The Clinical Effectiveness Team has sent updated action plans to the CBU for feedback to assess the current position of partial compliance actions. A new Clinical Effectiveness Manager is now in post and will support and monitor the progression of recommended actions.

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)?
In December, 17 new complaints were received to the Trust which was a decrease of -13 from the previous month. There were 3 dissatisfied complaints received in month, which is an increase from the previous month.	     	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues its performance in the timeliness of responding to complaints. There continue to be no complaints over 6 months old, and all complaints are currently within date.	All complaints continue to be monitored to ensure a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. The Complaints Team continues to share the Complaints Toolkit with the CBU's to support with investigating and responding to complaints appropriately.

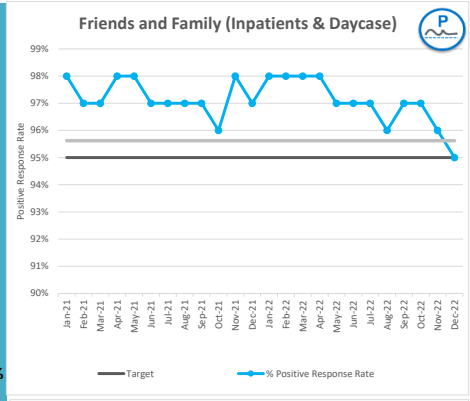
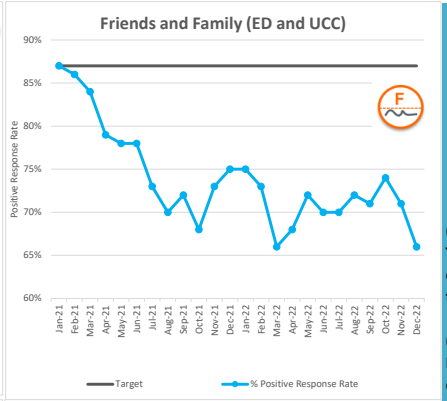
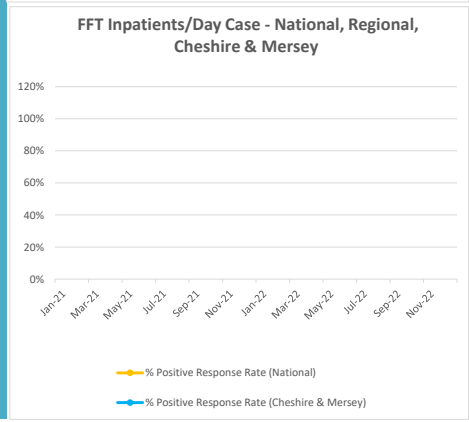
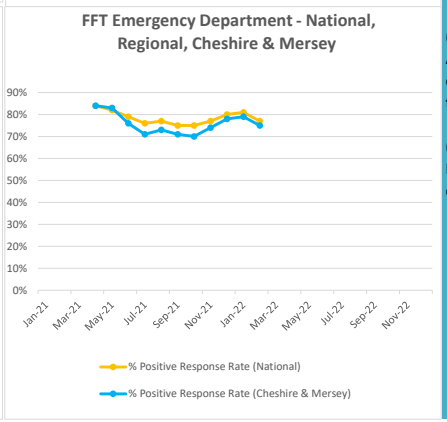
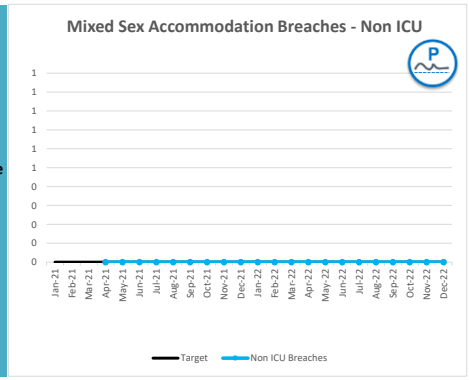
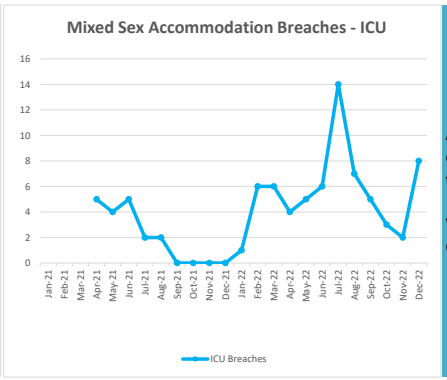
16. Complaints Target: Zero complaints open over 6 months old/in the backlog.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework (SOF)
Care Quality Commission (CQC)
Risk Register (RR115)
Trust Strategy (S)

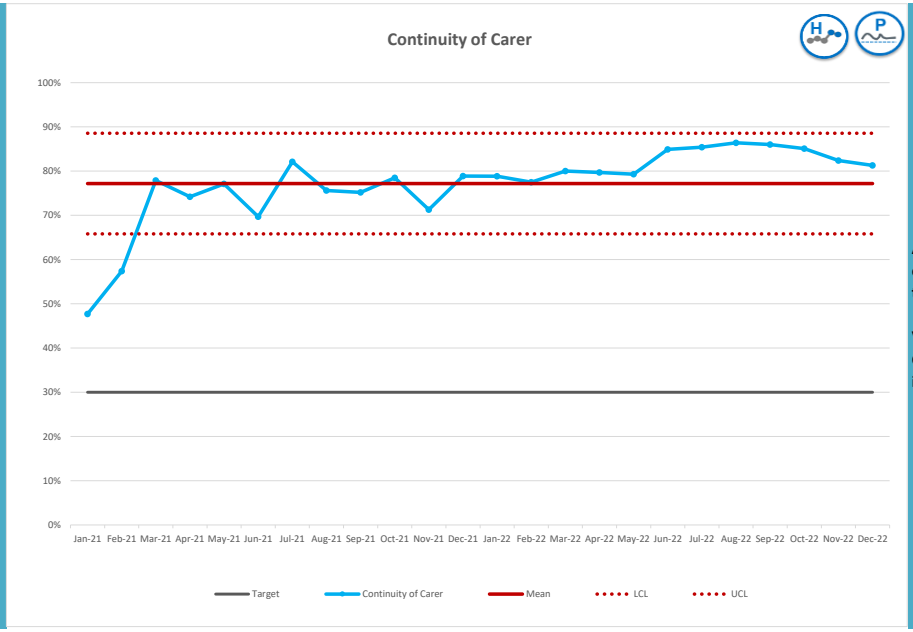
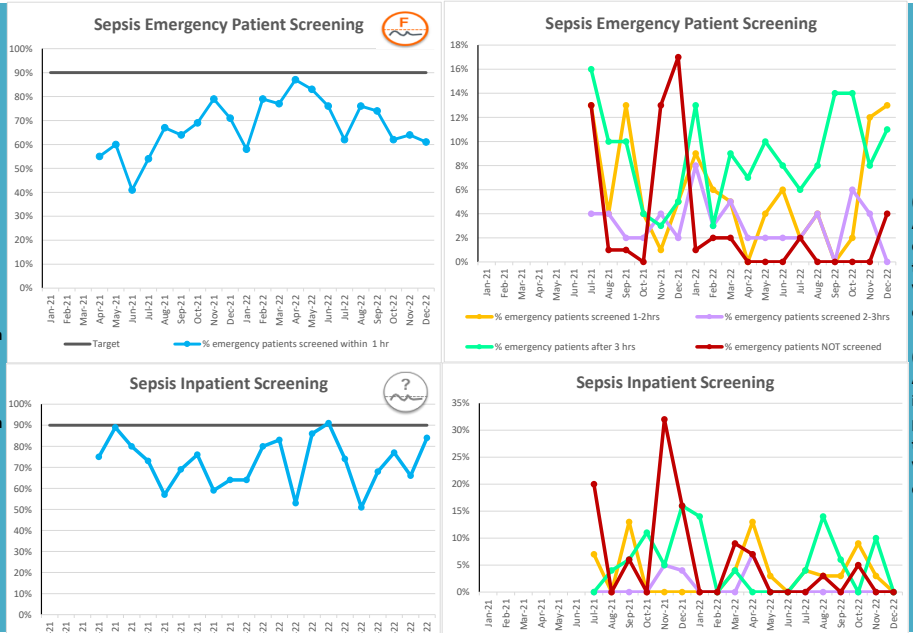
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
17. Friends and Family (Inpatients & Day cases) Target: 95% 18. Friends and Family (ED and UCC) Target: 87%	The Trust achieved 95% in month for Inpatient & Day case FFT and 66% for ED/UCC FFT.	   	(IP/DC) Assurance: The Trust consistently passes the target. (IP/DC) Variation: N/A - Not enough datapoints. (ED/UCC) Assurance: The Trust consistently fails the target. (ED/UCC) Variation: N/A - Not enough datapoints	ED/UCC - The Trust achieved 66.00% positive feedback in Friends and Family Test results in December 2022 which is a 5% decrease from the previous month. Recent data published in November 2022 relating to ED FFT performance across the Cheshire and Merseyside footprint reports an average positive recommendation rate of 74%. Inpatient/Day Case - The Trust achieved 95.00% positive recommendation rate in December 2022.	ED/UCC - Key themes for improvement in relation to positive recommendation rates are largely attributed to communication and extended wait times. This is perpetuated by the super stranded postition, operational pressures within the Trust and the increased attendees within the department. Measures taken in month to improve include but are not limited to: - Volunteer role fully embedded into the department assisting in nutrition and hydration and holistic needs of patients in the department - Trust wide Helping Hands programme - Enhanced corridor care support over Christmas and New Year period Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients.
19. Mixed Sex Accommodation Breaches (Non ITU Only) Target: Zero	There were 0 mixed sex accommodation incidents outside of the ITU during December 2022. There were 8 MSA incidents within the ITU.	 	Assurance: The Trust consistently passes the target. Variation: N/A - not enough datapoints.	There were 8 mixed sex accommodation breach reported in December 2022 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, this has been impacted by the increased escalation beds in use across the Trust. 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 patients with 'no right to reside' in the Trust bedbase.

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. Continuity of Carer Target: 51%	In December 2022, 100% of Warrington & Halton women are booked onto a MCoC pathway, if 'out of area' bookings are included the figure is 81.3% as we cannot provide the postnatal aspect of the pathway. 18 BME women were booked, those in area were booked onto MCoC pathway, four live out of area and were therefore not booked on a CoC pathway. (SOF)		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	The Trust achieved 81.3% onto a CoC pathway (including intrapartum care) in December 2022. This figure varies month on month as it is impacted by the number of women who are "out of area" being booked for care at WHH.	WHH continues to work towards ensuring women booked on a pathway receive continuity across the pathway. Updated national guidance was published in October has removed all national targets for MCoC. As a result and in light of other staffing pressures WHH is reviewing our model of care.
21. Sepsis - % screening for all emergency patients. Target: 90% 22. Sepsis - % screening for all inpatients Target: 90%	The Trust achieved: • 61% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 84% screening for all inpatients with suspected sepsis within 1 hour.		(Emergency) Assurance: The Trust consistently fails the target. Variation: N/A - Not enough datapoints (Inpatient) Assurance: The Trust inconsistently passes/fails the target. Variation: N/A - Not enough datapoints.	The significant ongoing challenge of increased attendances in the Emergency Department and delays through into the main hospital has contributed to the inability to screen all patients with suspected sespis within 1 hour. An improvement is noted for inpatient screening.	Education sessions continue to support staff, a full review of the Sepsis pathway will be undertaken Q4 with a new Task and Finish Group which includes the Medical Lead for Sepsis. Quality Improvement support in place to drive improvements across the Trust. Sepsis management remains a focus on Safety Huddles.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

System Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

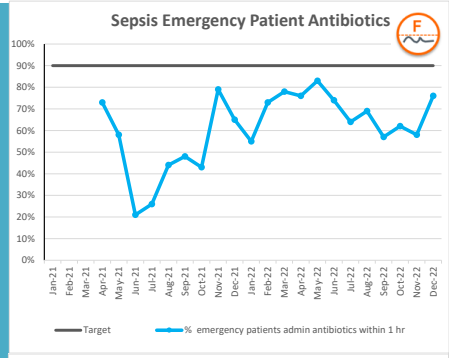
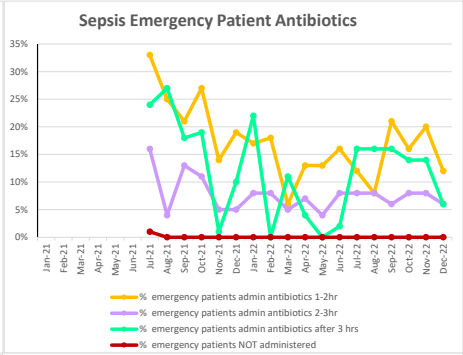
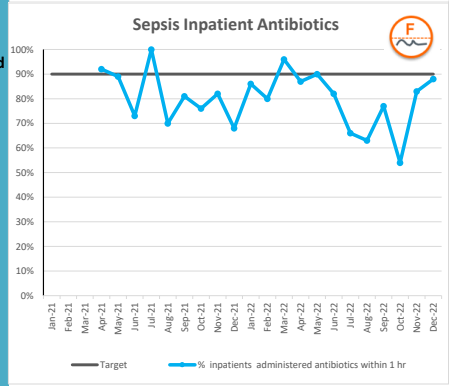
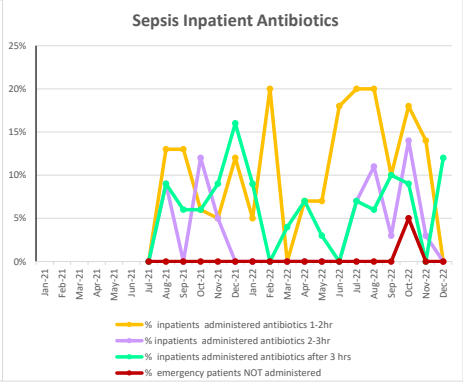
Quality Improvement - Trust Position

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)?
				

Quality Improvement - Trust Position

Appendix 2

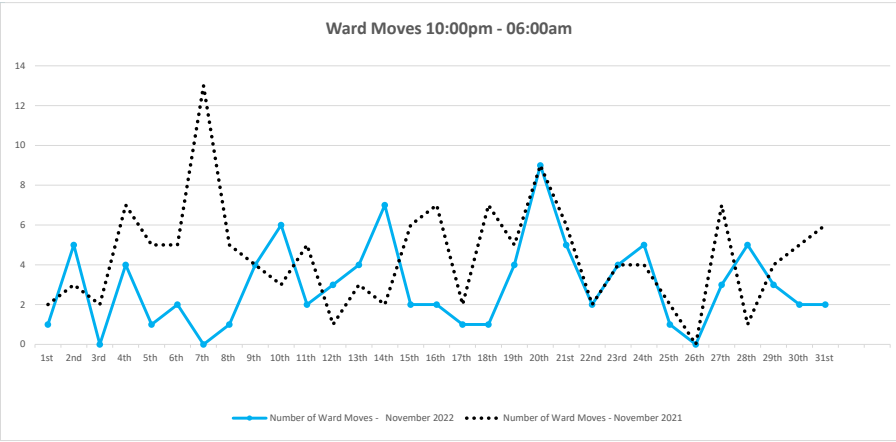
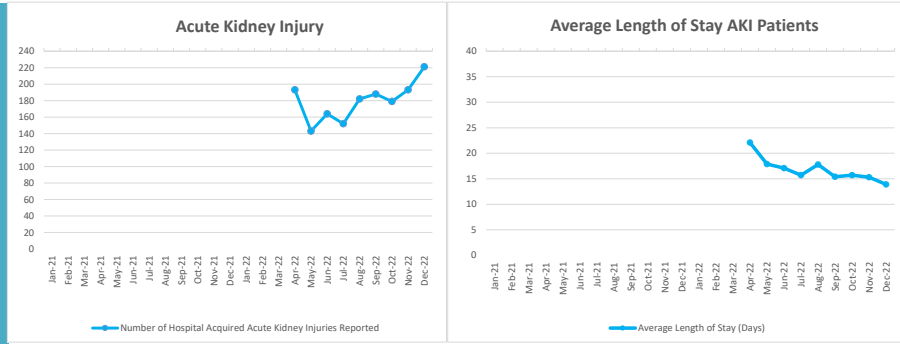
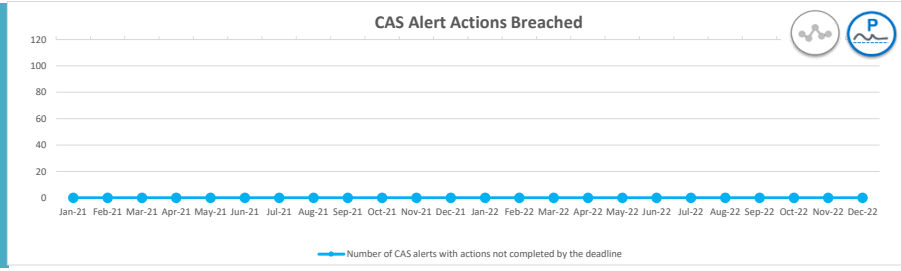
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag Target: 90% **24. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis Target: 90%** **The Trust achieved:** **• 76% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 88% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	   	**(Emergency)** **Assurance: The Trust consistently fails the target.** **Variation: N/A - Not enough datapoints** **(Inpatient)** **Assurance: The Trust inconsistently passes/fails the target.** **Variation: N/A - Not enough datapoints.**	**An improvement is noted in the administration of antibiotics within 1 hour for both emergency and inpatients. The increased number of attendances to the Emergency Department continues to contribute to the inability to administer antibiotics within an hour in the Emergency Department.**	**The Patient Safety Nurses review NEWS 2 scores for inpatients to support the wards to recognise symptoms of sepsis. Senior Nursing Teams reinforce the importance of sepsis recognition across the clinical areas. A full review of the Sepsis pathway will be undertaken in Q4 with support from QI and the Medical Lead for Sepsis.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework (SOF)
Care Quality Commission (CQC)
Risk Register (RR115)
Trust Strategy (S)

Quality Improvement - Trust Position

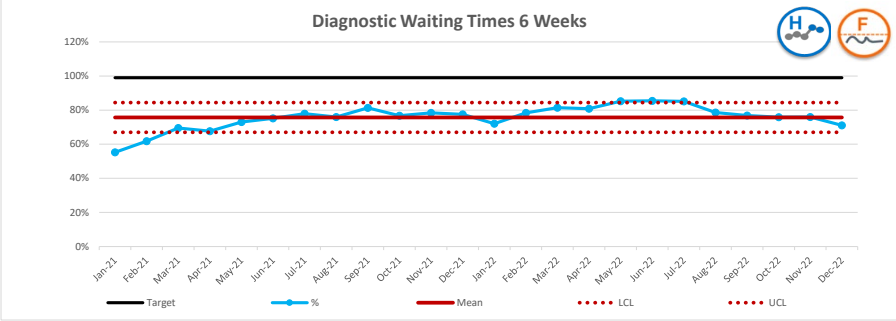
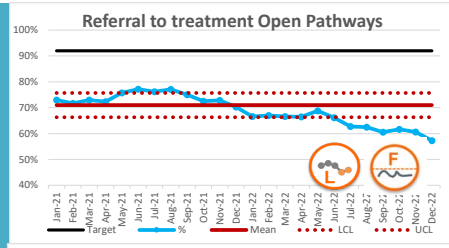
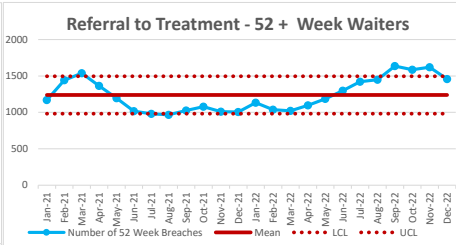
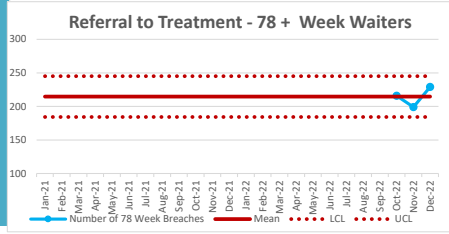
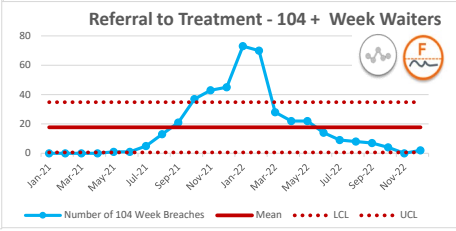
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
25. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 91 ward moves between 10pm-6am in December 2022 compared to 137 in December 2021.		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.
26. Acute Kidney Injury Target: Less than previous month	There were 221 acute kidney injuries reported in month.		N/A - Not enough datapoints.	Since the introduction of the AKI nursing role within the ACT, there is an improvement in mortality, LOS and rates of progression of AKI. WHH are no longer an outlier for Mortality. Hospital Aquired AKIs are also consistently down on 2019 levels.	Work continues across the Trust to improve the position for the number of patients who develop an AKI. A focus on continuing to reduce readmission rates and reductioin of patients admitted to the Intensive Care Unit- which are both improving as a result of the AKI focussed work. Education and training is included in the actions and support from the Acute Care Team.
27. CAS Alerts - Target: All relevant CAS Alerts actioned within timescales	There were 0 CAS alerts with breached actions in month.		Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) Variation.	There have been zero breaches to date.	CAS alerts are moniotred via the Trusts Health Safety Sub-Committee and Medical Devices Group. Action plans and monitoring arrangements are reviewed weekly by the Health & Safety Dept.

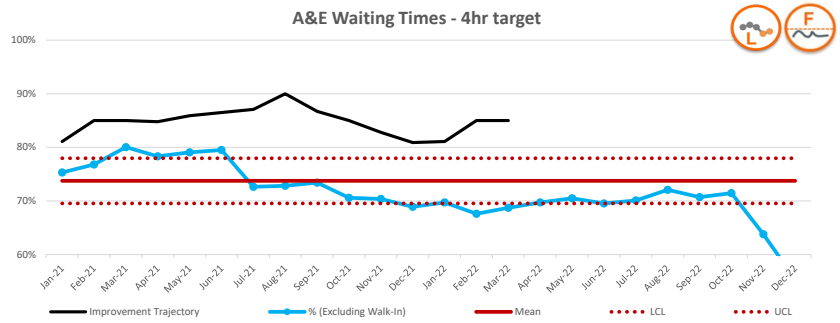
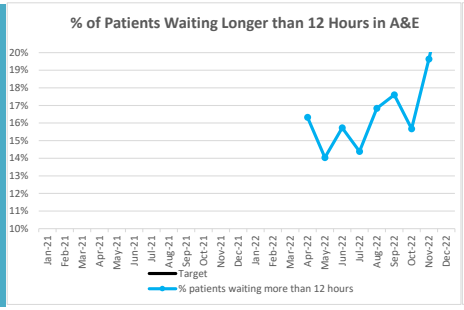
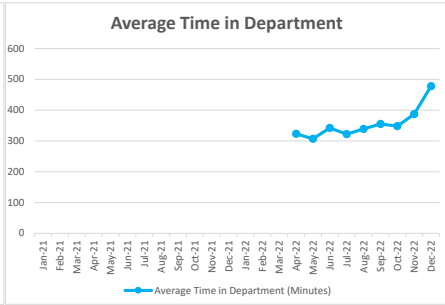
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
28. Diagnostic Waiting Times 6 Weeks Target: 99% **The Trust achieved 71.07% in month.** SOF CQC RR1215 RR1125		**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a improving nature**	**The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.**	**A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies.**
29. Referral to treatment Open Pathways Target: 92% **The Trust achieved 57.3% in month. There were 1459, 52 week breaches, 229, 78 week breaches and 2, 104 week breaches in December 2022.** **30. RTT - Number of patients waiting 104+ weeks Target: ZERO** SOF CQC 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: Common Cause (Normal) Variation.**	**RTT performance, 52 and 104 week wait performance in the reporting period was in line with the Trust's 2022/23 plan.**	**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 2022/23 have been drawn up in line with Operational Planning Guidance.** **• The 2 104 breaches were patient choice (P6)**

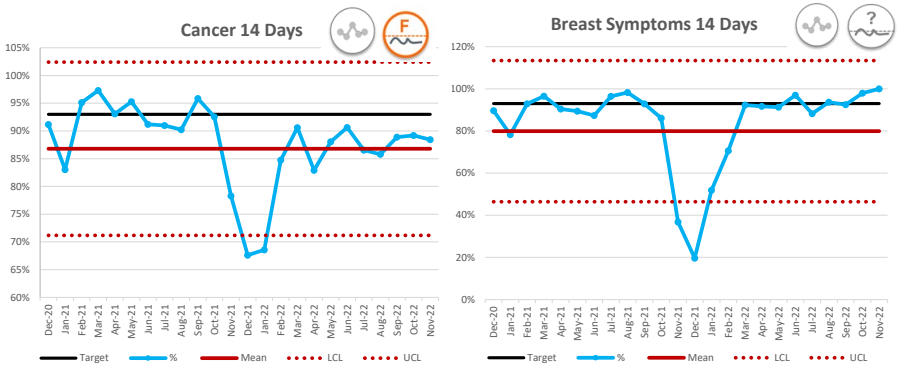
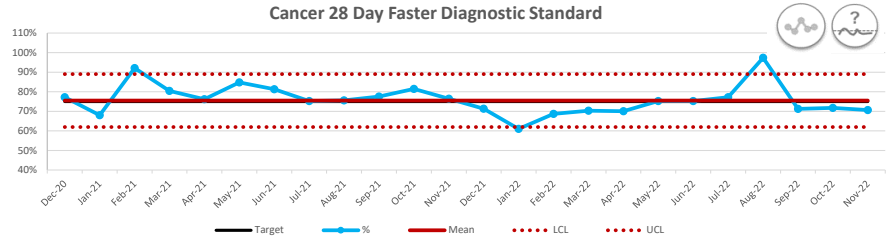
Access & Performance - Trust Position

	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)?
31.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 95% 32. Four Hour Standard Waiting Times - ICS Trajectory Target: Trajectory	CQC **The Trust achieved 55.34% excluding Widnes walk ins in month.** RR224		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature**	**Performance continues to be negatively impacted by high attends, long length of stay as a result of community discharge delays and the impact of COVID-19 Waves and Influenza.**	**• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** **• System resource investment in order to support Pathway 1 discharges.** **• Additional beds remain open on the Halton site to support bed capacity and flow.** **• Ward A10 opened in October (14 Beds) to support performance.**
33. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less 34. Average time in department ED No Target	**23.9% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 478 minutes.**	 	**N/A - Not enough datapoints.**	**12 hour performance continues to be monitored. This is also in line with the trend seen regionally and nationally. The Trust continues to perform well when compared to other Trusts against this standard. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through ED.**	**The Trust will continue to monitor and manage compliance around the 12 hour standard.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

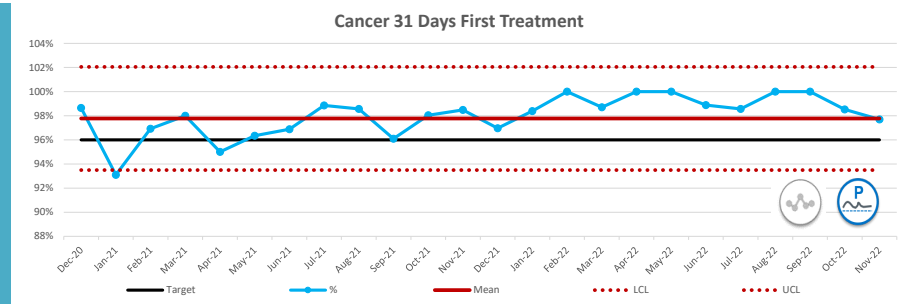
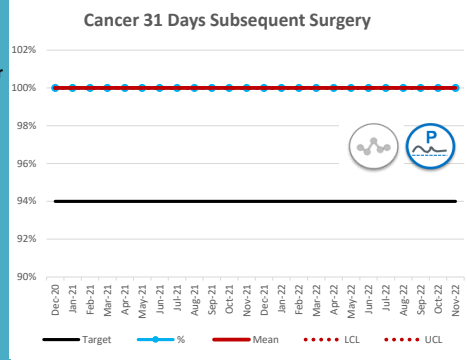
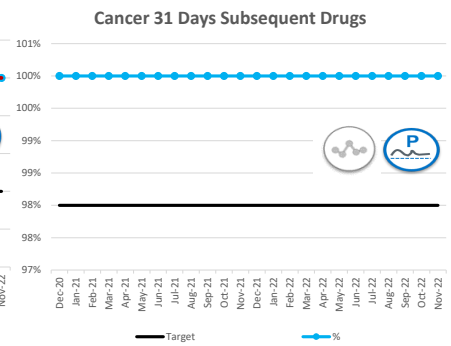
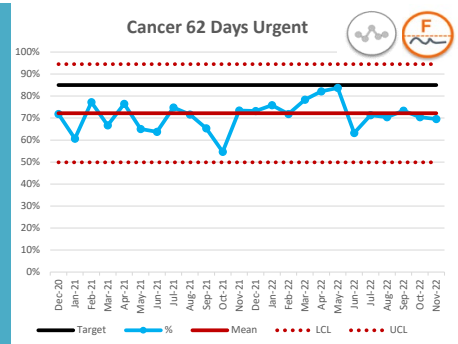
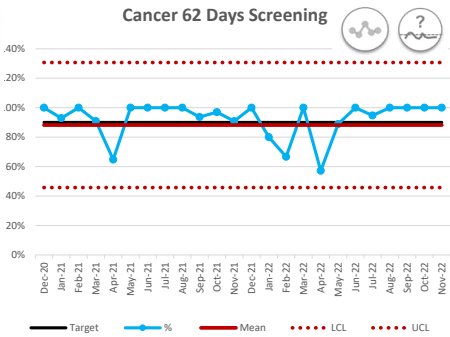
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
35. Cancer 14 Days Target: 93% 36. Breast Symptoms 14 Days Target: 93% RR1125 **The Trust achieved 88.44% in November 2022 for Cancer 14 days and 100% in November 2022 for Breast Symptomatic.**		**(C14) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) variation.** **(Breast) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) variation.**	**Overall the 2 Week Wait narrowly missed the target in the reporting period with the continued. Breast symptomatic fell just below the standard.**	**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), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG).** **Targeted capacity and demand work has been initiated for the Breast service.**
37. 28 Day Faster Cancer Diagnosis Standard Target: 75% SOF **The Trust achieved 70.69% in November 2022.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation.**	**This indicator is impacted by continued high volumes of referalls into General Surgery creating pressures on 2 week wait capacity. Short term additional capacity continues to be put in place.**	**The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and the KPI Sub-Committee.**

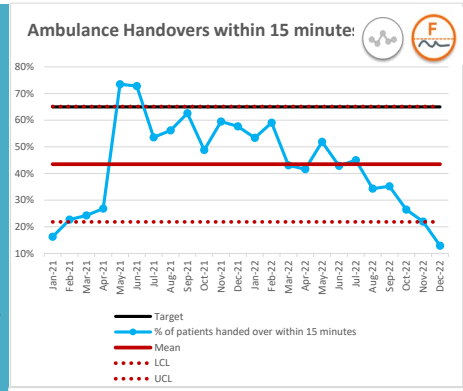
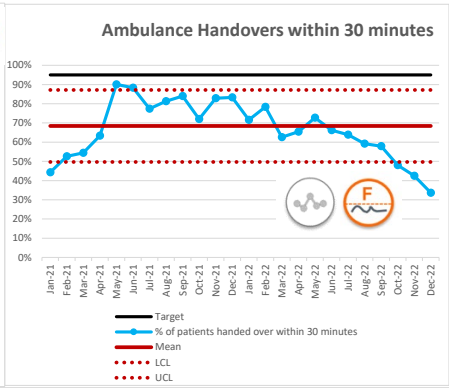
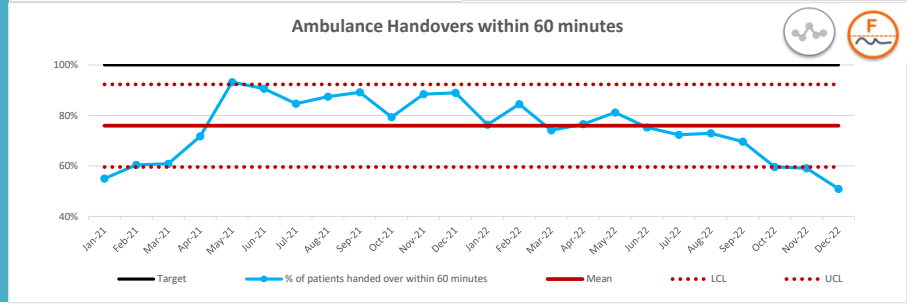
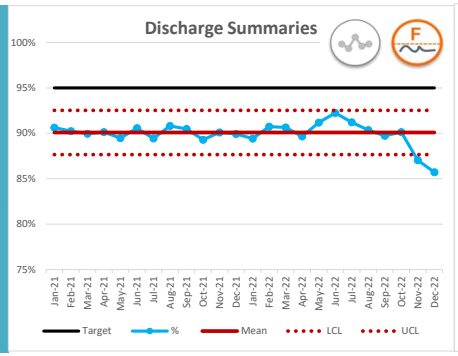
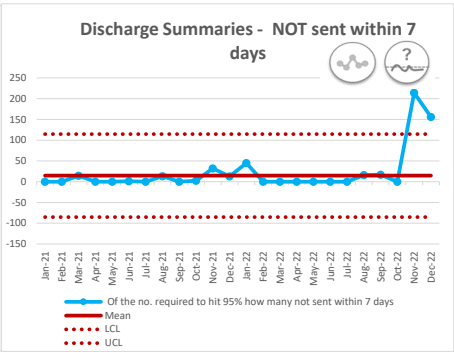
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

