# WHH Trust Board Meeting Part 1 (Meeting Held in Public)

**Wednesday  28 September 2022**
**10.00am-12.30pm**
**Halton Education Centre, Halton, Runcorn**

## TRUST BOARD MEETING – PART 1 *(Held in Public)*
## Wednesday 28th September 2022, 10.00am – 12.30pm
## Halton Education Centre/Via MS Teams

| AGENDA ITEM | TIME | AGENDA ITEM | OBJECTIVE/DESIRED OUTCOME | PROCESS | PRESENTER |
|---|---|---|---|---|---|
| BM/22/09/108 PAGE 6 | 10:00 | Engagement Story - Multi-Disciplinary response to Improve Health Outcomes | *To Note* | **Presentation** | Jen McCartney Head of Patient Experience & Inclusion |
| BM/22/09/109 | 10:15 | Welcome, Apologies and Declarations of Interest | *To note* | | Steve McGuirk Chairman |
| BM/22/09/110 PAGE 12 | 10:17 | Minutes and Action Log of the previous meeting held on 27th July 2022 | *For decision* | *Minutes* | Steve McGuirk, Chairman |
| BM/22/09/111 | 10:20 | Matters Arising | *For assurance* | *Verbal* | Steve McGuirk, Chairman |
| BM/22/09/112 PAGE 29 | 10:25 | Chief Executive's Report | *For assurance* | *Report* | Simon Constable, Chief Executive |
| BM/22/09/113 PAGE 50 | 10:30 | Chairman's Report | *For info/update* | *Report & Verbal* | Steve McGuirk, Chairman |
| BM/22/09/114 PAG 60 | | Board Assurance Framework | *For approval* | *Report* | John Culshaw, Trust Secretary |

Quality    People    Sustainability

| AGENDA ITEM | TIME | AGENDA ITEM | OBJECTIVE/DESIRED OUTCOME | PROCESS | PRESENTER |
|---|---|---|---|---|---|
| BM/22/09/115 PAGE 92 | 10.40 | Covid-19 Situation Report | *To Note for Assurance* | *Report* | Simon Constable, Chief Executive |
| BM/22/09/116 PAGE 107 | 10:45 | Integrated Performance Reports (IPR) and Assurance Committee Reports<br>i) IPR Dashboard | *For assurance* | *Report* | All Executive Directors |
| (a) PAGE 170 | | **Quality Dashboard**<br>• Nurse Safe Staffing Report | *For assurance* | *Report* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
| (b) PAGE 184 | | Assurance Report – Quality and Assurance Committee (02.08.22 & 06.09.22) | *To note for assurance* | *Report* | Cliff Richards, Committee Chair |
| (c) PAGE 190 | | **People Dashboard**<br><br>Assurance Report Strategic People Committee (21.09.22) | *For assurance* | | Michelle Cloney, Chief People Officer Julie Jarman, Committee Chair |
| (d) PAGE 194 | | **Sustainability Dashboard**<br><br>Assurance Report – Finance and Sustainability Committee (17.08.22 & 21.09.22) | *For assurance*<br><br>*For assurance* | <br><br>*Report* | Andrea McGee, Chief Finance Officer & Deputy CEO<br>Terry Atherton, Committee Chair |
| (e) PAGE 204 | | Clinical Recovery Oversight Committee (16.08.22 & 20.09.22) | | | |
| (f) PAGE 210 | | Assurance Report – Audit Committee (18.08.22) | *To note for assurance* | *Report* | Mike O'Connor, Committee Chair |

**Quality**

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| BM/22/09/117 **PAGE 212** | | Move to Outstanding (M20) Update | *To note for assurance* | *Report* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
| BM/22/09/118 **PAGE 232** **PAGE 260** | 11.50 | Maternity Update including; • Maternity Incentive Schemes & Birth Rate Plus • Maternity Governance • Ockenden • Cheshire & Mersey PMRT | *To note for assurance* | *Report* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |

**People**

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| BM/22/09/119 **PAGE 272** | 12.05 | WHH Annual Seasonal Influenza Vaccine Plan 2022/23 | *To note for assurance* | *Report* | Michelle Cloney, Chief People Officer |

**Sustainability**

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| BM/22/09/120 **PAGE 282** | 12.10 | Bi-Monthly Strategy Update | *To note for assurance* | *Report* | Lucy Gardner Director of Strategy & Partnerships |

**FOR APPROVAL**

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| BM/22/09/121 **PAGE 303** | | Audit Committee Annual Report | *For approval* | Committee: Audit Committee Date of Meeting: 18th August 2022 Agenda Ref: AC/22/08/71 Outcome: Supported | *Paper* | Mike O'Connor Committee Chair |
| BM/22/09/122 **PAGE 308** | | Finance & Sustainability Committee – Terms of Reference | *For approval* | Committee: Audit Committee Date of Meeting: 18th August 2022 Agenda Ref: AC/22/08/71 Outcome: Supported | *Paper* | Terry Atherton Committee Chair |

**SUPPLEMENTARY PAPERS (See Supplementary Pack for Page Numbers)**

**TO NOTE FOR ASSURANCE**

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| BM/22/09/123 | | Learning from Experience Report Q1 | *To note for assurance* | Committee: Quality Assurance Committee Date of Meeting: 2nd August 2022 Agenda Ref: QAC/22/08/210 Outcome: Noted for assurance | *Paper* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
| BM/22/09/124 | | Infection Prevention & Control Q1 Report | *To note for assurance* | Committee: Quality Assurance Committee Date of Meeting: 6th September 2022 Agenda Ref: QAC/22/08/214 Outcome: Noted for assurance | *Paper* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
| BM/22/09/125 | | Infection Prevention and Control - Board Assurance Framework | *To note for assurance* | Committee: Quality Assurance Committee Date of Meeting: 6th September 2022 Agenda Ref: QAC/22/09/236 Outcome: Noted for assurance | *Paper* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |
| BM/22/09/126 | | Safeguarding Annual Report | *To note for assurance* | Committee: Quality Assurance Committee Date of Meeting: 6th September 2022 Agenda Ref: QAC/22/09/235 Outcome: Approved | *Paper* | Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO |

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| BM/22/09/127 | | Learning from Deaths Review Q1 Report | *To note for assurance* | Committee: Quality Assurance Committee<br>Date of Meeting: 2nd August 2022<br>Agenda Ref: QAC/22/08/212<br>Outcome: Noted for Assurance | *Paper* | Paul Fitzsimmons Executive Medical Director |
| BM/22/09/128 | | Guardian of Safe Working Q1 Report, | *To note for assurance* | Committee: Strategic People Committee<br>Date of Meeting: 21st September 2022<br>Agenda Ref: SPC/22/09/103<br>Outcome: Noted for Assurance | | Paul Fitzsimmons, Executive Medical Director |
| BM/22/09/129 | | Freedom To Speak Up Bi-Annual Report | *To note for assurance* | Committee: Strategic People Committee<br>Date of Meeting: 21st September 2022<br>Agenda Ref: SPC/22/09/94<br>Outcome: Noted for Assurance | *Paper* | Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO |
| BM/22/09/130 | | EPRR Assurance Letter/Statement of Compliance | *To note for assurance* | Committee: Finance & Sustainability Committee<br>Date of Meeting: 21st September 2022<br>Agenda Ref: SPC/22/09/XXX<br>Outcome: Noted for Assurance | *Paper* | Dan Moore, Chief Operating Officer |
| BM/22/09/131 | | Digital Strategy Group Report | *To note for assurance* | Committee: Finance & Sustainability Committee<br>Date of Meeting: 21st September 2022<br>Agenda Ref: FSC/22/09/152<br>Outcome: Noted for assurance | *Paper* | Paul Fitzsimmons Executive Medical Director |
| BM/22/09/132 | | Health & Safety Annual Report | *To note for assurance* | Committee: Quality Assurance Committee<br>Date of Meeting: 2nd August 2022<br>Agenda Ref: QAC/22/08/202<br>Outcome: Approved | *Paper* | Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO |
| BM/22/09/133 | | Violence Reduction Strategy | *To note for assurance* | Committee: Quality Assurance Committee<br>Date of Meeting: 2nd August 2022<br>Agenda Ref: QAC/22/08/203<br>Outcome: Approved | *Paper* | Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO |
| BM/22/09/134 | | Trust Organisational Chart | *To note for assurance* | Committee: Executive Management Team<br>Date of Meeting: 8th September 2022<br>Agenda Ref: ETM/22/658 | | Simon Constable Chief Executive |
| BM/22/09/135 | | Bi-Annual Safe Staffing Report | *To note for assurance* | Committee: Quality Assurance Committee<br>Date of Meeting: 2nd August 2022<br>Agenda Ref: QAC/22/08/207<br>Outcome: Noted for assurance | *Paper* | Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO |
| **CLOSING** | | | | | | |
| BM/22/09/136 | | Any other business | | Steve McGuirk, Chair | | |
| **Date of next meeting – Wednesday 30th November 2022** | | | | | | |

## 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.

# Background

▪ The experience shared today centres around a 22 year old patient with severe learning disabilities and who is non verbal.

➢ Patient was an **emergency admission** to ward A4 requiring a range of treatment and interventions.

➢ Ward A4 nursing team completed and submitted referrals to the **Trust Learning Disability Lead** within the Safeguarding Team to ensure adequate care and support was in place to ensure effective care and treatment plans.

➢ Patient had a **Hospital Passport on admission** brought in by his next of kin.
  ➢ Things you must know about me
  ➢ Things that are important to me
  ➢ My likes and dislikes

This is my
**Hospital Passport**

For people with learning disabilities coming into hospital

My name is:

If I have to go to hospital this book needs to go with me, it gives hospital staff important information about me.

It needs to hang on the end of my bed and a copy should be put in my notes.

This passport belongs to me. Please return it when I am discharged.

Nursing and medical staff please look at my passport before you do any interventions with me.
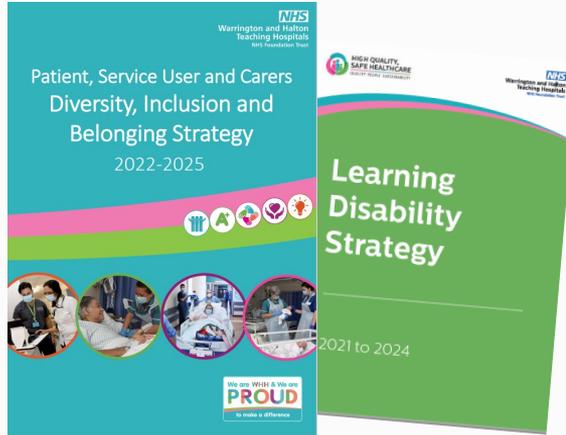
Things you must know about me
Things that are important to me
My likes and dislikes

# Multi-disciplinary response



To ensure the **patients needs** were highlighted, updated daily and **central to the care and treatment plans** the patient was discussed daily at ward board rounds in a multi disciplinary approach including but not limited to;

- Ward manager
- Matron
- Medical teams
- Therapy teams
- Patient flow

Outcomes of discussions highlighted multiple requirements for reasonable adjustments to be made such as;

- **Consent and patients' capacity** – mum supported to be an advocate for her son as per documentation.
- **Awareness of adjustments** to physical interventions such as venepuncture, cannulation ensuring mums presence for support and use of emla creams as a numbing agent.
- **Collaborative approach** to care with another Trust to ensure continuity of care in ongoing treatment

# Reasonable adjustments

➢ Open visiting 24/7 was implemented. This ensured a shared care approach and supported the patient to have familiar faces and interactions. Thus creating a calm environment and helping the patient to settle on ward A4.

➢ Patient allocated a side room to support care planning, privacy and dignity.

➢ Family able to bring in patient own personal belongings to support any anxiety and again ensure patient felt comfortable in the ward environment

➢ Care plan highlighted that patient would only eat chicken nuggets and chips. LD lead and catering effectively supported patient choice.

➢ Referrals completed to appropriate departments and other Trust to ensure patient received the correct scans needed for condition with adequate support linked to additional needs.

# Outcome

**Open visiting** - Reduced anxiety for both patient and relative.

**Impact of reasonable adjustments** - Supported privacy and dignity, understanding of patients triggers reduced noise level as patient treated in a side room, relative could stay overnight with a recliner chair provided.

**Impact of shared care** - reduced patient and families anxiety and enabled ward staff to provide effective care and treatment - an **improved patient journey** .

**Patient / family feedback** - Mum reported to feel heard by the ward teams, supported to make decisions and understand the care and treatment plans.

**Staff feedback** - Staff feel positive and valued for being included with the decision making around reasonable adjustments and empowered to effectively support the patient

Patient was discharged from the ward with appropriate follow up management and a referral to another organisation for ongoing treatment with a robust and collaborative approach to ensure  **continuity of care for the patient.**

# Next Steps

Ward staff have **reflected upon the importance of treating the patients holistically,** considering mental and physical health to ensure no delays in the effects of treatment.

Patient story shared on **ward safety brief** and also **throughout planned care group**.

Patient story has been displayed in **ward accreditation** file for **wider sharing and learning**

Patient story has been shared at Patient Equality Diversity and Inclusion Sub-Committee for **wider Care Group learning**

| Warrington and Halton Teaching Hospitals NHS Foundation Trust<br>Minutes of the Trust Board Meeting – Meeting held in Public<br>Wednesday 27 July 2022, Via MS Teams | |
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| **Present** | |
| Steve McGuirk (SMcG) | Chairman |
| Simon Constable (SC) | Chief Executive Officer |
| Jayne Downey (JD) | Non-Executive Director |
| Julie Jarman (JJ) | Non-Executive Director |
| Michael O'Connor (MOC) | Non-Executive Director |
| Cliff Richards (CR) | Non-Executive Director |
| Michelle Cloney (MC) | Chief People Officer |
| Paul Fitzsimmons (PF) | Executive Medical Director |
| Andrea McGee (AMcG) | Chief Finance Officer & Deputy Chief Executive |
| Kimberley Salmon-Jamieson (KSJ) | Chief Nurse & Deputy Chief Executive |
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| **In Attendance** | |
| Dr Rita Arya (RA) | Associate Chief Clinical Information Officer – Women & Children's Health |
| Zoe Harris (ZH) | Director of Operations and Performance, Deputy Chief Operating officer |
| John Culshaw (JC) | Trust Secretary |
| Lucy Gardner (LG) | Director of Strategy & Partnerships |
| Pat McLaren (PMc) | Director of Communications & Engagement |
| John Somers (JS) | Non-Executive Director Designate |
| Liz Walker (LW) | Secretary to the Trust Board (minute taking) |
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| **Staff Observers** | |
| Laura Hilton | Associate Chief People Officer |
| Jennie Dwerryhouse | Deputy Chief People Officer |
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| **Observing Governors** | |
| Norman Holding ) | Lead Governor |
| Paul Bradshaw | Public Governor |
| Allan Lowe | Partner Governor, Halton Borough Council |
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| **Public Observers** | |
| Richard Mangeolles | Meditech |
| Simon Crick (SC) | Good Governance Institute |
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| **Apologies** | |
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| Akash Ganguly | Staff Governor |
| Terry Atherton | Non-Executive Director |
| Dan Moore | Chief Operating Officer |
| Adrian Carridice-Davids | Associate Non-Executive Director |