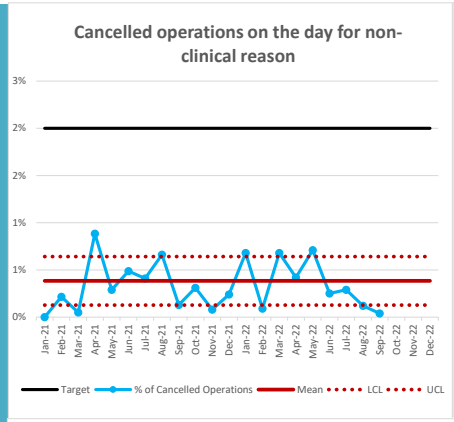
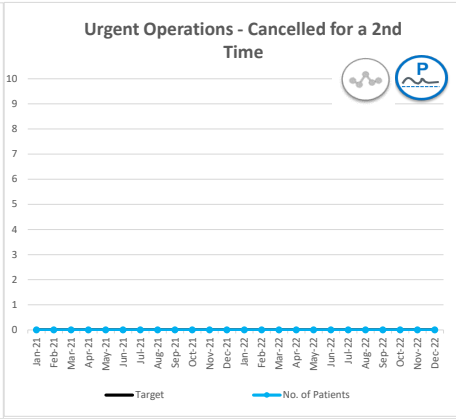
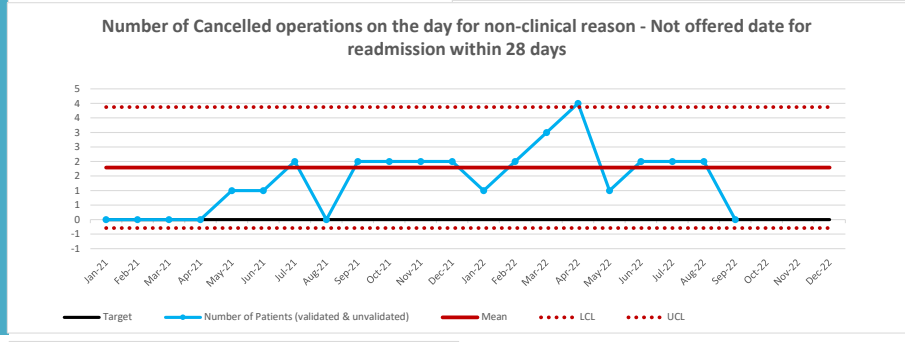
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
38. Cancer 31 Days First Treatment Target: 96% 39. Cancer 31 Days Subsequent Surgery Target: 94% 40. Cancer 31 Days Subsequent Drug Target: 98% SOF CQC **The Trust achieved 97.7% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in November 2022.** RR1125	  	**Assurance: The Trust consistently passes the target.** **Variation: There is Common Cause (Normal) variation.** **(Surgery)** **Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.** **(Drugs)** **Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**The 31 day cancer target was achieved in this reporting period. Good compliance against this standard continues to be tracked.**	**There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.**
41. Cancer 62 Days Urgent Target: 85% 42. Cancer 62 Days Screening Target: 90% SOF CQC **The Trust achieved 69.57% for Cancer 62 Day Urgent and 100% for Cancer 62 Day Screening in November 2022.** RR1125	 	**(Urgent)** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(Screening)** **Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**The 62 day urgent target was not achieved in this reporting period, despite an improving position. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.**	**There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.**

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)?
43. Ambulance Handovers within 15 minutes Target: 65% 44. Ambulance Handovers within 30 minutes Target: 95% 45. Ambulance Handovers within 60 minutes Target: 100% SOF	  	**In month 12.91% of patients were handed over within 15 minutes, 33.66% were handed over within 30 minutes and 50.95% were handed over within 60 minutes.** **(15)** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(30) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(60)** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Handover performance has declined as a result of the increase in bed demand and occupancy which impacts on flow out of the Emergency Department. This continues to be monitored and the Trust is working closely with NWAS to improve this.**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with NWAS to identify and implement improvements.** **A new service improvement initiative commenced in December aimed at releasing crews ahead of the 60 minute standard using a red card time awareness system.**
46. Discharge Summaries - % sent within 24hrs Target: 95% 47. 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.**

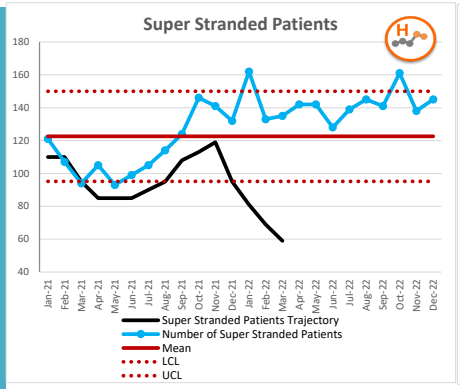
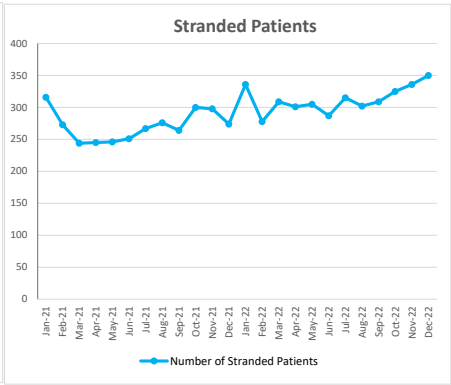
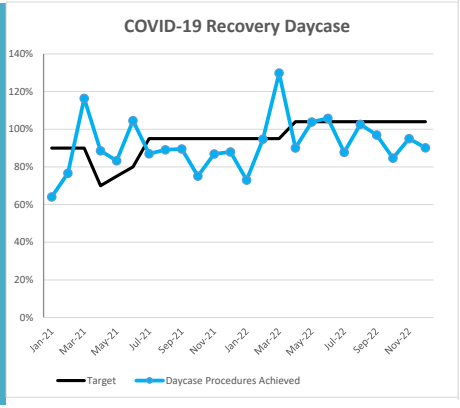
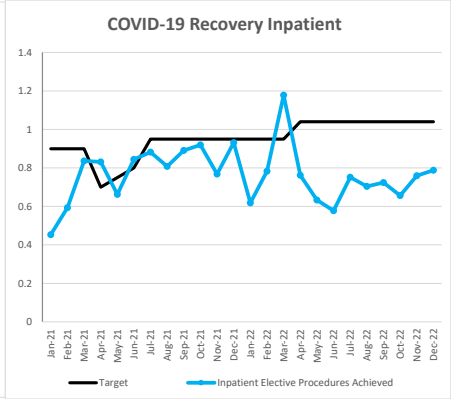
Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

Access & Performance - Trust Position

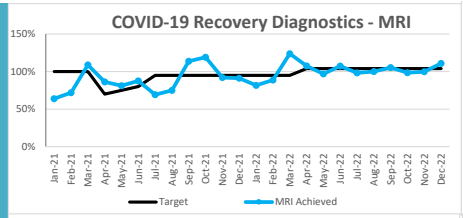
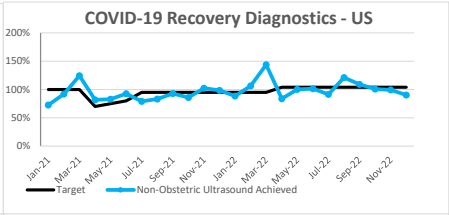
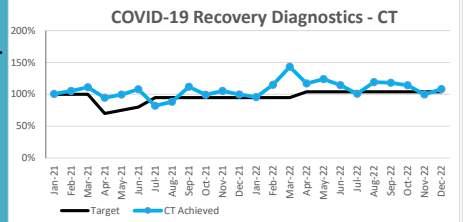
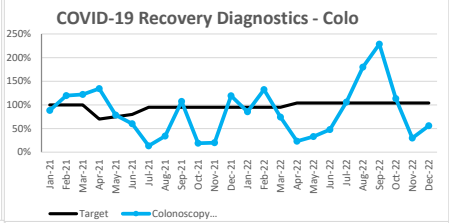
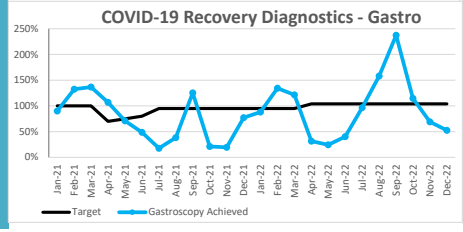
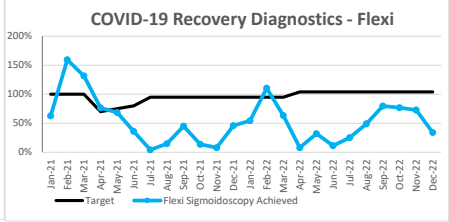
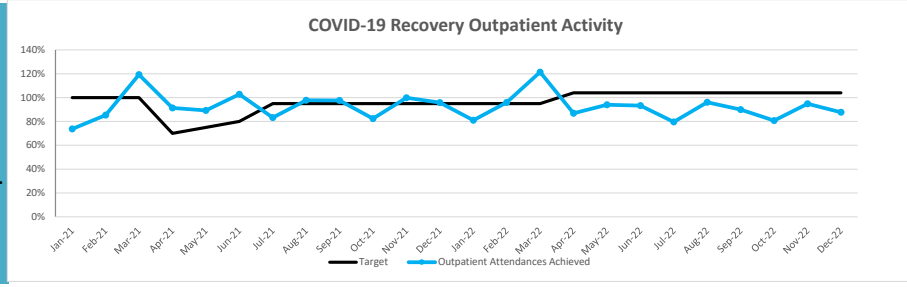
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. Cancelled Operations on the day for a non-clinical reason Target: Less than 2% 49. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO 50. Urgent Operations - Cancelled for a 2nd Time Target: ZERO CQC **Cancelled operations data validation for December is in progress.**	  	**(Urgent Ops) 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 the Clinical Services Oversight Group (CSOG).**

Access & Performance - Trust Position

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

Trust Performance	Trend		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
51. Super Stranded Patients Target: Trajectory	There were 350 stranded and 145 super stranded patients at the end of December 2022. A Superstranded Patient Trajectory has not yet been agreed for 2022/23.			Assurance: N/A Trajectory Not Agreed Variation: There is special cause variation of a concerning nature.	The number of Super Stranded patients continues to remain higher than trajectory as a result of the impact of COVID-19 and community and Local Authority discharge delays.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.
52. COVID-19 Recovery Elective Activity Target: 104% % activity is against activity in the same month in 2019/20	In December 2022, the Trust achieved the following % of activity against December 2019. This included 90.16% of Daycase Procedures and 78.76% of Inpatient Elective Procedures.			N/A - Grouped indicator.	Inpatient activity for the reporting period is below the Trajectory due to a higher than average profile as a result of additional activity being undertaken in October 2019 and a underperformance in key areas due to workforce constraints	The Trust monitors progress weekly via PRG and Clinical Services Oversight Group (CSOG)

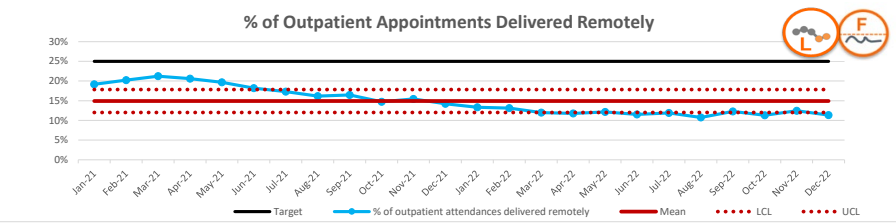
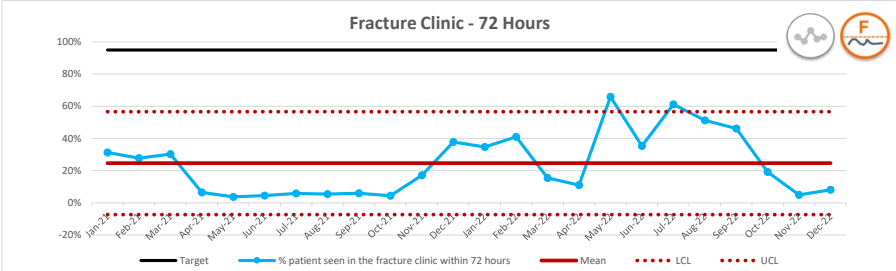
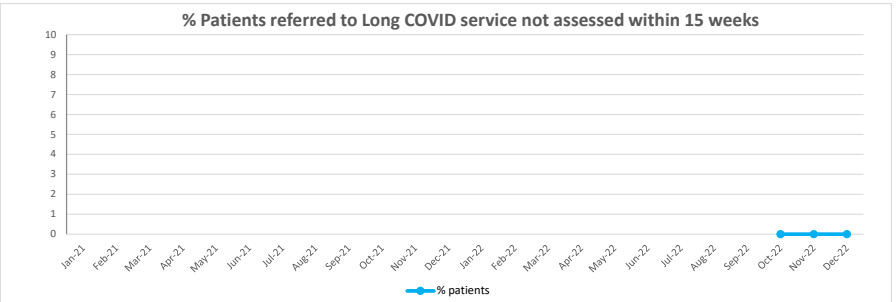
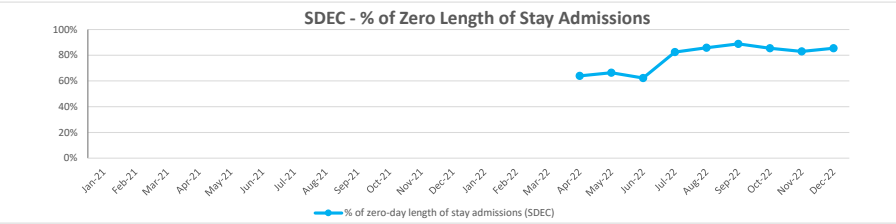
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
53. COVID-19 Recovery Diagnostic Activity Target: 104% % activity is against activity in the same month in 2019/20	SOF **In December 2022, the Trust achieved the following % of activity against December 2019. This included:** **110.84% of MRI** **108.3% of CT** **90.11% of Non-Obstetric Ultrasound** **34.07% of Flexi Sigmoidoscopy** **56% of Colonoscopy** **52.48% of Gastroscopy** RR1125	     	**N/A - Grouped indicator.**	**The Trust did not meet the diagnostic activity recovery trajectories for the reporting period across a number of specialties due to COVID-19 sickness. Colonoscopy, Flexi Sig and Gastroscopy have started to show an improvement. Cardiorespiratory, particularly Echo and sleep studies remain the most challenged areas although now improving.**	**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.** **The Trust has approached the ICB to close Out of Area referals into the sleep service to help reduce demand.**
54. COVID-19 Outpatient Activity Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 **In December 2022, the Trust achieved 87.68% of Outpatient activity against December 2019.**		**N/A - Grouped indicator.**	**The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative servcies such as patient initiated follow up.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

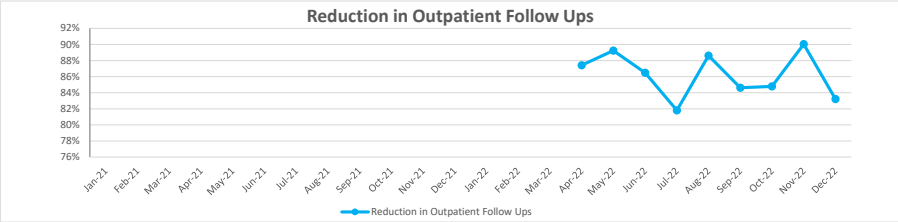
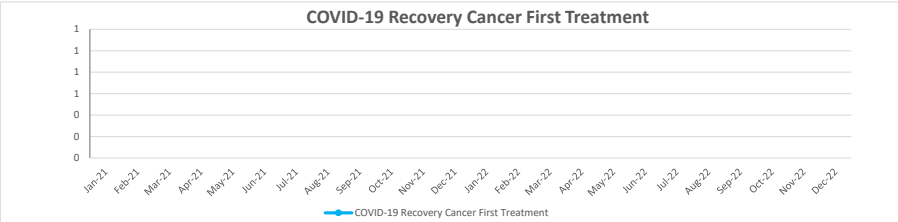
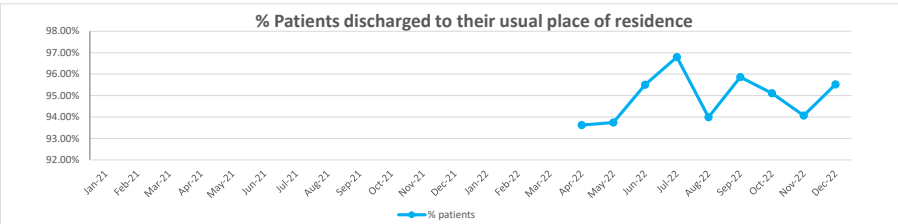
Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

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)?
55. Outpatient Activity Delivered Remotely Target: 25%	11.339305221761% of Outpatient Appointments were delivered remotely in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature.	The Trust did not achieve the standard in month for % of outpatient appointments delivered remotely. This is in line with reginal benchmarks and attributable to clinicains requesting first appointments being face to face given the time waited.	The Trust continues to identify opportunities to deliver additional outpatient activity remotely.
56. Patients seen in the Fracture Clinic within 72 hours Target: 95%	8.16% of patients were seen in the Fracture Clinic within 72 hours in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.	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. The Data from the etrauma system is outline below: October – 91.7% December – 100%
57. % 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 December		N/A - Not enough datapoints.		
59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	85.49% of SDEC Emergency Admissions had a zero day length of stay.		N/A - Not enough datapoints.		

Access & Performance - Trust Position

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

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
80. 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 83.21% of 19/20 activity in December.		N/A - Not enough datapoints.		
81. COVID-19 Recovery Cancer First Treatment Target: 100%	0% of people each month who receive their first treatment for cancer compared to the equivalent month in 2019/20 adjusted for number of working days.		N/A - Not enough datapoints.		
82. % Patients discharged to their usual place of residence Target: No Current Threshold	95.52% patients in December who were discharged to their usual place of residence.		N/A - Not enough datapoints.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

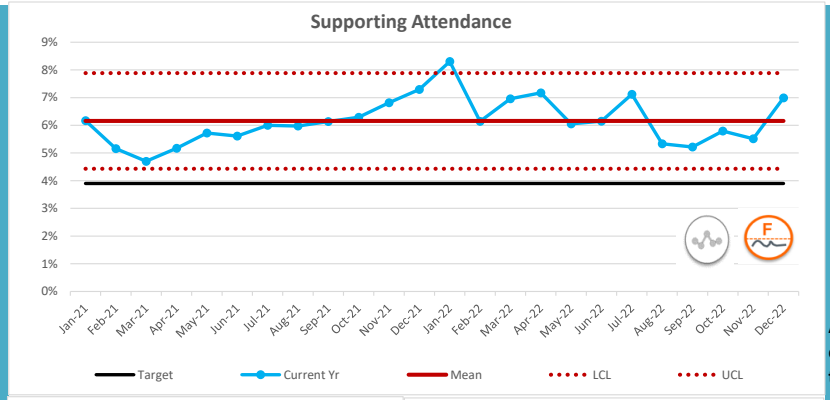
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

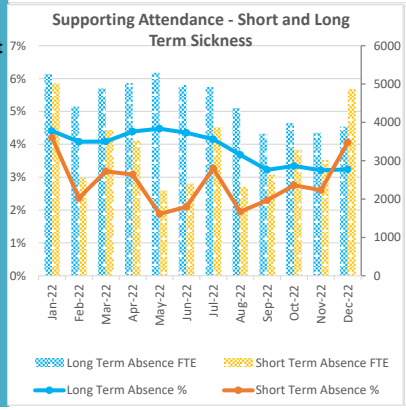
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

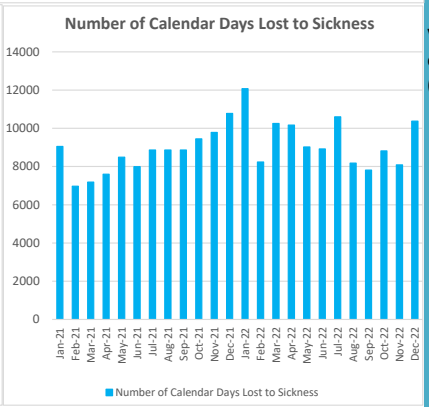
60. Supporting Attendance

Target: Below 4.2%

The Trust's sickness absence rate was 7.29% in month. There were 10380 calendar days lost to sickness in month.







Assurance: The Trust consistently fails the target.

Variation: There is a common cause (normal) variation.

Sickness absence is 7.29% for December 2022, it was last reported as 6.09% in October 2022.
Sickness absence in December 2021 was 7.60%.

The Trust implemented an updated Supporting Attendance policy in February 2022. Consequently, the Trust has seen a significant improvement in long term sickness absence rates reducing from 4.19% in April 2022 to 3.24% in December 2022.

Short term sickness absence levels for the Trust have been challenging due to the spikes of infection of Covid and Flu throughout the year. December 2022 short term sickness absence is 4.05%, up from November 2022 at 2.6%. This is representative of an increase regionally. Indepth analysis is being undertaken for absence data in December 2022 to identify any hotspots and areas for targeted interventions and support.

The rolling 12-month sickness absence rate is 6.70%.

In recognition of the challenges for the WHH workforce during the winter period, a Winter Well campaign and programme has been implemented which has included targeted wellbeing support in specific areas identified including Rugby League Cares, care packages for staff and financial wellbeing support.

Targeted health and wellbeing days are being developed to support areas where specific absence trends have been identified such as MSK, with wellbeing interventions, training and support being offered to staff as a preventative measure to minimise future absences. The first day is scheduled for February 2022.

Workforce - Trust Position

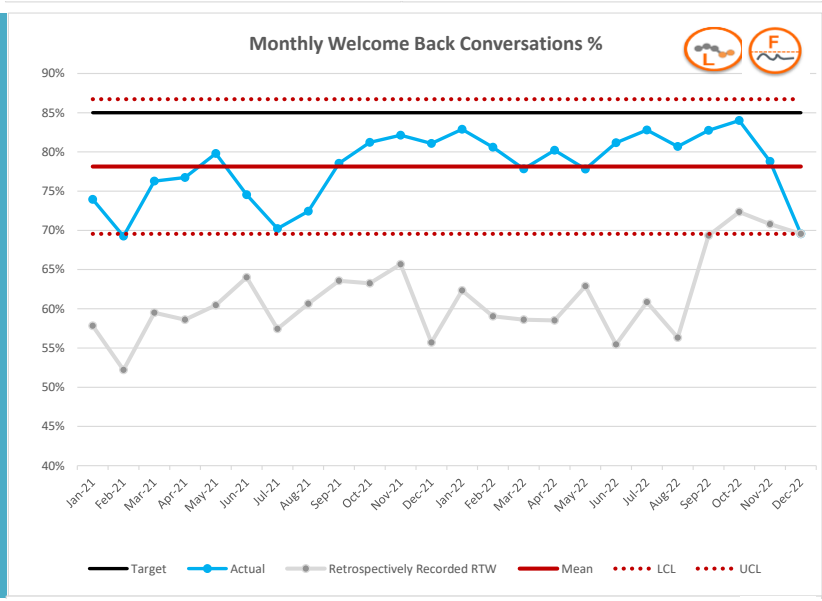
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

61. Welcome Back Conversations

Target: 85%

RR1108 RR1134

Welcome Back Conversation compliance was 69.55% in December 2022.



Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a concerning nature.

Welcome Back Conversations (WBC) compliance is 69.55% in December 2022.

Reported Welcome Back Conversations (WBC) compliance in October 2022 was 72.34%.

It is worth noting that previous months WBC compliance increases as managers input historic WBCs that occurred but were not recorded on the system at the time of reporting.

The 12 month WBC compliance is 79.76%.

Bespoke training and one to one management coaching on Welcome Back Conversations continue to be offered across all CBUs which has resulted in significant improvements in compliance reaching 84% in October 2022. This approach is now cited as a best practice case study by NHSE.

Monthly automated prompt emails have been developed for managers to remind them to complete WBC and log on ESR. There is also a pilot of absence reporting to alert managers when WBC are required, and triggers met with managers provided with a full toolkit to support completion of policy actions to ensure staff are fully supported.

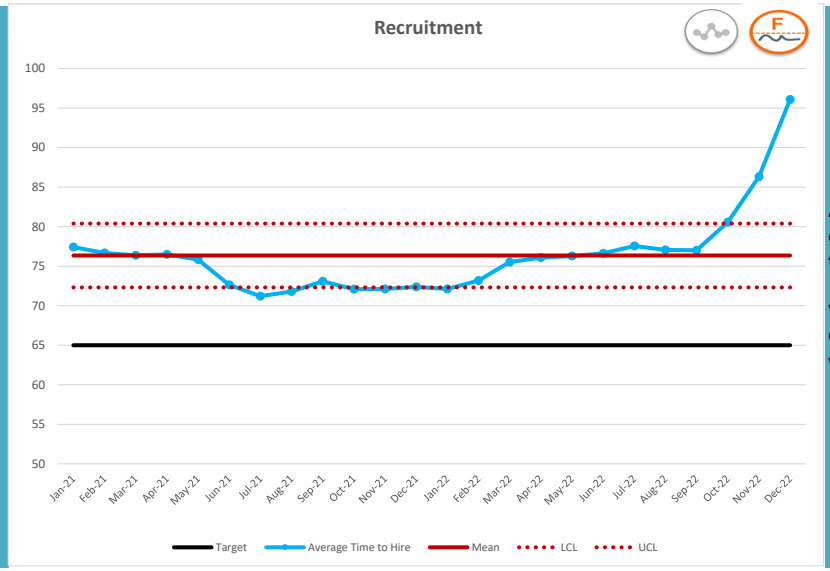
Lack of management capacity of clinical staff due to the management of patient safety risks has impacted the achievment of Welcome Back Conversation compliance in November 2022 and December 2022. The People Directorate are supporting departments to achieve compliance to ensure staff are supported with a wellbeing conversation and restrospective reporting of compliance is still captured.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

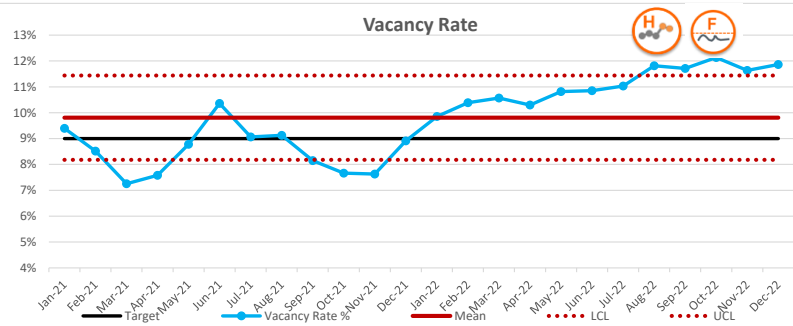
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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. Recruitment **Target: 65 days or below**	**The average number of working days to recruit is 79 days, based on the last 12 months average.**	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Recruitment time to hire for December 2022 is 96 working days, compared to 72 working days in December 2021. This includes notice periods.**	**In line with the implementation of NHS Jobs 3, the end-to-end recruitment process is constantly being reviewed to ensure the approach continues to be in line with best practice and takes into account the changes brought by NHS Jobs 3.** **There is a recognition that the new national system, NHS Jobs 3, does not have the system functionality of the previous system or the developments to the system expected, impacting time to hire. The Trust is currently procuring an alternative recruitment system to support improved time to hire. NHS Jobs 3 was implemented nationally in June 2022, demonstrating a direct correlation with the increases in time to hire.** **The Trust is working with an external recruitment marketing agency to support recruitment and onboarding of new staff with any lessons learnt to improve time to hire to be implemented internally. There is also a monthly review of time to hire to identify any themes in delays to time to hire so targeted action can be taken to improve.** **A new Occupational Health system implementation is underway which will digitalise new stater pre-employment checks, management referrals and staff records relating to occupational health with the aim of reducing time to hire, as well as improving the candidate experience.**



Workforce - Trust Position

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

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
63. Vacancy Rates Target: 9% or Below UoR The Trust's vacancy rate was 11.86% in December 2022.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Trust Headcount is currently 4,482 (3,986 FTE) compared to 4,462 (3,958 FTE) in December 2021. The Trust continues to engage with national directives such as international Nurse recruitment, AHP return to practice, international Fellow recruitment and international AHP recruitment. Our current international nurse recruitment programme is progressing inline with expected trajectories. For longer terms plans, the People Directorate is working in conjunction with the Trust Strategy Team and Senior Nursing/ Medical teams to develop a template for developing Workforce Plans at Service/Staff Group level to address workforce shortages through role redesign. In addition, there are projects specifally focusing on recruiting into the vacancies within ED, Pharmacy and Maternity. These include: • Recruitment open days • Developing a recrutment brand and marketing campaign • Improving our social media presence via a number of social media platforms

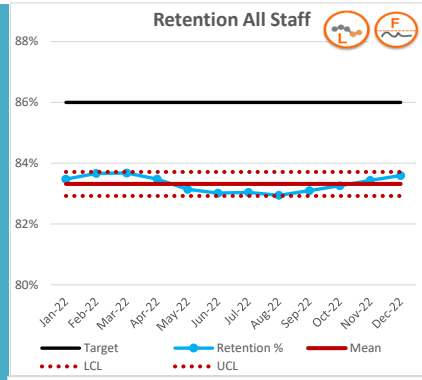
Workforce - Trust Position

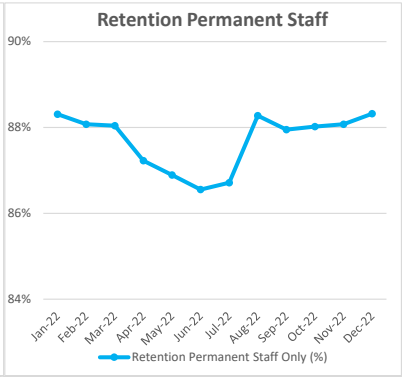
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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)?

64. Retention

Retention of all staff was 83.59% and Retention of Permanent staff only was 88.32% in month.





Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a concerning nature.

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

Work Life Balance
To support with the development of an Agile/Flexible Working Toolkit, views of the staff are being sought on the current agile working culture, barriers, opportunities and best practice.

The survey received 289 responses, however less than 50 of these were from clinical staff, and therefore the group have extended the survey to target clinical areas.

Retirement
A significant number of people delayed their retirement plans in 2020 and 2021, and we have now seen a significant increase in the number of individuals choosing to retire.

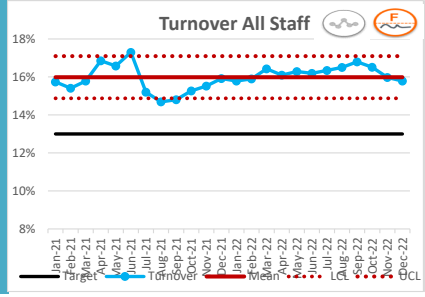
It is worth noting a number of retirees do return to the workplace (retire and return) and are supported to do so, however these still count as a leaver for the purposes of retention and turnover.

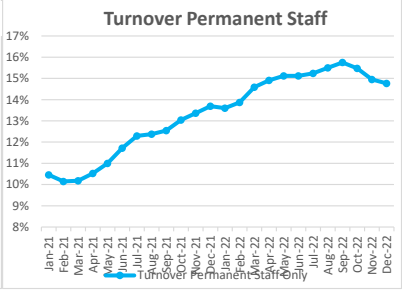
The Trust is currently working with a recruitment marketing company focusing on attraction and retention. The campaign went live on 26th December 2022

65. Turnover

Target: Below 13%

Turnover of All staff was 15.78% and Turnover of Permanent staff only was 14.77% in month.

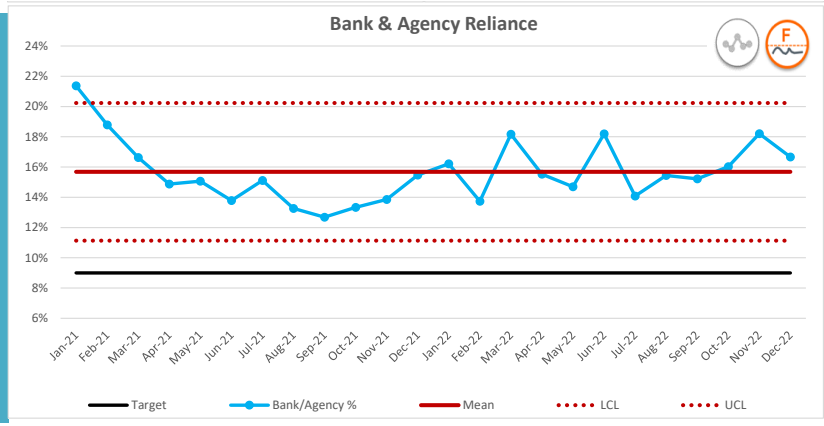
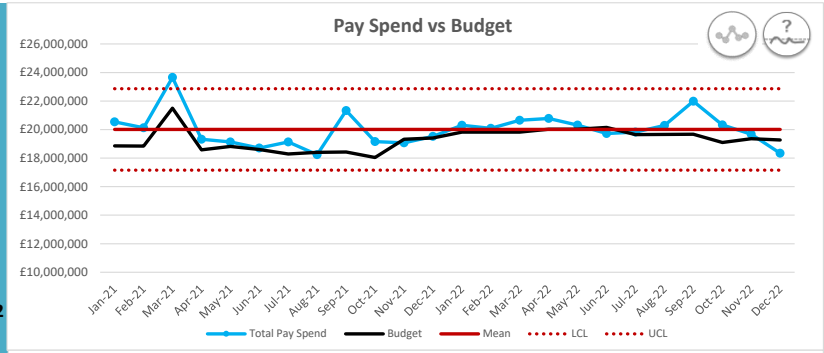
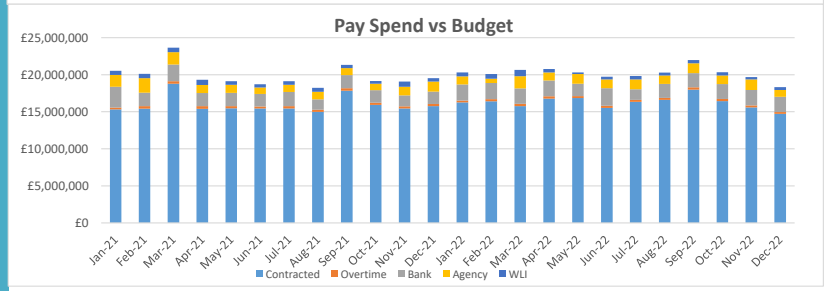




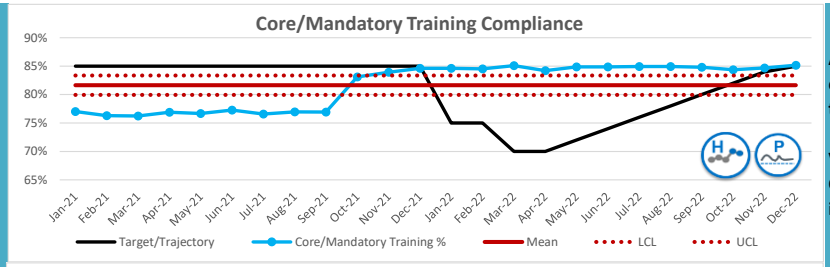
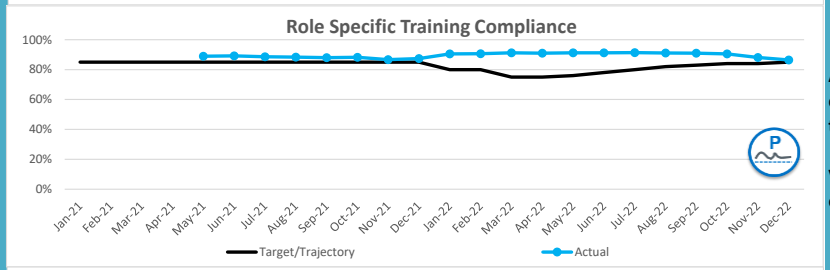
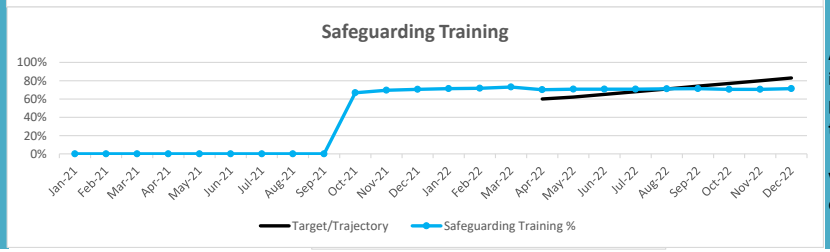
Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation.