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| Dave Thompson | Associate Non-Executive Director |
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| Agenda Ref | Agenda Item |
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| BM/22/07/81 | **ENGAGEMENT STORY – PERINATAL MOTALITY REVIEW TOOL – PARENT'S PERSPECTIVE**<br><br>Dr Rita Arya had been invited to present an engagement story, which included a presentation in relation to the Perinatal Mortality Review Tool and a parents' perspective. It explained the journey of the parents, their input into PMRT at the time, their thoughts on the process and the care received afterwards and when becoming pregnant after the loss of their child. The parents extended their heartfelt thanks to the whole team at the Trust.<br><br>SMcG thanked Dr Arya for the presentation and noted it was a very moving story with a happy outcome.<br><br>CR asked about mortality rates, in light of the information from Ockenden, and what would be the best way for the Board to be provided with appropriate assurance around the information and data provided. RA responded that quarterly reports were presented to the Quality Assurance Committee, along with an Annual report, however a synopsis of the Annual Report could be provided if Directors required this, and that future reports would include more descriptive content.<br><br>SMcG noted there would be a report later in the agenda that would provide this data, however it would be useful to have a presentation later. It was commented on the fact there were a lot of templates in order to provide consistency of reporting.<br><br>SMcG asked that patient confidentiality be considered and to be aware of the risk of sensitive information at a public meeting and limited information should be provided. RA added that patients had been happy to share their personal stories.<br><br>1. **The Trust Board discussed and noted the Patient Story.**<br>2. **The Trust Board noted further descriptive content would be provided as part of the quarterly update reports.** |
| BM/22/07/82 | **WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST**<br><br>The Chair welcomed everyone to the meeting and noted it was nearly two and a half years since everyone had met in person.<br><br>Apologies for absence were received from Terry Atherton, Adrian Carridice-Davids, Dan Moore, and Dave Thompson.<br><br>It was noted several governors were in attendance along with members of staff shadowing senior colleagues, including the new Non-Executive Director, John Somers. Simon Crick was in attendance observing on behalf of the Good Governance Institute (GGI) as part of the ongoing "Well Led" review work they |

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| | were undertaking.<br><br>It was advised that both Leadership Observation Visits with Executive and Non-Executive Directors and   Governor observation visits had been relaunched.  The first of the Leadership Observations had taken place that morning.<br><br>**The Trust Board noted the welcome and comments.** |
| BM/22/07/83 | **MINUTES  AND ACTION LOG FROM THE PREVIOUS MEETING HELD ON 25 MAY 2022**<br><br>The minutes of the meeting held on 25 May 2022 were agreed as an accurate record and approved subject to minor amendments.<br><br>There were no actions to be reviewed.<br><br>**The Trust Board approved the minutes of the meeting held on 25 May 2022.** |
| BM/22/07/84 | **MATTERS ARISING**<br>There were no matters arising in relation to the minutes or agenda. |
| BM/22/07/85 | **CHIEF EXECUTIVES REPORT**<br><br>SC took the report as read and highlighted Section 2.5 in relation to the opening of the Same Day Emergency Care centre (SDEC).  There had been an opportunity for Board colleagues to visit this morning and asked that if any members wanted to visit then there could be a further opportunity to do so if they wished.<br><br>It was noted that there was a new format of expressing performance and this was clearly part of the improvement journey; and the summary appended to the report was part of this improvement.<br><br>SMcG added there had been a recent Quality Academy showcase even which had been extremely useful in showcasing the research and quality improvement being undertaken and the presentations were available if anyone wanted them.<br><br>CR asking about impact of Covid patients in hospital and SC responded that the information was set out in the Covid-19 Situation Report, included in the paper, and the total numbers of patients with Covid were actually higher than in Wave 1, however the clinical impact had been very different; in particular, the number of patients in critical care and also the sickness absence issues.<br><br>The latest figures suggest at least 60% of patients entering hospital something other than Covid.  KSJ added it had impacted on partner organisations relating to onward flow of patients.<br><br>SMcG highlighted the spotlight on staffing levels across social care was nationally not just locally and asked whether it had peaked.  SC responded it had plateaued and MC added numbers showed a reduction in relation to staffing absence relating to Covid.<br><br>**The Trust Board noted the Chief Executive's Report.** |

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| **BM/22/07/86** | **CHAIRMAN'S UPDATE** |
| | SMcG provided an update on the work he had been involved in since the last meeting, stating a lot of time had been taken up with launch on the 1st July of the ICB and ICS. |
| | There had been a series of Regional as well as Cheshire & Merseyside meetings with Chairs of ICBs and Trusts, and Chairs had been asked to lead on specific programmes of work in CMAST, and advised he was the Project Sponsor Lead on the Workforce part of the ICB. |
| | Visits at both Warrington and Halton hospital sites had also taken place during the month, and had continued his work on engagement with local MPs and local political leaders within Warrington & Halton. |
| | In relation to CMAST, there had been several briefings to colleagues and the Exec team had been involved across the piece. The full papers had not been presented to Board regarding the ICB, but rather through a series of briefings and time out sessions, as it was thought this was the correct approach to take. |
| | It was now important to start to track from the Board Agenda how things were progressing with the partnership and provider collaborative, and he would bring CMAST to Board to support, and would update on a regular basis. It was important to test through our own internal governance process. |
| | Execs were asked to think about the future structure and management arrangements as part of the ICB. NEDs were also asked to think about whether they thought appropriate governance arrangements were in place to be able support the new ICB/ICS and also feed into the strategy going forward. |
| | LG responded it was a good time to start to think about this as it raised questions about how to involve elective members of councils, and it would be useful to have a session to discuss this. |
| | SMcG noted the NHS had gone through its most radical form and the new ICB would mean a fundamentally different way of working, and associated duties. We would need to be realistic about the unlikelihood of things being perfect but would ensure we did the best for our patients and push boundaries in order to gain a different perspective on this. |
| | CR asked if there were any plans to come together with the ICB and place based partners to understand how it would work. SMcG responded there was an ICB workshop planned for NEDs next week, but more needed to be done. At place level SMcG suggested a time out session with NEDs, but he had not been invited to along to any events where place partnership would be discussed or how it would work from an assurance/citizen point of view. There had been no councillor or NED involvement and it was important to understand when this would happen. |
| | **The Trust Board discussed and noted the update.** |

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| **BM/22/07/87** | **COVID -19 PERFORMANCE SUMMARY AND SITUATION REPORT**<br><br>SC noted the report as read and no questions were raised in relation to the report.<br><br>**The Trust Board noted the report.** |
| **BM/22/07/88** | **INTEGRATED PERFORMANCE DASHBOARD & COMMITTEE ASSURANCE REPORT**<br>*IPR Development and NHSE Oversight Framework Update*<br>Statistic Process Control (SPC) charts were introduced onto the IPR in 2019 and introduced Making Data Count. Following on from the Trust Board Development session in June, several developments in relation to the IPR were proposed, and were currently underway, and outlined in the report.<br><br>An updated version of the NHSE/I Oversight Framework was published on 27 June 2022 which included a new set of oversight metrics.  Further guidance was awaited from NHSE/I to understand how these would be reported/monitored, and the current proposal for mapping out these metrics was outlined in the paper.  The majority were being reported on, but some needed minor tweaks, and some were not being able to be reported.<br><br>SC noted the outline of the paper which set out what had been completed and what was proposed to be done.<br><br>AMcG noted there was further work to be undertaken, with some technical changes in relation to grouping of indicators to ensure triangulation. Any anomalies could mean a reset of the period to be reviewed.  It was important to ensure consistency of reporting and presenting intelligence in the same way.<br><br>Training was offered through NHSE/I of bite size webinars for staff at all levels in order to gain a better understanding of SPC and "Making Data Count".<br><br>SMcG suggested there was an opportunity to build on the NHSE/I training session recently undertaken for the Board and also to capitalise on the experience of NEDs to develop better ways of using SPC for triangulation.<br><br>*IPR Dashboard*<br>AMcG explained the new format of the report and noted some of the changes that had been made which included the "Making Data Count" icons, and Rag ratings had been removed.  There was some additional information included in Tables 1 and 2 which summarised assurance and variation categories.  The same applied to the information in the appendices with addition of icons and rag ratings removed.<br><br>*Sustainability*<br>The month 3 position was a £4.56m deficit but had not achieved the CIP target year to date, and this was a real risk and in total was just over £10m of risk at this point in time.<br><br>*CIP*<br>There was a lot of activity taking place with weekly oversight and scrutiny, and the programme had improved significantly from where we were, with more savings |

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identified, however there was still a high level of risk. The Exec team was meeting with care groups, leads, and corporate leads to review activities undertaken and if effective was there anything further to be done.

Other areas of risk included the elective recovery fund as we did not achieve activity plan in Q1, however had been told to assume this would be received but was not guaranteed.

*Capital*

There were a number of proposals to note which included backlog maintenance which was deferred to 2023/24 in order to complete safely. Doctors' contingency had also been deferred, which could reduce and there would also be slippage. Additionally, VAT refunds had been received along the way. The suggestions were not significant not significant from a risk perspective but would ask the Trust Board to support the changes to the plan. It was noted the VAT rebate would be added to the contingency.

There had been a number of emergency requests totalling £51k which had been approved by AMcG and the Trust Board is asked to note the additional capital requests to be funded from the £30k contingency.

There were two schemes not on the programme and these related to a DDA compliant reception desk, and asbestos clearance of the Fluoroscopy room which the Trust Board was asked to approve.

JJ asked about CIP and the level of non- recurrent CIP, from the discussion at the Finance and Sustainability Committee it felt like there was a significant grip of the area and receive a higher sense of assurance, having seen an increase in identified CIP.

SMcG asked about the increase in schemes and if there was a sense of confidence when identified CIP would be confirmed. AMcG responded there had been an additional £3m of schemes added into profile for the last quarter of the year as this was when additional monies would become available. There were a number of bids submitted and it was hoped the Trust would be successful. With regard to expenditure of CIP, this was being managed on a weekly basis for the rest of the year as it would be constantly changing. There had a GIRFT lead recruited to support the programme, and it was also being looked at whether there was additional reallocation of existing resources available in order to jump start the work and more granular detail was needed in relation to some of the schemes.

SMcG asked if it was confirmed SDEC would be finalised and whether the work on the new kitchen was still in the plan for approved schemes as it was an important care issues. AMcG responded that SDEC would be finalised this year and that the Kitchen refurbishment remained part of the plan.

**Finance Assurance**

AMcG noted there had been support for changes around digital governance and three business cases for Runcorn Town Deal, WLI and Clinical Excellence had been presented and supported by the Finance and Sustainability Committee.

**Quality Assurance**

In relation to Quality Assurance, and the IPR dashboard figures SC asked for further assurance in relation to Sepsis, Endoscopy and Medication Reconciliation.
PF provided an update regarding medicines reconciliation services and advised this area remains a challenge and it was a more difficult process to manage given the complexity of patients presenting to the ED and also the length of time patients were spending in the ED (the bulk of planned reconciliation taking placed on MAU). However, there had been no Datix incidents of harm associated with this as far as he was aware but would review and confirm. There had been a retrospective dip sample undertaken to assess for harm in patients waiting greater than 23 hours for reconciliation to be presented at QAC.

PF noted that current reported data also included data for patients who did not require reconciliation (Endoscopy etc) and that data cleansing would take place, but this should not distract focus from the reconciliation challenge which remains significant. Recruitment to additional ED pharmacist posts is underway.

SMcG asked about harm and direct harm on right or wrong medication and if this might be a reason for a number of falls. PF responded the figures were reflective of current pressures and an additional pharmacist in ED would help, however was not sure it would be enough. PF also responded that it was important to recognise the difference between Medicines reconciliation and medicines optimisation with the latter being much harder to measure.

KSJ added as part of any falls incident /RCA review for both concise and comprehensive reports, 'medication' did for part of the review and any key themes from patient falls would be examined by the Falls Group members   The Falls Group feeds into the patient safety meeting where further discussion of falls takes place.  Medicines reconciliation  if not flagging as a theme

JD asked what the plan was regarding medicines reconciliation and optimisation and in order to understand the detail and impact of not reconciling those patients, the data should include the last 12 month period, and asked if this could be presented to a future Quality Assurance Committee. PF responded that a Deep Dive into the consequences of and plans for improvement in medicines reconciliation would be presented at August's Quality Assurance Committee.

CR asked about the impact on patients and KSJ explained the impact could relate to a number of issues and would need to be considered.  JD added the focus was on staffing and impact on harm, but there was a requirement to look at impact on everyone in the organisation and the impact on what needed to be delivered.
*Sepsis*

KSJ provided information about the indicators for screening and antibiotics.  The June position for sepsis screening within one hour had been 83% in May but had fallen to 76% in June with a total screening compliance figure of 92% for all screening up to and over three hours.

For antibiotic administration, the compliance was 74% within one hour and 100%

for up to and over three hours.

Inpatient screening within one hour was at 91% and inpatient antibiotic administration was 82% within one hour and 100% for up to two hours.
Sepsis screening was being undertaken and a safety net check–for all those patients who did not have a screening. It was about numbers and timeliness to see patients, similar to ED and antibiotics. The same applied to in patient screening, however there was an action plan in place in order to achieve standards but were struggling with patient numbers in ED, and additionally for safety checks, with structured judgement reviews.

New guidance was awaited on Sepsis, which was due out in October which may mean making changes to the policy.

AMcG asked about whether investment in readymade antibiotics had impacted on administration. KSJ responded it had made a positive impact and noted in some areas Tazocin was being used as pre made antibiotic is already made up and this was being reviewed. Timeframes had also improved.

JD asked if it was the responsibility of the ambulance staff to highlight if a patient was suspected on Sepsis. KSJ responded once a patient was handed over from the ambulance a patient would wait to be triaged, meaning the onus was on A&E to move as quickly as possible. CR added it was almost an indication of the pressures that staff were under to be able to review patients for Sepsis.

SMcG noted it had been in the news about people spending hours with ambulance staff and asked if it could mean A&E staff screening patients whilst still on ambulance. KSJ responded there had been occasions when it had been difficult to take patients off ambulances, but this was very rare. KSJ identifies that terms of Cheshire & Mersey and the wider Lancashire and Cheshire position, the position at this Trust was no different to elsewhere.

PF recognised how much effort staff put in to make sure space is available for those Septic patients once off the ambulances.

***Quality Dashboard***

***Staffing Assurance Report***
The report provided assurance to the Trust Board with regard to staffing levels during the months of April and May 2022. The key elements highlighted included;

- 79 registered nurse vacancies, 54 RNs in the pipeline.
- HCAs 63 vacancies, 51 in pipeline

The current position in relation to recruitment in these areas were favourable.

***Super stranded position***
ZH provided an update on super stranded patients and noted there were currently 130 patients, with the total percentage of those with *no right to reside* at between 23 -25% of the bed base at any one time. Some patients were at various stages of

being ready to discharge and just waiting for next steps, but this causes significant pressure, and results in an exit block. ZH emphasised that this was a national concern, and several approaches are being taken to try to improve. Part of the work included a review of discharge processes, but this remained contingent upon the local authorities being able to put in place appropriate care pathways, as well as other community providers being able to support discharge

AMcG referred to the Trust's investment in *an adaptive reserve* with Warrington Council to connect the issues identified, and to work with partners to ensure capacity outside of the hospital was available. SC added it was important to ensure adaptive reserve was being spent where it should be. A verbal update would be reported at the Trust Board in November.

**Assurance Report – Quality Assurance Committee**
Assurance reports were received from the meetings held on 7 June and 5 July 2022. CR highlighted from the meeting on 7 June, the discussion relating to maternity issues and the system wide governance. There had been a presentation on Aortic Aneurysm patient reviews.

JD chaired the meeting on 5 July and highlighted surgical site infections which had found the team to be acting quickly and had addressed areas of concern by way of an audit with further work planned. An update would be presented at a future meeting. There was presentation relating to the Medical Examiner system and processes. Additionally, there was a Deep Dive into Acute Kidney Injury (AKI) and the investment that had been made in the team, with an additional role specific to AKI.

*People Assurance*
SC asked about welcome back and appraisal rates. MC responded Welcome Back discussions were part of new Supporting Attendance policy which had been implemented from 1 April 2022 and stressed the importance of culture change and the need to ensure that welcome back conversations were managed. The reporting showed a time lag, so there were issues around timeliness of data in the report (IPR). There were some areas of good practice, but also some challenged areas, with a number of strategies which would support achievement of consistency and improvement across the board. These were being managed through the Strategic People Committee.

During the last quarter, 8 members of staff exited the organisation (termination of contract), and it was noted the right processes had been followed including a need also to consider the wellbeing of the individuals concerned. In fact, wellbeing had been the main concern in the first instance, and it was only after all other avenues had been exhausted that the Trust was left with no alternative but to terminate the contract. It was noted that the supporting attendance approach was starting to make a difference.

SMcG asked about how welcome back conversations could be undertaken, other than a formal conversation, in particular for those staff who might have a good attendance record. For those staff where there was a pattern of sickness this would warrant a more formal conversation. MC responded the Trust policy is

aligned to other organisations and it was more about interpretation of the welcome back conversations.

SMcG asked about how welcome back conversations could be undertaken, other than a formal conversation, in particular for those staff who might have a good attendance record. For those staff where there was a pattern of sickness this would warrant a more formal conversation. MC responded the Trust don't do anything different than other organisations and it was more about interpretation of the welcome back conversations.

Appraisals were highlighted and it had been agreed after discussion in Move to Outstanding meetings, to continue to undertake them, but was not mandated. It was about reviewing how we supported care groups and was monitored through a number of mechanisms. The appraisals did not consist of a lot of documentation but was more a check in conversation and ensuring staff understood what their objectives were.

There was a new appraisal system currently being piloted called Scope for Growth and it was hoped this would support improvements where needed.

**Assurance Report – Strategic People Committee**
The assurance report was received from the meeting held on 20 July 2022. JJ noted there had been a hot topic around recruitment challenges in relation to the CDC and had received good assurance. Additional assurance included the speed at which the CDC needed to be submitted and approved, so it was important to start early to recruit recent graduates.

Agile working was also discussed relating to wellbeing, staff retention, sickness levels etc., along with work life balance. It was a crucial piece of work with moderate assurance as work was still ongoing.

The pay award was noted and also the changes in relation to terms and conditions of Covid related sickness. There were issues relating to the CQC insight as the RAG ratings were not correct. There were small change on the BAF, and a response was flagged up relating to race equality and disability standards, with a piece of work to be done to address levels of bullying and harassment. There was also a mismatch with data from FTSU and Staff Survey data.

**Assurance Report – Finance and Sustainability Committee**
Assurance reports were received from the meeting held on 22 June 2022; the meeting due to take place on 20 July 2022 was cancelled due to operational pressures. Chair's actions were taken in relation to any agenda items that required approval and/or support

**Assurance Report – Clinical Recovery Oversight Committee**
The assurance report was received from the meeting held on 21 June 2022 and no areas highlighted.

**Assurance Report – Audit Committee**
Assurance reports were received from the meetings held on 16 June and the

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| | extraordinary meeting held on 24 June 2022.<br><br>1. **The Trust Board discussed and noted the reports.**<br>2. **A verbal update on Adaptive Reserves will be provided at the meeting in November.** |
| BM/22/07/89 | **MOVE TO OUTSTANDING**<br>KSJ introduced the report which provided an updated position for May 2022 and noted the following across 77 indicators;<br><br>• 9 (12%) noted as better<br>• 3 (4%) noted as worse<br>• 1 (1%) noted as much worse 9<br><br>In comparison to the CQC insight report from March 2022 there was an increase of;<br><br>• 3 indicators from 6 to 9 categorised as better<br>• 2 indicators from 1 to 3 categorised as worse<br>• A static position of the indicator categorised as much worse<br><br>Further details were included in section 2.1.1 of the report.<br><br>There were still a number of declining indicators which included, staff sickness and turnover, constitutional targets, and effectiveness of care provision.<br><br>There were no mock inspections scheduled in the last month and for the Emergency Department (ED), crowding and risk of clinical deterioration remained a concern due to system challenges relating to capacity and capability. Action had been taken but the level of demand remained unprecedentedly high and there could not be absolute confidence that the action taken to mitigate these risks had been able to do so completely. A discussion had taken place around the ED action plan, which had now been completed. It was noted the Trust would remain in regulatory breach on those areas noted in the 2019 CQC report and would do so until there was a further inspection. Essentially, there was no means to get that breach corrected<br><br>All outstanding queries had been closed and a CQC meeting took place on 24 May 2022, and no concerns were raised.<br><br>Human Tissues Authority inspection had been completed and a draft report received which was under review for factual accuracy. A formal Ockenden visit was scheduled from NHSE/I on 29<sup>th</sup> July and all actions were on track for the visit.<br><br>SMcG asked about new SDEC and whether this would help with the regulatory breaches. KSJ closely monitoring attendees at SDEC which had increased during the week and would be monitored on a weekly basis. However, it would not impact on the regulatory breaches due to the issues of beds on corridors.<br><br>**The Trust Board discussed and noted the update and assurance provided.** |
| BM/22/07/90 | **MATERNITY UPDATE** |

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***Cheshire & Mersey PMRT Q2***

The current position was positive and showed the mean rate as lower than the national rate for reporting and annual still birth rate was also lower.

***Maternity Incentive Schemes & Birth Rate Plus***

The paper detailed still births and lessons learnt and KSJ highlighted the report had been reviewed and noted for information at the Quality Assurance Committee in July.

In relation to Birth Rate Plus, the report showed the Trust was in line with national recommendations. However, it does show retention issues in maternity and a deep dive had been undertaken, which noted staff moving on for promotion or retirement, and in some cases moving to other trusts as a result of less travel.

***Maternity Governance***

The paper explained the maternity assurance structure and noted how complex the governance of maternity and neonatal services now were. The paper provided a third line of assurance to the Trust regarding evidence of safe practices and services and the continued improvement of the outcomes of experience of the women and their families.

***Ockenden***

KSJ advised the report needed to be presented to Board for assurance purposes and noted a detailed report around the templates for PMRT and an update report on maternity services had been presented to QAC at the July meeting.

KSJ noted the update was in three parts, the first being the current position and WHH remains compliant with 95% of the actions and would continue to work on the remainder. Part 1, Phase 2 relates to a further action plan and was 86.89% compliant. Part 2 current position, the table set out the actions and the trajectory of those actions. There had been no risks identified to prevent WHH from embedding the 15 IEAs by the end of January 2023.

Meetings took place regularly and there we no major concerns foreseen not being able to complete by end of March.

There would be regional visit and the teams would comprise of midwifery, managerial, obstetrics and quality assessment team members from NHSE/I regional team. The visit would assess the current position, looking at all the evidence. A feedback report would then be provided which would give a benchmark in relation to the wider Cheshire & Mersey.

SMcG asked once actions were completed would this have a fundamental effect on the way in which services were provided within the Trust. KSJ responded some elements work better as a system and was better for pathways and doing things the same way, as well as failure to follow guidelines on policies which does push organisations in the right direction but was more around governance rather than Ockenden.

SC added it was best practice to share as a system and from a clinical and

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| | operational perspective it did work better as a system for specific areas, and there had been a number of step changes that had made a difference.<br><br>**The Trust Board  noted the report and assurance provided.** |
| BM/22/07/91 | **ENGAGEMENT DASHBOARD Q1**<br>An updated was provided which covered the period Q1 April to June 2022 and related to KLOE - 7 of the CQC regime/inspection process relating to Communicating with the Public.  The metrics included medica coverage and visits to the public website, social media posts, engagement and sentiment, engagement opportunities and engagement with feedback channels.<br><br>PMcL noted it provided an indication of trust reputation, perceived by external audiences.  The report provided the conclusion of a comprehensive audit of website accessibility and the remedial work undertaken to make improvements and would go live in the next few days.  Website engagement was c.40k per month, therefore it was helping people to engage and search for the information they need.<br><br>JJ asked about recruitment of expert by experience and PMcL responded there had been a total of 20 recruited which had enabled demonstration of patients being involved in the development of services.  There had been 6 involved in the design of the expanded breast service and had challenged around certain issues.  This was underpinned by a recruitment pack and SOP, and teams do request their services.<br><br>**The Trust Board discussed and  noted the report.** |
| BM/22/07/92 | **USE OF RESOURCES**<br><br>The paper set out the current status of the Use of Resources dashboard and noted a number of indicators had not been updated on the Model Hospital.  Also included was the date on the progress of findings of the 2020/21 corporate benchmarking exercise.<br><br>There had been movement in relation to Staff Retention on the dashboard since Q4 2021/22, and the trust had moved from Green to Red, however it was felt there was still an issue with the rating, and this had been raised as a concern.  As previously reported an issue had been identified and reported to the model hospital due to the data across various trusts being high compared to Trust data for March.  The model hospital had the data at 97.90% and the Trust's own data for the same period was 83.70%.<br><br>Corporate benchmarking is undertaken on an annual basis. The latest report issued in December 2021 presented the results of the 2020/21 benchmarking exercise.  There was no benchmarking exercise undertaken in 2019/20 due to the COVID-19 pandemic and therefore comparisons can only be made against 2018/19 data.<br><br>The cost per £100m income for each of the corporate functions has improved since the 2018/19 review. The benchmarking results also compare the Trust costs against the national lower quartile (LQ) which identifies any absolute opportunity for efficiency savings. |

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| | It was noted the narrative around KLOEs is refreshed routinely with a good library of positive evidence as it was about what had been achieved rather than a forward look.<br><br>SMcG asked if some of the actions could be streamlined and may feed into other workstream action plans. AMcG said this would be reviewed.<br><br>**The Trust Board discussed and noted the update.** |
| **BM/22/07/93** | **ANCHOR INSTITUTION**<br><br>It was noted the Trust was committed to being an anchor institution and in June 2021 the Trust Board provided a baseline assessment of the Trust activities and gaps against the expectations of being an anchor institution.<br><br>A further update was provided in November 2021 which detailed process, governance, and next steps in the three domains within anchor; social value, health inequalities and the green agenda. The presentation set out progress since this time and against additional priorities agreed at Trust Board in January 2022, and the proposed future governance of the programme.<br>The Trust's Anchor programme had been recognised as exemplary, both within Cheshire and Mersey, and nationally.<br><br>The presentation included existing areas of focus, progress highlights on several projects including Runcorn Shopping City, Warrington Town Deal and NHS Prevention Pledge. It also set out those areas which were off schedule due to a change of focus. Action against next steps for programme and opportunities were also highlighted.<br><br>LC highlighted the recommendations and asked the Board to note progress and further areas of development and support as part of the strategy refresh. There was still a lot of work to be done, but in terms of reporting this would be minimal.<br><br>Since the report had been written, a document had been received for approval, the document was the Anchor Institution Charter & Principles which compares the Trust, as an organisation against the principles defined in the document. One of the areas of concerns was the Issue of the minimum living wage, however with the news of the pay award this would support this concern.<br><br>The Trust is able to demonstrate it was working in line with the principles and recognised as exemplary so there were no concerns signing up to the charter.<br><br>JJ commented on the living wage and assurance that sub-contractors were paid at this level. LG noted there had been progress from procurement to ensure contractors comply in terms of social value and the living wage could be explored as part of this.<br><br>CR asked how many trusts had signed up to this and LG responded all trusts in the area had been asked to sign up, including local authorities etc. As an Anchor |

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| | institution the Trust had made significant progress.<br><br>**The Trust Board discussed and noted the contents of the report and commended the recognition of the work undertaken and noted the assurance provided.** |
| BM/22/07/94 | **TRUST STRATEGY REFRESH**<br><br>LG presented the Trust Strategy Refresh Plan noting the high level timelines, analysis, identify, review, and agree phases.<br><br>The Board were asked to note the refreshment of objectives in the strategy was undertaken on an annual basis.<br><br>LG noted that dates in terms of approval and to consider priorities based on data analysis of what has changed, a Board session would be scheduled to discuss these areas.<br><br>SMcG referred to a need to ensure that the strategy of the Trust also aligned to the strategy of the ICB.<br><br>**The Trust Board noted the update and supported the Trust Strategy refresh.** |
| BM/22/07/95 | **BOARD ASSURANCE FRAMEWORK (BAF)**<br><br>JC presented an update on the BAF and noted since the last meeting there had been no new risks added. There had been amendments to two of the risk ratings and these were Risk #115 and #145.<br><br>Four risks had been reviewed and description amendments made, these included Risk #115, #1275# 1233 and #145.<br><br>In relation to proposed amendments of descriptions to risks, six had been submitted to the appropriate committee for support. These included Risks #224, #1215, #1273, #1289, #134, #1372, #1134 and #125.<br><br>One risk on the BAF had previously been closed and it was proposed to close a further two and these were #1125 and #1079.<br><br>**The Board noted the assurance provided and approved the updates.** |
| **SUPPLEMENTARY PAPERS** | |
| BM/22/07/96 | **CYCLE OF BUSINESS – STRATEGIC PEOPLE COMMITTEE**<br>**The Board approved the Cycle of Business.** |
| BM/22/07/97 | **EPRR ANNUAL REPORT**<br>**The Board approved the EPRR Annual Report.** |
| BM/22/07/98 | **CHARITIES COMMISSION CHECKLIST – ANNUAL REVIEW**<br>**The Board approved the Charities Commission Checklist.** |
| BM/22/07/99 | **INFECTION PREVENTIAL AND CONTROL ANNUAL REPORT**<br>**The Board approved the Social Media & Medical Policy and Accessible Information Policy.** |
| BM/22/07/100 | **INFECTION PREVENTION AND CONTROL – BOARD ASSURANCE FRAMEWORK** |
| BM/22/07/101 | **DIGITAL BOARD REPORT** |

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| BM/22/07/102 | **CLINICAL RECOVERY OVERSIGHT COMMITTEE – CHAIRS ANNUAL REPORT** |
| BM/22/07/103 | **MEDICINES MANAGEMENT & CONTROLLED DRUGS ANNUAL REPORT** |
| BM/22/07/104 | **WORKFORCE RACE EQUALITY STANDARDS (WRES)** |
| BM/22/07/105 | **WORFORCE DISABILITY EQUALITY STANDARDS (WDES)** |
| | **The Trust Board noted** Agenda items BM/22/07/97, 98, 99, 100, 101, 102, 103, 104, 105. |
| BM/22/07/106 | **ANY OTHER BUSINESS**<br>There was no further business noted. |

**The Date and Time of the next Trust Board Meeting is Wednesday 28 September 2022**

Approved …………………………………………………………………………… Dated …………….………………………….

**CHAIRMAN    S McGUIRK**

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**Warrington and Halton Teaching Hospitals**
**NHS Foundation Trust**

| AGENDA REFERENCE | BM/22/09/110 | SUBJECT: | TRUST BOARD ACTION LOG | DATE OF MEETING | 28 September 2022 |
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## 1. ACTIONS ON AGENDA

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/22/07/81 | 27.07.22 | Perinatal Mortality Review Tool | To provide a further update to a future meeting. | Catherine Owens | | 28.09.22 | Agenda Item BM/22/09/118 | |

## 2. ROLLING TRACKER OF OUTSTANDING ACTIONS

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/22/07/88 | 27.07.22 | IPR Dashboard | To provide a verbal update in relation to Adaptive Reserve Fund | Andrea McGee/Dan Moore | 30.11.22 | | | |

## 3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

**RAG Key**

| | Action overdue or no update provided | | Update provided and action complete | | Update provided but action incomplete |
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**REPORT TO BOARD OF DIRECTORS**

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| **AGENDA REFERENCE:** | **BM/22/09/112** | |
| **SUBJECT:** | **Chief Executive's Briefing** | |
| **DATE OF MEETING:** | 28th September 2022 | |
| **AUTHOR(S):** | Simon Constable, Chief Executive | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Simon Constable, Chief Executive | |
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>(*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 |
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| **RECOMMENDATION:** | The Board is asked to note the content of this report. |
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| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
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| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** (*if relevant*) | None | |

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| SUBJECT | Chief Executive's Briefing | AGENDA REF: | BM/22/09/112 |
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## 1) BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues since the last meeting on 27th July 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 (21st September 2022), we have a total of 45 COVID-19 positive inpatients (14 days or less since their first positive sample); none of those patients are in critical care. In total, 83 of our inpatients have tested positive at any time during their admission (two of these are in critical care). There has been a gradual reduction in the number of our total COVID-19 inpatients over the last few weeks but more recently we have seen a slight increase.

The impact of this COVID-19 demand operationally continues to be not insignificant for infection control and staffing reasons. The clinical impact has been very different to the earlier waves of COVID, with greatly reduced critical care admissions with COVID-19. The vast majority of patients testing positive for COVID-19 are admitted for other conditions; their COVID-19 infection typically being incidental.

We have discharged a total of 4564 patients with COVID-19 to continue their recovery at home. Sadly, a total of 741 patients testing positive for COVID-19 have died in our care.

Total staff absence is just over 5.3% (a headcount of 249), some of the lowest levels of total sickness absence we have seen since the start of the pandemic.