Workforce - 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)?
66. Bank and Agency Reliance **Target: 9% or Below** (UoR) **Bank and Agency Reliance was 16.67% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Bank and Agency reliance is 16.67% in December 2022, in December 2021 it was 15.68%.**	**A Task and Finish group has been established to review any gaps identified through the Agency Controls best practice toolkit. This will support plans to work with agencies to ensure they are operating within controls and improve the use of the Trusts banks rather than agency staff.** **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.**
67. Pay **Target: On or Less than Budget** (UoR) (CQC) (S) **Total pay spend in December 2022 was £18.3m against a budget of £19.2m.** (UoR)	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Total pay spend in December 2022 is £18.3m against a budget of £19.2m. In December 2021, pay spend was £20m against a budget of £19.4m.** **The total pay spend for December 2022 is made up of the following elements:** **•£14.7m contracted** **•£2m Bank** **•£0.9m Agency** **•£0.38m WLI** **•£0.25m Overtime**	**The additional controls for pay spend that have been identified to support a reduction in premium pay are:** **•ECF process for non-clinical vacancies approval** **•ECF process for bank and agency temporary staffing pay spend approval** **•Medical Rate Escalations approved by Medical Director** **Through the Finance and Sustainability Committee, compliance against our processes and rate cards continues to be monitored.** **There is currently work underway to establish clear actions that the Trust needs to undertake to reduce agency expenditure. This includes:** **•Assessment by Deputy Medical Director and Deputy Chief Nurse against a combined NHSE and East Lancs Best Practice Toolkit for controlling agency spend** **•Development of recommendations and approaches to bring down agency costs including:** **•Reduction in commission for long line bookings** **•Walk down Medical and Dental agencies over a period of time; firstly, to within the 50% cap and then to close to the rate cap** **•Implementation of tiering of agencies, offering priorities to agencies who are within rate cap** **•Implementation of check and challenge around agency use** **•Review of the Frameworks being used to ensure best service and value for money**

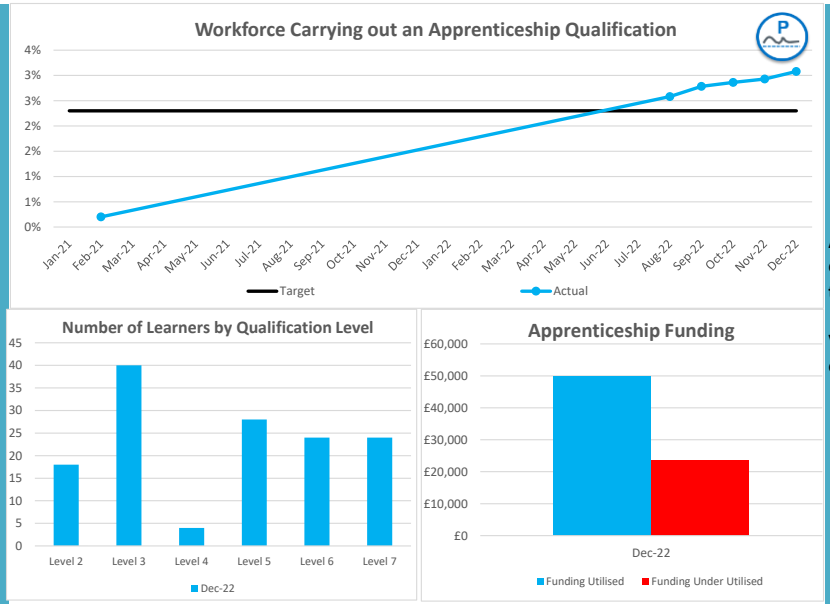
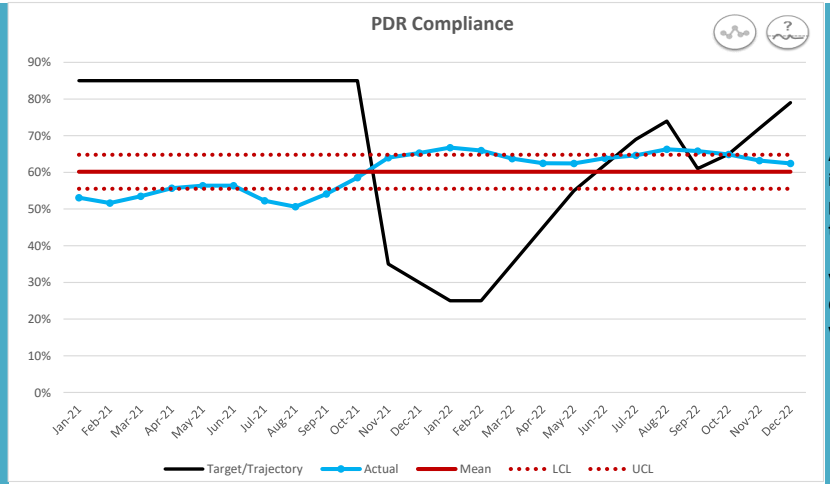
Workforce - Trust Position

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)?
68. Core/Mandatory Training **Target: 85%**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**In December 2022, CSTF Mandatory Training compliance is 85.16%, Role Specific Training compliance is 86.45% and Safeguarding compliance is 71.28%.** **In December 2021, CSTF was 83.35% and Role Specific 87.35% (Safeguarding was included in CSTF).**	**Mandatory Training compliance is now split by Mandatory, Safeguarding and Role Specific Training.** **Trajectories have been developed in order to continue to improve compliance which continues to be monitored through workforce governance structures and QPS.** **The Mandatory and Role Specific Training Group is reviewing all training offered by the Trust in relation to accessibility, training needs analysis and justification for mandatory status. A full reviw of Safegurading training is being undertaken with a relaunch of training planned in 2023 with the aim to support achievement of the target through streamlining of the delivery of the training.**
Core/Mandatory training compliance was 85.16% in month.				
69. Role Specific Training **Target: 85%**		**Assurance: The Trust consistently passes the target.** **Variation: N/A Not enough datapoints.**		
Role Specific Training compliance was 86.45% in month.				
70. Safeguarding Training **Target: Trajectory**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: N/A - Not enough datapoints.**		
Safeguarding Training compliance was 71.28% in month.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

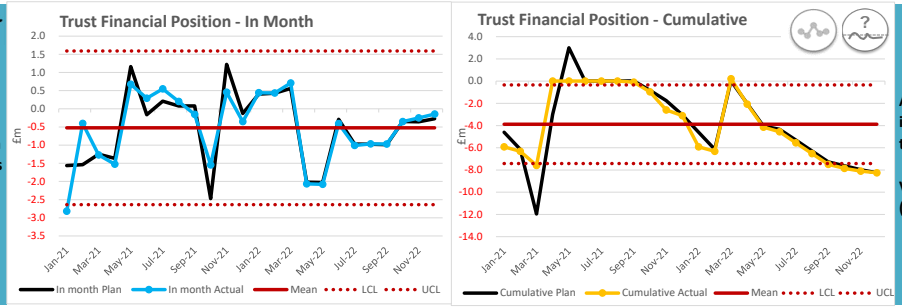
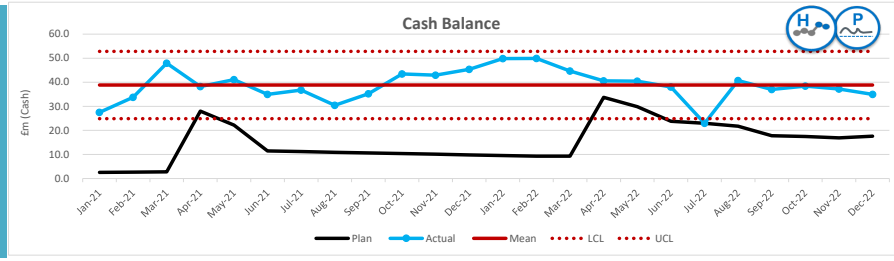
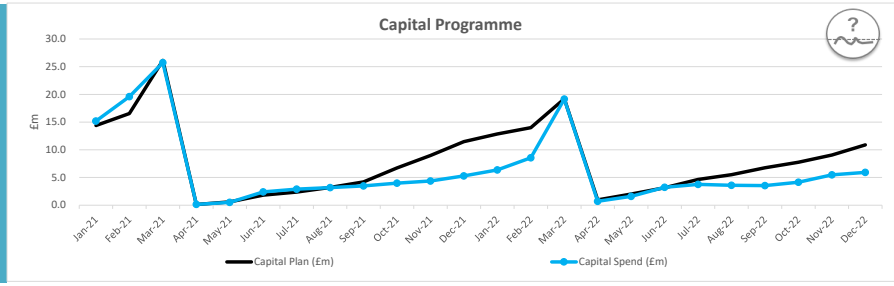
Key: System Oversight Framework (SOF) | Use of Resources Assessment (UoR) | Risk Register (RR200) | Care Quality Commission (CQC) | Trust Strategy (S)

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. Workforce carrying out an Apprenticeship Qualification **Target: 2.3% or above** **67.8% of staff were carrying out a qualification in month.**		**Assurance: The Trust consistently passes the target.** **Variation: N/A - Not enough datapoints.**	**In December 2022, 3.08% of the workforce is carrying out a qualification (previous year comparator data not available). Utilisation of the apprenticeship levy in December 2022 was 67.80% (previous year comparator data not available)**	**The organisation continues to widely promote qualification opportunities for staff to support their professional and personal development. This is evidenced in the continual over achievement of the Trust target of 2.3% of the workforce carrying out a qualification. The ECF Panel, supported by the Trusts Apprentice Team, continues to review all vacancies and support managers to supplement the vacancy with an external development offer, paid for by the Levy.** **The organisation is currently supporting 5 local organisations through the Levy Transfer opportunity which supports the organisation's ambitions as an anchor institution and our corporate social responsibility within the local area.**
72. PDR **Target: 85%** **PDR compliance was 62.43% in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**In December 2022, PDR compliance was 62.43%. In December 2021, PDR compliance was 64.81%.** **Currently PDR rates are below the trajectories.**	**The CBUs and Corporate Areas have been supported to develop trajectories and associated actions to improve PDR compliance, these continue to be monitored through the workforce governance structures and QPS.** **Following the piloting of the PDR talent management tool, Scope for Growth, the outcomes of the pilot are currently being reviewed to support successful implementation across the organisation. This includes ensuring conversations are supportive of personal development, and the framework is simple and intuitive to follow for staff and managers.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

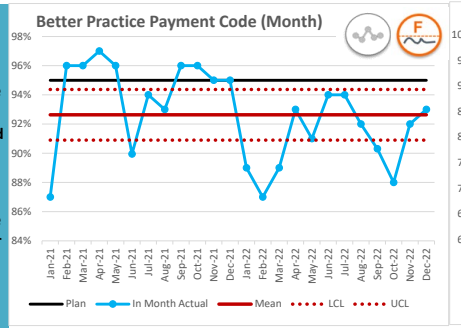
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
73. Trust Financial Position **Target: Plan**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**For the period ending 31 December 2022, the Trust has recorded a deficit of £8.25m, which is on plan. The position includes £6.0m ERF.**	**The Trust has been reviewing the forecast and following discussion at Trust Board the forecast remains at the planned £6.1m deficit.**
The Trust has recorded a deficit position of £8.25m which is on plan as at 31 December 2022				
74. Cash Balance **Target: On or better than plan**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**The current cash balance is £35m which is £17m better than the initial cash plan. In the main this relates to a timing difference in the payment of trade creditors , a timing difference in the payment of capital creditors , additional income from contracts and additional VAT recovery.**	**Payment of the creditors on receipt of invoices will move the cash back to plan.**
The cash balance as at 31 December 2022 is £35m.				
75. Capital Programme **Target: On plan 90%-100%**		**Assurance: The Trust inconsistently passes/fails the target.**	**The Trust annual capital plan is £23.0m of which £2.8m is the ED Plaza monies brokered to the C&M system in 2021/22 and £10.5m of schemes planned which will be funded from external sources. Capital expenditure year to date is £5.9m against a £10.9m plan.**	**The underspend year to date relates to some delays on backlog maintenance schemes and externally funded schemes which will catch up. There is slippage on the catering scheme which will require mitigation in Q4. In addition there has been £0.5m VAT reclaim increasing the underspend.**
Capital expenditure year to date is £5.9m against a £10.9m plan				

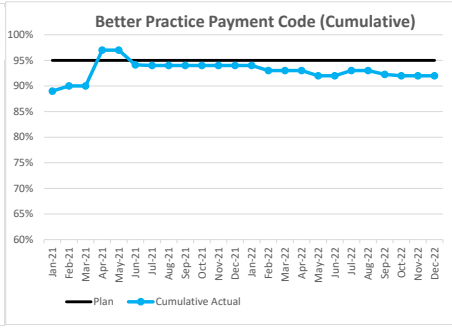
Warrington and Halton Teaching Hospitals NHS Foundation Trust

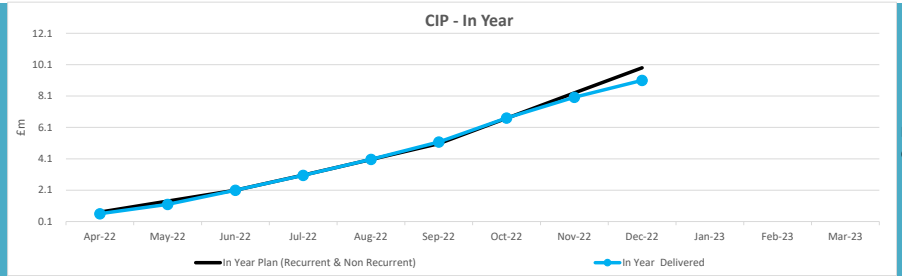
Finance & Sustainability - Trust Position

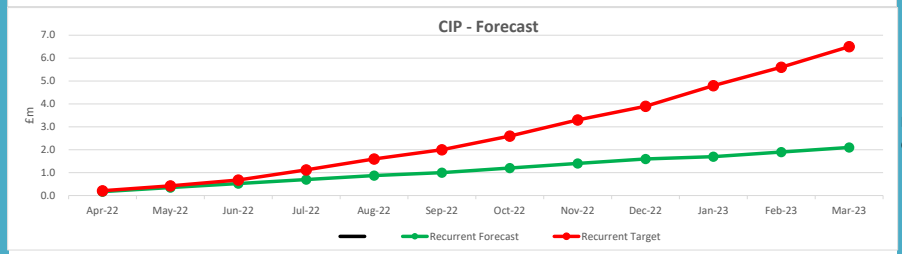
Key:
System Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
76. Better Payment Practice Code **Target: Cumulative performance 95%**	**The Better Payment Practice Code performance based on volume for NHS is 76% and non-NHS is 92%. The Better Payment Practice Code performance based on value for NHS is 82% and non-NHS is 93%.**	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Cumulative performance is 92.00% 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.**
77. Use of Resources Rating **Target: Use of Resource Rating 1 and 2**	**The Use of Resources Rating is not currently being reported. The Trust is awaiting further guidance from NHSE/I.**			
78. Cost Improvement Programme (recurrent & non recurrent) - In year performance to date **Target: >90% Plan delivered YTD**	**The year to date CIP plan is £9.9m and £9.1m has been delivered.**	**N/A - Not enough datapoints.**	**In year savings identified are £15m against a plan of £15.7m, many of these saving are high risk and further work is needed to finalise schemes. A significant amount of the CIP programme is non recurrent which if not resolved will impact on 2023/24.** **The Trust is working to identify recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust.**	**CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT conversations with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust.**
79. Cost Improvement Programme (Recurrent Forecast) - Target: Recurrent Forecast is more than 90% of the annual target	**The Trust is in the process of identifying recurrent CIP schemes for 2022/23.**	**N/A - Not enough datapoints.**		









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.**	**Healthcare Acquired Infections (MRSA, CDI and 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.
6.	**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).
7.	**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.
8.	**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.
9.	**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).

10.	**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.
11.	**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.
12.	**Care Hours Per Patient Day (CHPPD)**	• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
13.	**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.
14.	**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.
15.	**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.
16.	**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.
17.	**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?
18.	**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?
19.	**Mixed Sex Accommodation Breaches (Non-ITU)**	• Number of MSA Breaches in month (outside of ITU).
20.	**Continuity of Carer**	• Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women

		and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
21. **22.** **23.** **24.**	**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.
25.	**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.
26.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.
27.	**National Patient Safety Alerts not completed by deadline**	• Number of CAS (Central Alerts System) alerts with actions not completed by the deadline.
	Access & Performance	
28.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.
29. **30.**	**RTT Open Pathways and 52 & 104 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
31. **32.**	**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.
33.	**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.
34.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
35.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
36.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
37.	**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.
38.	**Cancer 31 Days - First Treatment**	• All patients to receive first treatment for cancer within 31 days of decision to treat.
39.	**Cancer 31 Days - Subsequent Surgery**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.

40.	**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.
41.	**Cancer 62 Days - Urgent**	• All patients to receive first treatment for cancer within 62 days of an urgent referral.
42.	**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.
43.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
44.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
45.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
46.	**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.
47.	**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.
48.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
49.	**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.
50.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.
51.	**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.
52.	**COVID-19 Recovery Elective Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
53.	**COVID-19 Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
54.	**COVID-19 Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
55.	**% Outpatient Attendances Delivered Remotely**	• Part of the transformation of outpatient care, this indicator will monitor the % of outpatient appointments delivered remotely via telephone or video consultation.
55.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
56.	**% Outpatient Attendances Delivered Remotely**	•
57.	**Advice & Guidance (A&G) Activity Levels**	• Number of Advice & Guidance contacts in month.
58.	**Patient Initiated Follow Up (PIFU) Activity Levels**	• Number of Patient Initiated Follow Ups (PIFU) in month.
59.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).

80.	**Reduction in Outpatient Follow Ups**	• % reduction of Outpatient follow ups compared to 19/20 activity.
81.	**COVID-19 Recovery Cancer First Treatment**	• % of people who received their first treatment for cancer compared to the equivalent month in 19/20.
82	**% Patients discharged to their usual place of residence**	• % of patients who were discharged to their usual place of residence.
	Workforce	
60.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
61.	**Welcome Back Conversations**	A review of the completed monthly return to work interviews.
62.	**Recruitment Timeframe**	A measurement of the average number of days it is taking to recruit into posts.
63.	**Vacancy Rates**	% of Trust vacancies against whole time equivalent.
64.	**Retention**	Staff retention rate % over the last 12 months.
65.	**Turnover**	A review of the turnover % over the last 12 months.
66.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
67.	**Pay Spend – Contracted and Non-Contracted**	A review of Contracted and Non-Contacted pay against budget.
68.	**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.
69.	**Role Specific Training**	A summary of role specific training compliance.
70.	**Safeguarding Training**	A summary of safeguarding training compliance.
71.	**Workforce carrying out an Apprenticeship Qualification**	% of the workforce carrying out an apprenticeship qualification.
72.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
73.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
74.	**Cash Balance**	The cash balance at month end compared to plan.
75.	**Capital Programme**	Capital expenditure compared to plan.
76.	**Better Payment Practice Code**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
77.	**Use of Resources (Finance)**	Suspended – awaiting further guidance from NHSE/I
78.	**Cost Improvement Programme – Plans in Progress in Year**	Cost savings schemes in-year compared to plan.
79.	**Cost Improvement Programme – Recurrent)**	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

1.0 What is SPC?

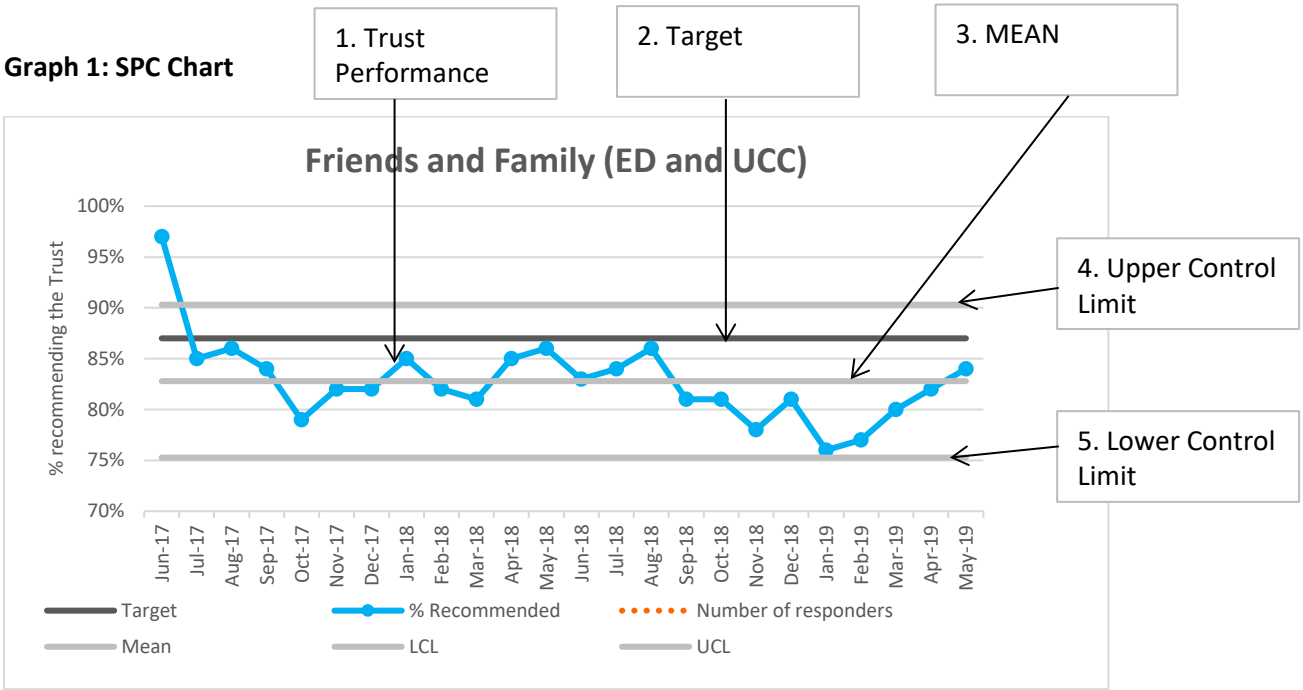
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

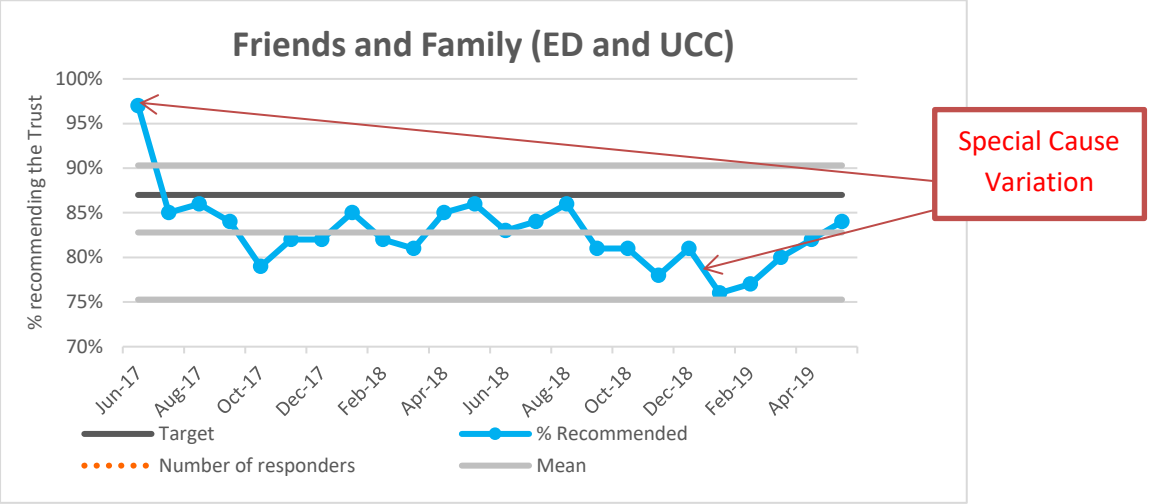


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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

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

Income Statement, Activity Summary and Use of Resources Ratings as at 31st December 2022

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							
Elective Spells	33,658	2,614	2,318	-296	25,049	22,546	-2,502
Elective Excess Bed Days	360	27	22	-5	269	53	-216
Non Elective Spells	76,974	6,687	5,937	-749	56,525	51,641	-4,883
Non Elective Bed Days	2,049	178	94	-84	1,504	2,077	573
Non Elective Excess Bed Days	2,930	255	392	137	2,152	1,887	-264
Outpatient Attendances	47,788	3,591	2,995	-596	35,380	30,080	-5,300
Accident & Emergency Attendances	15,398	1,177	1,466	289	11,992	12,572	580
Other Activity	70,668	6,125	7,745	1,619	52,998	69,038	16,040
ERF	7,964	664	664	0	5,973	5,973	0
COVID Block Income (Liverpool CCG)	35,420	2,952	2,923	-28	26,565	26,537	-28
Sub total	**293,208**	**24,269**	**24,556**	**287**	**218,407**	**222,405**	**3,998**
Non NHS Clinical Income							
Private Patients	0	0	2	2	0	7	7
Non NHS Overseas Patients	0	0	15	15	0	88	88
Other non protected	996	83	78	-5	747	606	-142
Sub total	**996**	**83**	**95**	**12**	**747**	**701**	**-47**
Other Operating Income							
Training & Education	9,093	758	779	21	6,820	7,138	318
Donations and Grants	2,910	480	18	-462	906	405	-501
Miscellaneous Income	13,248	1,271	1,893	623	9,437	12,758	3,321
Sub total	**25,251**	**2,509**	**2,690**	**181**	**17,163**	**20,302**	**3,139**
Total Operating Income	**319,455**	**26,860**	**27,341**	**481**	**236,318**	**243,408**	**7,090**
Operating Expenses							
Employee Benefit Expenses	-233,200	-19,228	-19,101	128	-176,302	-180,018	-3,716
Drugs	-17,585	-1,460	-1,803	-343	-13,236	-14,738	-1,502
Clinical Supplies and Services	-20,415	-1,681	-1,859	-178	-15,491	-16,222	-730
Non Clinical Supplies	-32,995	-2,745	-3,311	-566	-24,789	-27,243	-2,454
Depreciation and Amortisation	-13,760	-1,147	-1,134	12	-10,320	-10,198	122
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-317,955**	**-26,261**	**-27,208**	**-947**	**-240,138**	**-248,418**	**-8,281**
Operating Surplus / (Deficit)	**1,500**	**599**	**133**	**-467**	**-3,820**	**-5,010**	**-1,190**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	1	1	0	36	36
Interest Income	166	14	119	105	124	547	423
Interest Expenses	-192	-16	-14	2	-144	-122	23
PDC Dividends	-4,863	-405	-405	0	-3,647	-3,647	0
Total Non Operating Income and Expenses	**-4,889**	**-407**	**-300**	**108**	**-3,667**	**-3,185**	**482**
Surplus / (Deficit) - as per Accounts	**-3,389**	**192**	**-167**	**-359**	**-7,487**	**-8,195**	**-708**
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	-2,910	-480	-18	462	-906	-405	501
Add Depreciation on Donated & Granted Assets	192	16	39	23	144	354	210
Total Adjustments to Financial Performance	**-2,718**	**-464**	**21**	**485**	**-762**	**-51**	**711**
Adjusted Surplus / (Deficit) as per NHSI Return	**-6,107**	**-272**	**-146**	**127**	**-8,249**	**-8,247**	**2**

Appendix 6: Capital Programme
As At 18 January 2023

Scheme Name	Approved Programme 2022/23 £000	Budget Amendments Mths 1-8 2022/23 £000	Emergency Requests M09	Budget Adjustments approved by FSC 21/12/2022 2022/23 £000	Emergency Requests M10 2022/23 £000	Budget Adjustments approved by FSC 18/01/2023 2022/23 £000	Total Revised Budget 2022/23 £000
ESTATES							
Estates schemes greater than £250k c/f from 2021/22							
ED Plaza	2,859			(29)		(138)	**2,692**
Paeds (Childrens Outpatients)	130			251			**381**
Urology (Estates)	240			249			**489**
Estates schemes greater than £250k							
Appleton Ventilation Upgrade	300						**300**
Appleton Wing circulation Area Fire Doors Deferred from 21/22	300	(100)					**200**
Estates Capital Staffing	260						**260**
Fixed electrical testing site wide (£100k was b/f from 21/22)	150	100					**250**
Catering Upgrade	1,800			(800)			**1,000**
Induction of Labour Ward	300						**300**
Bath Street Lease						305	**305**
All other estates schemes less than £250k	973	1,255	0	(66)	0	4	**2,166**
Estates Total	**7,312**	**1,255**	**0**	**-395**	**0**	**171**	**8,343**

IM&T							
IM&T schemes greater than £250k							
Cisco Refresh Phase 2	817						**817**
IT Staffing	316						**316**

All other IM&T schemes less than £250k	980	(249)	0	0	0	(185)	**546**
Information Technology Total	**2,113**	**-249**	**0**	**0**	**0**	**-185**	**1,679**

MEDICAL EQUIPMENT							
Medical Equipment schemes greater than £250k							
Replacement of the Pharmacy Automated Dispensing System Robot	1,084	(689)					**395**
Ophthamology	308						**308**
Echo Machines	500						**500**
Defibrillator Replacement - Warrington				345			**345**
All other IM&T schemes less than £250k	1,072	200	18	0	40	(53)	**1,277**
Medical Equipment Total	**2,964**	**-489**	**18**	**345**	**40**	**-53**	**2,825**

Total Trust Funded Capital excluding depreciation	**12,389**	**517**	**18**	**(50)**	**40**	**(67)**	**12,847**

CONTINGENCY							
Prior Year Adjustments (VAT Rebates)							**0**
Contingency	400	(812)	(18)	50	(40)	67	**(353)**
Slippage from schemes	-295	295					**0**
Contingency Total	**105**	**(517)**	**(18)**	**50**	**(40)**	**67**	**(353)**

Total Trust Funded Capital	**12,494**	**0**	**0**	**0**	**0**	**0**	**12,494**

Externally Funded Schemes							
Warrington Town Deal Health and Wellbeing Hub- Capital Works*	2,560						**2,560**
Shopping City 21/22 underspend (added 04/02/2022)	350						**350**
3Dimensions System with 3MP Monitor (static) (BSP)		320					**320**
Halton Elective Centre (TIF Funding/PDC)	1,367						**1,367**

Community Diagnostic Centre (CDC) Estates	2,400						**2,400**
Community Diagnostic Centre (CDC) Equipment	3,510						**3,510**
MRI Software Upgrade		17					**17**
Total Externally Funded	**10,187**	**337**	**0**	**0**	**0**	**0**	**10,524**

Grand Total	**22,681**	**337**	**0**	**0**	**0**	**0**	**23,018**

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/09 (a) i		Trust Board	DATE OF MEETING	25 January 2023

Date of Meeting	6 December 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Jayne Downey
Was the meeting quorate?	No

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/22/12/306	**Deep Dive – Blood Transfusion Response to Alert Including Training**	The Committee received a presentation on the Trust's Blood Transfusion Service and the response the amber alert in October 2022. Particularly noted was the following: • Accountability and governance relating to Blood Transfusion • WHH current usage of blood components • WHH response to Amber Alert (October 2022) • Training compliance update • Next steps and monitoring In October, the NHS Blood and Transplant issued their first even Amber response to a red cell shortage; however, this was withdrawn in November.	**The Committee discussed the presentation and received moderate assurance.** **An update to be presented to the meeting in March 2023.**	**QAC March 2023**
QAC/22/12/312	**HTA Update**	The Committee received an update following the HTA inspection in May 2022. It was particularly noted that the shortfalls identified have been actioned and the HTA informed. The following were also noted: ▪ Privacy fencing is currently in progress ▪ Vehicular purchase options being explored by procurement team	**The Committee discussed the presentation and received moderate assurance.**	**Updates to monitored via Patient Safety & Clinical Effectiveness Sub-Committee**

		▪ ECF's approved to recruit portering staff to develop a hybrid model supported on occasion by the security team. ▪ Specific deceased handling training and reporting incidents will be provided by the Mortuary team.		
QAC/22/12/313	**Learning from Deaths Q3**	The Committee received a report detailing 'Learning from Deaths' in quarter 2, The key points noted were: • During Q2 2022, 316 deaths occurred within the Trust. • Of these, 103 met the criteria to be subject to a Structured Judgement Review (SJR). • 100 SJRs were completed in Q2. • In Q2, 6 serious incident investigations were reported where the patient had died. • The latest Hospital Standardised Mortality Ratio (HSMR) based on 12 months data up to June 2022 is 89.17. This result was a low value outlier. • The latest Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics (SHMI) for the 12-month period up to May 2022 is 101.53. This result was not an outlier. The Committee discussed specific incidents to gain assurance	**The Committee discussed the report and received good assurance.**	**QAC March 2023**

The Committee also received the following items:

QAC/22/12/304 - Patient Story – Parkinson's Disease – A Family's Perspective
QAC/22/12/305 - Hot Topic – Patient Safety Incident Response Framework (PSIRF)

Matters for Approval
QAC/22/12/307 – Strategic Risk Register & BAF

Papers to Discuss and Note for Assurance
QAC/22/12/309 - Maternity Update including;

- *Ockenden*

- *ATAIN*
- *MIS*

QAC/22/12/310 - Sepsis High Level Update
QAC/22/12/311 – Quality IPR Metrics

Papers to Note for Assurance
QAC/22/12/314 – DIPC Q2 Update
QAC/22/12/315 – Dementia Strategy Q2 Update
QAC/22/12/316 – Quality Improvement Progress Report Q2