### 2.2 Overview of Trust Performance

Once again, with this report I have included 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 5 - August 2022. This is included as appendix 1. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

Some changes in presentation will once again be evident this month. As previously reported the Trust introduced Statistical Process Control (SPC) charts onto the Trust IPR in 2019 and introduced Making Data Count SPC Assurance & Variation icons in May 2022. Following on from the Trust Board Development Session in June 2022 a number of developments in relation to the IPR are underway or are proposed. My summary dashboard reflects those continuous improvements. I anticipate further enhancements in the coming reports as we align all of our measures and reporting mechanisms.

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As previously reported, we have continued to see urgent and emergency care under relentless pressure across the North West, including Cheshire and Merseyside and WHH.

Our total number of super stranded patients with a length of stay greater than 21 days remains very high at 147. Pre-pandemic the NHSE/I threshold for this metric was set at 90 and we are consistently 'two wards' greater than that. The number of patients that do not meet the criteria to reside (CTR) is similarly very high at 120.

I called an urgent Warrington System meeting on 14th September 2022 because of heightened concern going into the additional bank holiday weekend. We continue to work positively within the local System Sustainability Group of health and social care leadership including Warrington and Halton Borough Councils and Bridgewater Community Healthcare NHS Foundation Trust on solutions for the short, medium and longer terms. There needs to be an added focus on preparation for winter which is rapidly coming upon us. Unfortunately, thus far, despite best efforts, the position, whilst not deteriorating further, has not improved to the extent we need.

As stated above, the context we are experiencing is similar to other acute trusts in Cheshire and Merseyside, and indeed, much of the North West.

The Trust continues to undertake an elective recovery programme, alongside diagnostic recovery.

Activity reports and dashboards have been developed and are reported routinely at Executive Team, Quality & Assurance and the Finance & Sustainability Committees. Given our financial position and plan, the Executive Team receive additional reporting regarding activity and cost improvement from the Care Group leadership every Wednesday. The Clinical Services Oversight group (CSOG) continues to oversee the waiting lists and the safety of patients.

### 2.3 Death of Her Majesty The Queen, Elizabeth II

It was with profound sadness that we learnt of the death of Her Majesty The Queen on 8th September 2022. As our Monarch and Head of State for over 70 years, most of us will not have known anything different. As a Trust we wanted to make sure we were able to demonstrate our respect and pay tribute in recognition of The Queen's extraordinary life of remarkable service and duty.

The Trust, like all other public bodies, entered the period of official national mourning which was concluded on the date of Her late Majesty's funeral. The Trust continued to deliver all its 'business as usual' activities; discrete social media messaging reinforced this and reminded patients to present as usual for their appointments.

All non-essential announcements, celebrations, events and activities were postponed, except those relating to trust operations and the safety and quality of care for our patients. Our website carried a message of condolence and our logos and branding were featured in dark colours as a mark of respect. All non-essential social media activity was paused.

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Framed photographs of Her late Majesty with our condolence message were produced for all main entrances.  Condolence books were opened in our Spiritual Care centres at Warrington Burtonwood Wing and Halton Nightingale Building for staff, patients and visitors. Our Armed Forces and Veterans Network and WHH Chaplaincy also held two memorial and reflective services: Friday 16th September at Warrington in the The Spiritual Health and Wellbeing courtyard, Appleton Wing and on Tuesday 20th September at Halton in the Remembrance Garden courtyard.

We arranged free television on the bedside systems at Warrington and additional screens for Halton until after the funeral and arranged an afternoon tea for inpatients on the day of the funeral itself.

As announced by His Majesty King Charles III, Monday 19th September was a Bank Holiday to commemorate the state funeral. We were keen to support all our staff members to have the opportunity to observe this day of national mourning and therefore our approach was like any usual Bank Holiday; an additional day's leave was added to all employees' annual leave entitlement.

However, clinical activity had already been scheduled for this day and that had included cancer and higher clinical priority patients. We were therefore keen to ensure we supported our patients to minimise any further delays in treatment following the COVID pandemic. Therefore, for elective and outpatient procedures, we reviewed, on a service-by-service basis, the number of patients still attending appointments, and whether any staff were willing to volunteer to work on Monday 19th September 2022. Similarly, we also endeavoured to support non-elective emergency patients in addition, again reviewing staffing on a service-by-service basis.

**2.4 Cheshire and Merseyside System Development**
As appendix 2 to this report I have included the most recent briefing document from the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative, of which WHH is an active member. This outlines the most recent developments since my last Board report, including progress within each of the main improvement workstreams led by CMAST on behalf of the wider C&M system.

In addition to their duties and responsibilities within this Trust, all executive directors play a role in the wider C&M system. Some of these C&M roles are detailed below. This is not an exhaustive list of roles and contributions; it does for instance not include borough level/place-based work, but it does give an indication of the breadth and depth of leadership contribution external to this Trust, as part of our duty to collaborate.

- ***Simon Constable, Chief Executive***
  Senior Responsible Owner, C&M Clinical Pathways Programme
  Senior Responsible Owner, C&M Ambulance Handover Improvement Programme
  Lead Chief Executive, C&M Urgent and Emergency Care Gold Command
  Member, C&M Providers Chief Executives
  Member, CMAST Leadershiop Board
- ***Andrea McGee, Chief Finance Officer & Deputy Chief Executive***

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Vice-Chair, NHS Finance Academy
Member, NW Skills Development Board
Member, C&M People Board and C&M Finance Committee
Chair, C&M Procurement Steering Group

- ***Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive***
Director of Nursing representative, C&M Women's Health & Maternity Service Programme Quality, Safety, Surveillance Group (QSSG)
Director of Nursing representative, Local Maternity & Neonatal System C&M (LMNS)
Director of Nursing lead, HCA recruitment for C&M

- ***Dr Paul Fitzsimmons, Executive Medical Director***
Member, C&M Medical Directors Group

- ***Michelle Cloney, Chief People Officer***
Vice-President, Healthcare Professionals Management Association (HPMA)
CPO Representative, C&M Diagnostic Delivery Board
Member, NW and C&M HRD Leadership Networks
Member, NW and C&M Social Partnership Forums

- ***Dan Moore, Chief Operating Officer***
Member, C&M Chief Operating Officers
Member, C&M Restoration of Elective Activity Programme
Member, C&M Cancer Alliance Gynaecology Cancers Programme Board
Member, Cheshire Local Health Resilience Partnership

- ***Lucy Gardner, Director of Strategy & Partnerships***
Chair, C&M CMAST Strategy Directors Group
Acute Trust representative, C&M Population Health Board
Member, C&M Sustainability Board
Member, C&M Strategic Estates Group
Employer representative, Cheshire & Warrington Institute of Technology Employers Board

- ***Pat McLaren, Director of Communication & Engagement***
Member, C&M NHS Communications Network


**2.5 WHH Organisational Structure**

In the Board's supplementary pack this month is also included the new graphical representation of the Trust's organisational structure. For clarity, there have not been any changes in our structure, simply a different way of presenting each of the portfolios. It is intended that this will be updated on a quarterly basis, presented on our website and to Trust Board accordingly.


**2.6 Opening of Children's and Young Person's Outpatient Department**

The previous children's outpatient department was built in 1996 with a capacity for 4,000 patients per annum. The capacity was adequate for the four consultants in the department that there were then, but there were no opportunities to offer our children and young people supportive services. Now the department has 11 consultants with additional consultants joining us later in 2022, taking our strength to 14 consultant paediatricians. The children and young people receive high quality care from the team despite year-on-year significant increases in referrals to our outpatients. The estate capacity was a limiting factor and we were unable to accommodate the growing referrals without modernisation.

The Trust Board approved a business case for renovation of the children's outpatients department last year. The work commenced in October 2021 and we continued to provide outpatient services from the Halton site during this work.

The newly refurbished department has the capacity to see more than 41,000 children and young people every year. It provides a wide range of excellent outpatient services in a safe, comfortable, welcoming, and reassuring environment. The design of the new outpatient department was led by our service users – the children and young people who will be using the new facility. By engaging with and listening to our patients, we have made several major improvements to the overall design, including separate waiting rooms for children and young adults – each themed and decorated accordingly.

As well as listening to the child's voice, we have also listened to parents, to improve their experience of the department. This includes a private infant feeding room, better pram storage facilities and other improvements to make the whole family enjoy a much better experience at the outpatient department. We have incorporated a dedicated virtual clinic room to ensure that we future-proof our services and meet the demand of the NHS Long Term Plan and our technologically evolving demographic.

With modernisation, we have also changed the name of the department to reflect our whole service user demographic. We have moved away from the 'Children's Outpatient Department' and proudly adopted the title of 'Children's & Young Person's Outpatient Department' represented by a new department logo, which was designed with our service users.

Through listening to and co-designing our new department in partnership with children, young people and families, we are confident it will meet their needs and enhance their experience of outpatient services at WHH for many years to come.

### 2.7 Organ Donation at WHH

Despite the challenges from the pandemic, lifesaving transplants in the UK have continued to occur. On 20th May 2020 the Organ Donation (Deemed Consent) Act 2019, known as Max and Keira's Law, came into force in England. The new law will help save and improve even more lives moving forward.

In England, during 2021/22 there were 459 occasions when consent was deemed from 794 occasions where deemed consent applied. In 2021/22, 382 people benefited from a solid organ transplant in the North West. However sadly, 68 people died on the transplant waiting list during this time.

In 2021/22, from 6 consented donors, Warrington and Halton Teaching Hospitals NHS Foundation Trust facilitated 6 actual solid organ donors resulting in 16 patients receiving a transplant during the time period. The referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service and the presence of a Specialist Nurse for Organ Donation when approaching families to discuss organ donation are key steps in ensuring the success of organ donation. We referred 60 patients to NHSBT's Organ Donation Services

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Team; 48 met the referral criteria and were included in the UK Potential Donor Audit. There were a further 9 audited patients that were not referred. A Specialist Nurse was present for 10 organ donation discussions with families of eligible donors; there were no occasions when a Specialist Nurse was absent for the donation discussion.

## 2.8 Creamfields Festival

The August Bank Holiday was once again host to the annual Creamfields Festival and another especially challenging weekend for emergency services.

I wish to pay a particular tribute to our Urgent & Emergency Care, Critical Care and supporting management teams, including Patient Flow, for all they did over a particularly busy and challenging bank holiday/Creamfields weekend. In a world where the bar for the 'new normal' has been reset upwards, the teams were fantastic and made a difference to both patients, their families and staff under exceptional circumstances once again.

Planning for the Creamfields weekend was once again meticulous and there was continuous communication between the Trust, our partners and the Creamfields site itself. The number of festival-goers treated onsite at Creamfields was 1615. A total of 24 NWAS ambulance transfers to our Warrington Emergency Department occurred over that weekend, resulting in 9 inpatient admissions (including 4 patients admitted for critical care).

## 2.9 Launch of the WHH Staff App

We have been delighted, after what seems like a very long time in development, to launch the *@WHH Staff* app for download (for free) to smartphones. The *@WHH Staff* app provides staff, at the touch of a button, quick links to latest news, ESR - including payslips, NHS webmail, Works Perks, wellbeing support, our staff networks, e-rosters/rotas and much more.

The app is still evolving. The app has been produced and designed to offer current employees relevant information relating to WHH. We will also be able to stay connected using urgent notifications on any important news or urgent messages that might affect day-to-day work. Currently, we are not able to offer access to policies and procedures through the app, but this may change with work that our IT Team are currently actioning within their SharePoint project.

## 2.10 Special Days/Weeks for professional groups

Since our last Board meeting in July 2022, a number of topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. WHH has recognised all of these:

Tropical Shirt Tuesday (Mental health awareness in healthcare workers): 2nd August 2022
World Sepsis Day: 13th September 2022
World Patient Safety Day: 19th September 2022
Falls Awareness Week: 19th – 25th September 2022

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**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 COVID-19 as well as other significant issues; similarly they have asked questions 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* has now passed its one year anniversary of operation. Nominations are reviewed and awards made by a mutli-professional panel.

**You Made a Difference Awards**

In arrears for logistical reasons, the winners shared since my last Board report in July 2022 are as follows:

**You Made a Difference Award (April 2022): Mandy Glover**

Mandy Glover is our Equality, Diversity and Inclusion Administrator and a small part of her role is in the administration of the *You Made A Difference* Awards each month. On this occasion she however has been a receipent, having been nominated by colleagues for the level of kindness and support she demonstrates to others on a daily basis.

**You Made a Difference Award (May 2022): Orthoptics Team**

The orthoptics team have been awarded the May 2022 *You Made A Difference* Award for all the individual/team professional development they do and take so seriously in the best interests of each other and their patients. The team have been exceptional in how they have provided opportunities to the staff members to develop and meet their career aspirations whilst providing a high-quality service to their patients.  They have a strong culture of mentorship and staff access several internal and external developmental opportunities to 'grow your own'.  Staff members are involved in completing masters' modules, leadership training, advance practice and extended scope courses and secondments, all of which lead to a highly skilled team providing a fantastic service.

**You Made a Difference Award (June 2022): Payroll, Pensions & ESR Helpdesk Team**

Our Payroll, Pensions & ESR Helpdesk Team were the winners of the June 2022 *You Made A Difference Award*. They are a very small team, based over in the former residences at Halton Hospital. It goes without saying that paying everyone correctly during challenging and unprecedented times has been critical over the last two and a half years. The team were often asked to implement changes to long standing and embedded processes in order to meet new and emerging national guidance. Like many things, this was changing rapidly. They navigated our way through COVID-19 by ensuring that everyone was paid correctly and on time. They received complex pension updates to enable individual decisions to be made about continuity of work; and they were on hand to help and hold difficult conversations when dealing with queries.

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Whilst we are now getting back to something more akin to pre-pandemic practices, the hard work and commitment from them has been reflected in the nomination for this award, with which the judges agreed.

### *You Made a Difference Award (July 2022): Sue Jones*

Sue Jones is a Paediatric Specialist Epilepsy Nurse. The award has been presented in recognition of the work she has done as going above and beyond over the past few months. Sue has been providing excellent patient care during a very challenging time, and has worked many extra hours to ensure the service is covered.

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

### *Chief Executive Award (June 2022): WHH Switchboard Team*

I was really pleased to recognise and appreciate our Switchboard Team with my own Chief Executive Award. Earlier in the summer they managed a very disruptive phone outage extremely smoothly. 'Coolness under pressure' describes what they managed. You can imagine what it was like for them over a sustained period with frustrated callers but they remained calm, professional and did an excellent job under difficult circumstances.

### *Chief Executive Award (July 2022): Abigayle Meikle-Roche*

Abi has been our lead pharmacist for clinical education. She joined the Trust in July 2019 and left the organisation in September 2022 as part of a relocation to another part of the country. She has had a very active involvement in the provision of prescribing and medication-related training to all professional groups, including undergraduate and postgraduate doctors. She has been dedicated to ensuring that nobody is left behind, delivering both high quality didactic workshops and 1:1 training sessions. Pastoral support has been a cornerstone of Abi's education and training ethos, she spends time understanding how people best learn. It was fitting that I was able to make this award as she moves on to pastures new.

### *Chief Executive Award (August 2022): Ward A4*

I receive many letters and emails of recognition and appreciation from patients and their families each week. Ward A4 has had more than their fair share over recent weeks and this award has been made in recognition of that, specifically with regards to kindness. There have been multiple examples of the whole team going above and beyond to support patients and families who are struggling to come to terms with their own or their loved one's diagnosis/prognosis. From finding a favourite song that prompted one patient to sing in memory of his late wife, to taking a gentleman at the end of his life outside on his bed to feel the sun and breathe in fresh air on multiple occasions.

The team are consistently delivering care within an overwhelming positive, caring and compassionate manner. The patients receive excellent care with the additional personal touches that make a huge difference to their (and their families') experience and the memories they will have from this chapter in their lives.

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***Chief Executive Award (August 2022): Dr Dan Edwards and Gemmell Johnston***

These awards have been made for the personal leadership of two individuals for their work in achieving Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists. ACSA engages anaesthesia departments in quality improvement through peer review. The scheme is voluntary. Participating departments benchmark their performance against a set of standards based on the College's Guidelines for the Provision of Anaesthetic Services (GPAS), which is produced via a National Institute for Health and Care Excellence (NICE) accredited process. Departments then work towards the goal of becoming accredited.