High Level Briefing Reports
QAC/22/12/317 – Patient Safety & Clinical Effectiveness Sub Committee
QAC/22/12/318 - Injection Control Sub Committee
QAC/22/12/319 – Safeguarding Committee
QAC/22/12/320 - Health & Safety Sub-Committee
QAC/22/12/321 – Complaints Quality Assurance Group
QAC/22/12/322 – Patient Experience Sub-Committee
QAC?22/12/323 – Patient Equality, Diversity & Inclusion Sub-Committee

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/08 (a) ii		Trust Board	DATE OF MEETING	25 January 2023

Date of Meeting	10 January 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/23/01/02	**Maternity Incentive Scheme**	The Committee received a report and presentation providing the Committee with the current position and trajectory of the 10 safety actions as recommended by NHSR. It was noted that all safety actions were 100% compliant or on track to be 100% compliant prior to submission to the Trust Board for approval 25th January 2023.	**The Committee discussed the update receiving good assurance and supported submission to the Trust Board**	**Trust Board - January 2023**
QAC/23/01/09 i	**Maternity Update - Ockenden**	The Committee received updates on compliance with the Ockenden Review recommendations and received good assurance. The Committee noted that the Trust had not yet received all the funding allocated. It was agreed this should be escalated.	**The Committee discussed the report and received good assurance; however, non-receipt of funding should be escalated.**	**Trust Board – January 2023**
QAC/23/01/09 iii	**Maternity Update – Perinatal Mortality**	The Committee received a report providing rates for stillbirths and neonatal deaths for the Trust and the national picture based on occurrences in 2020. The report analysed the previous five reports published by MBRRACE for the Trust (2016-2020) and the variations over that time. The Committee noted that the Trust had performed equal to or better than other comparator maternity units with regards to perinatal deaths until 2019 where a slight adverse variation was noted, and then again in 2020. The declining birth	**The Committee discussed the presentation and received good assurance.**	**QAC April 2023**

		rate and small death numbers are identified as a contributor to the variance, and emphasis is made of monitoring these rates over time.		
QAC/23/01/05	**Hot Topic – Arbury Court**	The Committee received a presentation in relation to Arbury Court, an 82 bedded unit provided low and medium secure beds and a Psychiatric Intensive Care Unit for female patients. The Committee noted concerns regarding Arbury Court that had been escalated since January 2021 and had been reviewed by Specialist Commissioners in 2021 with an action to discuss the concerns raised and a plan in place to review cases by appropriate handlers for assurance. A number of next steps were identified which included; ▪ Follow up meeting with Arbury Court and the Gastroenterology team. ▪ Continue to monitor incidents, themes and trends, reporting internally and externally. ▪ Continue to incident report all concerns including patients who attend WHH in handcuffs. ▪ Requested to be standing agenda item on Clinical Quality Focus Group and Warrington Adult Safeguarding Board, for system approach with next steps to be confirmed.	**The Committee discussed the presentation and received moderate assurance.**	**To be highlighted to Trust Board.**
QAC/23/01/06	**Deep Dive – Paediatric Ophthalmology & Dental Backlog**	The Committee received a presentation relating to a backlog in Paediatric Ophthalmology. The Committee were advised that there was backlog of 340 Paediatric Ophthalmology Outpatients overdue patients all waiting to see an Ophthalmologist. The Committee noted: • The longest wait is 12 months – Low risk patient • 60 children are waiting on an elective waiting list and the longest waiting is 45 weeks • All patient records reviewed by Head Orthoptist and Advanced Orthoptist	**The Committee discussed the presentation and received moderate assurance.** **The position is to be monitored at the Patient Safety & Clinical Effectiveness Sub-Committee**	**To be monitored at the Patient Safety & Clinical Effectiveness Sub-Committee**

		• All Children with a potential for harm / sight loss have had interim Orthoptic and Optometry appointments made for monitoring and maintenance of vision and amblyopia avoidance • All high risk patients have had an appointment scheduled across Jan / Feb with 3 additional clinics being booked in January for the Associate specialist Doctor • 88 children have been redirected to a telephone clinic or AHP clinic Reasons for the increase in backlog were documented as: • Increase in waiting list following the pandemic • Sickness within specialty workforce • Pre- pandemic demand exceeded capacity this was managed through additional premium cost sessions provided by existing workforce • Nationally recognised challenges in recruitment for this specialty Amongst the next steps, recruitment has commenced for a Paediatric Ophthalmology Consultant and there is an SLA in progress with Alder Hey who can offer some support		
QAC/23/01/08	**Cycle of Business**	The Committee approved the updated Cycle of Business	**The Committee discussed and approved the changes to the Cycle of Business**	**Submit to January Trust Board for ratification**
QAC/23/01/12	**Acute Kidney Injury update**	The Committee received a presentation providing an update on the position since it was previously reported in July 2022. It was particularly noted that: • Number of AKI's was increasing but the rise is largely from the community • Proportion of hospital AKIs down from 66% to 50% and falling • Number deteriorating down for 9.5% last year to 8.4% this year • ITU admissions for AKI reducing • 30 day mortality down from 31% in 2019 and 24% last year to 23% • Length of Stay is significantly down despite huge pressures • 20.1% 30 day all cause readmission rate post AKI last year compared to 16.7% this year	**The Committee discussed the report and received good assurance**	

		It was reported that work was taking place with GPs relating to referrals.		
QAC/23/01/13	**P11 Report update – Cases of Clostridium difficile**	The Committee received an update on the number of C-Diff cased reported. The Threshold for 2022/23 was 37 and the Trust had reported 42 cases year to date. Improvements in compliance with cleanliness reported. Next steps – continue with RCA investigations and look at how these are undertaken and alignment of approach with the Patient Safety Incident Response Framework (PSIRF) to identify system learning.	**The Committee discussed the report and received moderate assurance**	**QAC May 2023**

The Committee also received the following items:

QAC/23/01/06 – Paediatric Dental Backlog

Matters for Approval
QAC/22/12/307 – Strategic Risk Register & BAF

Papers to Discuss and Note for Assurance
QAC/23/01/10 - Medicines Reconciliation & Optimisation Update
QAC/23/01/11 – Arthroplasty -Surgical Site Infection – 6-month update

Papers to Note for Assurance
QAC/23/01/14 – DIPC Bi-monthly report

High Level Briefing Reports
QAC/23/01/15 – Injection Control Sub Committee
QAC/23/01/16 - IG & Corporate Records

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/09 (c)	MEETING:	Trust Board	DATE OF MEETING	25th January 2023

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

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/01/03	**Policies and Procedures Report**	The Committee received and approved the OPC Policies and Procedures report. Six policies were amendments due to Industrial Action. Seven policies were extensions to ratification dates until September 2023 SPC.	**The Committee received good assurance and approved the report.**	**Not applicable**
SPC/23/01/04	**Cycle of Business and Terms of Reference**	The Cycle of Business and Terms of Reference were reviewed in detail and a number of amendments proposed for approval by the Trust Board. In particular, SPC is proposed to Trust Board to be a monthly Committee.	**The Committee received good assurance and recommended for approval by Trust Board.**	**Trust Board 25th January 2023**
SPC/23/01/05	**Workforce Equality Assurance Report**	The Committee received and approved the Workforce Equality Analysis Report (WEAR) which looks at the personal demographics of individuals currently working at Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and those entering or leaving the workforce. As public sector organisations, all NHS Trusts are required to demonstrate how they meet the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010 via the WEAR report, which must be published online by 31st January every year.	**The Committee received good assurance and approved the report.**	**Published on Trust website by 31st January 2023**

The Committee also received the following items:

Sub-Committee Chairs Logs

SPC/23/01/06 - Workforce Equality Diversity and Inclusion Sub-Committee (11.01.2023)

SPC/23/01/10 – Operational People Sub-Committee (11.01.2023)

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/09 (d)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	25th January 2023

Date of Meeting	**21 December 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by John Somers**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/22/12/205	BAF & risk register	The committee considered the BAF report noting: - • No changes on BAF or corporate risks	The Committee **noted** the report	FSC January 2023
FSC/22/12/206	Pay Assurance	The Committee considered and reviewed the report noting: - • Groups of staff worked above funded WTE highlighted and further review on Healthcare workers will be undertaken • Vacancies continue to increase – retention work is key to this • Leavers, sickness and increase in establishment make it difficult to make improvement to vacancies. • Additional demand for corridor care and escalation areas (B3 & B4) • The current Trust AfC position for annual leave taken as at November is 54.82% against a target of 66.67%. The current Trust Medical and Dental position at November-22 is 67.91% against a target of 66.67%.	The Committee **noted** the report	FSC January 2023

FSC/22/12/207	CIP & GIRFT	The Committee considered and reviewed the monthly CIP & GIRFT report noting: - • Delivered £8.0m against a plan of £8.3m • Concern for next year as only £2.0m recurrent CIP highlighted • Identified £15m to date however £3.9m high risk, £0.7m unidentified • Consider how do we incentivise / reward CIP achievement in 2023/24 and review escalation process	The Committee **noted** the progress achieved so far but noted the risk to the financial position.	FSC January 2023
FSC/22/12/208	Exit strategy relating to unfunded additional capacity	The Committee considered and reviewed the paper noting: - • Decision needs to be taken with partners • 150 patients stranded • System sharing operational and financial risk relating to the additional capacity	The Committee **noted** the update	FSC January 2023
FSC/22/12/209	Financial Forecast	The Committee heard the verbal update noting:- • Presented risky £7.9m deficit to Board last week therefore £1.8m gap, key risks highlighted including ERF, Employment Tribunal's, non pay freeze, annual leave, all CQUIN monies received and opening more capacity • Continued to find mitigations to close the gap, as at today list of £2.1m some elements need further work, Adaptive reserve / BCF, IT scheme deferral, CEA calculation revision, Bank interest, in addition looking at revenue to capital, MHIS, VAT and asset lives	The Committee **noted** the update	FSC January 2023
FSC/22/12/210	Monthly Finance report	The Committee considered the report. Key points to note included: • Month 8 position £8.1m deficit, slightly worse than plan year to date by £0.1m • Capital is behind on the capital plan by £3.6m. The Trust will not get any underspend back in 2023/24 • The forecast was presented as a best, likely, and worse scenario considering the risk areas such as energy, ERF, agency, pay award, B3 and A&E, with the likely case c£2.2m from plan at	The Committee **noted** the update The Committee **supported** the capital changes for **approval** at the Trust Board	FSC January 2023 Trust Board January 2023

		£8.3m deficit, however there were a number of mitigations being worked on as previously highlighted		
FSC/22/12/211	Capital Expenditure Update	The Committee considered and reviewed the presentation noting: - • Emergency items approved £18k • Underspend returned to contingency £1,044k • Approval for the following expenditure noting detailed papers in next agenda item:- • Urology & Paediatrics £500k • Defibrillators £355k • ED minors £ 148k	The Committee **noted** the update The Committee **approved** the capital changes with delegated responsibility from Trust Board	FSC January 2023
FSC/22/12/213	Capital Requests –	The Committee considered and reviewed the papers noting: - • Defibrillators £355k • ED minors £ 148k	The Committee **approved** the papers	
FSC/22/12/213	Digital Strategy Group Report	The Committee considered the report noting items to escalate to FSC include: • Digital strategy deferred to January • EPR business case partnership agreement will go to the Executive Team in January, the timetable to present the business case to Trust Board is the 1/3/23	The Committee **noted** the report	FSC January 2023

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/		Trust Board	DATE OF MEETING	18 January 2023

Date of Meeting	18 January 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/01/05	**Pay Assurance Report**	The Committee received the report noting • Additional clinical services have been higher but are reducing • Annual leave utilisation and the risk to CIP target	**The Committee noted and discussed the report, receiving good assurance**	**FSC February 2023**
FSC/23/01/06	**Monthly CIP report**	The Committee received the report noting:- • Current position of CIP £9.1m against a plan of £9.9m • Significant level of non recurrent CIP and the risk this presents to 2023/24 • Ongoing work on GIRFT schemes • Progress with Care Groups to refine the CIP methodology for 2023/24	**The Committee discussed and noted the report receiving moderate assurance. It was agreed that a further update would be presented to the meeting in February 2023.**	**FSC February 2023**
FSC/23/01/07	**COVID Report**	The Committee received the paper noting:- • Items where expenditure has ceased • Items which are now business as usual and the impact on the cost pressures and budget setting for 2023/24	**The Committee discussed the report receiving moderate assurance and noted a further update would be presented to the Committee in February as part of budget setting.**	**FSC February 2023**

FSC/23/01/08	**Planning guidance**	The Committee received a presentation noting:- • The risk of the unknowns in particular the elective targets and ERF • The CIP and productivity challenge • The current escalation capacity • The risk linked to the PBR payment for Elective Activity • The need for system solutions • The need to understand CQUIN and agency	**The Committee discussed the guidance. A further update will be presented to the next meeting.**	**FSC February 2023**
FSC/23/01/10	**Finance Report**	The Committee received a report noting:- • The current financial position of £8.2m deficit year to date which is on plan • The Trust is forecasting achievement of the £6.1m deficit control total • The ICS is asking Trusts to improve their forecast if possible to support delivery of the system plan and avoid a triple lock • Elective activity is currently underperforming against the plan • Agency expenditure forecast this year is significantly higher than next years cap • Capital is underspending by £5m and a further review is planned • The emergency capital requests that have been approved and approved the capital spend put forward from Capital Planning Group.	**The Committee discussed the paper considering the review of capital underspend and approved the capital requests.**	**FSC February 2023**
FSC/23/01/11	**Capital Position**	The Committee received a presentation noting:- • Highlighted underspend and catch up of schemes • Schemes over £500k reviewed in detail including Catering, CISCO, Town Deal, TIF • Urology and Paediatric overspend update received – update and conclusion requested for next month.	**The Committee noted the update**	**FSC February 2023**
FSC/23/01/12	**Capital Requests**	The Committee received a paper and a presentation noting:- • CT/ MRI Scanners successful in bid to replace old MRI and CT scanner. The MRI scanner was signed off last week and the CT is pending approval. • Community Diagnostic Centre (CDC) – Phase 2 was reviewed by the national team last week, and the Trust has been asked to rework the bid	**The Committee approved the CT Scanner and supported the prior MRI approval. The Committee supported the CDC capital**	**FSC February 2023**

		to deliver the scheme on 2022/23. The Team has reviewed what is possible including scaling down the new build and utilising the Runcorn shopping city scheme. This will reduce the capital and revenue bid, however the majority of the benefits could still be realised if the updated proposal is supported. The Committee noted the clinical need along with the risk to approval by the national team and the ability to spend the capital by 31/03/23. The Committee noted the lack of time to rework the scheme and supported the bid to progress. The Committee discussed Board delegation of Capital to the Committee and agreed to propose an increased limit at the next Board meeting	**scheme. Final approval will be requested in the Trust Board meeting on 25 January 2023. The Committee will receive updates on the capital schemes as part of the capital standing agenda item**	**Trust Board January 2023**

The Committee also received the following items:

Papers for Approval

Papers to Discuss and Note for Assurance
FSC/23/01/04 – Board Assurance Framework

High Level Briefing Report
FSC/23/01/08– Operational Planning Guidance
FSC/23/01/09– Runcorn shopping city
FSC/23/01/13– Digital strategy
FSC/23/01/14– Bimonthly strategy report
FSC/23/01/15– Digital strategy group report

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/09 (d)		Trust Board	DATE OF MEETING	25 January 2023

Date of Meeting	17 January 2023
Name of Meeting & Chair	Clinical Recovery Oversight Committee (CROC) Chaired by Jane 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
23/01/08	Cancer waits	• 104 day has risen to 16 and >62 trajectory currently 57. The majority of these are urology and colorectal patients due to specific issues with prostate biopsy capacity and subsequent longer reporting times in pathology. This Trust, however, is not still not deemed to be a risk at Cancer Alliance level with the 62 day backlog. • Continued increase in 2ww referrals over and above pre pandemic levels. The Trust routinely receives 300 extra 2ww referrals over previous levels- this rose late 2021 and has not reduced. Colorectal and breast affected. This is reflected at Alliance level with sustained 34% increase in referrals	**The Committee noted the update**	Update due at February meeting
23/01/04	CROC risks	• Risk 224 and 1215 reviewed. The committee agreed the rating and descriptions were accurate and relevant.	**The Committee noted the update**	Update due at February meeting
23/01/08	Radiology and Endoscopy	• The committee acknowledged the good progress in the reduction of the Endoscopy waiting lists. And that mutual aid of circa 40 patients /	**The Committee noted the update**	Update due at February meeting

		procedures was being provided to Mid Cheshire to help their backlog starting in January 23. • DM updated the committee that the replacement of Endoscopes BC was due to be signed off at execs on 18/1.		
23/01/08	Cardio Respiratory	• Cardio-respiratory waiting list recovery remained a significant challenge. Particularly Echo and Sleep studies. DM updated that the Trust has received waiting list support funding from the regional recovery team to help with additional insourcing support between now and the end of the financial year. This work commenced on the 15th January. Options to support the reduction with Sleep Studies, a regional problem, continues to be a focus for the Unplanned Care group.	**The Committee noted the update**	Update due at February meeting
	78 week wait position	• DM update that following the impact of the festive period and Industrial action in December, the Trust was forecasting to not meet the 78 week elective target by the end of March by circa 100 patients. Solutions to reduce this number over the next 10 weeks were being worked on internally and with Cheshire and Mersey side provider partners.	**The Committee noted the update**	Update due at February meeting

The Committee also received the following items:

Papers to Discuss and Note for Assurance

23/01/04 – Board Assurance Framework (BAF) / Risk update

23/01/02 - Draft Minutes from the Clinical Services Oversight Group meeting held on 16 November 2022, 29 November 2022 & 11 January 2023

23/01/06 - Harm Profile Update
23/01/07 - Corporate Performance Report
23/01/08 – Waiting List updates
23/01/09 – Access to recovery fund update
23/01/10 - Cheshire & Merseyside update
23/01/11 - Committee Effectiveness – annual review

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/10 i (a)**
SUBJECT:	**Maternity Update Ockenden Report – December 2022**
DATE OF MEETING:	25th January 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy 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): **(*Please DELETE as appropriate)***	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Ockenden recommendations require the Trust Board to be informed and have oversight of maternity safety updates. This paper provides the Board with an update with regards to Ockenden recommendations, the report has previously been shared at Quality Assurance Committee. In summary, WHH has 3 Ockenden action plans: Ockenden Part 1 following release of the first Report, Ockenden Part 1, Phase 2 following receipt of the Trust Provider Report of Ockenden 1 evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update for end October 2022 is: • **Ockenden Part 1a**: WHH is 98% compliant and on trajectory to be compliant by 30th November 2022. • **Ockenden 1b**: WHH is 92% compliant and on trajectory to be 100% compliant by 31st May 2023. • **Ockenden 2**: WHH is 45% compliant and was on trajectory to be 100% compliant by 30th June 2022. This trajectory has been impacted by cancellation of 6-month High Dependency Training Programme scheduled for Band 7 staff. Training rescheduled to commence May 2023. • Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023.

PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the report as per Ockenden Recommendations.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/22/12/309**		
	Date of meeting	06/12/2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/23/01/10 i (a)

1. BACKGROUND/CONTEXT

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

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

KEY

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring
White	Action for LMNS/National/Regional

2. KEY ELEMENTS

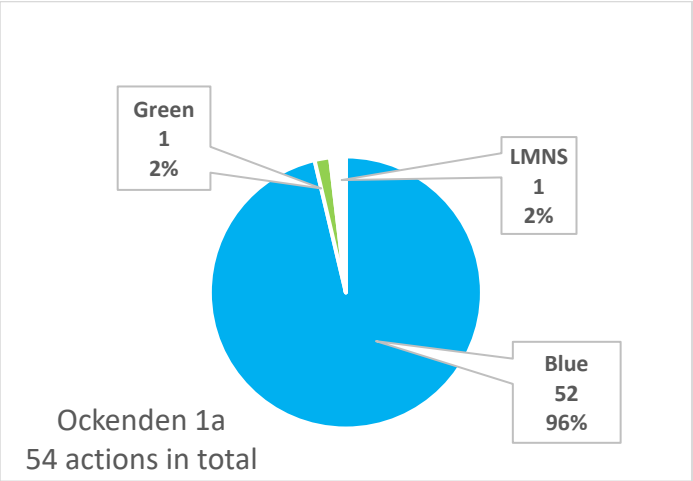
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report

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

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

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update
0 Amber (previously 0)

1 Green (previously 2): -
On track to move to blue:-
1 end November 2022

52 blue (previously 51)

1 –action not for WHH

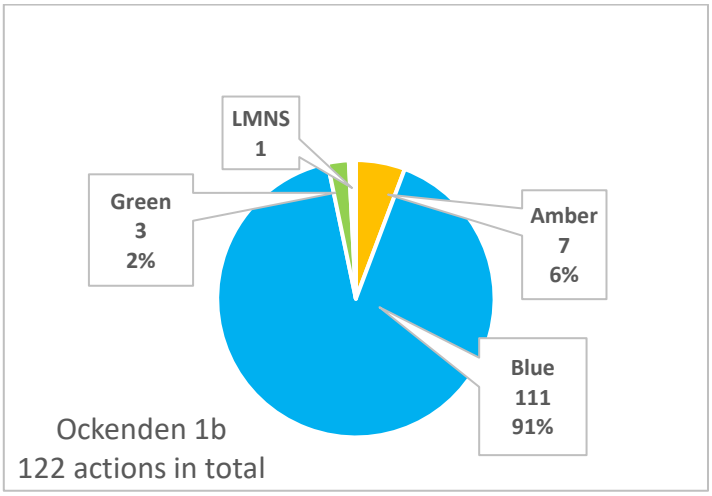
The 1 Green action is in relation to resolving teething problems following implementation of the new BadgerNet system. It is anticipated that all maternity patient records will be recorded on BadgerNet by the end of November 2022.

Excluding the LMNS action, Ockenden Part 1a action plan is currently 98% compliant.

2.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



Update

0 Red (previously 4)
Relating to appointment to role

7 Amber (previously 3): -
On track to move to green as follows:
3 end November 2022
4 end May 2023

3 Green (previously 3): - –
On track to move to blue as follows:
2 end November 2022
1 end December 2022

111 blue (previously 110)

1 – action not for WHH

7 amber actions relate to:-

- 4 actions previously rated Red - due to the role of Lead Obstetrician in Fetal Surveillance failing to be fulfilled at the Consultant Away Day in October 2022, the CBU will include the role into the vacant Consultant post. The timeframe of the 4 actions has therefore been extended from end November 2022 to 31 May 2023 to allow recruitment process to be completed. The actions previously Rag rated Red have now moved to Amber
- 3 actions are for scheduled audits concerning complex pregnancies having a named consultant lead, and informed decision making around place of birth and caesarean section.

3 Green actions relate to:-

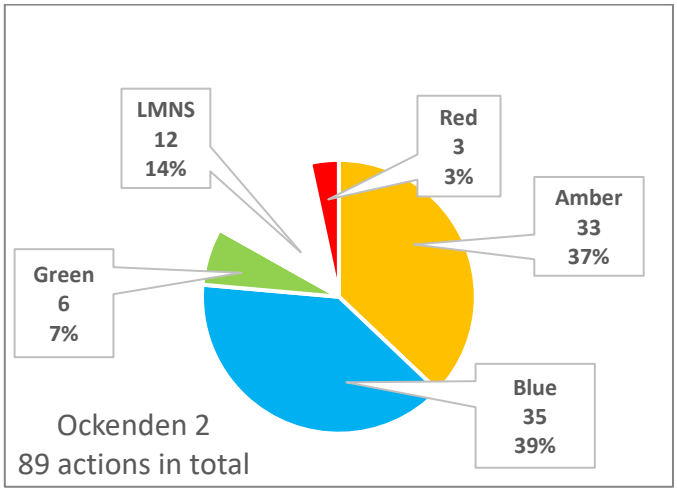
- Following results of the staff survey, the W&C triumvirate is developing a communication strategy for the CBU, which will include MVP involvement to ensure all voices are represented.
- 2 actions concerning evidence gathering relating to ongoing review of intended place of birth based on developing clinical picture.

Excluding the LMNS action, Ockenden Part 1b action plan is currently 92% compliant.

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



3 Red actions relate to:-

Update

3 Red (previously 0)

33 Amber (previously 36)

On track to move to green as follows:
21 end November 2022
5 end December 2022
3 end January 2023
1 end February 2023
1 end March 2023
1 end April 2023
1 end May 2023

6 Green (previously 7)
On track to move to blue as follows:
5 end November 2022
1 end December 2022

35 blue (previously 34)
12 white – actions not for WHH

- Cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.
- Post-mortem consent training compliance – the Trust Medical Consent Training for Women's and Children's CBU is 76% at end September 22. The external post-mortem consent training is 53.84% at end October 22.
- Lack of funding to recruit an Education Midwife, options being explored by the CBU.

33 Amber and 6 Green actions relate to evidence gathering and completion of audits which have been scheduled and are all on track.

Trajectory for completion of this action plan was the end of June 2023. However, this has been impacted by the cancellation of training for High Dependency care skills by the University of Salford.

Excluding the 12 LMNS actions, Ockenden 2 action plan is currently 45% compliant.

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 will be included in the vacant Consultant post due to be advertised and appointment is dependent upon successful recruitment.

There is also requirement for an Audit Midwife and Education Midwife. Currently WHH has not received any additional funding to support the Trust in becoming compliant in these recommendations. The CBU is exploring alternative options to fulfil these roles.

Following Ockenden 1 the Trust incurred a financial deficit in the region on £179K due to a discrepancy in projected and actual funding received.

PROMPT training and CTG Competency Assessment is on track to meet the necessary trajectory. However, to meet this trajectory is dependent on staff attending the scheduled training. Within the CBU this training is prioritised and closely monitored to ensure all staff will meet the necessary compliance.

b. Ockenden Summary

Ockenden recommends Trust Boards have oversight of the implementation of Ockenden IEAs. This paper provides the Board with details of the current Ockenden position:

- Ockenden 1a is 98% compliant and on trajectory to be 100% compliant by 30th November 2022.
- Ockenden 1b is 92% compliant and on trajectory to be 100% compliant by 31st May 2023.
- Ockenden 2 is 45% compliant and was on trajectory to be 100% compliant by 30th June 2023. This trajectory has been impacted by the cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.
- Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023.

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 6th December 2023.

5. RECOMMENDATIONS

The Trust Board is asked to note this report as per Ockenden recommendations.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/10 I (b)**
SUBJECT:	**Maternity Update Ockenden Report – January 2023**
DATE OF MEETING:	25/01/2023
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy 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): **(*Please DELETE as appropriate)***	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Ockenden recommendations require the Trust Board to be informed and have oversight of maternity safety updates. This paper provides the Board with an update with regards to Ockenden recommendations, the report has previously been shared at Quality Assurance Committee. In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update for end December 2022 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 91% compliant and on trajectory to be 100% compliant by 31st May 2023. • **Ockenden 2**: WHH is 45% compliant and was on trajectory to be 100% compliant by 30th June 2023 This trajectory has been impacted by cancellation of 6-month High Dependency Training Programme scheduled for Band 7 staff. The theory aspects of the course will take place in May 2023. Staff will be fully compliant by November 2023 when all clinical shifts and competencies will be completed. • Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023. • The CBU has been advised that a MIAA audit will take place on 18th and 19th January 2023. The

	overall objective is to review the process the Trust has in place to monitor and report on the implementation of the Immediate and Essential Actions raised in the Ockenden Report (Part 2). Outcomes and recommendations will be fed back via Governance and QAC.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to receive and note the report as per Ockenden Recommendations.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/23/01/09**		
	Date of meeting	10/01/2023		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/23/01/10 I (b)

1. BACKGROUND/CONTEXT

The report will update in relation to progress towards meeting the recommendations of the Ockenden Report.

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

KEY

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring
White	Action for LMNS/National/Regional

2. KEY ELEMENTS

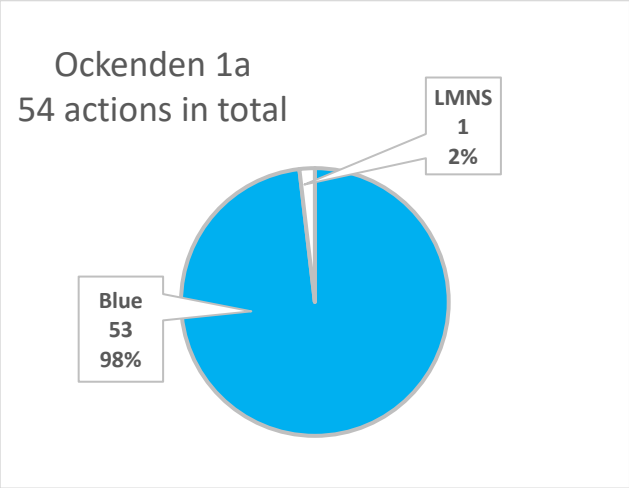
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report

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

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

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

0 Green (previously 1): -

53 blue (previously 52)

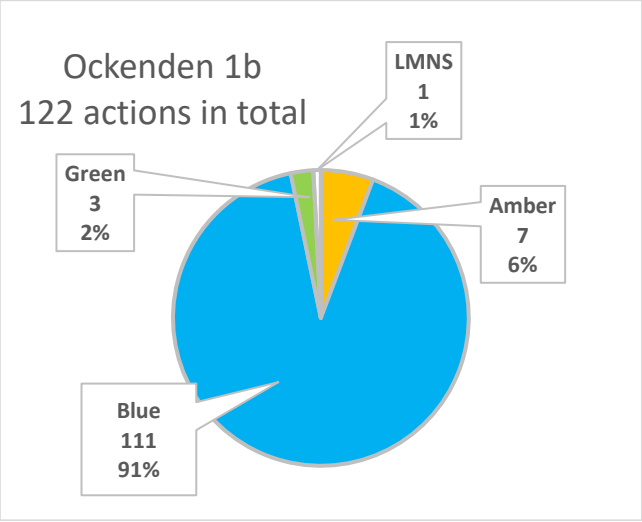
1 action not for WHH

Excluding the LMNS action, Ockenden Part 1a action plan is currently 100% compliant.

2.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



Update

7 Amber (previously 7): -
On track to move to green as follows:
3 end January 2023
4 end May 2023

3 Green (previously 3): - –
On track to move to blue as follows:
2 end January 2023
1 end March 2023

111 blue (previously 111)

1 – action not for WHH

7 amber actions relate to:-

- 4 actions are attributed to the role of Lead Obstetrician in Fetal Surveillance. This role will be included in the vacant Consultant post when advertised.

- 3 actions are for scheduled audits concerning complex pregnancies having a named consultant lead, and informed decision making around place of birth and caesarean section.

3 Green actions relate to:-

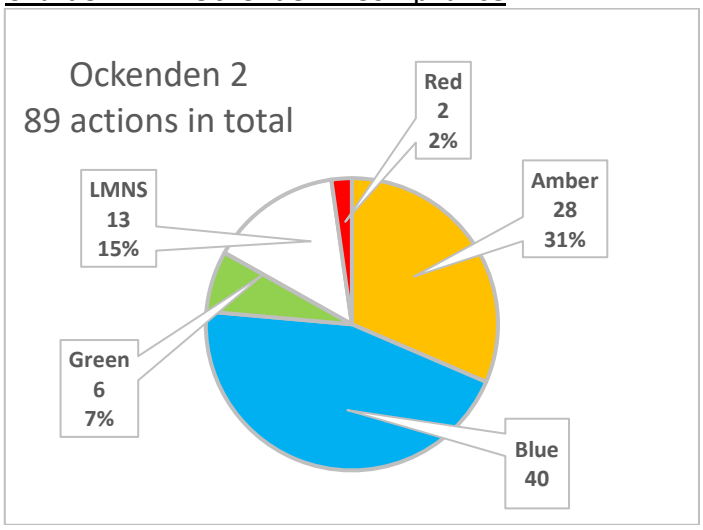
- Following results of the staff survey, the W&C triumvirate is developing a communication strategy for the CBU, which will include MVP involvement to ensure all voices are represented.
- 2 actions concerning evidence gathering relating to ongoing review of intended place of birth based on developing clinical picture.

Excluding the LMNS action, Ockenden Part 1b action plan is currently 91% compliant.

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



Update

2 Red (previously 3)

28 Amber (previously 33)

On track to move to green as follows:
23 end January 2023
1 end February 2023
2 end March 2023
1 end April 2023
1 end May 2023

6 Green (previously 7)
On track to move to blue end January 2023

40 blue (previously 35)

13 white – actions not for WHH

2 Red actions relate to:-

- Cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.
- The recommendation for visible, supernumerary clinical skills facilitators. The Maternity service has a Practice Development Midwife and an externally funded Retention Midwife (temporary funding till May 2023), both of whom will work in a supernumerary role supporting clinical skills. The CBU are reviewing how to further support this in a sustainable way in the long term.

28 Amber and 6 Green actions relate to evidence gathering and completion of audits which have been scheduled and are all on track.

Trajectory for completion of this action plan was the end of June 2023. However, this has been impacted by the cancellation of training for High Dependency care skills by the University of Salford. The University of Salford is the only local provider which has a nationally aligned course. The necessary staff are booked on the next course which will run in May 2023. Staff will be fully compliant by November 2023 when all clinical shifts and competencies will be completed.

Excluding the 13 LMNS actions, Ockenden 2 action plan is currently 45% compliant.

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 will be included in the vacant Consultant post due to be advertised and appointment is dependent upon successful recruitment.

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

Fundong has now been identified via vacancies to fund a full time Audit & Assurance Midwife and a Band 4 part time Failsafe Clerk. Recruitment for these posts will commence in January 2023. The CBU continues to explore alternative options to increase the availability of supernumerary clinical skills facilitators.

Following Ockenden 1a, the Trust incurred a financial deficit in the region on £179K due to a discrepancy in projected and actual funding received. The Trust are currently mitigating this deficit through CBU underspends and in 2023/24 will review the ongoing investment required and explore utilising the CNST reinvestment and any 2023/24 Ockenden funding allocations to eradicate this deficit.

PROMPT (Practical Obstetric Multiprofessional Training) and Newborn Life Support (NLS) training is on track to meet the necessary trajectory. Within the CBU this training is prioritised and closely monitored to ensure all staff will meet the necessary compliance. Two face to face sessions have been arranged for January 2023 as well as a virtual training session for staff unable to attend in person. Meeting the trajectory is dependent on staff attending the scheduled training. Attendance will be monitored on a daily basis to ensure attendance and compliance.

b. Ockenden Summary

Ockenden recommends Trust Boards have oversight of the implementation of Ockenden IEAs. This paper provides the Board with details of the current Ockenden position:

- Ockenden 1a is 100% compliant.
- Ockenden 1b is 91% compliant and on trajectory to be 100% compliant by 31st May 2023.
- Ockenden 2 is 45% compliant and was on trajectory to be 100% compliant by 30th June 2023. This trajectory has been impacted by the cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.
- Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023.

3. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. However, this Report has been provided to the Quality Assurance Committee first due to the deadline of the Maternity Incentive Scheme submission. The Report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting on 31st January 2023.

An MIAA audit took place on 18th and 19th January 2023. The overall objective was to review the process the Trust has in place to monitor and report on the implementation of the Immediate and Essential Actions raised in the Ockenden Report (Part 2). Outcomes and recommendations will be fed back via WCH Governance Quality Assurance Committee and Trust Board.

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 10th January 2023.

5. RECOMMENDATIONS

Board is asked to note this report as per Ockenden recommendations.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/10 ii**			
SUBJECT:	**2022/2023 Quarter 2 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**			
DATE OF MEETING:				
AUTHOR(S):	Annabel Grossmith, Consultant Obstetrician & Gynaecologist / Emma Bentham, Personal Assistant to CBU Management Team			
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)***				
EXECUTIVE SUMMARY *(KEY ISSUES):*	• Q2 2022/23 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 4.9% which continues to remain well under local and national targets. The Q2 ATAIN rate in 2021/22 was 6.2%. • The WHH ATAIN rate has met and gone beyond the national ambition of 6% and the North West Neonatal Operational Delivery Network (NWNODN) target of 5.6%. • All term admissions in Q2 were reviewed and learning from these cases informs the ATAIN action plan. • The ATAIN action plan is monitored via WCH Governance.			
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/22/12/309**		
	Date of meeting	06/12/2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	2022/2023 Quarter 2 Avoiding Term Admission into Neonatal Unit (ATAIN) Report	AGENDA REF:	BM/23/01/10 ii

1. BACKGROUND/CONTEXT

NHS Resolution is operating a fourth 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%. 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 4 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 4 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 Q2 reporting period from 1st July 2022 to 30th September 2022.

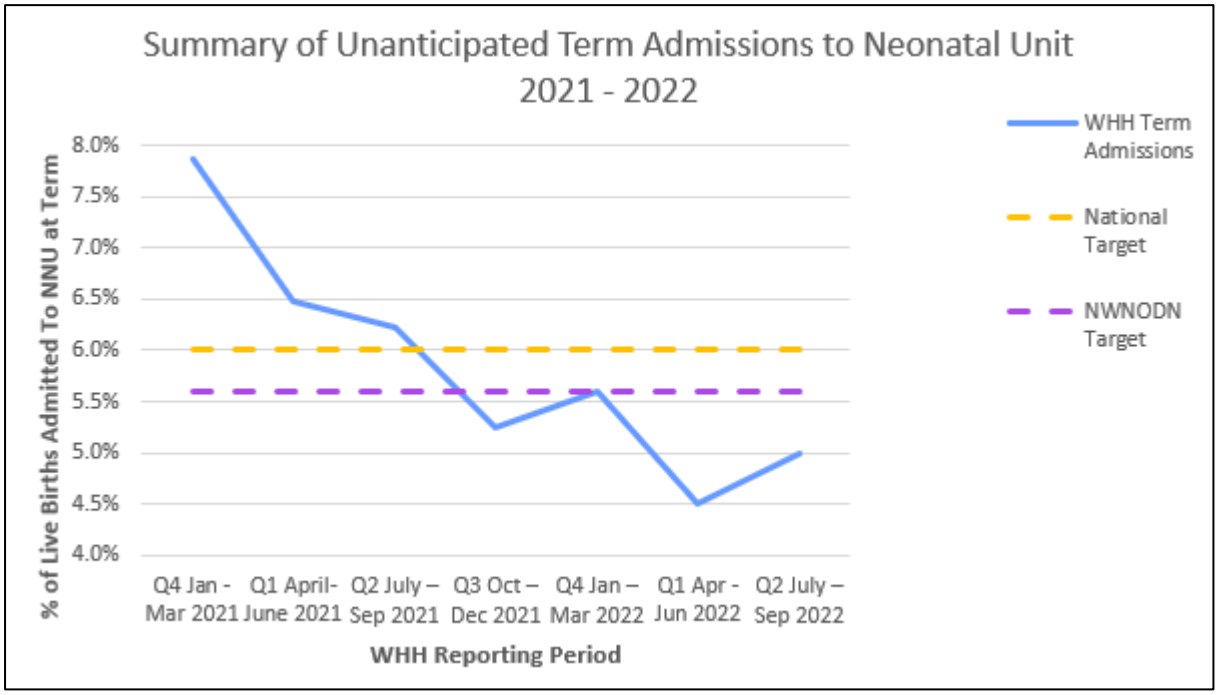
Each case is reviewed by a multidisciplinary team (MDT) of Obstetrician, Neonatologist, Midwife and Neonatal Nurse. The ATAIN MDT group meet fortnightly to ensure any learning is captured in a timely manner but with capacity to increase frequency where indicated.

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

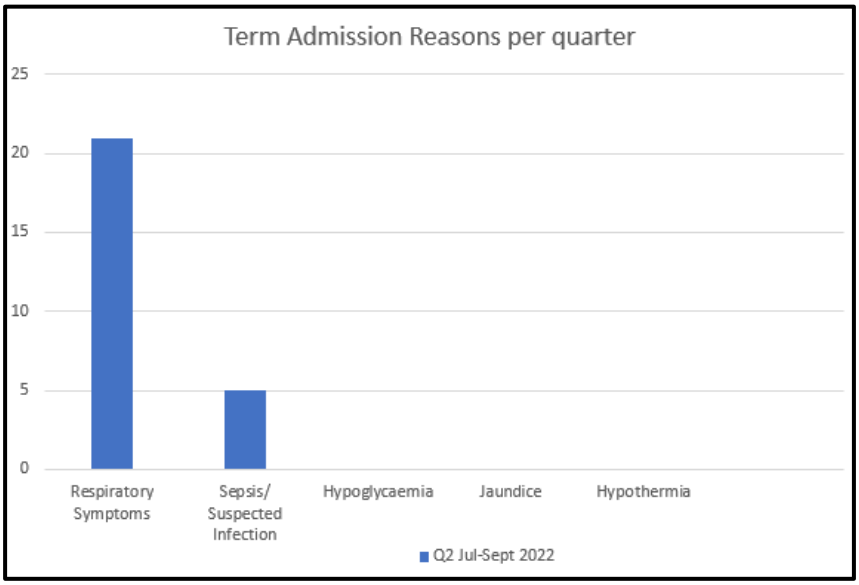
WHH is pleased to report a Q2 ATAIN Rate of 4.98% which is a continued improvement that remains well under the local and national targets.

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%
Q4 Jan – Mar 2021	597	47	7.87%		
Q1 April- June 2021	617	40	6.48%		
Q2 July – Sep 2021	706	44	6.23%		
Q3 Oct – Dec 2021	687	36	5.24%		
Q4 Jan – Mar 2022	647	36	5.56%		
Q1 Apr – Jun 2022	574	26	4.52%		
Q2 Jul – Sept 2022	682	34	4.98%		



Reasons for term admissions

WHH Number Live Births 2021-2022		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
Q3 Oct-Dec 2021	687	36	5.24%	13	36.1%	6	16.7%	2	5.6%	2	5.6%	0	0%
Q4 Jan-Mar 2022	647	36	5.56%	13	36.1%	3	8.3%	3	8.3%	0	0%	0	0%
Q1 Apr-Jun 2022	574	26	4.52%	13	50.0%	4	15.4%	0	0%	2	7.7%	2	7.7%
Q2 Jul-Sep 2022	682	34	4.98%	21	61.8%	5	14.7%	0	0%	0	0%	0	0%



61.8% (21) 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, 12 cases were diagnosed with Transient Tachypnoea of the Neonate (TTN). Of the babies with TTN, 8 were deemed avoidable admissions:

- 6 babies could have had delivery safely delayed in line with national guidance or there was no documentation of consideration of antenatal corticosteroids
- In 2 cases, there were issues identified with suboptimal interpretation of fetal monitoring during the process of Induction of Labour (IOL). These have been addressed by the Fetal Monitoring Lead Midwife.

Of the other respiratory-related admissions, 3 babies had Respiratory Distress Syndrome (RDS), of which none were deemed avoidable admissions. Other diagnoses included:

- Meconium aspiration
- Systemic inflammatory response
- 2 babies were later proven to have sepsis

Themes and Learning: Outcomes of ATAIN review

WHH 2020/21 2021/2022	Number of Term Admissions	Outcome of ATAIN review	
		Avoidable Admissions	Unavoidable Admissions
Q3 Oct – Dec 2021	36	10	26
Q4 Jan – Mar 2022	36	16	20
Q1 Apr – Jun 2022	25	6	19
Q2 Jul – Sept 2022	34	13	21
TOTAL	131	45	86

Reasons for categorising term admissions as avoidable included identification of elements of care that were suboptimal and where improvement could have changed the outcome. The recurring theme this quarter was delay in expediting delivery based on pathological Cardiotocography (CTG).

Good Practice:

- Generally excellent neonatal care resulting in reduced separation of mother and baby noted
- Good early identification of deterioration of the neonate with timely intervention and escalation.
- Noted that the transition to fully electronic notes and CTG monitoring on BadgerNet makes the records much clearer and easier to review retrospectively with good documentation noted in general.

Learning Points/Themes/Actions:

- CTG learning – multidisciplinary
- Induction of Labour (IOL) process being reviewed – task & finish group in progress
- Warm care bundle should include facilitation of skin-to-skin in 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 Educational Supervisors.

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
- MAMU 2 Fetal Monitoring course to be attended by 100% of midwives and doctors providing intrapartum care by November 2022

- All maternity care providers to be compliant with fetal monitoring training and competency assessments in accordance with Maternity Incentive Scheme (MIS) standards
- Focus on improvement of culture systems and guidelines to reduce overall incidents of avoidable term admissions
- 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

ATAIN ACTION PLAN

No	Action	Owner	Review Date	Target Completion Date	RAG status
1	Induction of Labour (IOL) guideline to be reviewed in relation to timing of induction for Large for Gestational Age (LGA) and maternal request; no Propess to be given following Spontaneous Rupture of Membranes (SROM).	Associate Clinical Director		31/01/23 – date extended to allow task & finish group meetings to take place. Will continue to be reviewed.	
2	General culture change to avoid elective caesarean sections before 39 weeks without fetal or maternal indication - to be consultant decision. To be disseminated by ATAIN Lead Consultant at new doctors' induction and discussed at CBU Governance meeting.	ATAIN Lead Consultant		Action completed 3/8/22. Further audit to confirm if successful	
3	Review of process of transferring women from the Nest for emergency delivery.	Nest Manager / Obstetric Governance Lead Consultant	In progress with new Nest Manager	31/01/23 (NB Nest not currently open)	
4	To achieve 90% or greater compliance with CTG training as per MIS Safety Action 8 recommendations.	Fetal Monitoring Lead Midwife	30/11/2022	30/11/2022 – training taking place before end of November. Did not meet target by end October as had been expected. To review compliance following next training session.	
5	Warm care bundle to be adapted for theatre environment. For consideration: facilitation of skin-to-skin in theatre, removal of weighing scales from theatre	Maternity Theatre Co-ordinator / Birth Suite Manager / Infant Feeding Co-ordinator	28/02/2022	28/02/2022	
6	Appointment of fetal monitoring lead consultant as per Ockenden requirements. Associate Clinical Director currently fulfilling role.	Associate Clinical Director / CBU Manager		Associate CD fulfilling this role still. Funding for new consultant still being confirmed. Due to advertise in Jan 2023.	
7	Participation in Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) training with a focus on perinatal optimisation, which will also have positive implications for ATAIN (reducing TTN in particular).	ATAIN Lead Consultant / Neonatal Lead Consultant		Training commenced already 20/9/22	
8	Raise awareness of perinatal optimisation tool in line with Saving Babies' Lives (SBL) 2 recommendations and forthcoming SBL 3 expected Jan 2023 at December audit meeting.	ATAIN Lead Consultant / Neonatal Lead Consultant		14/12/2022	
9	Improve multidisciplinary attendance and participation in CTG teaching (C-SHOP) by increasing frequency and ensuring mailing list of invitees is up to date.	Fetal Monitoring Lead Midwife			

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

3. MONITORING/REPORTING ROUTES

The ATAIN programme and action plan is monitored at the monthly Women's Health Governance and Women's and Children's Clinical Business Unit Governance meetings.

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 6th December 2023.

5. RECOMMENDATIONS

Trust Board is asked to note this report as per as per MIS Year 4 recommendations.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/10 iii**	
SUBJECT:	**Maternity Update: Maternity Incentive Scheme**	
DATE OF MEETING:		
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy Head 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): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Resolution (NHSR) is operating year four 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 have been released in October 2022 and advised Trusts must submit the completed Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023. This paper will update the Quality Assurance Committee of the current position and trajectory of the 10 safety actions as recommended by NHSR. • **Safety Action 1** WHH is 100% compliant in all elements of Perinatal Mortality Review Tool (PMRT) following submission of the Quarter 2 report in November 2022. • **Safety Action 2** The Maternity Strategy has been approved at FSC and Board Committee on the 19 October 2022 • **Safety Action 3** WHH is 100% compliant following submission of Quarter 1 Avoiding Term Admissions to Neonatal Unit (ATAIN) and Transitional Care (TC) reports for all requirements in November 2022. • **Safety Action 4** WHH is on track to be 100% compliant for all medical and neonatal staffing specifications by 30th December 2022 • **Safety Action 5** WHH will be 100% compliant in all elements of Maternity staffing specifications in following presentation of the bi-annual staffing review to QAC in January 2023. • **Safety Action 6** WHH is 100% compliant with delivering all elements of Saving Babies Lives Version 2 (SBLV2) and is on	

<table>
<tr><td></td><td colspan="4">track to submit 6 months of consistent SBLV2 smoking data by 31st January 2023
• Safety Action 7 WHH is on track to complete all Maternity Voice Partnership (MVP) specifications by 31st January 2023
• Safety Action 8 WHH is on track to meet training standards by 30th December 2022
• Safety Action 9 WHH is on track to be 100% compliant for all requirements in relation to Maternity and Neonatal Safety Champions
• Safety Action 10 WHH is on track to be 100% compliant for all requirements related to Healthcare Safety Investigation Bureau (HSIB) reporting and investigations.

Maternity Incentive Scheme (MIS) actions are all on track to be compliant by the 31 January 2023.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to receive and discuss the report as per Maternity Incentive Scheme Year 4 Recommendations.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">QAC/22/12/309</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">06/12/2022</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
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REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Incentive Scheme Year 4 Update	AGENDA REF:	BM/23/01/xx

1. BACKGROUND/CONTEXT

NHS Resolution is operating year four 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. The Year 4 scheme paused in December 2021 due to the challenges placed on Trusts during the COVID pandemic.

Revised specifications and timelines were released in October 2022 and advised Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023.

In preparation of the submission deadline a monthly update report will be provided. This paper will update the Quality Assurance Committee of the current Warrington and Halton position for the month of October 2022.

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 4 Guidance relaunched in May 2022 and revised in October 2022.

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 100% compliant in all elements of SA1 PMRT MIS Year 4 specifications.

  SA1 PMRT was also audited externally by MIAA on 13th and 14th June and provided additional assurance of WHH PMRT pathway and processes.

  The W&C CBU present quarterly PMRT reports to QAC which are shared with the Trust Board. Quarter 1 (Q1.) was presented in September 2022 and Quarter 2 (Q2.) was presented to QAC in November 2022. Each PMRT review has met 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 by 31st December 2022.

  SA2 specifications stipulates each maternity provider has their own digital strategy and must reflect the '7 Pillars of What Good Looks Like' framework into the strategy. The Maternity Strategy has been approved at FSC and Board Committee on the 19 October 2022

- Safety action 3: Can you demonstrate that you have transitional care (TC) services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme?

  WHH is on track to be 100% compliant by 30 December 2022.

  ATAIN and TC quarterly reports have been submitted to QAC and updates are included in to the quarterly Maternity Trust Board Report. Q1 ATAIN has been shared with QAC and will be submitted to the next Trust Board meeting. WHH will be compliant when Q2 TC audit is submitted to December QAC.

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

  WHH is on track to be 100% compliant for all medical and neonatal staffing specifications by 31st December 2022.

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

  WHH is 100% compliant with MIS SA5 specifications.

  WHH Midwifery workforce has been assessed externally using the National Midwifery Acuity Tool. The Birth Rate plus assessment was completed in February 2022 and staffing ratio identified as 1 midwife:24 births. Staffing paper and action plan presented to QAC and summary shared with Trust Board in July 2022 as part of quarterly maternity update report.

  Maternity staffing is reviewed by W&C CBU Governance meeting and Workforce Review meeting monthly. Maternity staffing is also included in the Trust bi-annual Safe Staffing Report. In light of the ongoing national, regional and local issues in relation to maternity staffing an action plan is being developed and once agreed within the CBU will be shared.

- Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2 (SBLV2)?

  WHH is 100% compliant with all 5 elements of SBLV2
  WHH is on track to submit SBLV2 data

Women's and Children's Clinical Business Unit has previously escalated to QAC the technical challenges in submitting smoking data due to the previous Lorenzo maternity database. As previously discussed in SA2, MIS SA2 submission is reliant on evidencing 6 months smoking data consistently. Previously Lorenzo did not facilitate the required data fields to be compliant. Since the implementation of BadgerNet in May 2022 WHH is on track to report 6 months' worth of continuous data and to be MIS compliant by 31 January 2023.

- Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to co-produce local maternity services?

  WHH is on track to be 100% compliant in all specification by 31 January 2023.

  Outstanding specification of SA7 relates to new MIS guidance which specifies the MVP Chair is invited to attend maternity governance meetings and actions and themes and trends from meetings are shared with the MVP chair. Following discussion with the Trust Lead for the Patient Safety work programme it is recommended that the MVP role is aligned to that of the Patient Safety Partner role as part of the National Patient Safety Strategy. This will provide an appropriate framework and governance structure to the MVP Chair role. The W&C CBU are working alongside the Patient Safety Lead for the Trust in conjunction with the Patient Safety programme to implement this. It is anticipated this new approach which will meet the standard of SA7 will be implemented by January 2023.

- Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

  WHH is on track to meet SA8 training standards by 31st December 2022.

  Training updates are monitored monthly at W&C's Governance meeting.

  In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4?

  Training Trajectory on track to be compliant by December 2022. To meet this trajectory is dependent on staff attending the scheduled training. Within the CBU this training is prioritised and closely monitored to ensure all staff will meet the necessary compliance. In the wider MDT team, there is a lack of compliance within the Anaesthetist cohort. Non-attendance will prevent WHH from meeting the required 90%. This has been escalated as a priority.

- 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?

  WHH is 100% compliant with all specification of SA9.

- Safety action 10: Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

  WHH is 100% compliant with SA10 HSIB specification.

2.2 WHH MIS Next Steps and timeline:

	Action
6th September	The Women's and Children's Clinical Business Unit Triumvirate is meeting with each MIS Safety Action Lead to benchmark all evidence in relation to their associated Safety Action on the 6th of September 2022.
21st September	Bi monthly Triumvirate MIS review of outstanding actions
29th September	The Trust Board will be updated on the MIS Trajectory including September benchmarking report.
4th October	MIS update paper presented to QAC meeting
25th October	Bi Monthly Triumvirate review of outstanding actions
1st November	MIS update paper presented to QAC
6th December	MIS update paper presented to QAC
12th December	CBU Review and Sign off and Chief Nurse review
19th December	Review and sign off with Chief Executive
10th January	Review and sign off with QAC
25th January	Present MIS Evidence and presentation to Trust Board and Trust Board sign off
	Share evidence and sign off with Accountable officer within Integrated Care Board prior to Chief Executive Officer sign off
MIS compliance declaration is to be submitted no later than 12 noon on 2 February 2023	

2.3 Summary

WHH is on track to be 100% compliant with MIS Year 4 Safety Standards by 31 January 2023.

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 6th December 2023.

5. RECOMMENDATIONS

Trust Board is requested to receive and note the report as part of the MIS recommendations.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/10 iv**
SUBJECT:	**Maternity Update – East Kent Report initial review of implications for WHH**
DATE OF MEETING:	25th January 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy 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): ***(Please DELETE as appropriate)***	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The East Kent report of the independent investigation into Maternity and Neonatal services in East Kent by Dr Bill Kirkup CBE was published on 19th October 2022. The East Kent report has outlined a number of failures. • Failures of teamworking • Failures of professionalism • Failures of compassion • Failures to listen • Failure to change dysfunctional behaviours after incidents • Failure in Trust's response, including at Trust board level Kirkup has deliberately kept the recommendations in the report succinct and but clear. The recommendations are overarching and the responsibility of NHSE, educators, Colleges, regulators and the Govt. However, there are actions for all Trusts, in particular Trusts will be required to review their approach to reputation management and to ensure there is proper representation of maternity care on their boards. WHH has a number of assurance measures in place to monitor the quality of maternity services. However, in response to Kirkup the WHH maternity team will work

	closely with the WHH Learning and Organisational Development team in the context of "reading the signals" paying particular attention to the concerns raised in Kirkup relating to MDT working, workplace culture and behaviour. WHH will also participate in the LMNS commissioned cultural survey planned for 2023.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/22/12/309**		
	Date of meeting	06/12/2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Maternity Update – East Kent Report initial review of implications for WHH**	**AGENDA REF:**	**BM/23/01/10 iv**

1. BACKGROUND/CONTEXT

The East Kent report of the independent investigation into Maternity and Neonatal services in East Kent by Dr Bill Kirkup CBE was published on 19th October 2022. The report makes difficult reading for anyone involved in the delivery of maternity and neonatal services and sadly reflects many of the themes identified in previous reports into maternity services in England. The full report is attached as Appendix 1.

The report outlined several failures.

- Failures of teamworking
- Failures of professionalism
- Failures of compassion
- Failures to listen
- Failure to change dysfunctional behaviours after incidents
- Failure in Trust's response, including at Trust board level

2. KEY ELEMENTS

In response to the findings of the report Bill Kirkup has identified four key recommendations. These recommendations are short but clear. The report stresses that all areas must be delivered to prevent the same issues arising elsewhere.

The recommendations are multi-faceted and will require action from organisations, providers and partners across the maternity and neonatal sector. To support this NHSE will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables in 2023.

2.1 Key areas for action

Key Action Area 1: Monitoring safety performance – finding signals among noise:

'Something more reliable needs to be put in place, not only in East Kent but also elsewhere and nationally, to give early warning of problems before they cause significant harm. The aim must be for every trust to have the right mechanism in place to monitor the safety of its

maternity and neonatal services, in real time; for the NHS to monitor the safety performance of every trust; and for neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years.'

Recommendation: establishment of a national task force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough:

Recommendation: for action by those who train undergraduates, postgraduates and continuous clinical learning and Royal Colleges/Regulators

Key Action Area 3: Flawed teamworking – pulling in different directions: The report found very poor teamworking both within and between professional groups. This resulted in bullying behaviours as well as conflict between professionals which was evident to women and families at critical points in their care.

Recommendation: for action by those who train undergraduates, postgraduates and continuous clinical learning and Royal Colleges/Regulators

Key Action Area 4: Organisational behaviour – looking good while doing badly: The Trust were very keen to protect their reputation and as a result, reacted defensively rather than seeking to learn from criticism. The report highlights that organisational behaviour which places reputation management above honesty and openness is pervasive within the NHS and suggests that the government should consider legislation to prevent this.

Recommendation: Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

2.2 Implications for WHH

Key Action Area 4 has the most immediate implications for the Trust. Following the publication of the report, NHS England wrote to all Trust Chief Executives, Trust Chairs, ICB Chief Executives and LMNS Chairs with the following: 'We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals.'

At WHH there is representation of maternity care on the Trust Board via two Maternity Safety Champions, the Chief Nurse/ Dep CEO and the Maternity Safety Champion Non Executive Director.

There are a number of forums within which Maternity Services at WHH are monitored and assurance obtained, this includes internal CBU governance meetings, Trust wide committees such as the M2O steering group as well as Quality Assurance Committee and Trust Board. WHH have processes in place to review recommendations and action plans from all previous initiatives and investigations. Maternity Services reports monthly against the both the Ockenden and Maternity Incentive scheme immediate actions and requirements. The service was recently subject to an insight visit to provide external assurance in response to the first Ockenden report. The feedback and recommendations from this visit have been embedded into the Women's and Children's CBU M20 action plan. The maternity service also works closely with the Maternity Voices Partnership to ensure the views and experience of those who choose to receive maternity care at WHH are heard. WHH also submit data to regional and national safety dashboards Where the WHH service is highlighted to be an outlier against local or national measures further investigation will be undertaken.

In response to Kirkup the WHH maternity team will work closely with the WHH Learning and Organisational Development team in the context of "reading the signals" paying particular attention to the concerns raised in Kirkup relating to MDT working, workplace culture and behaviour. WHH will also participate in the LMNS commissioned cultural survey planned for 2023.

In addition to any internal activity, Cheshire and Mersey LMNS have confirmed it will also take a role in ensuring assurance mechanisms are effective.

In advance of the 2023 NHSE single delivery plan, the LMNS will continue to have oversight over provider deliverables as per the Perinatal Quality and Safety Framework via the Quality and Safety Surveillance Group.

The C&M LMNS will continue to work with the ICB, Place Associate Directors for Safety and Quality, the Regional team and the CQC to develop and act on early warning of problems before they cause significant harm. This will include reporting concerns to the NW Regional Perinatal Safety and Concerns group.

The C&M LMNS will also monitor trends and themes from Perinatal Mortality Review Tool reviews and the single SI panels via the Patient Safety meeting proposed by the LMNS Lead for Safety and QI.

Once the 2023 publication of a single delivery plan for Maternity and Neonatal care is published and received. WHH Maternity services will embed the findings for further implementation and ongoing assurances to trust board and the ICB.

3. MONITORING/REPORTING ROUTES

The maternity service will continue to report to Women's and Children's Clinical Business Unit Governance Meeting, to Quality Assurance Committee and to Trust Board as part of existing assurance

processes. Any additional learning as a result of the LMNS cultural survey will also be fed back via these governance structures.

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 10th January 2023.

5. RECOMMENDATIONS

Implementation of the Kirkup recommendations will be driven nationally and are particularly focussed on the education and training of healthcare professionals.

WHH will continue to review care provision via internal, local, regional and national assurance frameworks. In addition, the WHH maternity team will work closely with the WHH Learning and Organisational Development team in relation to MDT working, workplace culture and behaviour. WHH will also participate in the LMNS commissioned cultural survey planned for 2023. The Trust Board is asked to note this report.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/10 v**	
SUBJECT:	**Perinatal Mortality Surveillance**	
DATE OF MEETING:	25th January 2023	
AUTHOR(S):	Deborah Carter, Project Director Patient Safety	
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): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Since 2013 "Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) produces an annual "Perinatal Mortality Surveillance Report". This report provides rates for stillbirths and neonatal deaths for each provider as well as reporting the national picture. Warrington and Halton NHS Foundation Trust (WHH) participates in reporting data into the Perinatal Mortality Review Tool (PMRT) which allows the analysis to take place. The timelines for submissions of deaths and the analysis of these means that when the reports are published by MBRRACE that they are based on deaths that occurred two years previously. The report published by MBRRACE in 2022 was based on deaths that occurred in 2020. This paper analyses the previous five reports published by MBRRACE for WHH (2016-2020) and the variations over that time. The paper notes that WHH has performed equal to or better than other comparator maternity units with regards to perinatal deaths until 2019 where a slight adverse variation was noted, and then again in 2020. The declining birth rate and small death numbers are identified as a contributor to the variance, and emphasis is made of monitoring these rates over time. Ongoing reporting and investigation of deaths alongside analysis of themes and trends to support learning should continue. Recommendations are made to ensure good quality data is submitted, and that there is appropriate oversight, scrutiny and learning from all deaths.	

PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents and recommendations within the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/23/01/09 iii		
	Date of meeting	10 January 2023		
	Summary of Outcome	The Quality Assurance Committee noted the contents of the report and the recommendations.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Perinatal Mortality Surveillance	AGENDA REF:	BM/23/01/10 v

1. BACKGROUND/CONTEXT

Every year since its inception in 2013 the "Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) produces several reports including an annual "Perinatal Mortality Surveillance Report". This report provides rates for stillbirths and neonatal deaths, and rates for these deaths combined; known as 'extended perinatal deaths. The reports provide data to each provider who report deaths and in addition reports which represent the national picture.

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

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

Mortality rates vary between hospitals, particularly if those hospitals care for larger numbers of babies or very sick babies. MBRRACE-UK use the number of babies born in an organisation, as well as whether they have either a neonatal intensive care unit (NICU) or a NICU and facilities for surgery for newborn babies, to group together similar Trusts into five comparator groups:

(i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision (units routinely accepting for birth babies with a known congenital anomaly likely to require surgery in the neonatal period)
(ii) Level 3 NICU
(iii) 4,000 or more births per annum at 22 weeks or later
(iv) 2,000-3,999 births per annum at 22 weeks or later
(v) Under 2,000 births per annum at 22 weeks or later

Warrington & Halton NHS Trust (WHH) is included in comparator group 4, i.e., those Trusts with 2,000-3,999 births per annum

MBRRACE-UK publishes both crude death numbers (the numbers of deaths per 1000) and the stabilised and adjusted mortality rate, the latter provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth.

MBRRACE-UK compares the mortality rates for each organisation to the average mortality rates for their own group with the expectation that Trusts whose mortality rates are marked RED, or AMBER should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate.

A full list of definitions used in this paper is provided at Appendix 1 along with further information.

2. KEY ELEMENTS

The MBRRACE-UK Perinatal Mortality Report

The MBRRACE-UK reports are published annually and because of reporting timelines and the analysis needed they represent deaths that occurred 18 months to two years previously. This means for example that the report published in October 2022 reflected baby deaths which occurred between January 2020 to December 2020. The national reporting timescales mean that there will be a disconnect within Trusts as reports that are being submitted to committees will reflect deaths in real/near time, whilst the national reports reflect the deaths two years previous. In addition, the MBRRACE-UK reports provide comparison with other similar sized Trusts, as well as adjusting for factors that can increase the likely hood of a death occurring.

All baby deaths that meet the MBRRACE-UK criteria are required to be submitted via an on-line portal within 7 days of the death, this collects detailed information relating to the mother, the baby, the pregnancy, and the circumstances of the death. Once submitted this starts a tracking process which is managed via the on-line tool. This ensures timely and comprehensive data is captured including information about babies who are transferred to other organisations or those transferred to Warrington & Halton NHS Foundation Trust (WHH). MBRRACE-UK also monitors all births and deaths from national sources to ensure that data collection is comprehensive. All data is expected to be submitted relating to the death within 90 days following the death.

MBRRACE-UK will determine which cases reported satisfy the criteria for a Perinatal Mortality Review Tool panel review (PMRT is the tool used nationally to review perinatal deaths in order to standardise the review process and the outcome). This means that once the death has been investigated and reviewed by the local team the investigation report is subjected to a case review by external experts. The external experts are made up of colleagues with considerable expertise in their given area and are allocated to the panels based on their subject area knowledge dependant on the circumstances in each case. Following the review, cases are given a grading outcome A – D, based on care provided to the mother and baby this includes the time until the baby is born/has died and care after the death has been confirmed:

- A – No care issues
- B – Care issues that did not make a difference to the outcome
- C – Care issues that may have made a difference to the outcome
- D – Care issues that were likely to have made a difference to the outcome

Parents are advised of the review process and are encouraged to raise any questions they may wish to be included in the review Terms of Reference. Communication is maintained with the family throughout the review, and they are provided a copy of the final report and offered support and any follow up they need.

Each report focuses on stillbirths and neonatal deaths among the babies born within the Trust each year and excludes births before 24 weeks gestational age (although all deaths from 22+weeks are reported) and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where the baby's death occurred (for example if a baby is transferred to another hospital for care not available at WHH and dies the death will still be attributed to WHH). Local investigations may still take place when a baby dies prior to 24 weeks gestation depending on the circumstances identified.

The information in the MMBRRACE-UK report may not match other local or national reported rates as births before 24 weeks gestational age have been excluded from most tables due to differences in reporting by Trusts and Health Boards.

Irrespective of where they fall in the spectrum of national performance all Trusts should use the national Perinatal Mortality Review Tool (PMRT) to review all their stillbirths and neonatal deaths.

WHH PMRT reporting

WHH is fully compliant with the reporting requirements for MBRRACE-UK for all death types. This means that each year all deaths which meet the PMRT criteria at WHH have been reported via the on-line reporting tool and investigated in line with requirements. The investigation reports generated are subject to normal internal governance review processes as well as those required by the PMRT process.

Action plans are developed to support the learning from each report. Where there have been concerns about the care provision additional attention is given to ensure the learning as well as improvement actions are made. System wide changes can be seen in WHH maternity service as a result of the learning from deaths, this includes adopting the Birmingham System of Triage (BSOTS) and the introduction of the Badger Net Electronic Maternity Patient Record.

Perinatal Mortality reporting forms part of the Maternity Incentive Scheme for Trusts (MIS). This is part of the national work in England to achieve the ambition to reduce the stillbirth and neonatal death rate by 50% by 2025. Performance and progress are reported through the Women and Children's Governance Group and quarterly to the Quality Assurance Committee, with an annual report being taken through the Trust Board.

WHH MBRRACE-UK Reports Over 5 years (2016-2020)

Perinatal Mortality 2016

The 2016 report related to stillbirths and neonatal deaths among the 2,917 babies born at WHH (and home births), there were 8 deaths considered in this report. In this report

neonatal deaths (4) were noted to be up to 10% higher when compared with similar Trusts and were therefore flagged as 'Amber'.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	4	1.37	3.56 (2.86 to 4.45)	Up to 10% lower
Neonatal	4	1.37	1.12 (0.71 to 1.73)	Up to 10% higher
Extended perinatal	8	2.74	4.68 (4.02 to 5.92)	Up to 10% lower

The report noted several other features relating to the deaths:

- That the age of the mothers under 25 years was higher than that of the UK at 20.7% versus 18.2%. Mortality rates are acknowledged to be higher for babies born to mothers under 25 years of age
- Socio-economic deprivation was similar to deprivation of those giving birth across the UK
- The proportion of babies of non-white ethnicity was considerably lower than that of the UK as a whole: 7.1% versus 21.8% (the report notes that 20.8% of births at WHH reported the baby's ethnicity as not known)
- 5 babies (0.2%) were born at 24-27 weeks gestational which is lower than that seen UK wide (0.4%)
- There were 3 late neonatal deaths which gives a crude death rate of were 1.0/1000 compared to 0.5 UK wide
- Post-mortems were offered to all families whose babies were stillborn against 96% national rate and all families whose babies died during the neonatal period against 91% national rate.