It has been a significant team effort and collectively touches on one of our largest teams, in anaesthetics and theatres across both our hospitals. I would like to congratulate and thank everyone involved in this achievement. However I have highlighted two individuals. This has been superbly led by Dr Dan Edwards, Consulatnt Anaesthetist, who has led with great tenacity over the last few years. He has done this with the support of others, not least of which has been Gemmell Johnston, Assistant CBU Manager, who has worked so very diligently on this since the start.

We expect to formally receive our certification from the President of the Royal College of Anaesthetists personally in October 2022 and we will celebrate this accordingly.

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

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

- Dave Gallagher, Ward Manager - Ward K25, Integrated Medicine & Community
- Sharon McGarity, Specialist Nurse - Integrated Medicine & Community
- Sheila Cawley, Specialist Nurse - Integrated Medicine & Community
- Eileen Spurling, Specialist Dental Nurse - Surgical Specialities
- Charlene Oakes, Deputy Ward Manager - Ward C20, Women's & Children's Health
- Christine Unsworth, Specialist Biomedical Scientist, Clinical Support Services
- Dr Diane Matthew, Chief Pharmacist, Clinical Support Services
- Beverley Griffiths, Clerical Officer, Women's & Children's Health
- Zoë Harris, Deputy Chief Operating Officer, Trust Executive
- Jenny Clarke, Nurse Practitioner, Urgent & Emergency Care
- Jane Hurst, Deputy CFO/FTSU Guardian, Finance & Procurement
- Carole Grimes, Recruitment Officer, HR/OD
- Gail Cannon, Senior Domestic Supervisor, Estates and Facilities
- Beverley Collins, Cancer Nurse Specialist, Digestive Diseases
- Sheila Murphy, Midwife, Women's & Children's Health
- Brian Burge, Head of Procurement, Finance & Procurement
- Mr Mohamad Al Machhoor, Locum Consultant Urologist, Surgical Specialities
- Bev Caine, Ward Manager - Ward B4, Digestive Diseases
- Liz Tankard, Domestic Assistant, Estates and Facilities
- Shannen Maddocks, Staff Nurse - Ward A4, Digestive Diseases
- Dr James Wallace & Team, Clinical Director, Urgent & Emergency Care
- Dr Laura Langton & Team, Clinical Director, Medical Care

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- Mr Ashtin Doorgakant, Consultant Orthopaedic Surgeon, Surgical Specialities
- Barbara Duckers, Staff Nurse - Ward A4, Digestive Diseases
- Barbara Jeffers, Domestic Assistant, Estates and Facilities

**2.13 Signed under Seal**
Since the last Trust Board meeting, there has been nothing further signed under seal.

## 3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended in August and September 2022 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)
- CMAST Clinical Pathways Programme (Various)
- Steve Broomhead, Chief Executive, Warrington Borough Council
- Stephen Young, Chief Executive, Halton Borough Council
- Warrington Wider System Sustainability Group (Monthly)
- Clinical Research Network North West Coast Health Research Alignment (Monthly)

In addition, in August I was pleased to host Raj Jain, Chair of the C&M Integrated Care Board for a visit to Warrington Hospital and a tour of some of our redeveloped facilities, including the NEST Midwifery Unit as well as the newly opened Same Day Emergency Care Centre.

## 4) RECOMMENDATIONS

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

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## 5) APPENDICES

Appendix 1: CEO Dashboard – Month 5 (August 2022)
Appendix 2: Cheshire and Merseyside Acute and Specialist Trust (CMAST) Briefing (August 2022)

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# Appendix 1 - CEO Dashboard Month 5 – August 2022

**NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust**

## Quality

### Operational Performance

| Indicator | Target | Actual | SPC |
|---|---|---|---|
| Diagnostic 6 Weeks | 99.00% | 78.54% | |
| RTT 18 Weeks | 92.00% | 62.45% | |
| RTT 104 Weeks + | 0 | 8 | |
| A&E % patients seen within 4 hours | 95.00% | 72.10% | |
| A&E % waiting longer than 12 hours | < 2.00% | 16.84% | No SPC |
| Cancer 14 Days | 93.00% | 86.54% | |
| Breast Symptomatic 14 days | 93.00% | 88.24% | |
| Cancer 28 Day Faster Diagnostic Standard | 75.00% | 77.17% | |
| Cancer 62 Days Urgent | 85.00% | 70.75% | |
| Ambulance Handovers within 60 mins | 100% | 72.92% | |
| Discharge Summaries 24 hours | 95.00% | 90.06% | |
| Cancelled Operations – 28 days | 0 | N/A | No SPC |
| Fracture Clinic – 72 Hours | 95.00% | 52.39% | |
| % Outpatient Appointments Delivered Remotely | 25.00% | 10.73% | |
| Super Stranded Patients | Trajectory | 146 | No SPC |

### Quality of Care

| Indicator | Target | Actual | SPC |
|---|---|---|---|
| Incidents open over 40 days | 0 | 0 | |
| Sepsis Screening Emergency | 90.00% | 76.00% | |
| Sepsis Screening Inpatients | 90.00% | 51.00% | |
| Sepsis Antibiotics Emergency | 90.00% | 69.00% | |
| Sepsis Antibiotics Impatient | 90.00% | 63.00% | |
| Inpatient Falls (cumulative) | 20.00% reduction | 78 | No SPC |
| VTE | 95.00% | 95.39% | |
| Pressure Ulcers (cumulative) | 10.00% reduction | 10 | No SPC |
| Medication Reconciliation (24 hrs) | 80.00% | 58.00% | |
| Complaints over 6 months | 0 | 0 | |
| Continuity of Carer | 51.00% | 86.40% | |
| Healthcare Infections - MRSA | 0 | 0 | |
| Healthcare Infections – CDI (cumulative) | Less than 37 | 4 (21 YTD) | No SPC |
| Healthcare Infections - E. coli (cumulative) | Less than 57 | 5 (26 YTD) | No SPC |
| Healthcare Infections – Klebsiella (cumulative) | Less than 19 | 1 (10 YTD) | No SPC |
| Healthcare Infections - P. aeruginosa (cumulative) | Less than 6 | 0 (1 YTD) | No SPC |

## People

### Workforce

| Indicator | Target | Actual | SPC |
|---|---|---|---|
| Supporting Attendance | Less than 4.20% | 5.54% | |
| Welcome Back Conversations | 85.00% | 56.33% | |
| Vacancy Rates | 9.00% or less | 11.81% | |
| Retention | 85.00% | 83.05% | |
| Core/Mandatory Training | 85.00% | 85.57% | |
| Role Based Training | 85.00% | 91.62% | |
| Payspend (month) | Budget (£19.7m) | £20.3m | |
| PDR Compliance | 85.00% | 62.96% | |

## Sustainability

### Finance

| Indicator | Plan | Actual | SPC |
|---|---|---|---|
| Income & Expenditure (culm) | -£6.28m | -£6.53m | |
| Capital Spend | £5.5m | £3.59m | |
| Cash | £21.76m | £40.7m | |
| Better Practice Payment Code (culm) | 95.00% | 93.00% | |
| CIP In Year Delivered (culm) | £2.1m | £2.1m | No SPC |
| CIP Forecast (Recurrent) | £6.5m | £2.1m | No SPC |

## Strategy

### Strategy ★

- **Runcorn Shopping City Health Hub** – The refurbished unit in Shopping City is due to be handed over to the Trust on 23rd September, with clinical service delivery due to commence on 31st October
- **Warrington Town Deal** - Stage 4 designs for the new Living Well Hub are now completed, enabling the tender process for the building contractors to commence. An agreement in principle has been reached with the landlord of the preferred location and the Trust is expected to take over the lease of the building in the coming months. A delivery group is now being formed to finalise the operating timetable for the Hub and work through the operational challenges associated with creating a complex multi-use, multi-partner facility for the benefit of the people of Warrington.
- **Health and Social Care Academy** – The Health and Social Care Academy at Warrington and Vale Royal College has formally opened.
- **Community Diagnostic Centre** – Our fast-track CDC business case has been approved by Cheshire and Merseyside and the regional team, with some required amendments.
- **Trust's 5-year Strategy** – Refresh of the Trust's 5 year strategy has commenced with planned approval of the refreshed strategy in March 2023

# CMAST Briefing

## ICB Update

### Covid Booster Vaccine Roll-out Announced for Autumn

People living in Cheshire and Merseyside will soon be among the first in the world to receive the new Covid-19 vaccine, when the autumn booster programme begins this month.

Care home residents and people who are housebound will be vaccinated in the first phase of the campaign (from September 5).The National Booking Service will also open as part of the wider rollout, due to start on September 12, for those most susceptible to serious illness from Covid-19 and those aged 75 and over to book an appointment for their jab.

### COVID Testing

Patient-facing healthcare staff who have no symptoms of a respiratory infection are no longer required to test for COVID-19 on a regular basis.

Routine asymptomatic testing for patient-facing healthcare staff should only continue where local healthcare organisations have sought appropriate advice to undertake this testing as part of broader infection prevention and control measures.

This could be, for example, to asymptomatically test staff who may be in close contact with patients who are at higher risk of serious illness from Covid-19. Patient-facing healthcare staff who *have* symptoms of a respiratory infection, and who have a high temperature or do not feel well enough to attend work, should take a Lateral Flow test as soon as they feel unwell..

### Virtual Wards

Cheshire and Merseyside is leading the way in the development of virtual wards – to support people who would otherwise be in hospital to receive the care and treatment they need in their own home.

Support delivered through Virtual Wards is clinically supervised and can include remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters.

Mobilised during the pandemic in response to COVID-19, virtual wards have since been expanded by Cheshire and Merseyside clinical leaders to support other conditions and acute respiratory infections, including COPD, Bronchiectasis and community-acquired pneumonia.

A heart failure virtual ward pilot is now operating in Liverpool University Hospitals NHS Foundation Trust,

while frailty virtual ward experience is being applied from Wirral University Teaching Hospital NHS Foundation Trust. Both are set to be expanded to all sites across Cheshire and Merseyside by the end of 2022-23.

### Increasing Capacity this Winter

Investment of over £13m has been agreed to support several schemes across Cheshire and Merseyside which will see an expansion of the hospital, community, and care home bed-base this winter, totalling more than 200 additional beds. For more details contact ICB Director of Planning and Performance Anthony Middleton.

### Super September

Nearly 80% of our waiting lists are made up of patients who will be treated as outpatients. There is a pressing need to recover services for these patients, transforming them in the process to improve access to and experience of outpatient care.

To support us do this, NHS Cheshire and Merseyside is participating in Super September, a national initiative that will enable us to focus on outpatients in the most impactful way. For 2 weeks, from 26 September, we'll be taking 'action on outpatients' by working together to implement and accelerate the use of a range of interventions.

### Introducing Christine Douglas MBE

Christine Douglas was welcomed to the ICB Executive team in August, taking up the role of Director of Nursing and Care. Chris brings her passion for ensuring safe, personal and effective care to Cheshire and Merseyside, along with a wealth of experience – something which was recognised when receiving an MBE in the Queen's New Year's Honour's list in 2021 in recognition of her services over more than 40 years. For full details of the ICB's leadership team visit here.

## CMAST Development

CEOs and Chairs met on 2nd September as the CMAST Leadership Board. The meeting had both a developmental and operational focus.

The Leadership Board discussed final proposals for the proposed CMAST Joint Working Agreement and Committee in Common as had been progressed through the summer. Final comments were provided, which, mainly related to requests for enhanced definition to ensure consistent understanding. The Board sponsored and supported consideration by Trust Boards through September and October with a view to securing system wide agreement to this timescale.

The Leadership Board also took the opportunity to receive, discuss and explore full updates on all CMAST workstreams.

# Elective Recovery and Transformation Programme

### Waiting List Backlog

- We achieved a zero capacity breach position at the end of July, which mean no 104 week waits at that time. Agreed exceptions related to patients that had opted to wait longer for their treatment (patient choice), and some very complex cases that were excluded from that national target.
- We continue to focus on maintaining that position of zero 104 breaches and are on track to ensure that continues to the end of September. This is still very challenging, but trusts are committed to that end and the programme team are working very closely with waiting list managers to offer support. Support includes facilitating mutual aid, identifying additional capacity through independent sector, and support in waiting list management techniques.
- The next focus is on eliminating over 78 week waits by end of March 2023. We currently have 3252. We will need to ensure all OP waits are down to 78 weeks by December to allow for any ongoing surgical requirements to progress before the end of March or they will tip into the 78 week category.
- Liverpool University Hospital remains the highest risk Trust across the system as they will lose capacity due to operational changes. The PTL team are working closely on all actions with the Trust including mutual aid and identifying alternative capacity.
- We have completed a review of the independent sector (ISP) capacity and processes. We are taking forward actions from that review and have now extended the same waiting list monitoring to the ISP sector with weekly waiting list review meetings.
- Streamlining mutual aid systems and processes is a priority for the system. We have developed a mutual aid Standard Operating Procedure which is due for full release over the next few weeks. This will bring together a system wide approach to long waiters at speciality level.
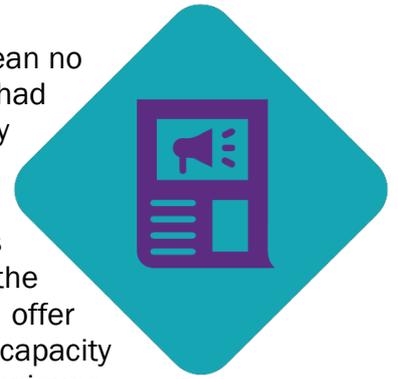
### Elective Hubs

- Broadgreen procedure room plans are now signed off, and the unit is to be ready in December and open for system access in early January 2023. This will largely focus on upper limb orthopaedics work in the first instance.
- Clatterbridge hub (phase 1) is two modular theatres. There has been a slight delay in opening with projected full opening at the end of September/early October. Timetables and Consultants allocations have been agreed with the Countess of Chester Hospital who will be using the facility as well as Wirral. A business case for 2 additional theatres is being taken through the national approvals processes.
- Liverpool Women's Hospital have offered a theatre for system usage and we have had 2 expressions of interest (COCH and Warrington and Halton). We are aiming to develop the timetable and case mix to be signed off in next 2-3 weeks and plan to open in early December (due to recruitment timelines).
- Mid Cheshire Hub on the Victoria Infirmary site has now completed the work on its business case. The team will take this to the national panel in mid-September.
- We have reserved funding for a hub on the North Mersey geography. Options are being developed to determine the best use of this funding. The scheme will be in (2024/25)

### Theatre Productivity

- A formal programme of work has been launched for theatre productivity to identify and address opportunities for improving the throughput and utilisation of our theatres.
  - We are currently performing well against the national picture, but there are still opportunities. There is variation between trusts with some performing better than others. Cheshire & Merseyside theatre utilisation is shown in the black bar below.

Uncapped Theatre Utilisation %: Total touch time vs planned session time, National Distribution

Cheshire And Merseyside ICB (My System)
Uncapped Theatre Utilisation %: Total touch time vs planned session time : 80%

- A theatre productivity check list has been launched across C&M, and this has now been shared with the NW region and NHSI to roll out further.
- "High Volume Low Complexity" pilots are being launched in August to try and focus on more dedicated HVLC lists which will lead to greater efficiencies. There will be further roll outs in November.

## Outpatient Transformation

- Outpatients forms majority of our waiting list now, and now requires significant focus, as shown below.