The report further comments positively that essential data recording into the PMRT for this period was 100% accurate. The issue regarding the ethnicity of the baby is captured via coding and will form part of the action plan.

Perinatal Mortality 2017

The 2017 report related to stillbirths and neonatal deaths among the 2,793 babies born at WHH (and home births), there were 13 deaths considered in this report. In this report stillbirths (11) and neonatal deaths (2) were noted to be up to 5% higher

or up to 5% lower when compared with similar Trusts and were therefore both flagged as 'Amber'.

When further reviewed the stabilised and adjusted mortality rates for WHH were similar, or lower than, those seen across similar Trusts. The 'Amber' flagging in this case is to prompt Trust's to go further with improvement efforts and seek rates comparable with the best performing countries, for example those in Scandinavia.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	11	3.94	3.28 (2.75 to 3.96)	Up to 5% higher or up to 5% lower
Neonatal	2	0.72	0.98 (0.57 to 1.59)	Up to 5% higher or up to 5% lower
Extended perinatal	13	4.65	4.24 (3.66 to 5.27)	Up to 5% higher or up to 5% lower

The report noted several other features relating to the deaths:

- That the age of the mothers under 25 years was higher than that of the UK at 19.5% versus 22.6%. Mortality rates are acknowledged to be higher for babies born to mothers under 25 years of age
- Socio-economic deprivation was considerably less likely (based on mothers' postcode) to those giving birth across the UK
- The proportion of babies of non-white ethnicity was considerably lower than that of the UK as a whole: 7.9% versus 21.2% (the report notes that 21.2% of births at WHH reported the baby's ethnicity as not known)
- 10 babies (0.4%) were born at 24-27 weeks gestational similar to that seen UK wide (0.4%)
- There were 3 intrapartum stillbirths (babies who died during labour) giving a crude death rate of 1.1/1000 compared to a rate of 0.4 nationally
- Post-mortems were offered to all families whose babies were stillborn (96% national rate) and all families whose babies died during the neonatal period (91% national rate)

The report comments that essential data recording into the PMRT for this period was 99% accurate for all elements. The issue regarding the ethnicity of the baby is captured via coding and will form part of the action plan.

Perinatal Mortality 2018

The 2018 report related to stillbirths and neonatal deaths among the 2,829 babies born at WHH (and home births), there were 14 deaths considered in this report. In this report stillbirths (12) were noted to be up to 5% higher or up to 5% lower when compared with similar Trusts and were therefore flagged as 'Amber'.

When further reviewed the stabilised and adjusted mortality rates for WHH were similar, or lower than, those seen across similar Trusts. The 'Amber' flagging in this case is to prompt Trust's to go further with improvement efforts and seek rates comparable with the best performing countries, for example those in Scandinavia.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	12	4.24	3.10 (2.50 to 3.96)	Up to 5% higher or up to 5% lower
Neonatal	2	0.71	1.01 (0.62 to 1.71)	More than 5% and up to 15% lower
Extended perinatal	14	4.95	4.09 (3.36 to 5.40)	Up to 5% higher or up to 5% lower

The report noted several other features relating to the deaths:

- That the age of the mothers under 25 years was higher than that of the UK at 19.7% versus 16.9%. Mortality rates are acknowledged to be higher for babies born to mothers under 25 years of age
- Socio-economic deprivation was similar to deprivation of those giving birth across the UK
- The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 8.2% versus 21.7% (the report notes that 21.6% of births at WHH reported the baby's ethnicity as not known)
- Antepartum stillbirths (prior to commencement of labour and more than 24 weeks gestation) (11) were 3.9 compared to 3.1 UK wide
- Intrapartum stillbirths were 0.4 (1) compared to 0.3 UK wide
- Late neonatal deaths (2) were 0.7 compared to 0.5 UK wide
- Post-mortems were offered to all families whose babies were stillborn (97%national rate) and all families whose babies died during the neonatal period (87% national rate)

The report comments that essential data recording into the PMRT for this period was 100% accurate. The issue regarding the ethnicity of the baby is captured via coding and will form part of the action plan.

Perinatal Mortality 2019

The 2019 report related to stillbirths and neonatal deaths among the 2,636 babies born at WHH (and home births), there were 10 deaths considered in this report. In this report stillbirths (5) were noted to be up to 5% higher or up to 5% lower and Neonatal deaths (5) were noted to be more than 5% when compared with similar Trusts and were therefore flagged as 'Amber' and 'Red' respectively.

As two of the stabilised and adjusted mortality rates were noted to be high compared with similar Trusts WHH were encouraged to undertake a review of the data that was entered locally to ensure it was accurate and complete and review existing records

regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care implemented.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	5	1.90	2.97 (2.39 to 3.55)	Up to 5% higher or up to 5% lower
Neonatal	5	1.90	1.25 (0.71 to 2.24)	More than 5% higher
Extended perinatal	10	3.80	4.23 (3.56 to 5.52)	More than 5% higher

The report noted several other features relating to the deaths:

- Socio-economic deprivation was similar to deprivation of those giving birth across the UK
- The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 7.9% versus 22.5% (the report notes that 23.4% of births at WHH reported the baby's ethnicity as not known)
- There were 5 antepartum stillbirths (death occurred prior to commencement of labour and at more than 24 weeks gestation) giving a rate of 1.9/1000 compared to 3.0 UK wide
- There were no Intrapartum stillbirths in this reporting period compared to 0.3 UK wide
- Late neonatal deaths (3) were 1.1 compared to 0.5 UK wide
- Post-mortems were offered to all families whose babies were stillborn (98%national rate) and all families whose babies died during the neonatal period (88% national rate)

The report comments that essential data recording into the PMRT for this period was 97% accurate, with smoking data, intended care at booking and estimated date of birth all at 83.3%. The issue regarding the ethnicity of the baby is captured via coding and will form part of the action plan. Data quality therefore requires improvement.

Perinatal Mortality 2020

The 2020 report related to stillbirths and neonatal deaths among the 2,579 babies born at WHH (and home births), there were 17 deaths considered in this report. In this report stillbirths (13) and Neonatal deaths (4) were noted to be more than 5% when compared with similar Trusts and were therefore flagged as 'Red' for each element.

As each of the stabilised and adjusted mortality rates were noted to be high compared with similar Trusts WHH were encouraged to undertake a review of the data that was entered locally to ensure it was accurate and complete and review

existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care implemented.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	13	5.04	3.52 (2.69 to 4.75)	More than 5% higher
Neonatal	4	1.56	0.99 (0.60 to 1.58)	More than 5% higher
Extended perinatal	17	6.59	4.51 (3.69 to 5.86)	More than 5% higher

The report noted several other features relating to the deaths:

- Socio-economic deprivation was considerably less likely (based on mothers' postcode) than those giving birth across the UK
- The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 8.6% versus 22.8% (the report notes that 21.9% of births at WHH reported the baby's ethnicity as not known)
- Antepartum stillbirths (deaths prior to commencement of labour and more than 24 weeks gestation) (12) were 4.7 compared to 3.0 UK wide
- Intrapartum stillbirths (1) were at 0.4 compared to 0.2 UK wide
- Late neonatal deaths (2) were 0.8 compared to 0.5 UK wide
- Post-mortems were offered to all families whose babies were stillborn (98%national rate) and all families whose babies died during the neonatal period (92% national rate)

The report comments that essential data recording into the PMRT for this period was 97% accurate, with smoking data, intended care at booking and estimated date of birth all at 83.3%. The issue regarding the ethnicity of the baby is captured via coding and will form part of the action plan. Data quality requires improvement, it is also noted that the Covid-19 pandemic impacted on data quality because of changes to service provision during this time.

Perinatal Mortality Findings WHH

Of the 62 deaths that met the criteria for submission to the PMRT over the 5 year period 1/1/2016 to 31/12/2020, 40 cases were eligible for a full PMRT panel review.
At the time of the PMRT panel review care provided to the mother and baby is given a grading outcome A – D, based on care until the baby is born/has died and care after the death has been confirmed:

- A – No care issues
- B – Care issues that did not make a difference
- C – Care issues that may have made a difference
- D – Care issues that were likely to have made a difference to the outcome

The following chart demonstrates the grading of care for mothers and babies. There were 3 cases where a grading of C was agreed and 3 cases where a grading of D was agreed for babies who were stillborn or late fetal deaths.

Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 40)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	3	7	1	1	14
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	2	5	1	2	3	13
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	2	1	3
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	2	0	1	3
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	2	6	5	2	5	20
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	2	2	5	3	1	13
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	1	1	1	3
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	1	0	0	0	1	2
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

PMRT focus's specifically on the D grading of care i.e., where the review group concluded that there were issues in the care that could have made a difference to the outcome. However, an analysis of the 6 cases where a C or D grading was given identifies the following:

Where a C grading was given:

- One learning outcome was linked to the management of the woman's diabetes in pregnancy and an attendance to WHH Emergency Department (ED) and management of her hypertension of pregnancy

- One learning outcome was associated with the care provided by another Trust and Northwest Ambulance Service (NWAS), as well as assessment in Triage at WHH
- One learning outcome was associated with a woman who had an undiagnosed pregnancy and attended WHH ED with a condition and she was not screened to exclude a pregnancy

Where a D grading was given:

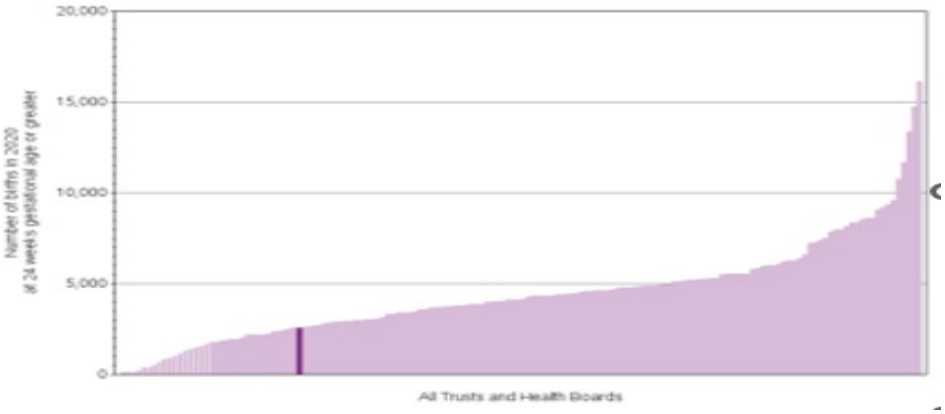
- 2 cases the learning outcomes were linked to the mothers presenting to the triage service with reduced fetal movement in pregnancy, and issues relating to interpretation of the fetal heart, CTG (Cardio-toco-graph)
- The remaining case was where a woman presented with symptoms of the condition "Obstetric Cholestasis" which were not recognised

WHH Maternity Services have worked to embed system wide learning to ameliorate the risk of reoccurrence of the issues identified, this includes cross working with ED and other organisations, the implementation of the Birmingham System of Triage BSOT's and the Badger Maternity Electronic Patient Record.

In addition to the gradings of care the panel also make additional recommendations (incidental findings). The analysis for this report has identified that there is potentially other system learning which may support further improvements for the service.

Perinatal Mortality over time WHH

The information shown in the perinatal mortality reports over the 5 year period demonstrates birth numbers at WHH decline from 2,917 in 2016 to 2,579, the report expresses the death rate in 1:1000 births. The declining birth rate and the low number of deaths at WHH will adversely impact on the way the figures are represented.
The chart below shows the total number of births in the UK for 2020 and where WHH sits (by the dark line) for birth numbers compared to all other Trust's and Health Boards. This means that WHH sits in the bottom 25% for birth rates nationally.

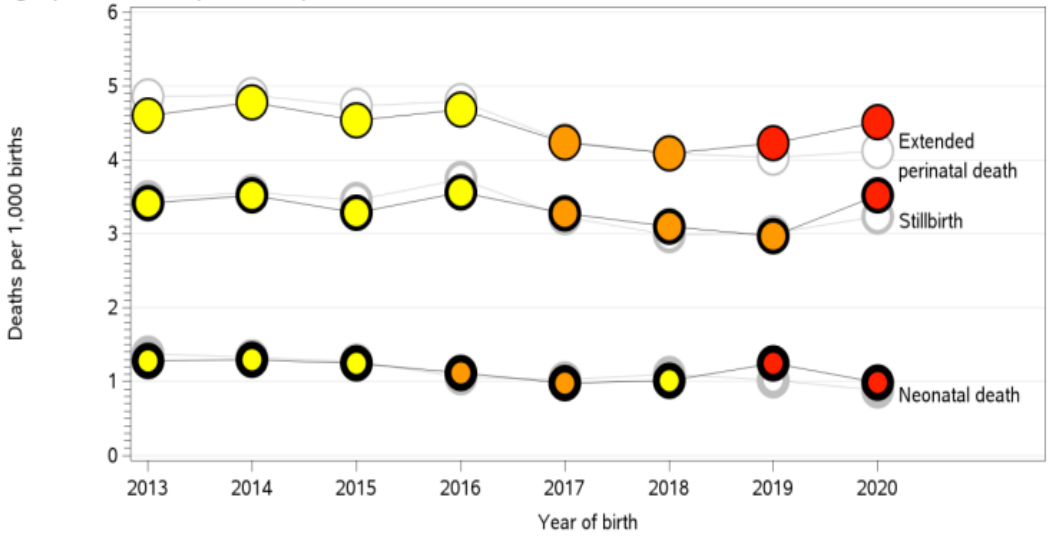


The declining birth rate at WHH is in line with that seen within the national census data. Where the number of live births in 2020 for England and Wales decreased to 613,936 which was the lowest since 2002 and represents the fifth consecutive year where the birth rate has fallen.

Stabilised & adjusted mortality by year of birth

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

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



The above chart which shows the rates for both stillbirths and neonatal deaths at WHH since the inception of MBRRACE-UK in 2013, mapped against others in the comparator group. WHH has generally performed better or equal to others in the group until 2019, where a slight adverse variance has been noted. As these data are better reviewed over time, it will be important to continue to track performance alongside robustly reviewing each death as they occur and embedding learning recommendations. Themes and trends should also be monitored and used to drive improvements in the service.

WHH maternity service provides the Local Maternity and Neonatal Services Network (LMNS, Northwest Coast) with data on a monthly basis which relates to stillbirth and neonatal deaths. These data are then reproduced in a dashboard form which enables comparison with other maternity services across the LMNS footprint. Where any services are identified as an outlier the service has to provide a narrative response. Where there is variance noted for WHH this should be shared through the governance structure to ensure appropriate review and scrutiny is in place.

3. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report and the recommendations made to the Quality Assurance Committee to consider the report and receive updates in line with the following recommendations;

- Align internal reporting to QAC about Perinatal Mortality to the national reporting schedule to run January to December each year

- Provide an annual report to QAC in April each year which includes all relevant deaths in the previous year and the findings of the reviews, including trends and themes and improvement activities
- Reference in the annual report the timeline for these data to be published as part of the National Perinatal Surveillance Report (likely to be up to 2 years hence)
- Improve data quality for the PMRT submission
- Ensure that the coded data for ethnicity of the baby is improved (this includes information relating to ethnicity into the patient administration system (PAS)
- Develop a PMRT Standard Operating Procedure (SOP) in line with the "Guidance for Trusts and Health Boards, 2018"
- Report through to the W&C governance meetings compliance with reporting timelines against the PMRT tool as part of the governance midwife's high level briefing paper
- Ensure that both the audit and governance midwives have oversight of the PMRT data submissions and take a lead in ensuring these are made timely and comprehensively
- WHH to participate in "The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)" which is one of the National improvement collaboratives aimed at improving patient safety in the NHS
- Undertake a thematic review of the findings from all PMRT reviews to ensure that learning has been captured and improvements are part of ongoing work programmes or already embedded
- Report through the governance structures any areas of variance in the Northwest Coast dashboard data, this could act as an "early warning" and ensure appropriate actions are taken (note this will not be like for like as data has not been standardised and adjusted)

Appendix 1

Definitions and further information

MBRRACE-UK Com

- Commenced 2013
- Produce yearly reports on perinatal and maternal deaths
- Subdivide and benchmark data using comparator groups – WHH are in the comparator group of Trusts with 2,000-3,999 births per annum
- Crude data undergo “stabilising and adjustment”
-

MBRRACE-UK Definitions

- Stillbirth – death in the uterus after 24 weeks of pregnancy (gestation)
- Stillbirth rate expressed per 1,000 total births
- Neonatal death – baby born alive after 24 weeks gestation but died within 28 days
- Neonatal death rate expressed per 1,000 live births
- Late Neonatal death between 7 days and 28 days of life
- Extended perinatal deaths - all stillbirths over 24 weeks and all neonatal deaths, baby born alive after 24 weeks gestation, but died before 28 days of age

MBRRACE-UK Adjustment Criteria

- Mother’s age
- Socio-economic deprivation based on the mother’s residence
- Baby’s ethnicity
- Baby’s sex
- Whether they are from a multiple birth
- Gestational age at birth (neonatal deaths only)

Perinatal Mortality Review Tool (PMRT)

The nationally agreed tool designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum (before labour commenced) and intrapartum (baby died during labour) stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die

The tool has been agreed nationally and is supported by parent and professional groups.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/11**	
SUBJECT:	**Trust Engagement Dashboard Q3 2022-23**	
DATE OF MEETING:	25th January 2023	
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications and 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. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Engagement Dashboard is for the period October to December 2022 inclusive (Q3) and addresses: 1. Level of success in managing the Trust's reputation in the media and across digital and social platforms 2. Our engagement with patients, staff and public via our social media channels 3. The Trust's website and levels engagement with this key platform 4. Patient enquiries via our website 5. Patient/public feedback on the independent platforms (recent addition of Google) 6. Level of staff engagement with internal communications channels, including WHH Staff App and Staff Closed Facebook Group **Media** 7. **Coverage this quarter** was varied and included conjecture on the outcome of the new hospitals bid, plus Community Diagnostic Centre plans, hospital waiting times, publication of infant mortality figures plus many positive stories about donations to the charity. The story with the highest reach was a Daily Mail article citing Warrington Hospital in an article about advertisement for 'diversity officer' roles. 8. **Media sentiment** was mostly positive (40%) of articles or neutral (41%) of articles. **Social Media** 9. The total number of social media posts generated organically by WHH was 799. This was down on the previous reflecting lower activity over the festive period. 10. **Twitter** – the number of posts posted by WHH was 294 generating 335,800 impressions.	

	11. **Facebook** posts totalled 270 achieving a reach of 299,302. 12. **Instagram** – 235 posts were created on Instagram achieving 89,170 impressions. Impressions were lower than the previous quarter due to losing a number of followers during October as part of an Instagram platform purge of inactive or 'non-legitimate' accounts which removed some accounts as followers. **Website** 13. **Website visits** declined slightly between Q2 and Q3 with 257,875 visits across October, November and December. 14. The Runcorn Urgent Treatment Centre service page had the most views this quarter (8,173), possibly reflecting the increased focus on 'Choose Well' type messaging during the winter months. This is the first time in since late 2020 that the Covid-19 status page was not the most viewed page on the Trust website. Pages outlining contact numbers for the Trust and wards were also featured in the most viewed pages. 15. The page 'Work at WHH' also featured again in the most viewed pages, which is positive in light of the increased focus on recruitment campaigns in the quarter. 16. **Patient/visitor enquiries** through the website totalled 516 in the quarter, which was up on Q2 (411). **Patient Feedback** 17. There were 36 patient reviews on the three main external channels: NHS Choices, Care Opinion and I Want Great Care of which 25 were positive and 11 negative. This is an improved position on the previous quarter when 18 were positive and 21 negative. 18. **Google Reviews** We continue to attract Google reviews for our Trust. This is an increasingly popular star(*) ratings system accessible to online audiences. Current ratings for Warrington Hospital are 3.2*, Halton General at 3.9* and Halton Hospital – CSTM is rated 4.5*. **Communicating with staff** 19. **Team Brief** attendance fell slightly during the quarter, down from 769 in Q2 to 608 attendances in Q3. The 2pm slot remains the most popular for staff, with a 7pm slot offered as an alternative. 20. **Staff App** there were 479 downloads of the Staff App during the period, with 1,114 active downloads of the App.

PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report and dashboard			
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		AGENDA REF:	BM/23/01/xx

1. BACKGROUND/CONTEXT

2. KEY ELEMENTS

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

6. TRAJECTORIES/OBJECTIVES AGREED

7. MONITORING/REPORTING ROUTES

8. TIMELINES

9. ASSURANCE COMMITTEE

10. RECOMMENDATIONS

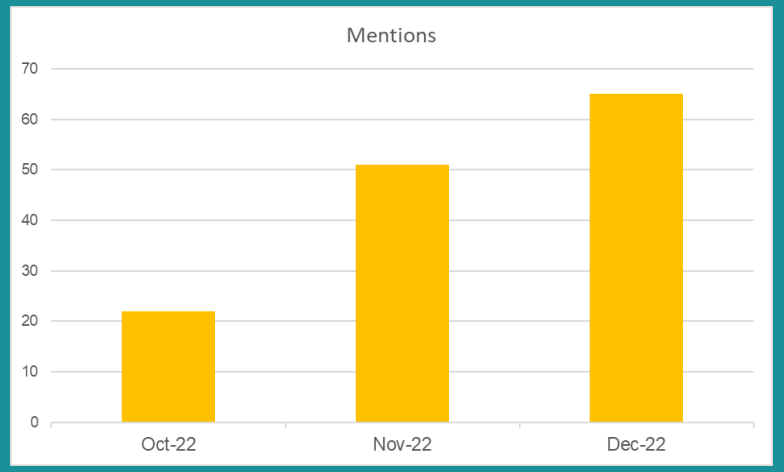
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

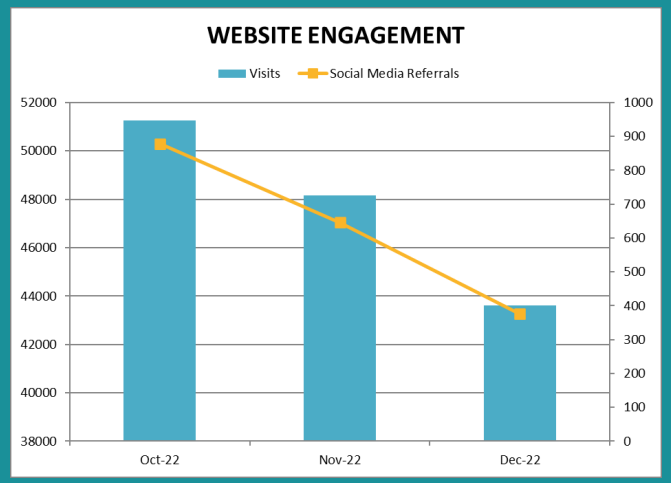
WHH Communications, Engagement and Involvement

Dashboard Q3 October – December 2022

‘Well-Led’ KLOE 7: Communicating with the Public

Metric	Media coverage Visits to the public website
Current Performance	During quarter three, there were 138 **media** articles/broadcast items about the Trust. Of these 40% were considered positive, 41% neutral and 19% negative in their tone and sentiment about the Trust. **Top positive news stories:** • *Warrington Hospital rewarded for high-quality patient care - Warrington Guardian* • *Nominate your inspirational charity champions and health heroes – Yahoo News UK* **Most viewed/shared negative news stories**: • *NHS advertises £700,000's worth of diversity officer roles in just a month! Outrage as 'precious' cash is used to hire equality and wellbeing positions – Daily Mail* **Website:** ‘Urgent Treatment Centre’ service page was the most viewed page in Q3, followed by ‘Contact us’ and the Maternity services page, although website engagement overall was down on the previous quarter.
Actions / Comments	• Although positive and neutral stories had a lot more impressions than negative stories this quarter, coverage was quite mixed with the Daily Mail’s article concerning diversity officer roles having the greatest reach • In Q3 the ‘Urgent Treatment Centre’ became the most viewed web page after the home page, with 8,173 views. The peak was Tuesday 27 December 2022. • 71.29% of visits to the site were via Google search engine with 15.62% accessing direct. The remainder came via a variety of social media, NHS.uk other website and search engines. • One of our key aims is to drive more traffic to the working at WHH page. In Q3 there were 6,541 visits to the Working at WHH section of the website. This something we still need to work towards with the Trust Recruitment team to support promotion of vacancies and benefits of working at WHH in a challenging recruitment climate, particularly for clinical posts.



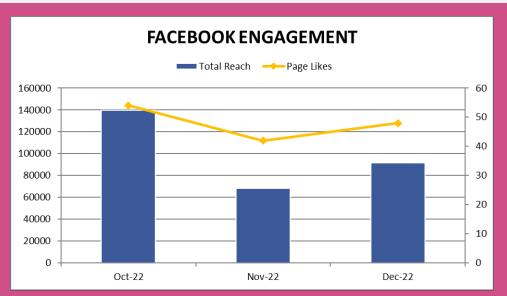


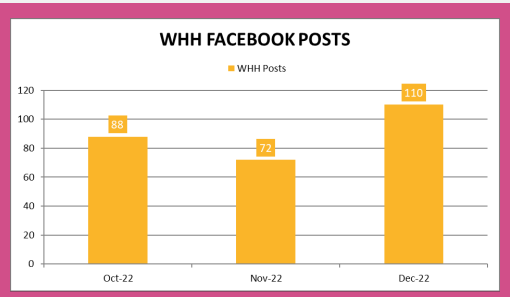
Website visits: most popular sections	257,875
/	34,099
/services/urgent-treatment-centre-runcorn	8,173
/Contact-us	7,775
/services/maternity	7,295
/about-us/our-hospitals/halton-general-hospital	7,117
/ward-contact-numbers	6,674
/workWHH	6,541
/blood-test-clinics	6,379
/covid-19-current-status	6,131

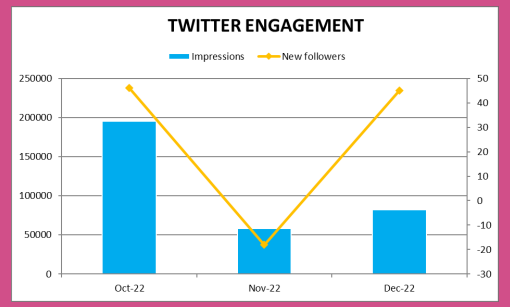
‘Well-Led’ KLOE 7: Communicating with the public

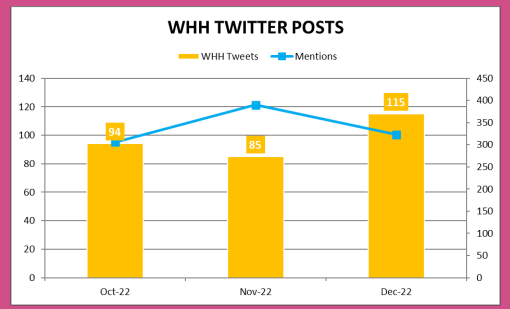
Metric	Social media posts, engagement and sentiment
Current Performance	This quarter, there were a total of 799 social posts across three social media channels (Facebook, Twitter and Instagram) WHH social media channels reached an audience of over 720k, with a combined following of 27k. In October 2022, there was an initiative by Instagram to suspend accounts that it deemed not legitimate or inactive in the past 12 months. This has led to a loss in the number of followers for the WHH Instagram account.
Top Posts for Engagement	

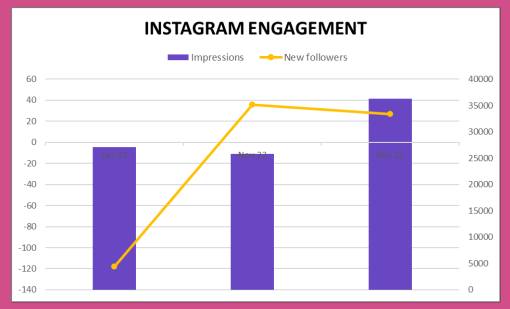
Top post

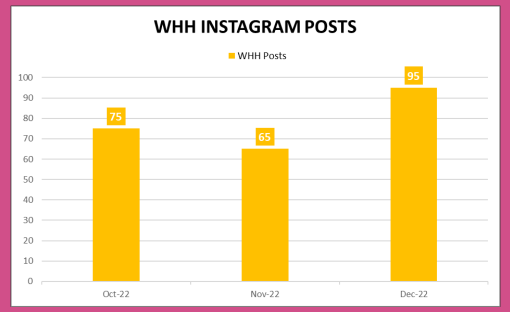






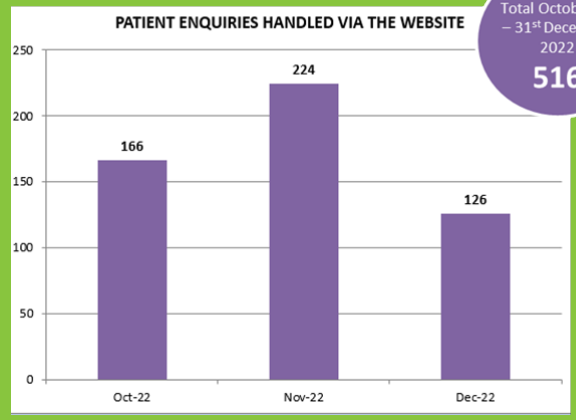






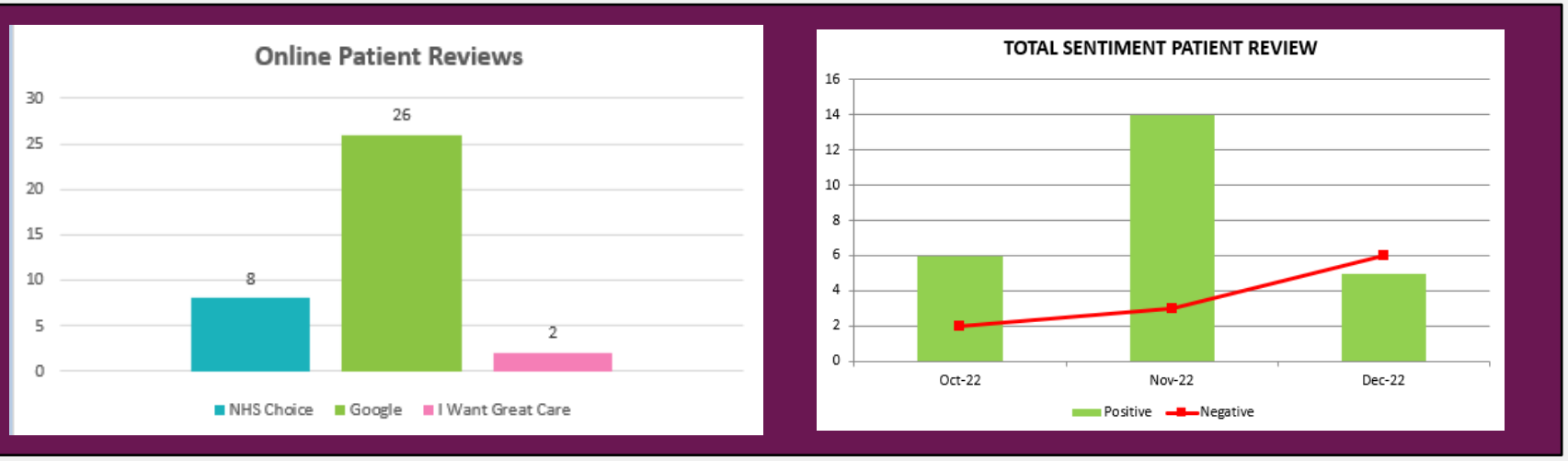
‘Well-Led’ KLOE 7Metrics: Engaging with and Involving our community

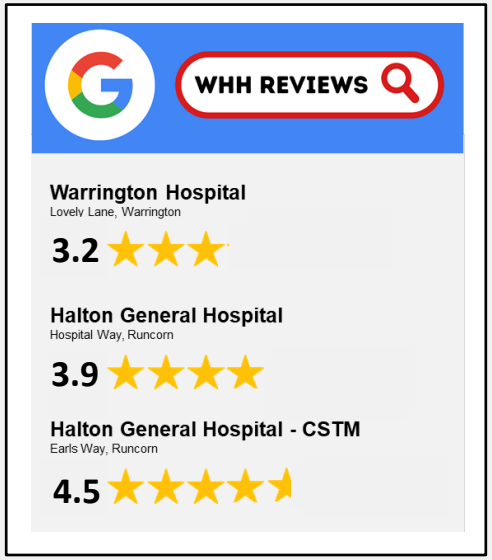
Metric	Engagement opportunities
Current Performance	**Public Consultations:** **Reconfiguration of Breast Services (Phase 2)** • The final review of the Breast Consultation Outcomes report was presented to WHH Trust Board on 30th November and has been shared with Warrington Together and NHS England Specialist Commissioning for review, prior to publication. • As part of the plans to enhance the Breast Screening provision at Bath Street Health and Wellbeing Centre, a site visit and discussion workshop was completed with WHH Experts by Experience joining the project leads and architect to discuss the proposed plans with lots of useful feedback. **Engagement:** **Annual Members’ Meeting 30th November** • The first hybrid meeting took place in the Education Centre, Warrington Hospital, with British Sign Language interpretation provided and 21 people joining via MS Teams. • The event followed a marketplace in the Kendrick’s Café area, Warrington main entrance with information stands provided by Governors, WHH Charity Tombola, Diabetes Team, Long Covid Support Service, Strategy (New Hospitals and Living Well Hub), Patient Experience and Volunteers, Apprenticeship Team, Healthwatch Warrington and One Halton. **Governor Engagement** • A communications campaign was held to encourage greater involvement in the role of Public Governor in our Foundation Trust during September and October which resulted in 19 nominations submitted across the constituencies. • This was more engagement than in recent elections and resulted in a number seats being contested by multiple candidates. **Civica Membership Engagement Database** • To support the elections, Foundation Trust Membership data was migrated over to the Civica Engage Database with a full data cleanse. • The database will support more frequent communications with the cohort of Foundation Trust membership whose member record includes a current email address. This is something more members were encouraged to update on their member record during the election process. • An initial trial of member communications via Engage was completed in December 2021 with the distribution of a Season’s Greetings Card and an electronic copy of the ‘Your Hospitals’ supplement. **Social Value:** • A Clinical Recruitment Event was held at the Village Hotel on 1st November with 180 people booking onto the event via Eventbrite following a communications campaign on social media and with universities. At least 30 conditional offers were made to candidates interviewed on the day and further events are to follow during 2023.