% RTT Split
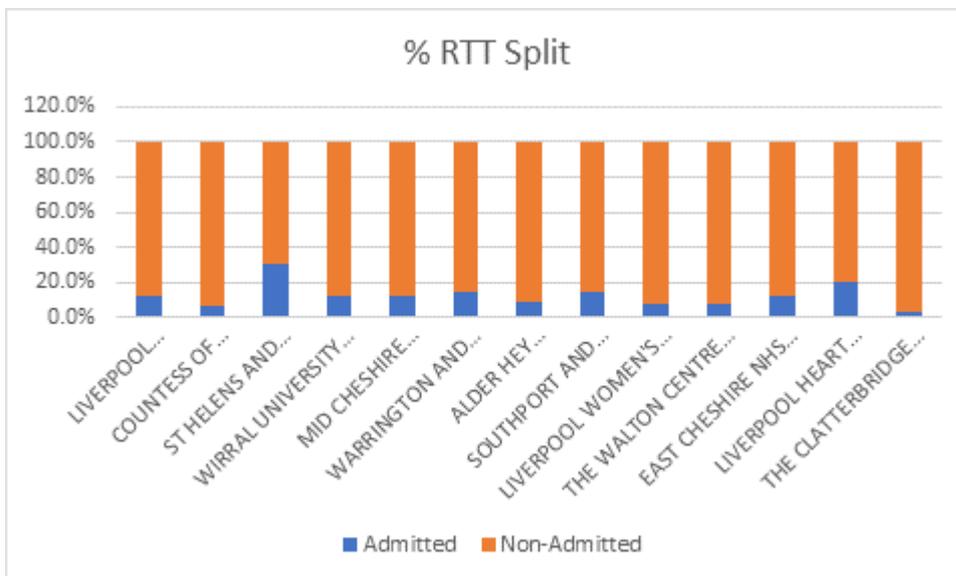
- The OP Programme continue to focus on the national "Action on Outpatients: Super September" Initiative. This includes 3 main areas of focus:
  - **Specialty Level – Ophthalmology:** We will use Super September to expedite our Glaucoma Community Follow Up pilot. This will help us to release OPFU capacity within the acute setting and allow trusts to redirect capacity where it is needed most.
  - **Intervention Level – Patient Initiated Follow Up:** We will expand our current PIFU offering to include a priority focus on dermatology PIFU for Long Term Conditions. This will begin a process of moving suitable patients onto PIFU and ensure OPFU slots are used by the most urgent patients.
  - **Trust Level – Countess of Chester:** We will work closely with our colleagues at COCH and Consultant Connect to drive forward a project to validate and prioritise the longer waiters (focus on 50-60 week waits – that have not been subject to the weekly PTL validation exercises). This will focus on ENT in the first instance.

- These projects are progressing well and will give the system an opportunity to provide proofs of concept, gathering the evidence of impacts for specific interventions required to support wider roll out.
- Colleagues from across the system will attend a series of 4 NHSE/AQuA practically focussed workshops during September and October to help systems with the delivery of the Personalised Outpatient Programme as part of the wider elective recovery effort.
- The roll out of Gastroenterology Referral Pathways across primary and secondary care is now underway. This project is being led by the Elective Programme, in partnership with the Endoscopy Network and primary care forums.

## Clinical Pathways

### Orthopaedics

The system wide Orthopaedics Alliance will hold its inaugural meeting in early September. Phase 2 of the project for Orthopaedics – the Options Appraisal will conclude in early October with a second workshop scheduled.

A final Orthopaedics specialty review report will be completed for the end of October which will conclude the review for Orthopaedics. The implementation roadmap e.g., recommendations and next steps will then be handed over to the Orthopaedics Specialty Clinical and Project Leads.

### Programme Phasing

A prioritisation matrix approach was used to support programme phasing, using a heatmap of key high-level indicators by speciality supporting the decision-making process. Scoping and mobilisation work will begin in the next two specialities, Dermatology and ENT, in August with the first workshops for these workstreams due in November.

# Diagnostics Programme

### Community Diagnostic Centres (CDCs)

- CDCs are delivering a run rate of 110,000 tests per year. We have 5 CDCs operational with plans for an additional 4 submitted. 3 of these 4 plans have been approved. Approval for Endoscopy provision in all sites has not yet been received as national funding has been redirected to fund NHS pay award.

### June Performance Headlines

- C&M ICS is ranked 13th out of 42 ICSs for diagnostic waiting time performance. Improved as was 16th in April 2022.
- C&M ICS sustained its position of delivering the 3rd highest level of diagnostic activity. C&M ICS has the 4th largest population.
- In the following tests, we are delivering more activity than we were before the pandemic – CT, MRI, Colonoscopy.
- The number of patients waiting over 13 weeks has reduced by 202 but there are still 5699 people waiting more than 13 weeks for a test.
- CT – The number of patients waiting has reduced by 1492 and activity across the system is at 117% of that in 2019/20.

### Echocardiography – a system recovery plan is in place.

- System support is required to:
  - Purchase a networked Cardiac Reporting system which would link to overall electronic records, reduce duplication of tests and result in greater productivity.
  - Fund Independent Sector capacity on a short term basis to aid recovery.
  - Over recruit to Cardiac Physiologist trainee placements so that we have an improved pipeline of trained staff who wish to work in this area. There are national staff shortages, an issue impacting on Cheshire & Merseyside.
- The majority of C&M trusts had implemented British Society of Echocardiography standards for appointment slots, 3 Trusts which were using longer appointment slots have been asked adhere to these standards.
- 5 trusts (where waiting times are within the 6 week target) have been asked to provide mutual aid within existing capacity to other trusts who have longer waiting times, 3 trusts have put plans into place to begin to provide this system support.

### Pathology – COVID temporary staffing.

- Confirmation that Pillar 1 funding for hospital laboratory testing staff will be provided after September 2022 has not been received. Trusts have been asked to prepare to cover these costs until the end of 2022/2023 so that capacity to cover covid testing in autumn and winter is not lost.

### Imaging – Collaborative contract for the provision of a single Picture Archiving Communication System (PACS) across C&M

- Trusts will be asked to sign off this collaborative contract for a networked PACS solution and agree which trust hosts and manages the contract.

## Workforce

- A proposal for a Collaborative C&M Diagnostic Staff Bank has been supported by C&M Chief Executives. This will help to grow our workforce, reduce use of agency, insourcing and outsourcing and ensure less capacity is lost due to staffing shortages.

## Digital

- 3-year digital roadmap applications have been made to NHSEI for £24M of capital funding over 3 years that will connect and standardise much of our imaging and pathology worlds. This will prevent duplication, speed up working practices and allow for mobile delivery.

## System Capacity

- For most diagnostic tests, system capacity exists in a neighbouring trust which could bring down waiting times and reduce variation. Trusts are asked to respond to requests to provide support (within existing activity levels) to neighbouring trusts to improve system performance.

# Urgent and Emergency Care – Gold Command

- Acute Trusts remain pressured in terms of continued high occupancy. C&M G&A occupancy average for July was 96% (range 93%-100%), with majority of Trusts consistently over 95%.

- Overall COVID occupancy and COVID G&A occupancy has slowly decreased over the course of the month;.

- C&M Acute Trust COVID related staff absence reduced from 20% of all sickness absences at beginning of August, to around 14% at end of the month.

- Type 1 and All Types of A&E Performance remained challenged throughout August, with high numbers of both ambulance handover delays over 60 minutes and patients waiting over 12 hours from decision to admit to admission. Latest data (July 2022) for proportion of patients who waited less than 4 hours from arrival in A&E to admission, transfer or discharge was 71.1% for C&M, against the 95% standard (NW 69.2% and England 71.0%).

- Focus currently on winter planning; Weekly C&M ICB Winter Planning Operational Meetings commence 07.09.2022, with initial C&M Places' Winter Assurance Framework drafts due submission 06.09.2022.

# Finance

The financial position to July, month 4 sees CMAST reporting a £44m deficit compared to a plan of £36m deficit with 8 organisations requiring improvement in their run rates to return to plan by the year end. To support early action to manage this before all attention shifts to the winter, a workshop will be scheduled led by Claire Wilson.

Work is going in the following areas:

- **Assurance** – regular CMAST and organisational level revenue, capital and cash reports including KPIs to drive transparency and target areas for attention.
- **Strategy** – developing a CMAST approach to specialised commissioning delegation as part of the ICB response.
- Establishing the Collaboration at scale priorities including prescribing, productivity, premium pay rates and corporate services and early discussions to resource this work to ensure delivery.
- **Governance** – establishing the ways of working and principles which organisations will work to, aligning to the MOU and including risk and reward share, how we collaborate and how we make investment decisions.

Other updates:
- Elements of the finance and workforce streams are brought together to leverage traction through the CFO/CPO networks.
- Data on workforce growth by Trust circulated to support understanding and identify options and issues. Continued links with Chair sponsor, Ian Haythornthwaite.

**REPORT TO TRUST BOARD**

| AGENDA REFERENCE: | **BM/22/09/113** | |
|---|---|---|
| **SUBJECT:** | **Chair's Briefing** | |
| **DATE OF MEETING:** | 28th September 2022 | |
| **AUTHOR(S):** | Steve McGuirk, Trust Chair | |
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>(*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):**<br><br>(*Please DELETE as appropriate*) | All | |
| **EXECUTIVE SUMMARY**<br>*(KEY ISSUES):* | This is the first occasion that the Chair has produced a written update/report for the Board. The body of the paper explains why it is considered important to do so now, but, essentially, it reflects not just the expansive range of pressing issues facing the Trust directly, but, more pertinently, the change in obligations and duties imposed on Foundation Trusts associated with the introduction of integrated care systems (ICSs). In particular, the governance complexity connected with the enactment of the Health and Social Care Act 2022 (July 2022).<br><br>It is felt important, consequently, for the Board (and wider audiences and stakeholders – including governors) to be more sighted on the activities of the Chair, as well as the wider engagement across the system that is undertaken on behalf of the Trust.<br><br>Consequently, the paper summarises the various meetings and engagement activity undertaken by the Chair in the reporting period since the previous board meeting.<br><br>The paper then outlines several key, strategic issues that the Board are asked to note, and to take into account within the management arrangements of the Trust; within the Board Assurance Framework (BAF) where appropriate; within the Board Assurance/ Governance arrangements and committees; and, where appropriate, within the wider system.<br><br>There is one other aspect for the Board to note that is encompassed within the paper. |

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| | For some time, it has been recognised that there is a clear flow of information from the Board of Directors to the Council of Governors (COG) to enable them to fulfil their assurance responsibilities, but there has not been a formal vehicle for a reciprocal flow of information in the other direction, i.e., from the COG to the Board.<br><br>Consideration has been given to reproducing COG Minutes for noting at the Board, but it is also considered that Board agenda are sizeable already, and there is a risk that insufficient attention would be given to matters that are of importance to governors. Thus, the move from a verbal Chair's report to a written report provides the opportunity for the Chair (who is also the Chair of the Council of Governors (COG)) to include a COG update. In this way, there is now a more formal and two-way communications channel, but, equally, there is proportionality in relation to minimising any necessary bureaucracy.<br><br>It is proposed that the Chair will produce a written report for all subsequent Board meetings. | | | |
|---|---|---|---|---|
| **PURPOSE:** *(please select as appropriate)* | Information<br>X | Approval | To note<br>X | Decision |
| **RECOMMENDATION:** | The Trust Board is asked:<br><br>i)      To note the meetings/engagement of the Chair over the reporting period (since the last Board meeting)<br>ii)      To make any comments or ask any questions arising from the report.<br>iii)      Note the intention to produce written reports going forward. | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED:** *(if relevant)* | Choose an item. | | | |

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| SUBJECT | Chair's Briefing | AGENDA REF: | BM/22/09/113 |
|---------|------------------|-------------|--------------|

## 1. BACKGROUND/CONTEXT

The Trust Chair is responsible for leading both the Board of Directors and the Council of Governors (COG) and is accountable to the COG for the performance of the Board, as well as ensuring the Board establishes the parameters of the Trust's culture, values, and behaviours.

It is the Chair's role to ensure that the Board of Directors and Council of Governors work effectively together, and, in support of this, the Chair oversees the operation of the Board of Directors, setting the agenda to ensure that the Board is dealing with the critical issues facing the Trust, and, alongside this, ensuring that the Board receives accurate and timely information.

Ultimately, while the Board of Directors is collectively responsible for agreeing the strategic direction of the organisation and for the success of the Foundation Trust, by directing and supervising its arrangements and affairs, it is the Chair who is the custodian of the Board of Directors' decision-making process. Additionally, the Chair is also the Trust's ambassador within the local community, as well as its representative at a regional and national level.

What has recently changed, however, has been the enactment of the Health and Social Care Act 2022.

This primary legislation provides the legal basis for the introduction of integrated care systems (ICSs). It also imposes new duties and obligations on trusts to collaborate, and to have regard to wider system needs and priorities together with local needs and priorities. In support of this fundamental change, the Act further introduces new, operational delivery structures – namely, *Integrated Care Boards*, *Integrated Care Partnerships*, *Provider Collaboratives* and *Place Partnerships* – and these significantly increase the demands and governance complexity of the roles of Board Directors – both from the Executive and Non-Executive Director (NED) point of view – as well as the role of the Trust Secretary. The new requirements also change the focus of consideration of governors, who are now obliged to have regard to the wider system needs and to assure themselves that the Board (via NEDs) are testing that the wider system responsibility is understood and being acted upon.

Consequently, the context of the long-standing responsibilities of the Chair - outlined above - to ensure that the Board is acting effectively, has been extended considerably to encompass this broader perspective.

In addition to the change outlined, it is also true to say that the Trust continues to grapple with the implications of Covid-19, Elective Recovery, unprecedented demand, major financial challenges, and significant workforce issues (amongst many other matters), that further add to the burden of complexity when seeking to ensure the Board operates effectively.

Accordingly, it is considered timely to introduce more detailed governance associated with the reporting of the activity of the Chair as part of providing stakeholders generally, but

governors in particular, assurance that the Chair is very active in their endeavour to address their full responsibilities.

This report, therefore, forms part of the custodian/ambassadorial role described and journals the activities of the Chair. In doing so, it should be noted that the activity described summarises only the 'formal' events/meetings and does not take account of the daily activity via email telephone, nor social media. Similarly, not does it take account of the more informal day-to-day interaction with Directors, Governors, Stakeholders and Partners.

In addition, the paper draws the attention of the Board to several strategic issues that are felt to be of importance to the Board's decision making, assurance and risk management processes.

It is proposed to continue to produce written reports going forward.

## 2.  MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

The period covered runs from 27th July to 28th September 2022

| DATE | ACTIVITY |
|------|----------|
| 28th July 2022 | New Hospital Strategic Oversight Meeting |
| 29th July 2022 | CMAST Leadership Board and Meeting in with local MP |
| 1st August 2022 | CMAST Provider Collaborative workshop (with several other NEDs) at Haydock Park Racecourse |
| 3rd August 2022 | Visit to Emergency Department |
| 5th August 2022 | Accompanying Clinical Leaders on leadership walkabout (sepsis theme); visited the Emergency Department. |
| 15th August 2022 | Pre-interview meetings with consultant candidates. |
| 16th August 2022 | Chair, Advisory Appointments Committee (AAC) – Emergency Medicine and Anaesthetic Consultants |
| 16th August 2022 | Chair, Complaints Assurance Group |
| 17th August 2022 | Chair, Extraordinary Trust Board Meeting |
| 18th August 2022 | Agenda setting for Charitable Funds Committee; Meeting with CMAST Workforce Programme Lead (CEO, Liverpool Women's Hospital) as CMAST Project Sponsor |
| 22nd August 2022 | Good Governance Institute (GGI) Interview (as part of 'Well-Led' Review) |

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|---|---|
| 23rd August 2022 | Combined NW System Leaders Meeting with NHSE NW Regional Director |
| 25th August 2022 | New Hospital Oversight Group Meeting; NHS Providers Governor Training Event |
| 29th August 2022 | Meeting Cllr Hussein re relationship between the Trust and Warrington's minority communities. Cllr Hussein is a Trustee of the Warrington Ethnic Communities Association (WECA)[1] |
| 30th August 2022 | Meeting with Warrington Place Director regarding Place Partnership development |
| 1st September 2022 | Chair, NED strategy workshop. Topics included ICB/ICS update and reflection and performance dashboard discussion. |
| 2nd September 2022 | CMAST Leadership Board; Clinical Leaders Walkabout (Nutrition theme) - visited Wards A1 and A2 |
| 8th September 2022 | New Hospital Strategic Oversight Group; Chair, Advisory Appointments Committee (AAC) – Urology consultant; Meet with Chair of the ICB |
| 9th - 10th September 2022 | Attendance at inaugural Asian Professionals Networks Association (APNA) at Warwick University |
| 12th September 2022 | Chair, Advisory Appointments Committee (AAC) – Gastroenterology consultant |
| 14th September 2022 | CMAST Chairs Meeting; Briefing Meeting regarding Electronic Patient Record System (EPR) procurement |
| 15th September 2022 | Council of Governors Briefing/Q&A |
| 20th September 2022 | Chair, Complaints Assurance Group (Surgical Specialities) |
| 21st September 2022 | Meeting with Halton Place Director regarding Place Partnership development |
| 22nd September 2022 | Chairing Charitable Funds Committee |
| 27th September 2022 | Combined NW System Leaders and Chairs Meeting; Workforce Programme Update (CMAST) Meeting with CEO Lead |
| | |

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[1] WECA's purpose is the promotion of the minority ethnic community voluntary sector in Warrington for the public benefit. In particular it seeks to act as a representative of the minority ethnic community voluntary sector in relation to statutory and non-statutory decision-making systems to adequately reflect the needs and wishes of ethnic community groups in Warrington.