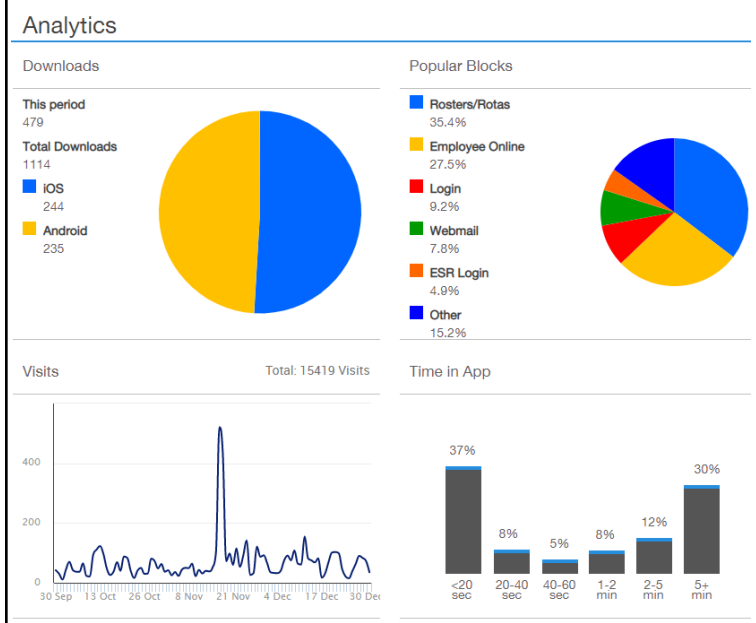
‘Well-Led’ KLOE 7 Metrics : Patient engagement through public channels and media

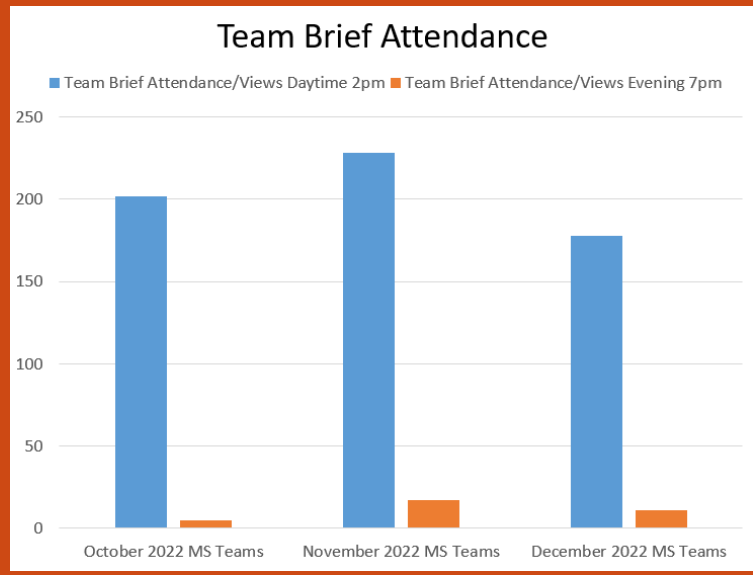
Metric	**ENGAGEMENT WITH FEEDBACK CHANNELS** These channels in the public domain include : Google reviews, NHS Choices and I Want Great Care
Current Performance	In Q3 there were 36 reviews about the Trust, of which 69% were positive.
Actions / Comments	**Top online source for public feedback:** Google reviews **General Theme:** A&E was mentioned the most and generally in a positive light, the Ambulatory Care team was also praised on several occasions. The number of negative reviews rose between November and December, but overall the total number or negative reviews was down on the previous quarter (11 in Q3 compared to 21 in Q2) and the number of positive reviews was up on the previous quarter (25 in Q3 compared to 18 in Q2) **Positive feedback:** “I just wanted to say how fantastic the staff are at Warrington hospital. I had a good long stay there a few weeks ago after a bad fall. My god they work hard! They were so supportive and caring and I was taken good care of with coffee and painkillers in A & E. Then after the staff in Ambulatory Care were amazing sorting my x-rays and scans and finding something I had that's was nothing to do with the fall. Again they had me back in for ultrasound scans to give me the piece of mind I need, they are hero's to me amazing lovely hardworking people.”





‘Well-Led’ Metrics : Communicating with staff

Metric	**Engagement with Staff Communication Channels** Trust-wide staff communications channels include: The Daily Trust-Wide Safety Brief Good Morning WHH from the CEO The Week A closed staff-only Facebook group WHH People Monthly Team Brief Extranet announcements and content Staff App	
Current Performance	**TEAM BRIEF TOTAL ENGAGEMENT FOR 2022-23** Attendance during Q3 • 2pm slot - 608 • 7pm slot - 33 • November saw the highest attendance, top story – Halton Health Hub **MEMBERS ON WHH PEOPLE FACEBOOK PAGE** 608 staff members.	**STAFF APP DATA** 



REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/12**			
SUBJECT:	**Bi-monthly Strategy Programme Highlight Report**			
DATE OF MEETING:	25th January 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)***	**#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.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following Strategy Programme Highlight Report provides a progress update on key strategic projects and initiatives that underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives.			
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	FSC/23/01/14		
	Date of meeting	18th January 2023		
	Summary of Outcome	Report received for information		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Bi-monthly Strategy Programme Highlight Report	AGENDA REF:	BM/23/01/12

1. BACKGROUND/CONTEXT

This report summarises the progress of key strategic projects which underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives. It is intended to be a useful reference point for regular updates.

2. KEY ELEMENTS

The Strategy Programme Highlight Report consists of the following elements:

- The stakeholder engagement log provides a snapshot of external stakeholder engagement over the 2-month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums
- Individual project updates, including budget updates, key milestones (RAG rated), progress since the last report, risks
- Details of how the overall Trust Strategy is being developed
- Description of strategic opportunities that are in the pipeline

The report is produced every two months and therefore the most recent version (appended to this paper) reflects the status of the key strategic projects as at the end of September 2022.

Since the end of November, the following key updates should be noted:

Living Well Hub in Warrington – Three bids have been received from contractors looking to undertake the refurbishment work on the building in Warrington town centre. The bids are currently being evaluated in line with the plan to award a contract for the work in mid-February to coincide with signing the lease on the property.

Community Diagnostic Centre – The business case for phase 2 (new build) of the project was not approved by NHSE in early January due to a change in the funding parameters set at national level. A revised plan to utilise the agreed funding from phase 1 plus additional short-term funding has now been drawn up and resubmitted for approval. A response is anticipated within days. The revised plan includes a smaller-scale new build on the Halton site alongside refurbished space in the Nightingale building and utilisation of the second phase of the Trust's Shopping City development.

Breast Service Reconfiguration (Phase 2) – The lease for the new space in Bath Street Health and Wellbeing Centre has now been signed by all parties. Therefore, the work to expand and upgrade the breast screening space will now commence in early February. Once complete, this will facilitate the re-location of the final clinical elements of the Breast

service to re-locate from its current location within Kendrick Wing on the Warrington Hospital site.

The next full report produced will reflect these updates and the status of the key strategic projects as at the end of January 2023.

3. MONITORING/REPORTING ROUTES

Key strategic projects report to the Strategy and a Greener WHH sub-committee which reports to Finance and Sustainability Committee.

4. TIMELINES

This report is be produced and circulated every two months.

5. RECOMMENDATIONS

It is recommended that the Trust Board note the report for information.

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Strategy Programme
Highlight Report – November 2022

Page	Project	SRO	Strategy Lead	Status
5	Living Well Hub in Warrington	LG	SB/CL	
6	Runcorn Town Deal	LG	CM	
7	Halton Health Hub	LG	CM	
8	New Hospitals Programme	LG	KJ	
9	Community Diagnostic Centre	LG	SB/LZ	
10	WHH Green Plan	IW	VR	
11	Warrington Wider Estates Review	LG	KJ	
12	Halton Blocks	LG	CM	
13	Breast Service Reconfiguration – Phase 2	LG	CL	
14	C&M Pathology Network	LG	KJ/VR	
15	Health & Social Care Academy	WVRC	SB/CL	Complete
16	Anchor Programme Development	LG	KJ	
17	Development of Overall Trust Strategy	LG	KJ/SB	

Key code	
	On track
	Potential delay that is recoverable and/or does not impact materially on completion date
	Likely material delay to completion date

Pipeline of Strategic Opportunities	
18	Brief updates on other potential strategic opportunities for the Trust

This strategy report provides a progress update on key strategic projects and initiatives that underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives.

The stakeholder engagement log provides a snapshot of external stakeholder engagement over the 2 month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums.

Should further information be required on any projects contained within the report, please contact the strategy team directly.

Stakeholder Engagement Log

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Lisa Sculpher	Strategic Estates, NHSEI	New Hospitals Programme & staff facilities – health and wellbeing framework development
Andy Carter	MP	New Hospitals Programme and promotion of case of need to key decision makers
Charlotte Nichols	MP	New Hospitals Programme and promotion of case of need to key decision makers
Mike Amesbury	MP	New Hospitals Programme and promotion of case of need to key decision makers
Derek Twigg	MP	New Hospitals Programme and promotion of case of need to key decision makers
Warrington System Clinical Leaders (PCN Clinical Directors)	Warrington Together Clinical and Care Professional Leadership Forum	Presented Community Diagnostic Centre project
Warrington Place Senior Leadership	Warrington Together Partnership Board	Presented Community Diagnostic Centre project
Samantha Pearce	Senior Health Improvement Specialist, Public Health Warrington	Integration of Public Health with the Living Well Hub project
Steve Cullen	Head of Warrington Citizen's Advice (CAB)	Involvement of CAB in Living Well programme across Warrington
Rowan Pritchard-Jones	Medical Director, NHS Cheshire & Merseyside	Living Well Hub stall at C&M ICB event. How the Hub will support prevention agenda as part of place-based integrated care
Nicki Goodwin	Senior Programme Manager, One Halton	One Halton Programme, Shopping City Clinical Hub, Prevention Pledge at Place
Bryan Lipscombe	Climate Change and Sustainability Manager	Mutual support and assistance for delivering respective Sustainability/Green plans.
Ian Triplow	CDC Programme Director Cheshire & Merseyside	Submission and approval process for Phase 2 CDC business case
Helen Pressage	Head of Healthcare Commissioning, Warrington	Discussed Community Diagnostic Centre project and primary care engagement
Emma Washbourn	OPE and Land Commission Officer	New Hospitals Programme, Halton Blocks project and potential future funding

Stakeholder Engagement Log

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Linda Buckley	MD Provider Collaborative, Cheshire & Merseyside	Regular catch up with Provider Collaborative leadership
Neil Hutchinson, Mark Lloyd	Owen Ellis Architects/NHS Property Services	Further review latest stage 4 designs for the Living Well Hub and sign off room plans
Ian Baddiley	Principal Manager Health Improvement, Halton Borough Council	Utilisation of Halton Health Hub
Lauren Sadler	Transformation and Change Lead – Warrington Together Partnership	Living Well programme branding/Living Well Hub and development of virtual hub
Steve Park	Growth Director, Warrington Borough Council	Local plan, new hospitals, Estates planning
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M fragile services
Steven Broomhead	CEO, Warrington Borough Council	New hospitals
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy, Living Well hub
Alison Moore	HSJ	Commercial partnerships
Matthew Philpott	Executive Director, Health Equalities Group	Prevention Pledge
John Boileau	NHS Transformation Unit	C&M pathology collaboration
Andy Davies	NHS C&M	New hospitals
Sinead Clarke	Associate Medical Director for System Quality and Improvement C&M ICS	Addressing health inequalities
Leonora Volpe	Senior Policy Manager, NHS Providers	Anchor, sharing best practice
Colin Thomasson	Executive Director, CBRE	Commercial property advice, Living Well Hub
Wesley Rourke	Operational Director, Economy, Enterprise and Property	Runcorn Shopping City, Levelling up, Runcorn Town Deal

Living Well Hub in Warrington

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) will be 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 close 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

- Heads of Terms are ready to be shared with Execs prior to approval
- Owen Ellis architects have completed the tender documents
- Build contract tender went live on 14th November
- Planning approval was received on the 11th November.
- Progress has been made with confirming the service provision within the hub, particularly for the families and children's offer.
- Refining the detail around the offer for managing long term conditions will now the focus for the timetable.
- Regular monthly delivery group meetings are now taking place as we move into the mobilisation phase of the project.
- A site visit to Hartlepool Hub was undertaken which provided insights into a similar project to the vision that is being created within the Living Well Hub.

Financial Implications/ Budget Update

Total project value is £3.1m, which is funded via central government. Ongoing revenue implications and how they will be covered across all system partners are to be confirmed.

Upcoming Key Milestones	Date	Status	Comments
Appoint build contractor	Jan 22		Tender issued November 22
Agree provisional timetable	Dec 22		Challenges with operational diaries.
Lease Heads of Terms agreed	Nov 22		
Full lease signed	Jan-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Formal agreement to be reached with all partners around ongoing financial and management arrangements of the Hub.	Significant impact on project if agreement is not reached. Alternative options will need to be considered.	12	All partners fully engaged in discussions around possible options and impacts.	8
Failure to secure preferred building from Landlord Caused by: Landlord having other plans for the building/ unsuccessful lease negotiations	Project delays whilst scoping new location for the hub	12	Progress lease negotiations as quickly and strategically as possible	4

Runcorn Town Deal

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

- Confirmation of acceptance of submitted business case by HM Government.
- Planning for next stage of delivery commenced
- Confirmation that Halton Borough Council will lead procurement of design team for RIBA stage 3

Financial Implications/ Budget Update

Total value of project as submitted through Runcorn Town Deal Programme: £3.89mil (across 5 years). Town Deal contribution: £2.85mil. Providers, including education, Council and Health bodies expected to meet remaining project costs of: £1.04m (across 5 years)

Upcoming Key Milestones	Date	Status	Comments
Commence recruitment of project officer	Dec-22		
Commence appointment of Design Partner	Dec-22		
Implementation and first meeting of delivery group	Jan-22		
Opening	Autumn 2024		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Failure to: procure the programme to time and / or budget Caused by: programme overruns / unforeseen issues requiring spend	Failure of project, no health and education hub	8	Good partnership working arrangements, clear project governance, implementation of best practice from Halton Hralth Hub project	6
Failure to: reach formal agreement regarding ongoing financial and management arrangements Caused by: various causes	Alternative options for delivery will need to be considered	9	All partners fully engaged in discussions around options, mitigations and impacts	6

Halton Health Hub

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Halton Health Hub programme aims to utilise void space in Runcorn Shopping City to deliver health and wellbeing services closer to community in line with the NHS Long Term Plan.

The scheme includes a refurbishment of retail space to re-purpose for access to hospital services, including audiology, ophthalmology and dietetics. This programme is part funded by Liverpool City Region Combined Authority.

Progress since last report

- Staff in place to occupy unit
- Operational guidance issued
- Local inductions underway
- Completion of Fire Risk assessment actions
- Water risk assessment undertaken
- Sign off from Infection prevention & control
- Communications issued to patients

Financial Implications/ Budget Update

Total Programme Budget: £950.4k, funded via:

Internal Trust Capital Programme: £600.1k
Donated income: £350k (via LCR Town Centre Commission)

Current forecast cost: £913.57k

Actions being taken to identify sources of additional funding and reduce costs.

Upcoming Key Milestones	Date	Status	Comments
Service Delivery Commencement	Nov-22		Delivery due to begin November 22 following delays to construction programme
Post completion project support period to commence	Nov-22		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Failure to: secure long term sustainability of services Caused by: Ability to afford revenue costs over time	Resulting in: reconfigured service offer, delayed delivery	12	Revenue case agreed March 2021, additional controls agreed Autumn 2022	8

New Hospitals Programme

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 Health and Wellbeing Campus vision.

Progress since last report

- Briefings held with MPs and partners to promote key messages and identify opportunities to ensure the case for need is understood by key decision makers.
- Comms messaging reviewed and a high level forward plan developed.
- A meeting took place with Mersey Care to discuss the future of the Brooker Centre on the Halton site and it was agreed to continue to engage with each other as estate plans progress.
- Estates plan in development which will take account of how current estates decisions can support our journey towards a new hospital.
- Next steps for the New Hospitals programme are dependent on the outcome of the EOI process. Until a decision is made nationally progress will be limited.

Financial Implications/ Budget Update

Agreed capital funding to progress with financial affordability model and benefits enhancement work has been spent as planned. Capital costs for the programme have been revised by Turner and Townsend, following a review from EDGE and updated drawings from Gilling Dodd. This will determine future budget requirements

Upcoming Key Milestones	Date	Status	Comments
Outcome received from EOI stage of application to the New Hospitals Programme	Spring-22		Results will determine next steps in the comms plan and project direction. Have been advised EOI results could arrive towards the end of the year due to government delays
Refresh of the Warrington and Halton financial and economic cases within the SOCs.	Jan-23		Original deadline of September-22 has been extended. No material impact to the programme due to the delay as this is prep for the next stage EOI.
Selection of preferred site for new Warrington Hospital	Sep-22		On hold pending review by the Strategic Oversight Group

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
The required investment may not be available if unsuccessful with the EOI process	May lead to scope of implementation being limited to meet an affordability envelope, reducing the benefits able to be achieved.	12	Exploring opportunities for external funding and buy in from C&M for investment prioritisation	12

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 CDC Project is split into 2 phases. Phase 1 will develop a Fast-Track CDC by end of March 2023 based within the existing Nightingale building on the Halton site. Phase 2 (when approved) will see the development of a a full new build CDC as an extension to the CSTM building on the Halton site

Progress since last report

- The Trust's Fast Track CDC (Phase 1) case was approved in September 2022. The Phase 2 New Build CDC case was submitted to the C&M team for approval in November.
- Approval by the national team of the Phase 2 Business Case is expected by mid-December 2022.
- The Trust is currently running a tender exercise to appoint a contractor to deliver the Phase 1 project.
- Appointment of the contractor is expected by 14/12.
- The project will formally commence on 19/12, with the design for the fast track CDC expected to be competed and signed off by end of January 2023.

Financial Implications/ Budget Update

Fast-Track CDC (phase 1) - £10.5m capital
Full New Build CDC (phase 2) - £14.9m capital

Upcoming Key Milestones	Date	Status	Comments
Complete design work for Fast-Track CDC	Jan-23		Revised date following amendment to plan.
Decision from regional/national team on Full CDC	Dec -22		Phase 2 case was submitted in November 22.
Fast-Track CDC operational	Mar-23		
Full CDC operational	Jul-24		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Availability of workforce across multiple specialties to staff a potential large scale CDC in the short to medium term	Will significantly impact on ability to operate enhanced capacity.	10	National discussions re: workforce development strategy.	8
Financial risk with revenue beyond year 2	Potentially need to decommission beyond year 2 if funding does not match costs	10	Regional team have confirmed plan to develop national CDC	6

WHH Green Plan

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The NHS has set the target to achieve net zero by 2040. The "For a Greener NHS" campaign was launched in 2020 by NHS England. While this is a nationally mandated programme, the Trust has a strategic commitment to developing and expanding on its role as an anchor organisation. The Green Plan will form a core pillar of this programme.

WHH has worked in partnership with WRM Sustainability to assess the Trust's current position and develop an implementation plan to achieve our emissions targets.

Progress since last report

- National Climate Change Risk Assessment pilot underway. Pilot comprises a risk assessment template to be completed. The risk assessment will require input from wider teams across the Trust – Estates, Health & Safety, EPRR – and wider partners including both Warrington and Halton Borough Councils. The assessment is due to be completed by the end of January 2023 and will inform an adaptation action plan to support the Trust's Green Plan.
- Project to calculate the carbon footprint of a surgical procedure is underway and will allow identification of carbon hotspots and highlight potential areas of carbon and waste reduction.
- Review of actions and progress underway. Workshop planned for 23rd January to review progress and prioritise next steps.

Financial Implications/ Budget Update

TBC. Significant investment will be required to enhance Trust estates to meet required carbon savings.
External funding opportunities are being researched.

Upcoming Key Milestones	Date	Status	Comments
Complete Climate Change Risk Assessment document	Jan 2023		
Progress review and prioritisation workshop	Jan 2023		
Complete progress review and prioritisation exercise	Feb 2023		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Insufficient funding to enable deliver against actions e.g. estate improvements, technological solutions	Do not achieve required reductions in emissions	15	Capital pressures to be assessed and logged via Capital Planning Group -External funding sources to be sought	9
Capacity and expertise – prog lead required to oversee and progress plan supported by technical expert	Do not achieve required reductions in emissions	15	Explore funding recurrent roles to provide Sustainability	9

Warrington Wider Estates Review

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Trust, in partnership with Halton Borough Council and Warrington Borough Council, submitted a bid to the One Public Estate Programme in November 2020, via the Liverpool City Region Combined Authority, partly to:

- Review the wider estate across the Warrington region, and produce a shared delivery plan, recommendations and opportunities to improve utilisation of buildings, with an end product of a framework to utilise estate asset database to enable informed decisions on future use, configuration and occupancy

AIM: To get more from collective public sector assets, and take a strategic approach to asset management.

Progress since last report

- Scoping discussions are progressing with Warrington Borough Council who are exploring opportunities to host the asset map online.
- Work progressing with Place partners and GB Partnerships to embed utilisation of the Asset Map within Warrington's Place based Estates Strategy..

Financial Implications/ Budget Update

Total costs (inc. VAT) = £42,637
Externally funded via One Public Estate 8 funding agreement

Upcoming Key Milestones	Date	Status	Comments
Agree digital solution for the asset map	Jan-23		
Partners to work through their individual opportunities identified in the Delivery Plan and report back on the outputs.	Jul-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Technical queries around database hosting and enabling external access to refresh the database remain unresolved.	The potential solution may require capital investment and/or capacity from WHH to support a refresh.	12	Technical queries around database investigated, resolutions identified and escalated to Place for discussion on resolution across the partnership.	6

Halton Blocks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Trust has been engaged with local partners, including Halton Borough Council, since 2016 in contributing to regeneration schemes within Halton Lea. This is reflected within the Trust's New Hospitals Programme, which outlined a bold and exciting future for the site as the Halton Hospital and Wellbeing Campus.

The Trust and its local partners are now keen to identify how best the Halton Blocks could be used to generate social value in line with the regeneration plans of the area, as well as providing a financial benefit if developed as part of the wider masterplan for the Halton site.

Progress since last report

- A fully drafted report has been issued and shared with key individuals for comment.
- Final draft delivered July 2022.
- Final draft reviewed internally. Additional changes requested.
- Bid submitted to Department of Levelling Up, Housing and Communities to relocate staff and facilities from the Blocks and decommission the site, totalling £1.41million

Financial Implications/ Budget Update

Total costs (inc. VAT) = £44,733.60
Externally funded via One Public Estate 8 funding agreement

Upcoming Key Milestones	Date	Status	Comments
Report to execs outlining report recommendations and next steps	Aug-22		Delayed to December as above
Outcome expected for Levelling Up bid	Nov-22		Likely decision early 2023
Project planning to commence following funding decision	Feb-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
If Halton Blocks aren't reconfigured, then the Trust won't contribute to the Halton Lea regeneration programme in full and elements of the Halton Hospital and Wellbeing Campus masterplan will not be delivered in short term	Resulting in reputational damage among local delivery partners including Halton Borough Council, impacting access and opportunities for future funding	10	A number of other schemes are in development with Council to identify sources of funding and opportunities to strengthen the Trust's contribution to local regeneration	8

Breast Service Reconfiguration – Phase 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Trust is looking to consolidate and expand Breast Screening Services at Bath St Health & Wellbeing Centre in Warrington through a relocation from Kendrick Wing on the Warrington Hospital site.
This is phase 2 of a reconfiguration and improvement of Breast services for Warrington, Halton, St Helens and Knowsley (WHSKBSS) following the relocation of Breast Assessment and Symptomatic clinics from Warrington Hospital to the new £1.2m Breast Care Centre located in the Captain Sir Tom Moore building at Halton.
The planned reconfiguration will improve WHSKBSS by increasing staffing efficiencies, modernising facilities and increasing the physical space available to carry out the screening.

Progress since last report

- An Experts by Experience event was held at Bath Street to obtain views from the public around the proposed expansion of services. A particular focus was on accessibility for those with additional needs.
- The NHSE/I funded mammography machine was approved for purchase and a PO has been raised
- The contract for the new upgraded broadband connection at Bath Street was signed off
- A delay in approval of funding by CHP for the build renovations will lead to a delay in the go live date for the expanded unit.
- Heads of Terms for the new space have been agreed and the new combined lease is nearing completion for sign off
- An order has been made for IT equipment required to support the new upgraded broadband connection
- Enquiries have been made regarding the decommissioning of the lease expired mammography unit which will need to be carefully timed with the build works once commenced.
- New lease to be capitalised in this financial year as per the new SFI's.

Financial Implications/ Budget Update

The renovation works for this project are being financed and completed by Renova. As such, the Trust do not share any of the financial risk surrounding the renovation element of the project. Funds secured for the first phase of the project included £30,000 for relocation of existing equipment from Kendrick Wing to Bath Street. Their will be a one off 6% capital charge which will be jointly financed by WHH and Warrington CCG (50:50 split). Ongoing rental agreements have also been agreed with Warrington CCG funding the majority of the costs.

Upcoming Key Milestones	Date	Status	Comments
NHSE/I funded mammography purchase to be completed	Dec-22		
Build works to commence	Jan -23		
Project completed and allocated capital for this financial year spent.	Mar-23		Delayed due to increased refurbishment works to accommodate new improved design and delay of finance agreements

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Disruption to current service caused by build works	Reduced number of appointments available	9	Produce a contingency plan and liaise closely with build team to minimise disruption	6

Cheshire & Merseyside Pathology Network

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The transformation of the provision of pathology services in Cheshire & Merseyside by restructuring pathology services to generate levels of efficiency savings to the local health economy whilst maintaining and improving high quality standards.

Progress since last report

- The Transformation Unit have completed a readiness assessment to progress to FBC. An update is awaited in January 2023 on the outputs and next steps.
- Procurement for a managed service contract for a haematology automated track system is underway with full costings received.
- The Network has confirmed it is unable to compensate Trusts who are financially penalised by moving to short-term contracts to support quicker harmonisation of procurement. A paper outlining the implications of this for existing and upcoming procurement activity has been prepared for execs and is scheduled for discussion on 29-Nov-22.
- A risk and gain share principles workshop was held by the network in November, and attended by Trust representatives.
- The Network is working on defining the specification of a hub and ESL. While this is awaited, internal work streams with STHK have been reframed to focus exclusively on mapping existing service provision across both Trusts – i.e. test repertoire, volumes, pathways, turnaround times etc, to create a service baseline.

Financial Implications/ Budget Update

Financial implications to be worked up through development of Collaboration Agreement to Business Case.

Upcoming Key Milestones	Date	Status	Comments
Sign off of Collaboration Agreement at Cheshire and Merseyside HCP.	Nov-20		Collaboration agreement reviewed but not formally approved. This may resurface through the readiness assessment.
Risk and Gain Share Principles agreed	Jun-21		Paused pending network direction on next steps
Next steps from readiness assessment agreed	Nov-22		Pending – To be discussed at Network Management Meeting in December 22.
FBC produced and reviewed by Board	TBC		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Cellular Pathology – Cohort of Pathologists nearing retirement.	Shortage of staff in service and difficulties in recruiting until service configuration confirmed.	16	Mutual aid being provided by STHK.	8

Health & Social Care Academy

Project Overview

The Trust is working closely with another local anchor institution, Warrington and Vale Royal College, to develop a Health & Social Care Academy on the college's main campus in Warrington.

The project is led by the college team and forms part of the Town Deal programme but WHH is a key partner and will play a fundamental role in helping shape the curriculum and identify the areas of greatest need in terms of the health and social care workforce in future.

Progress since last report

- Project complete and facility now open on the Winwick Road campus of Warrington and Vale Royal College
- Future work will seek opportunities for the Health & Social Care Academy to support the training and development of existing and new roles within health and care sectors.
- The Academy will continue to explore opportunities to support the wider integrated care agenda across Warrington with the delivery of training opportunities.

Upcoming Key Milestones	Date	Status	Comments
Project Complete			

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Project Complete				

Anchor Programme Development

Project Overview

As an anchor institution, WHH has an opportunity to positively influence the health and wellbeing of the patients we service and the local communities we are part of. The anchor programme seeks to ensure we use our position and influence to work with others in responsible ways, to have an even greater impact on the wider factors that create happy, healthy and thriving communities.

Collectively the Trust's strategic projects support delivery of the ambitions of the anchor programme

Progress since last report

- Progress continues to be made in advancing the Trust's anchor maturity and the anchor programme has been recognised as exemplary both within Cheshire and Merseyside and nationally.
- An inclusion for Trust wide job descriptions has been drafted to ensure sustainability and social value are key considerations for all roles. This has been shared with workforce for review and refinement.
- A review and refinement of the Prevention Pledge Action Plan is underway.
- Consideration is being given to development of a Social Value and Anchor dashboard to enable slicker reporting of impact. Wirral Community Health & Care NHS Foundation Trust have adopted this approach and learning is being taken from their work.

Upcoming Key Milestones	Date	Status	Comments
Incorporating Anchor into Strategy refresh Embedding WHHs anchor ambitions will be further cemented by including them as core features of the Trusts strategy refresh. Anchor priorities will also be included in Place based delivery plans.	Apr-23		
Streamlining reporting Reporting against the key strategic projects which constitute the anchor programme will become part of reporting against the Trust's overall strategy	Apr-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
The anchor programme is vast and there is a risk the totality of work is not captured.	Gaps and opportunities may be missed and not reflected. Equally impact may be underrepresented.	8	Reporting linked to overall strategy report. Mechanism to visually identify anchor work to be implemented	6

Development of Overall Trust Strategy

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

Development and subsequent delivery of overall WHH Trust strategy.

Support to the development, delivery and governance of enabling strategies, clinical strategies, and strategic priorities.

Progress since last report	Upcoming Key Milestones	Date	Status	Comments
• Strategy development session held with Executive Team. • Strategy development session planned with Trust Board in December. • Marketplace stalls were held in Warrington Hospital and Halton Hospital to gather views from staff regarding key priorities for the strategy. Staff engagement was further supported by a GMWHH and staff survey. • Service level clinical strategies are being refreshed through the annual business planning round and an additional session is being planned for January 23 to ensure relevant QPS priorities are reflected by CBUs. • An initial review of enabling strategies has been completed to identify opportunities to realign planning horizons and consolidate a number of strategies. Outputs are ready to be shared with Execs.	Refreshed Trust Strategy approved	Aprt-23		
	Service level clinical strategies approved	April -23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
No risks identified to date.				

Strategic Opportunity Pipeline

Overview

This section lists the strategic opportunities that are currently in the pipeline and are in the process of being explored/assessed for the potential to progress by the Strategy Team. For more information about these opportunities or to suggest any further opportunities, please contact a member of the Strategy team.

Proposal Name	Brief Description	Strategy Team Contact
Warrington Wolves – Combined Training and Wellbeing Facility	Early discussions around the potential to create a new facility combining state of the art training space for the rugby team with community health and wellbeing space(s)	Lucy Gardner
Halton Health Hub– Phase 2	Additional space is available for development in Runcorn Shopping City adjacent to the facility that is being developed by the Trust and partners (see slide 7). A bid has been submitted within Halton Borough Council's Levelling Up programme to DLUHC for £1.6million	Carl Mackie
Halton Primary Care Collaboration	Potential opportunities to work in collaboration with Primary Care services in Halton on a number of opportunities including; provision of health checks in Runcorn Health & Education Hub, use of GP ARRS roles, Use of Runcorn UTC, and the use of fallow sessions and out of hours at Halton Health Hub	Carl Mackie
Burtonwood Parish Council Building	Working alongside Warrington Borough Council (WBC) to scope out potential to repurpose some disused space in Burtonwood as a sports and wellbeing facility. Links to the wider Living Well agenda. Capital refurbishment requirements have been submitted by WBC under the latest Levelling Up bids.	Steve Bennett
Levelling Up funding - Halton	Two bids submitted, one for the creation of Halton Health Hub phase 2 (£1.66m) and one for the Halton Blocks project (£1.42m). Decisions expected in Winter 2022/23.	Carl Mackie
Shared Education Facility	Very early discussions with WBC about potential to develop a new education facility that could provide a space for learning and education for both the council and the Trust.	Lucy Gardner
Time Square phase 2 development	Early discussions with WBC to look at potential for the Trust to utilise some space within the proposed new Time Square phase 2 development in Warrington town centre. Will link to New Hospitals planning.	Kelly Jones
UK Shared Prosperity Fund - Warrington	Working with WBC to develop plans to make use of the UK Shared Prosperity Fund (UK SPF) monies – a UK replacement for European Regional Development Funding post-Brexit. Current ideas include investment in digital solutions to support improved health including a new Warrington	Steve Bennett

Strategic Opportunity Pipeline Cont'd

Proposal Name	Brief Description	Strategy Team Contact
One Public Estate £140k	The Liverpool City Region One Public Estate programme was awarded £140k in April 2022. The funding is being utilised to complete an NHS Place Estates Asset Review across the boroughs in Liverpool City Region, with the goal of producing a five-year strategic pipeline which identifies opportunities to optimise current and future NHS estate and outline potential non-NHS funding routes to achieve this. Work is currently ongoing with outputs expected by March 2023.	Carl Mackie

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Operational Planning Guidance 2023/24

Trust Board
25 January 2023

Andrea McGee
Chief Finance Officer and Deputy Chief Executive

Introduction

- Planning guidance published 23 December 2022
- Templates issued 10 January 2023
- Key elements to the operational plan includes Activity, Finance and Workforce

Key Points from guidance

- Range of national NHS objectives for 2023/24 including A&E waiting times (76% not more than 4 hours), reducing bed occupancy to 92% or below, reducing cancer waiting times and supporting earlier diagnosis
- Actions designed to increase capacity and improve patient flow to ease UEC pressures (Cat2 response times 30 mins and meet 70% 2 hour urgent community response)
- 2 year revenue allocations for ICBs, Elective allocated to systems on fair shares basis
- Agency spend limits to be set as proportion of systems total pay 3.7%

Urgent and emergency care

- Guidance sets out actions to increase capacity and improve patient flow to ease A&E pressures
  - Increase physical capacity – additional 7000 beds funded in winter to be maintained, increase use of virtual wards to 80%
  - Improve timely discharge – BCF provide £600m to support discharge
  - Increase ambulance capacity
  - Manage system risk – ICB operationalise clinically led system control centres
  - Category 2 ambulance response times to an average of 30 minutes in 2023/24

Elective Care and unit price

- Target 30% more elective than pre-pandemic by 2024/25 – ACTUAL TARGET FOR 2023/24 ICS & INDIVIDUAL TRUSTS **TBC** (as per national team 10/1/23 worse performing in 2022/23 will be expected to improve the most)
- Eliminate waits over 65 weeks by March 2024
- **Contract elective activity paid at unit rate of that delivered** (excluding follow ups)
- Elective recovery funding allocated to systems on fair shares basis
- Key areas of focus
  - Transform outpatient care reduce follow ups by 25% against 2019/20 levels
  - Increase productivity 85% daycase and 85% theatre utilisation using GIRFT and moving procedures to most appropriate setting
  - Offer meaningful choice (including digital mutual aid system DMAS)

Cancer & Diagnostics

- Objective to reduce waiting times and support earlier diagnostics
  - Implement priority pathway changes for lower GI, skin and prostrate
  - Increase diagnostic capacity for 25% for cancer and treatment by 13%
  - Support early diagnosis – targeted lung health check programme
  - Systems to deliver minimum 10% productivity in pathology and imaging networks by 2024/25 - £2.4bn capital funding over 2023/24 and 2024/25 for diagnostics

Maternity & Neonatal

- Improve personalisation of care, implement local equity action plans
- Investing £72m above the £93m to address Ockenden issues

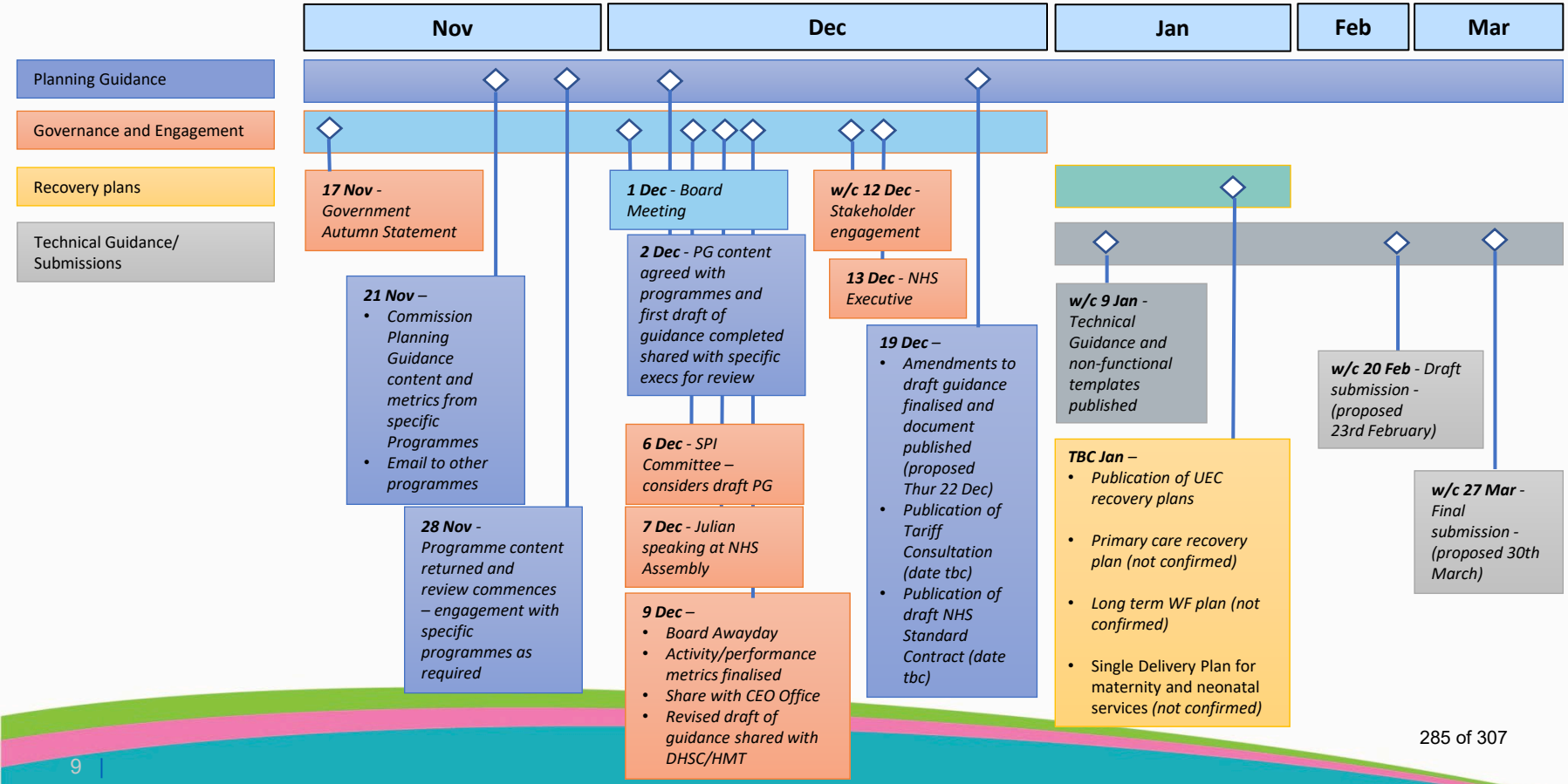
Funding

- Balanced net system position, 2.2% **efficiency** target and improving **productivity** levels – **EXPECTED TO BE HIGHER DUE TO NON RECURRENT 2022/23 CIP**
- Providers expected to clearly outline performance monitoring processes and financial controls
- Increase of £300m capital – access conditional on system financial performance 2022/23 – **AVOIDING TRIPLE LOCK**
- Systems should identify **productivity loss** and design actions to improve this. Including flexible deployment of staff and improved theatre utilisation (using model hospital)
- Must **reduce** agency, corporate running costs, Procurement and supply chain costs, along with improve inventory management and purchase medicines at most effective price point
- Agency to be not more than 3.7% of total pay spend for the ICS – if forecast actual at month 7 is below 3.7% it will be adjusted accordingly – **ICS to distribute target**

Significant challenges

- Reduction in COVID funding with remaining costs
- On going inflation (pay and non pay)
- Move to Payment By Results for elective
- Agency to 3.7% of total pay spend – currently WHH 6%
- Non recurrent CIP in 2022/23 along with next year efficiency – challenge - it could hit double digits for some Trusts impact on quality and workforce
- Ability to close unfunded escalation areas from 1 April 2023

Timetable and engagement



Conclusion

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Productivity, escalation and CIP remain the biggest challenges to the Trust as we prepare the operational plan for 2023/24.
- System solutions are required in order to support an achievable plan for 2023/24

Recommendation

- The Trust Board is asked to note the presentation

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/14**	
SUBJECT:	**Risk Appetite Statement**	
DATE OF MEETING:	25th January 2023	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**All**	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings Working with the Good Governance Institute (GGI), the Trust has defined the Risk Appetite Statement specifically for five types of risk: Quality, People, Finance & Sustainability, Regulation and Reputation	

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

RECOMMENDATION:	The Trust Board is asked to review, discuss, and approve the Risk Appetite Statement	
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	Risk Appetite Statement	AGENDA REF:	BM/23/01/xx

1. BACKGROUND/CONTEXT

The risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings

Working with the Good Governance Institute (GGI), the Trust has defined the Risk Appetite Statement specifically for five types of risk: Quality, People, Finance & Sustainability, Regulation and Reputation

2. KEY ELEMENTS

DRAFT Risk Appetite Statement

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

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

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

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

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

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

Quality

Providing the best care and treatment we can is our purpose. We will actively avoid risks to the quality of clinical services and will take a cautious and balanced approach. Where innovation may improve quality of care we will however be more open to risk. When making significant decisions about our services, we will assess and record any risks affecting safety, patient experience and clinical effectiveness, and apply the necessary control measures. The impact of changes on quality will be monitored continuously and reported using both quantitative data and qualitative intelligence.

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

3. RECOMMENDATIONS

The Trust Board is asked to review, discuss, and approve the Risk Appetite Statement

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/01/15**	
SUBJECT:	**Quality Assurance Committee Cycle of Business 2023-24**	
DATE OF MEETING:	26th January 2022	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Business and Terms of Reference (ToR) on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. A summary of changes to the cycle of business are as follows: • All High Level briefings removed. Escalations will be reported in an exception report from Patient Safety & Clinical Effectiveness Sub-Committee or in quarterly/bi-annual update reports • A number of quarterly reports (Moving to Outstanding, Sepsis, Clinical Audit, Dementia, Quality Improvement) have been changed to bi-annual reports • Ward Accreditation Bi-annual report added • Patient Experience Annual report changed to bi-annual • SI & Complaints quarterly report removed to avoid duplication as this is already reported in the 'Learning From Experience' quarterly report and Complaints Annual report	

PURPOSE: *(please select as appropriate)*	Information	Approval **√**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2023-2024 Cycle of Business for QAC.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/23/01/08
	Date of meeting	10th January 2023
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

QUALITY ASSURANCE COMMMITTEE
CYCLE OF BUSINESS 2023/24

Item	Process	Lead	10-Jan	07-Feb	07-Mar	11-Apr	09-May	13-Jun	11-Jul	08-Aug	12-Sep	10-Oct	07-Nov	12-Dec	09-Jan	13-Feb	12-Mar
OPENING BUSINESS																	
Welcome, apologies, declarations, cycle business	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Minutes and Action Log	**Decision**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review rolling attendance log	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story (Bi-monthly)	**Note**	Dep Chief Nurse		✓		✓		✓		✓		✓		✓		✓	
Deep Dive (as required)	**Assurance**	Chief Nurse & Deputy CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Moving to Outstanding Update (Quarterly)	**Assurance**	Chief Nurse/Dep Dir Gov		**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**	
Hot Topics (as required)	**Assurance**	Chief Nurse & Deputy CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sepsis high level update (Quarterly)	**Assurance**	**Dep CN PS&C Effectiveness**		**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**	
COMPLIANCE & OVERSIGHT																	
Quality IPR Metrics	**Discuss & Assurance**	CN & Dep CEO		✓		✓		✓		✓		✓		✓		✓	
Review and Refresh of Trust KPIs	**Discuss & Assurance**	CFO & Deputy CEO			✓												✓
SAFETY																	
Maternity Update & Maternity Safety Champion including: - Update on Ockenden Review - SI Maternity Monthly Report	**Discuss & Assurance**	Director of Midwifery/Associate Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cheshire & Merseyside Quarterly Perinatal Mortality Report	**Assurance**	Director of Midwifery/Associate Chief Nurse		**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**	
Avoiding Term Admission into Neonatal Unit (ATAIN)	**Assurance**	Director of Midwifery/Associate Chief Nurse			**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**
Perinatal Mortality Annual Report	**Assurance**	Director of Midwifery/Associate Chief Nurse				✓											
Maternity Incentive Scheme (MIS)	**Approval**	CN+Dep CEO/Assoc CN (Midwifery)	✓												✓		
Liberty Protection Safeguarding (LPS) update		Director of Integrated Governance	✓		✓		✓		✓		✓		✓		✓		✓
Safeguarding (Bi-Annual Report)	**Assurance**	Deputy CN					✓						✓				
Safeguarding (Annual Report)	**Approval**	Deputy CN							✓								
Medicines Management/CD Annual Report	**Assurance**	Exec Med Director					✓										
CIP/GIRFT Quality Impact Assessment Compliance (Finance)	**Assurance**	Exec Med Director / Chief Finance Officer & Deputy CEO			✓								✓				
Quality Impact Assessment (CIP)	**Assurance**	Chief Nurse & Deputy CEO				✓								✓			
Learning from Experience Report	**Assurance**	Director of Integrated Governance		**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**	
6 monthly staffing report	**Assurance**	CN&Deputy CEO		✓						✓						✓	
DIPC Infection Control (1/4)	**Assurance**	CN&Deputy CEO		**✓Q3**			**✓Q4**			**Q1**			**✓Q2**			**✓Q3**	
DIPC Infection Control Annual Report	**Assurance**	CN&Deputy CEO							✓								
Infection Prevention and Control BAF Bi-Annually	**Assurance**	Associate Director Infection Prevention and Control	✓						✓						✓		
Health and Safety Annual Report	**Approval**	Director of Integrated Governance							✓								
DNACPR 6 month position report	**Assurance**	Exec MD / Dep CN P Safety				✓						✓					
CLINICAL EFFECTIVENESS																	
Learning From Deaths Review Quarterly report	**Assurance**	Exec Med Director			**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**
Clinical Audit Forward Plan	**Assurance**	Dir Integrated Gov			✓												✓
Clinical Audit Bi-annual report	**Assurance**					✓						✓					
Clinical Audit Annual Report	**Assurance**								✓								
PATIENT EXPERIENCE																	
Dementia Strategy Annual Review	**Assurance**	Deputy CN			✓												✓
Dementia Strategy Bi-annual Report	**Assurance**	Deputy CN				✓						✓					
Complaints Annual Report	**Approval**	Director of Integrated Governance						✓									
Patient Experience Bi-annual Report	**Assurance**	Deputy Chief Nurse				✓						✓					
COMPLIANCE & OVERSIGHT																	
Strategic Risk Register and Board Assurance Framework (Bi-monthly)	**Approval**	Trust Secretary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review and Refresh of Trust KPIs	**Discuss & Assurance**	CFO & Deputy CEO			✓												✓
Quarterly Quality Priorities Report	**Assurance**	Director of Integrated Governance			**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**
Quality Priorities 2023-24	**Approval**	Director of Integrated Governance			✓												✓
Quality Strategy annual update	**Assurance**					✓											✓
Quality Strategy 2021-2024 **(due 2024)**	**Approval**																

Risk Management Strategy Annual Report	**Assurance**							✓									
Nursing & Midwifery Strategy 2021-24 Annual Update	**Approval**	Deputy Chief Nurse						✓									
Quality Improvement Progress Biannual Report	**Assurance**	Chief Nurse& Deputy CEO				✓						✓					
Enabling Strategy alignment 6 mth Progress report	**Assurance**	Director of Strategy & Partnerships					✓						✓				
Patient Safety & Clinical Effectiveness Sub Cttee Exception Report	**Assurance**	Exec Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Experience Sub Committee Biannual Report	**Assurance**	Deputy Chief Nurse				✓						✓					
Palliative and End of Life Care Biannual Report	**Assurance**	Cons Palliat Med /Dir Med Educ				✓						✓					
IG + Corporate Records Group Quarterly Report	**Assurance**	CIO		**✓Q3**			**✓Q4**			**Q1**			**✓Q2**			**✓Q3**	
PATIENT Equality, Diversity & Inclusion Sub Committee Bi-annual Report	**Assurance**	Deputy Chief Nurse				✓						✓					
High Level Briefing Strategy & Sustainability (Exception report when required)	**Assurance**	Director of Strategy & Pships															
Ward Accreditation Bi-annual Report	**Assurance**	Deputy Chief Nurse				✓						✓					
Governance																	
Terms of Reference	**Approval**	Chair/Trust Secretary										✓					
Cycle of Business	**Approval**	Chair/Trust Secretary	✓												✓		
Committee Effectiveness Annual Review	**Assurance**	Chair/ Trust Secretary			**✓rep to Apr**												**✓rep to Apr**
Committee Effectiveness Bi-Annual Review	**Assurance**	Chair/Trust Secretary								**✓rep Sep**	✓						
Committee Chair's Annual Report to the Board	**Approval**	Chair/ Trust Secretary							✓								
High Level Enquires & External Assessment / Inspections (when notified)	**Assurance**	Director of Integrated Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Summary (assurances/risks to escalate to Board)	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/01/16**			
SUBJECT:	**Strategic People Committee – Terms of Reference & Cycle of Business**			
DATE OF MEETING:	25th January 2023			
AUTHOR(S):	Michelle Cloney, Chief People Officer & John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(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 **#1757** 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			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The proposed amended Terms of Reference and Cycle of Business for the Strategic People Committee are attached for consideration and approval. Key updates include a move from bi-monthly to monthly meetings, updates to members and quoracy and updates to the Committee's duties and responsibilities.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the Strategic People Committee Terms of Reference and Cycle of Business			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/23/01/04		
	Date of meeting	18.01.2023		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

STRATEGIC PEOPLE COMMITTEE

Cycle of Business (22 February 2023 to March 2024)

OPENING BUSINESS (2023)	Lead (Refer to key)	22 02 23	22 03 23	19 04 23	17 05 23	21 06 23	19 07 23	16 08 23	20 09 23	18 10 23	22 11 23	20 12 23
Apologies for Absence	C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the last meeting	C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising / action log	C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
STANDING ITEMS												
Staff Story – Lived Experience	CPO			✓			✓			✓		
BAF & Corporate Risk Register - Workforce	TS/DCPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BAF & Corporate Risk Register Review (Bi-Annual)	TS/DCPO			✓					✓			
Hot Topic Presentation	Committee Members	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Deep Dive Presentation	Committee Members	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Workforce Brief on National, Regional, ICB, or Local Workforce Issues – as required	Committee Members	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief People Officer Report	CPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Workforce Integrated Performance Report	CPO/DCPO/ACPO (WS&I)		✓		✓		✓		✓		✓	
Workforce Integrated Performance Recommendations for 2023/24 (annual)	CPO/DCPO	✓										
WHH People Strategy Update (Bi-Annual)	DCPO / ACPO			✓					✓			
WHH Workforce Equality, Diversity, and Inclusion Strategy Update (Bi-Annual)	DCPO/HWEDI					✓						✓
Workforce Policies and Procedures Overview Report (Quarterly)	DCPO/ACPO (HRBP)		Q3✓				Q4✓				Q1✓	
Improving People Practices Report (Bi-Annual)	DCPO / ACPO (HRBP)				✓						✓	
National Staff Opinion Survey (Annual)	DCPO			✓								
Freedom to Speak Up Report (Bi-Annual)	CN&DCEO		✓						✓			
Health & Wellbeing Guardian Report (Annual)	CPO/ACPO(HWB)/HWBG				✓							
Trust Board Monthly Staffing Report – Key Issues Report	CN&DCEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital Volunteer Report (Annual)	CN&DCEO			✓								
NATIONAL/STATUTORY REPORTS												
General Medical Council (GMC) Patient Survey Response Report (when required)	EMD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Education England (HEE) Monitoring Visit (Annual Assessment Visit)	EMD								✓			
General Medical Council (GMC) National Trainee Survey (Annual)	EMD								✓			
General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA)	EMD								✓			
Guardian of Safe Working Hours Report (Quarterly)	EMD	Q3✓			Q4 ✓			Q1 ✓			Q2 ✓	
Facilities Time Off Annual Report	DCPO					✓						
EQUALITY DIVERSITY + INCLUSION – Regulated Reports (as required)												
Equality Duty Assurance Report (EDAR) PSED Standard & Armed Forces Act Report	DCPO		✓									
Workforce Equality Assurance Report (WEAR) PSED Standard	DCPO											✓
Equality Delivery System (EDS) 2022	DCPO	✓										
Gender Pay Report	DCPO	✓					✓					
Workforce Race Equality Standard (WRES)	DCPO							✓				
Workforce Disability Equality Standard (WDES)	DCPO							✓				
GOVERNANCE												
Terms of Reference	C/TS											
Annual Cycle of Business	C/TS											
Committee Chairs Annual Report to Trust Board	C/TS				✓							
Committee Effectiveness – Annual survey	C/TS		circulate ✓	Report ✓								
Committee Effectiveness Survey – 6-month survey	C/TS							circulate ✓	Report ✓			
Sub Committee Chairs Log /Closing												
Operational People Committee	CPO		✓		✓		✓		✓		✓	
Workforce Equality, Diversity, and Inclusion Sub Committee	CPO	✓		✓		✓		✓		✓		✓
Nursing and Allied Health Professional Workforce Resourcing Group (as appropriate)	CN&DCEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of meeting / Items to Escalate	C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

STRATEGIC PEOPLE COMMITTEE

Cycle of Business (22 February 2023 to March 2024)

OPENING BUSINESS (2024)	Lead (Refer to key)	17 01 24	21 02 24	20 03 24
Apologies for Absence	C	✓	✓	✓
Declarations of Interest	C	✓	✓	✓
Minutes of the last meeting	C	✓	✓	✓
Matters Arising / action log	C	✓	✓	✓
STANDING ITEMS				
Staff Story – Lived Experience	CPO		✓	
BAF & Corporate Risk Register - Workforce	TS/DCPO	✓	✓	✓
BAF & Corporate Risk Register Review (Bi-Annual)	TS/DCPO			
Hot Topic Presentation	Committee Members		✓	✓
Deep Dive Presentation	Committee Members		✓	✓
Workforce Brief on National, Regional, ICB, or Local Workforce Issues – as required	Committee Members	✓	✓	✓
Chief People Officer Report	CPO	✓	✓	✓
Workforce Integrated Performance Report	CPO/DCPO/ACPO (WS&I)	✓	✓	✓
Workforce Integrated Performance Recommendations for 2023/24 (annual)	CPO/DCPO		✓	
WHH People Strategy Update (Bi-Annual)	DCPO/ACPO	✓		
WHH Workforce Equality, Diversity, and Inclusion Strategy Update (Bi-Annual)	DCPO/HWEDI			
Workforce Policies and Procedures Overview Report (Quarterly)	DCPO/ACPO(HRBP)			Q2✓
Improving People Practices Report (Bi-Annual)	DCPO/ACPO (HRBP)			✓
National Staff Opinion Survey (Annual)	CPO			
Freedom to Speak Up Report (Bi-Annual)	CN&DCEO			✓
Health & Wellbeing Guardian Report (Annual)	CPO/ACPO(HWB)			
Trust Board Monthly Staffing Report – Key Issues Report	CN&DCEO	✓	✓	✓
Hospital Volunteer Report (Annual)	CN&DCEO			✓
NATIONAL/STATUTORY REPORTS				
General Medical Council (GMC) Patient Survey Response Report (when required)	EMD			
Health Education England (HEE) Monitoring Visit (Annual Assessment Visit)	EMD			
General Medical Council (GMC) National Trainee Survey	EMD			
General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA)	EMD			
Guardian Quarterly Report, Safe Working Hours Jnr Doctors in Training	EMD		Q3 ✓	
Facilities Time Off Annual Report	DCPO/ACPO			
EQUALITY DIVERSITY + INCLUSION – Regulated Reports (as required)				
Equality Duty Assurance Report (EDAR) PSED Standard	DCPO/HWEDI			✓
Workforce Equality Assurance Report (WEAR) PSED Standard	DCPO/HWEDI			
Equality Delivery System (EDS) 2022	DCPO/HWEDI	✓		
Gender Pay Report	DCPO/HWEDI			
Workforce Race Equality Standard (WRES)	DCPO/HWEDI			
Workforce Disability Equality Standard (WDES)	DCPO/HWEDI			
GOVERNANCE				
Terms of Reference	C/TS			✓
Annual Cycle of Business	C/TS			✓
Committee Chairs Annual report to Trust Board	C/TS			✓
Committee Effectiveness – Annual survey	C/TS			circulate ✓
Committee Effectiveness Survey – 6-month survey	C/TS			
Sub Committee Chairs Log / High Level Briefing Papers/Closing				
Operational People Committee	CPO	✓		✓
Workforce Equality, Diversity, and Inclusion Sub Committee	CPO		✓	
Nursing and Allied Health Professional Workforce Resourcing Group (as appropriate)	CN&DCEO	✓	✓	✓
Review of meeting / Items to Escalate	C	✓	✓	✓

STRATEGIC PEOPLE COMMITTEE

Cycle of Business (22 February 2023 to March 2024)

Key To Leads

Job Title / Committee Role	Abbreviations
Chair	C
Chief People Officer	CPO
Deputy Chief People Officer	DCPO
Chief Finance Officer & Deputy Chief Executive Officer	CFO&CEO
Chief Nurse & Deputy Chief Executive Officer	CNO&DCEO
Trust Secretary	TS
Secretary to Trust Board	STB
Executive Medical Director	EMD
Chief Operating Officer	COO
Director Strategy & Partnerships	DS&P
Director Communications & Engagement	DC&E
Associate Chief People Officer (Workforce Systems and Intelligence)	ACPO (WS&I)
Associate Chief People Officer (HR Business Partnering)	ACPO (HRBP)
Associate Chief People Officer (Staff Health, Wellbeing, Training, OD, Occupational Health and Staff Engagement)	ACPO (HWB)
Head of Workforce Equality, Diversity & Inclusion	HWEDI
Health & Wellbeing Guardian	HWBG

1. PURPOSE

The Strategic People Committee is accountable to the Trust Board and will maintain a strategic overview of the Trust's human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

Linked to the Trust's Strategic Objective 2: *We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture and collaborative leadership development:
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers,
- Risks relating to workforce and culture as defined in the Risk Register and that the Board Assurance Framework are being managed and that action taken will result in the intended outcomes, and
- Trust's Due Regard for the Public Sector Equality Duties relating to the workforce, seeking to:
    - Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct,
    - Advance equality of opportunity between people who share a relevant protected characteristic and those who do not, and
    - Foster good relations between people who share a protected characteristic and those who do not.

The Committee will oversee strategic actions to enable the Trust to deliver the WHH Strategy and specifically the People Strategic Objectives, and respond to the national NHS People Promise. In addition, the Committee will provide assurance to Trust Board that the Strategic People Objectives will support our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Committee will provide assurance to the Trust Board on the management of risks related to our people.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Chief People Officer
- Deputy Chief People Officer
- Chief Finance Officer & Deputy Chief Executive
- Chief Nurse & Deputy Chief Executive
- Chief Operating Officer
- Executive Medical Director
- Director of Strategy & Partnerships
- Director of Communications & Engagement
- Company Secretary & Associate Director of Corporate Governance

Normally in attendance for specific agenda items scheduled in SPC annual Cycle of Business:

- Associate Chief People Officer (Workforce Systems and Intelligence)
- Associate Chief People Officer (HR Business Partnering)
- Associate Chief People Officer (Staff Health, Wellbeing, Training, OD, Occupational Health, and Staff Engagement)
- Head of Workforce Equality, Diversity, and Inclusion
- Shadow Board participants or alumni participants

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Strategic People Committee may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members Trust email account.

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

4. QUORUM

A quorum shall be two (2) members, one of who must be a Nob-Executive Director. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non-Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

5. AUTHORITY

The Strategic People Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic People Committee.

The Strategic People Committee may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee.

6. REPORTING

The Strategic People Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair of the Committee will provide a written Committee Assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.

The Strategic People Committee will report to the Trust Board annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board.
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy.
- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately.
- To ensure the Workforce Equality, Diversity and Inclusion Strategy is designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided.
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates.
- To ensure that the Trust attracts and retains our workforce using the principles of Model Employer to become the employer of choice.
- To review the consultation, negotiation and approval of all employment policies, including:
    - Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy,
    - Details of any employee relations negotiations delaying policy approval,
    - Details of extensions to policy dates,
    - Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and,
    - Details of any trends or employment issues associated with external factors influencing policy content.
- To receive the annual National Staff Opinion Survey results and to provide a set of recommendations for action by the Trust.
- To receive, agree and monitor the ~~staff engagement~~ Health and Wellbeing activity in the Trust ~~and employee reward~~ in order to be assured of the effectiveness of these activities on ~~improved morale; improved quarterly Staff Pulse results and~~ improving staff experience.

Duties – advisory:

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Strategic People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Integrated Performance Indicators relevant to the remit of the Strategic People Committee.
- To report any areas of significant concern to the Trust Board as appropriate via the Chair Key Issues Report.
- To monitor the implementation of Improving People Practices principles through the adoption of a Restorative Culture, including
    - Details of Employee Relations Cases in respect of numbers,
    - Summary of workforce demographics,
    - Analysis and impact assessment of emerging themes,
    - Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs,
    - Overview of lessons learned and actions taken to address these,
    - Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

Sub-Committees (Groups):

- Operational People Sub Committee
- Workforce Equality Diversity & Inclusion Sub Committee
- Nursing and Allied Health Professionals Resourcing Group
- ~~Workforce Recovery Steering Group~~
- ~~Medical Education Quality Sub-Committee~~

Each Sub-Committee will submit a Chair Log Report detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

The Strategic People Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business ~~(workplan)~~ will be established

Papers to this Strategic People Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Strategic People Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / People Professional Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting unless otherwise agreed with the Chair of the Committee
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair of the Committee.

10. REVIEW / EFFECTIVENESS

The Strategic People Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Strategic People Committee.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	V7
Implementation Date:	January 2023
Review Date:	12 months from approval
Approved by:	Draft v3 approved by TRUST BOARD (July 2018) Draft v4 – to be presented to September TRUST BOARD Draft v5 - to be presented to May 2019 Trust Board Draft V6 – approved by SPC 18 March 2020 to Trust Board 25 March 2020 and approved Draft V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020 V6.2 SPC 21.07.2021, Trust Board 28.07.2021 Draft V7 – approved by SPC 18.01.23 to Trust Board 25.01.2023
Approval Date:	19 September 2018 – SPC V4 approved 26 September 2018 – Trust Board V5 approved 20 March 2019 – SPC V6 approved 18 March 2020 at SPC and Trust Board 25 March 2020 V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020 V6.2 approved by SPC 21.07.2021, Trust Board 28.07.2021 Draft V7 – approved by SPC 18.01.23 to Trust Board 25.01.2023

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
May 2018	Draft TORs v1		Amendments – AW / MC
June 2018	Draft TORs v2		Amendments – AW / MC
July 2018	Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval		Amendments – AW / MC
July 2018	Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees		Amendments – AW / MC
September 2018	**Purpose**	Clarification on Well Led KLOEs to be reported to SPC and further confirmation of role of SPC as an assurance committee.	Amendments agreed by members of the Strategic People Committee 19 September 2018 Approved Trust Board (September 2018)
September 2018	**Membership**	Written approval by quorate membership rather than full membership.	
September 2018	**Duties & Responsibilities**	Section on Decision Making. Clarity on SPC role to assure	

		actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan.	
September 2018	**Subcommittees**	To include Triangulation Group	
20 March 2019	**Section 3 – Membership**	Updated attendee titles	
20 March 2019	**Section 7 – Duties + Responsibilities**	Triangulation Group removed	
18 March 2020	**Section 3 – Membership**	Updated attendee titles	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 10 – Administrative Arrangements**	Updated submission of papers timeframe	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 3 - Membership**	Removal of reference to Head of HR Strategic Projects	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 4 - Quorum**	To amend in line with other assurance committees	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 8 - Attendance**	To insert the term 'nominated' before deputy	V6 SPC 18.03.2020 Trust Board 25.03.2020
22 July 2020	**Section 3 – Membership**	Updated Executive Director titles, Deputy HRD&OD and attendee titles	V6.1 SPC 22 July 2020
18 November 2020	**Section 7 – Duties & Responsibilities**	Added Equality Diversity & Inclusion Sub Committee	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
14 July 2021	**Section 7 – Duties & Responsibilities**	Added Workforce Recovery Steering Group – meeting monthly	V6.2 SPC 22.07.2021 Trust Board 28.07.2021
14 July 2021	**Section 7 – Duties & Responsibilities**	Amended Equality Diversity & Inclusion Sub Committee to Workforce Equality Diversity & Inclusion Sub Committee	V6.2 SPC 22.07.2021 Trust Board 28.07.2021
TBC	**Sections 1 – Purpose**	Updated the description of the purpose of the Committee to include reference to equity for all	TBC
TBC	**Section 6 - Reporting**	Updated reporting arrangements to the Trust Board	TBC
TBC	**Section 7 – Duties & Responsibilities**	Added Medical Education Quality Sub-Committee	TBC
18 January 2023	**Section 1 - Purpose**	Clarification on assurance related to Risks – BAF and Corporate.	V7 SPC 18.01.2023 Trust Board 25.01.2023

		Inclusion of reference to assurance on Due Regard for Public Sector Equality Duties relating to the workforce. Reference to NHS People Promise	
18 January 2023	**Section 2 – Frequency of Meetings**	Moving from bi-monthly to monthly	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 3 - Membership**	Revision of new title for Company Secretary – to include Associate Director of Corporate Governance. Addition of Associate Chief People Officers, Head of Workforce Equality, Diversity and Inclusion and Shadow Board participants or Shadow Board alumni participants Removal of Head of Staff Engagement & Wellbeing; Head of HR & Head of Workforce Systems & Intelligence	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 4 – Quorum**	Changed quoracy to confirm that one of the members present must be a Non-Executive Director.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 7- Duties & Responsibilities** **Duties – decision making**	To include reference to the Workforce Equality, Diversity and Inclusion Strategy's design, development, delivery, management, and monitoring.	V7 SPC 18.01.2023 Trust Board 25.01.2023
		To review the consultation, negotiation, and approval of all employment policies, including: ○ Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy, ○ Details of any employee relations negotiations delaying policy approval, ○ Details of extensions to policy dates,	

		○ Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and, ○ Details of any trends or employment issues associated with external factors influencing policy content.	
		To include reference to receiving, agreeing, and monitoring the Health and Wellbeing activity in the Trust in order to be assured of the effectiveness of these activities on improving staff experience. To remove reference to staff engagement, Staff FFT and morale.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 7- Duties & Responsibilities** **Duties – monitoring**	To include the term Integrated Performance Indicators.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023		To include monitoring of the implementation of Improving People Practices principles through the adoption of a Restorative Culture, including ○ Details of Employee Relations Cases in respect of numbers, ○ Summary of workforce demographics, ○ Analysis and impact assessment of emerging themes, ○ Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs, ○ Overview of lessons learned and actions taken to address these, ○ Specific information on those cases where suspension/exclusion is involved, including any	

		Supporting Attendance dismissals/appeals.	
18 January 2023	**Section 7- Duties & Responsibilities** **Sub-Committees (Groups)**	Change EDI Sub Committee to Workforce EDI Sub Committee. Include Nursing and Allied Health Professional Workforce Resourcing Group Remove Workforce Recovery Steering Group to report to Operational People Committee. Remove Medical Education Quality Sub Committee to report to Operational People Committee.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 9 – Administrative Arrangements**	Bullet Point 3 – Members: Replacement of reference to HR/OD Service Leads to People Professional Service Leads	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 9 – Administrative Arrangements**	Bullet Point 5 – Presentation submission to also include statement: 'unless otherwise agreed with the Chair of the Committee'.	V7 SPC 18.01.2023 Trust Board 25.01.2023

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
	Version 5 replaced with Version 6	SPC 18.03.2020 and Trust Board 25.03.2020
	Version 6 replaced with Version 6.1	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
	Version 6.1 replaced with Version 6.2	V6.2 SPC 21.07.201 Trust Board 28.07.2021
	Version 6.2 replaced with Version 6.3	TBC
	Version 6.3 replaced with Version 7	V7 SPC 18.01.2023 Trust Board 25.01.2023