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

By way of introduction, this is the Chair's first 'written' update to the Board having previously provided a verbal update. As indicated in the outline of activities above, we recently held a NED workshop to take stock of the way in which the more recently appointed NEDs have been integrated into the work of the Board, but also to reflect on the strategy going forward. It is apparent that there has been a sea-change in direction for the NHS with the introduction of ICSs and Place Partnerships and it is important that, as a Trust, we reflect on what that means to us. It is also important that we have clear lines of governance and accountability and, arising from this, it seems appropriate, now, to ensure that there is an audit trail of activity; hence, the decision to produce a written update.

It is not intended that this will replace or reproduce the CEO Update and so, inevitably, it will be focus on matters not readily covered elsewhere as well as what the Chair considers to be key, strategic issues the Board should be sighted on and again, not covered elsewhere on the Board agenda. Moreover, it is not intended to repeat NED updates that are covered in their key issues reports included as part of the main Board Agenda.

The first thing to note is that this last period has been seismic in the level of change that has occurred and that will have a major impact on all of us in the months and years ahead. Of course, we had the election and appointment of a new Prime Minister, as well as a new Secretary of State for Health in early September. But, within a couple of days of that happening, we were all then thrown into a state of shock at the tragic news of the passing of Her Majesty Queen Elizabeth II on Thursday 8th September. So much has been said about that in the aftermath of her death, and on the run-in to her funeral, that I do not propose to add any more commentary to the reflections and thoughts I outlined in the GMWHH note I provided on 12th September. As sad is it is, life must continue and there remain a huge number of pressing issues before us. Save to say I would just express the deepest sympathy of everyone at WHH to the Royal Family and wish our new King every success in the years to come.

The second most important thing to thing I would want to do, then, is to say thank you to all of our staff and partners who continue to work together in incredibly challenging times, and I include in this our Chief Executive and Executive Management Team. We have just been through the seventh wave of Covid; we face unprecedented demand; we are grappling with immensely challenging elective recovery targets; we face huge financial pressures – and Winter is just around the corner as is the next vaccination programme. We recently featured in a TV Documentary that illustrated much of this in a very stark way. The programme made for very tough viewing but what was assuring from a Board point of view was that all the patients spoken to were complimentary about the care and compassion they received

Thirdly, I would also like to make mention of the fact that this is the last formal meeting for two Board colleagues. This is Terry Atherton's last Board meeting. Terry has been an outstanding NED and has served the Board for over seven years now, having been the chair of FSC for that whole period, but also a member of several, other, governance committees. When we needed to establish a new oversight committee for recovery (CROC), it was difficult to think of anyone better to align quality, safety and cost and, here too, he has done an

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amazing job. He has been a great colleague and friend and we will all miss the value of his experience as well as his wise words of counsel, but we all wish him the best of luck in whatever he does next. Terry will be replaced by John Somers who I know is extremely grateful for the comprehensive handover he has received.

It is also Pat McClaren's last Board meeting. Pat has been our Director of Communications and Engagement for the last six years and has done us a great job not just from the point of view of her 'day job' but she has also thrown herself in to the development of our COG. We all wish Pat well in whatever she chooses to do next in her life. I know that she will continue to support the Trust.

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

### 3.1 CMAST Update

For the avoidance of doubt 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 ICS architecture.  In the spirit of sharing information related to the wider agenda, the latest CMAST briefing is attached to the Chief Executive's Briefing. Equally, in the spirit of not making comment for the sake of it, I do not propose to repeat that update in my report. The only comments I would add is to note the attendance of several NED colleagues at an ICB workshop at Haydock Racecourse recently, which was part of ensuring NEDs had a good appreciation of the nature of the change now expected. And, as touched upon earlier, a WHH NED workshop in which we similarly debated the nature of the change and will feed the thinking through for wider Board consideration as part of the strategy refresh timeline.

### 3.2 ICB Update

The Chair of the ICB, Raj Jain, was hosted for a visit to Warrington by the CEO (as mentioned in his report) and I also met Raj on a one-to-one basis for a discussion about the development of the ICB more generally, the workstreams of the CMAST Provider collaborative and the development of Place Partnerships (*Warrington Together* and *One Halton*).

### 3.3 Place Partnerships – *Warrington Together* and *One Halton*

I have now met with the recently appointed Place Directors for the two Place Partnerships by way of introduction (Carl Marsh and Anthony Leo). Both partnerships have essentially built on existing partnership structures to evolve them in to place partnerships. However, it is fair to say that they are still work in progress in relation to finalising exactly how the governance of the partnerships can be developed to encompass non-executive/elected member involvement and assurance, as well as the linkages to the respective health and well-being boards as well as the relationships to primary care/Primary Care Networks (PCNs). It is hoped that the Place Directors will be able to attend in future to provide updates to the Board and the CEO is in discussion with the relevant people to enable this.

### 3.4 Council of Governors

On a general point I would also like to thank our governors for the time and energy they expend on ensuring NEDs maintain a focus for the Board to fulfil its goals of patient safety and patient care. It is to governors' enormous credit that they give their time so generously, as they are a vital check and balance. They provide an important patient voice (for example, being part of our Patient Experience Committee) and they remind us of the importance of matters that might not, initially, appear 'strategic' in their locus, but which are critically important to the overall patient experience. Good examples of this include hospital food (nutrition), first impressions, transport arrangements (getting to the hospitals and getting around the hospitals), etc.

I would especially like to thank our Lead Governor, Norman Holding, who is a familiar figure both in the hospitals and at various Assurance and other committees, and who works tirelessly to ensure all our governors are involved. In recognition of the growing importance of the role, however, the COG has also now created a Deputy Lead Governor position and I am pleased to report that Keith Bland has been elected to this new role.

### 3.5 Observation Visits

By way of update, therefore, I am delighted to be able to record that, after more than two years, governors have now been able to restart their observation visits, the first of these being to the Emergency Department (ED), on 18th August 2022. It would be fair to say that while governors commented positively on the caring approach, professionalism, and attitude of the staff they encountered, there was an element of surprise at the difference in their experience pre-pandemic and their experience in a changed world.

Figure 1 below is a snapshot of the positive comments:

Staff observed and spoken to were calm, professional, and very knowledgeable
Staff were aware of key issues, service pressures, what is being done to alleviate this and their role in this
Very well led but not always obvious. Recent commissioning of the SDEC unit illustrates a calm, organised and well-planned facility.
Extremely strong leadership. Team building, cultural and professional development
Emma Painter, talked well about the Patient 'Experience' as a focus. Knew her stuff!!
SDEC unit much more relaxed vs overwhelmed ED. (Air conditioned too) striking differences between the two areas.
Staff ready for teatime surges of demand and since Covid, genuine complex conditions presented.
Staff spoken to stated that they are not treated as numbers and are part of a team, they felt valued and part of a WHH family
Unit has a Practice Elevator, in-house training days, Team building events held.
Senior management always available is needed

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Figure 2 on the other hand represents some of their less positive, but nonetheless honest observations:

| | |
|---|---|
| **FIRST IMPRESSIONS** | Based on your first impressions on entering this department, how confident are you that patients are experiencing good care?<br>Using your senses, what do you hear, see, smell and feel? Why?<br>What do you notice? Does that build confidence and trust? Does your experience or score change as you are in the department?<br><br>A&E (waiting room)<br>Very busy and noisy waiting area<br>Screen showing wait times not working – no idea of wait times.<br>Cluttered walls - overwhelming amount of patient information – very confusing<br>Organised chaos springs to mind.<br>Screen notifications not working<br>An overwhelmed department.<br>Patient lying on floor for 'comfort'. Beds in Corridor<br><br>SDEC<br>Cool, calm & peaceful, TV working in the spacious and almost empty waiting room<br>Well-equipped and comfortable treatment bays and rooms |

The Chief Nurse will be seeking to respond to governor observations – notwithstanding some observations are a genuine reflection of the difficulties that confront staff on a daily basis. The outcomes will be reported through the respective Assurance Committees.

### 3.6 The Council of Governors – August Meeting

The Council itself met on 11st August. It received observation reports from the relevant governors of their respective assurance committees, as well as constituency meeting updates, as well as the Chair's report and the Lead Governor's report (I was on annual leave and so the COG was chaired by the Vice Chair of the Trust). Governors also received a new Handbook (mentioned below) and raised questions about the Diabetes Service and the provision of catering in the area of the main entrance. In addition, they renewed the contract of the Trust's External Auditor, they accepted the Annual Report and Accounts update and agreed an Annual Members' Day and Annual Members' Meeting (30th November 2022). Finally, they noted the situation of the Trust with regard to Complaints; the latest Engagement Dashboard, the Bi- Annual Update to the Workforce Race Equality Standard (WRES); the report of compliance with the Trust provider Licence and their annual effectiveness survey.

Other matters relating to the COG that are worthy of note for the Board of Directors:

- A number of governors participated in a training day in August 2022 which was delivered by NHS Providers and part of preparing governors for the change in emphasis of their role and to think 'system'. Board colleagues should be aware that NHS Providers provide a lot of information for governors, the majority of which is channelled to the wider group by the Lead Governor who is very active in this respect.
- The Governor Engagement Group (GEG) have been working hard over the last few months to produce our first, *WHH Governor Handbook*. It has been important that this is in place in time for the elections this year (November) to be able to inform prospective governors about the nature of the role and the associated commitment.

- Other important work undertaken by GEG includes the organisation of governor constituency meetings, the production of a governor engagement toolkit, a 'task and finish patient letters' group; and a review of the Engagement Dashboard.
- In terms of elections, further to terms of office of coming to an end for some governors, there have also been several governor resignations for a variety of reasons. However, it means that there will be several new governors elected by the Trust membership by the end of the year. The nomination process to stand for election opened on 22nd September 2022 and will close at 17:00 hrs on 19th October 2022. Voting will then open on 8th November 2022 and close at 17:00 hrs on 28th November 2022.

And in terms of Trust membership – for many years we have had a database of members, but it is fair to say that it has had limitations in terms of being able to use for circulating important information/newsletters etc. We have therefore recently purchased a new member database that is currently being populated, and we will shortly publish our latest Newsletter in which we will seek to recruit more Trust members.

## 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.
iii)    Note the intention to produce written reports going forward.

**REPORT TO BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/22/09/114** | |
| **SUBJECT:** | **Board Assurance Framework** | |
| **DATE OF MEETING:** | 28th September 2022 | |
| **AUTHOR(S):** | John Culshaw, Trust Secretary | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Simon Constable, Chief Executive | |
| **LINK TO STRATEGIC OBJECTIVE:** <br><br> *(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. <br><br> Since the last meeting: <br> • No new risks have been added; <br> • The rating of one risk has been reduced <br> • The description of two risks on the BAF have been amended and there is a proposal to update one further risk; <br> • Two risks have been closed. <br><br> 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 22/07/178 |
| | **Date of meeting** | 05.07.2022 |
| | **Summary of Outcome** | Approved |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** *(if relevant)* | None | |

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**REPORT TO BOARD OF DIRECTORS**

| SUBJECT | Board Assurance Framework and Strategic Risk Register report | AGENDA REF: | BM/22/09/11 4 |
|---------|---------------------------------------------------------------|-------------|---------------|

## 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 no new risks have been added to the BAF

### 2.2 Amendment to Risk Ratings

Since the last meeting, the rating of one risk has been reduced.

Following review and approval at the Quality Assurance Committee on 6th September 2022, and as the Trust is not currently experiencing significant delays in transferring patients with time critical urgent care needs to specialist units; the rating of risk **#1579** (detailed below) was reduced from 16 to 12

| ID | Risk description | Rating (previous) | Rating (current) | Executive Lead |
|----|------------------|-------------------|------------------|----------------|
| 1579 | Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay | 16 | 12 | Dan Moore |

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## 2.3 Amendments to descriptions

Since the last meeting, the descriptions of two risks have been updated and it is proposed to amend the description of one further risk.

### Approved

Following review and approval at the Quality Assurance Committee on 6th September 2022, it was agreed to amend the description of two risks as described below to fit with the new risk wording template.

**1. Risk #1579**

**Previous:** *Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute*

*Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay*

**Current:** *If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm*

**2. Risk #1215**

As described below in section 2.4, it was agreed to close risk #1289 and update the description and content of risk #1215 to capture the risk, assurances, and gaps in risk #1289.

**Previous:** *If the Trust does not deliver the capacity required because of the ongoing COVID-19 pandemic then there may be delayed appointments, treatments, and potential patient harm*

**Current:** *If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing 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.*

### Proposed

**Risk #1134**

Following discussion at the Strategic People Committee on 21st September 2022 it is proposed to update the description of Risk #1134 to better reflect the current circumstances and risks associated with workforce.

**Current:** *If we see an increase in absence relating to COVID-19, then we may experience resource challenges and an increase within the temporary staffing domain.*

**Proposed:** *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*

## 2.4 De-escalation of Risks

Since the last meeting, two risks have been closed.

Following review and approval at the Quality Assurance Committee on 6th September 2022, it was agreed to close two risks as described below:

1. Previously risks #1289 and #1215 both related to concerns in respect of capacity. Following a review of these risks it was agreed to close **risk #1289** (detailed below) and update the description and content of risk #1215 as described in section 2.3 to capture the risk, assurances, and gaps in risk #1289.

| ID | Risk description | Rating | Executive Lead |
|---|---|---|---|
| 1289 | If the Trust does not have sufficient capacity (Theatres, Outpatients, Diagnostics), then we may be unable to deliver planned elective procedures, which may cause potential delays to treatment and possible subsequent risk of clinical harm and failure to achieve constitutional standards. | 20 | Dan Moore |

2. It was agreed to close **Risk #1233** (detailed below) with the opening of the Same Day Emergency Care Centre (SDEC) which cannot be bedded, the risk of assessment capacity previously provided in the Combined Assessment Unit (CAU) is resolved.

| ID | Risk description | Rating | Executive Lead |
|---|---|---|---|
| 1233 | If we bed the Combined Assessment Unit (CAU) then we will not have a suitable environment to review surgical patients in a timely manner resulting in a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base. | 16 | Paul Fitzsimmons |

## 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 |
|---|---|---|---|---|
| 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. | • Triage and testing on emergency admission using molecular and PCR testing; to pause for asymptomatic patients from 1/09/2022<br>• Environmental Safety Action plan in place reported by exception to Silver Infection Control; Silver Infection Control Group meeting paused from September 2022 | 20 | No impact on risk rating |

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| Risk ID | Strategic Risk | Update since last Risk review | Current Risk Rating | Impact of update on risk rating |
|---|---|---|---|---|
| | | • Process for assurance of 3 and 5 day swabs in place; to pause from 1/09/2022<br>• Surveillance of patient in bays for 7 days following Covid-19 exposure; early release plan from 1/09/2022 (5 days)<br>• Updated National Guidance in place from 1st September 2022 | | |
| 134 | If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken | <u>Assurances</u><br><br>• 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.<br>• TIF funding application to support recovery at Halton c£8m over 3 years and also £26.4m bid for a Community Diagnostics Centre (CDC) at Halton. CDC bid part of c£11m support provided the scanner is situated on the Halton site<br>• ICS executive peer to peer review June 2022, and September 2022. 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.<br>• Bid for additional bed capacity £2.4m supported by NHSE/E in August 2022; however, the Trust has requested that this is re-purposed to support B3 and Ready for Discharge Lounge<br>• Appointed GIRFT Clinical Lead to commence in August 2022 and a GIRFT Finance Lead to commence in October 2022<br><br><u>Gaps</u><br><br>• CIP of 15.7m . Of the £15.7m CIP target £14.4m has been identified (£1.3m unidentified), however £5.4m is high risk and the £3m income target to be | 20 | No impact on risk rating |

| Risk ID | Strategic Risk | Update since last Risk review | Current Risk Rating | Impact of update on risk rating |
|---------|----------------|------------------------------|---------------------|----------------------------------|
| | | identified. Therefore, the CIP risk at the end of month 5 is £9.7m | | |
| 1134 | If we see an increase in absence relating to COVID-19, then we may experience resource challenges and an increase within the temporary staffing domain. | • Overall absence rate was 6.25% for June 2022, 7.38% for July 2022, 5.54% for August 2022 and August 2021 absence rate was 6.28% against a target of 4.25%.<br>• 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.<br>• Full training sessions have been implemented with the offer communicated via informal and formal channels.<br>• In order to support accessible learning and development bitesize sessions continue to be offered via a hybrid format.<br>• Specific support continues within areas of high N&M sickness and low compliance RTW figures.<br>• 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.<br>• 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. The group workplan aims to focus attention in September on stress awareness. The group's membership has been reviewed along with the TOR and a work plan. The first meeting was held in August 2022 with a schedule | 20 | No impact on risk rating |

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| Risk ID | Strategic Risk | Update since last Risk review | Current Risk Rating | Impact of update on risk rating |
|---------|----------------|-------------------------------|---------------------|---------------------------------|
| | | populated for the remainder of the calendar year. | | |

Continuing from the table above, the Update column content:

- 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 is also plans to produce flipping book versions of the Supporting Attendance Policy once the interim policy review has taken place in September 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
- 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
- Updated and refreshed COVID Risk Assessment process has been implemented to align to the Living with COVID principles and the updated COVID vulnerabilities:
  - Blood cancer (Leukaemia or Lymphoma)
  - Weakened immune system due to treatment (such as steroid medication, biological therapy, chemotherapy or radiotherapy)
  - Organ or bone marrow transplant
  - A condition that means that individuals have a

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| Risk ID | Strategic Risk | Update since last Risk review | Current Risk Rating | Impact of update on risk rating |
|---|---|---|---|---|
| | | high risk of getting infections<br>○ Down's syndrome<br>○ Sickle Cell disease<br>○ Pregnancy<br>○ Chronic kidney disease<br>○ Severe liver disease<br>○ Certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease)<br>○ HIV or AIDs<br>○ A condition affecting the brain or nerves (such as Multiple Sclerosis, Motor Neurone Disease, Huntingdon's, Myasthenia Gravis) | | |
| 1372 | If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety | <u>Assurances</u><br><br>• 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<br>• 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<br>• Procurement relaunch to start November 2022<br>• Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs<br><br><u>Gaps</u><br><br>Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC | 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.

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# Board Assurance Framework

## Board Assurance Framework

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

| Risk ID | Executive Lead | Risk Description | Strategic Objective at Risk | Current Rating | Target Rating | Risk Appetite | Monitoring Committee |
|---|---|---|---|---|---|---|---|
| 224 | Daniel Moore | If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, 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. | 1 | 25 (5x5) | 8 (2x4) | TBC | Clinical Recovery Oversight Committee |
| 1215 | Daniel Moore | If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing 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. | 1 | 25 (5x5) | 6 (3x2) | TBC | Quality Assurance Committee |
| 1273 | Daniel Moore | If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. | 1 | 25 (5x5) | 5 (5x1) | 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 is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken | 3 | 20 (5x4) | 10 (5x2) | TBC | Finance & Sustainability Committee |
| 1134 | Michelle Cloney | If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. | 2 | 20 (4x5) | 8 (4x2) | TBC | Strategic People Committee |
| 1114 | Paul Fitzsimmons | FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR) RESULTING in a potentially reduced quality of care, data quality, a | 1 | 20 (5x4) | 8 (2x4) | TBC | Finance & Sustainability Committee |

# Board Assurance Framework

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|---|---|---|---|---|---|---|---|
| | | potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. | | | | | |
| 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 | 16 (4x4) | 12 (4x3) | TBC | Quality Assurance Committee |
| 1372 | Paul Fitzsimmons | If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety | 3 | 16 (4x4) | 8 (2x4) | TBC | Finance & Sustainability Committee |
| 125 | Daniel Moore | If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a rwduction 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 |
| 1579 | Daniel Moore | If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm | 1 | 12 (3x4) | 8 (2x4) | TBC | Quality Assurance Committee |

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

# 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 then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, 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. | | | **Initial:** | 16(4x4) |
| | | | | **Current:** | 25(5x5) |
| | | | | **Target:** | 8 (2 x 4) |
| **Assurance Details:** | •Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day<br>•Systemwide relationships including social care, community, mental health and CCGs<br>•Discharge Lounge/Patient Flow Team/Silver Command<br>•ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing<br>•Controller<br>•Private Ambulance Transport to complement patient providers out of hours<br>•FAU/Hub operational from June 2018 - Now operating 5 days per week.<br>•Discharge Lounge opened 26th November 2018<br>•Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance.<br>•System actions agreed supporting the Winter Plan<br>•Further development of Rapid Response to avoid admission<br>•Increase IMC provided by the system such as the opening of the Lilycross site<br>•Increase IMC at home<br>•Regular monitored at the Mid Mersey A&E Board<br>•Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.<br>•Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.<br>•The Trust participates at the system & regional UEC improvement meeting on each Wednesday<br>•Redeveloped ED 'at a glance' dashboard<br>•Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments<br>•Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza<br>•Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings<br>•Integrated discharge Team now in place<br>•Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients<br>•ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised.<br>•Respiratory Ambulatory Care Facility agreed by CCG<br>•Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved<br>•Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream<br>•Reinstated CAU 24/7<br>•Upgrade to Minor's resulting in Oxygen points in all cubicles<br>•Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3<br>•Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly.<br>•Monthly Focus on Flow weeks scheduled every month until July 2022<br>• Additional Senior Manager on call support a weekends<br>• Successful bid for c£618k to support urgent care pressure in H2<br>• Same Day Emergency Care Centre (SDEC) planned opening July 2022 | | | **25**<br>**16**  **16**<br>**8**<br><br>INITIAL  PREVIOUS  CURRENT  TARGET | |

# **Board Assurance Framework**

|  |  |  |
|---|---|---|
|  | • Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges.  This is creating necessary capacity to support wave 5.  This is in line with national guidance.<br>• w/c 3rd January 2022 Ward B4 at Halton converted  to provide additional G&A capacity  (additional 27 beds) and flow in ED<br>• To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme<br>• Senior Dr at Triage Function.<br>• Extended Minor Injuries and Minor Illness functions<br>• Plan being worked up to utilise what will be the be old CAU as an additional area to support urgent care and decompression of A&E<br>• Plans being progresses 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<br>• Phlebotomy business case approved (5th May) to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.<br>• Plans to co-locate ED Minors in the SDEC building to enhance patient pathways being worked up for Winter 2022/23<br>• Revenue bid submitted to the ICS to open additional urgent care capacity (CAU) over Q3/4 2022/23 |  |
| **Assurance Gaps:** | •Staffing pressure created as a direct result of COVID-19 Global pandemic.<br>•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 | 30/09/2022 |  |
| Ongoing Monitoring of the Emergency Access Standard | ED Insight report<br>daily SITREP report<br>National report and benchmarking outcome<br>UEC north dashboard<br>Robust ongoing monitoring | Ongoing monitoring of risk via daily report SITREP,<br>Daily Capacity and Demand report from 4* daily bed meetings.<br>Weekly PRG | Field-Delaney, Sheila | 30/09/2022 |  |

# 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) because of the ongoing 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. | | | **Initial:** | 25 (5x5) | |
| | | | | **Current:** | 25 (5x5) | |
| | | | | **Target:** | 6 (3x2) | |
| **Assurance Details:** | • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery<br>• Operational planning to be 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.<br>• 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<br>• The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance.<br>• Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care.<br>• In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted.<br>• Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics.<br>• Workforce is continually reviewed to ensure that all wards and teams are staffed safely.<br>• Reconfiguration of Paediatric ED completed and operational<br>• Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.<br>• All elective patients have been clinically reviewed and categorised in line with national guidance.<br>• The Halton site is being developed as a covid secure site and will be run as an Elective Centre.<br>• Capacity identified and being utilised at spire Healthcare<br>• Clinical Services Oversight Group (CSOG) established<br>• Clinical Recovery Oversight Committee (CROC) established<br>• 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 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway.<br>• New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.<br>• Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely.<br>• Weekly theatre scheduling to ensure listing of patients in line with national guidance.<br>• Post Anaesthetic Care Unit (PACU) operational from January 2021<br>• Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists.<br>• Working in collaboration with system partners to increase adult social care capacity for pathway 1 & 2 categories of patients. This will in turn create additional capacity for managing the pandemic, restoration & recovery in Q3 2022/23<br>• New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery.<br>• Waiting lists monitored and measured weekly<br>• Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients | | | | | |

Rating chart:
25 (INITIAL) — 25 (CURRENT) — 6 (TARGET)

# Board Assurance Framework

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|---|---|---|
|  | • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks<br>• Continue to ensure urgent cancers are prioritised in line with national guidance<br>• 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.<br>• Bioquell Pods in ED live and operational<br>• Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.<br>• Safe staffing levels reviewed daily.  If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.<br>• The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint.  At present this supports cancer and other green pathways on the Warrington site<br>• Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.<br>• 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<br>• Additional ultrasound contract awarded to start in January 2022<br>• Successful bid of c£3m to support elective recovery in H2<br>• All priority/urgent cancer P1 and P2 elective plans have been maintained<br>• Elective activity moved to CSTM Halton facility to protect elective programme<br>• 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<br>• Increase in Trust WLI rate extended until 31.05.2022 to support restoration and recovery.  Business Case to support the increase in to 2023/24 approved by the Trust Board in June 2022<br>• Additional echo activity as per the H2 elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week.<br>• New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery.<br>• Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients<br>• Same Day Emergency Care Centre (SDEC) opened in August 2022 |  |
| **Assurance Gaps:** | Expansion of the emergency department is required to ensure any increase in demand can be accommodated in line with RCEM guidance<br>Referrals do not include adequate information to triage and prioritise patients appropriately<br>• Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems<br>Capacity challenge with social workers to keep on top of demand and necessary patient assessments.<br>Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility.<br>• This is being progressed with the support of the estates and capital planning team.<br>Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021<br>Limited bed base within A5 elective footprint<br>Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op |  |

| 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 |  |
| Build Urinary Investigation Unit & Paediatric Outpatients (one footprint) | Complete building works | Complete Building work | Val Doyle | 31/08/2022 |  |

# Board Assurance Framework

| Risk ID: | 1273 | 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 we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. | | **Initial:** | 25 (5x5) |
| | | | | **Current:** | 25 (5x5) |
| | | | | **Target:** | 5 (5x1) |
| **Assurance Details:** | Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. | | | | |

Assurance Details (continued):

Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19.

Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows

Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning.

The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays.

'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3.

Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity.

New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed.

Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges.

Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly.

Monthly Focus on Flow weeks scheduled every month until July 2022

Daily bed meetings organised by the Director of Operations & Performance to provide timely and effective benefits to patient flow

Approval of IMC business case which will support a reduction in frailty length of stay and admission avoidance through geriatric input in to the Emergency Department.

500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients

Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance.

w/c 10th January 2022, the Trust is supporting system designation of the Lilycross facility as being able to receive COVID positive patients. This is supporting wave 5 bed capacity.

Working closely with Warrington Borough Council on a short, medium and long term solution to community bed capacity, matching demand to capacity.

An increase in capacity in the community and a decrease in community prevalence and transmission has resulted in almost all the Care Homes in Warrington & Halton to be open. This has seen a decrease in the number of super stranded patients form a peak of 170 to 115 (03.03.22)

Revenue investment to be proposed to increase the Hospital Discharge Team . This would increase the number of discharges and reduced length of stay.

Working with system partners to double the amount of intermediate care at home capacity by Quarter 3 2022/23

System-wide agreement to invest in Dom Care ICHAT & Discharge Team recruitment now underway and set to complete in Q4 2023

Funding agreed by Warrington Borough Council to keep Lilycross open for 2022/23

**Rating chart:**

25 — INITIAL
25 — CURRENT
5 — TARGET

# Board Assurance Framework

| | Trust Executive approval to keep Ward B3 open for 2022/23 | |
|---|---|---|
| **Assurance Gaps:** | Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. <br> Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. <br> Access to community capacity impacted by Covid-19 as a result of staff sickness <br> Internal staff shortages to help support discharge planning.  Restricted as a result of Covid-19 sickness and self-isolation <br> High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity <br> Significantly reduced capacity in the domiciliary care market due to the high number of vacancies.  This is causing package of care delays. | |

| 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: | 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:** | | 20 (4x5) |
| | | | | **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

**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

Rating chart — INITIAL: 25, CURRENT: 20, TARGET: 5

# Board Assurance Framework

| | |
|---|---|
| | 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 | 30/09/2022 | |
| Review findings of site-wide ventilation survey to assess compliance with HTM. | Reviewed within the Ventilation Group which reports to Health & Safety Sub-Committee | Develop action plan to address non-compliance with HTM ventilation standards | Wright, Ian | 30/09/2022 | |

# 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 is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken | | **Initial:** | 20 (5x4) |
| | | | | **Current:** | 20 (5x4) |
| | | | | **Target:** | 10 (5x2) |

| **Assurance Details:** | •Core financial policies controls in place across the Trust <br> •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning <br> •Weekly review at extended Executive team meeting <br> • Achieved Break Even in 2021/22 <br> • Delivered 2021/22 Capital Plan <br> • Unqualified audit opinion (2021/22) <br> • Workshop undertaken with - Exec, CBU, Corporate to review 2022/23 cost pressures <br> • Workshops undertaken 2022/2023 budget setting <br> • Completed MIAA Governance Checklist received by Audit Committee <br> • Capital Plan 2022/23 approved by Trust Board on 30th March 2022 <br> • 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. <br> • Procurement/tender waiver training in place <br> • 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. <br> • 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 <br> • TIF funding application to support recovery at Halton c£8m over 3 years and also £26.4m bid for a Community Diagnostics Centre (CDC) at Halton. CDC bid part of c£11m support provided th scanner is situated on the Halton site <br> • Latest guidance from MIAA Counter Fraud Team circulated <br> • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. <br> • Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced. <br> • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 <br> • ICS executive peer to peer review June 2022, and September 2022. 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. <br> • Bid for additional bed capacity £2.4m supported by NHSE/E in August 2022; however, the Trust has requested that this is re-purposed to support B3 and Ready for Discharge Lounge <br> • Appointed GIRFT Clinical Lead to commence in August 2022 and a GIRFT Finance Lead to commence in October 2022 |  |
|---|---|---|
| **Assurance Gaps:** | • CIP of 15.7m . Of the £15.7m CIP target £14.4m has been identified (£1.3m unidentified), however £5.4m is high risk and the £3m income target to be identified. Therefore the CIP risk at the end of month 5 is £9.7m <br> Of the £14.4m identified £12.2m is non recurrent (85%) <br> • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. <br> • Requirement for £3m additional income and delivery of activity plan to achieve c £8m ERF. <br> • No external funding support for Halton Healthy New Town or Warrington Hospital new build. <br> • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) <br> • Risk of unforeseen costs due to further COVID-19 surge <br> • Availability of social care to support the current super stranded position (currently c25% of bed base) | |

# Board Assurance Framework

| | |
|---|---|
| | • Current financial plan shows deficit of £6.1m, which is the control total set by the ICS<br>• Operational activity plan not currently being delivered; therefore, placing ERF at risk |

| 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 | |
| All Trusts asked to undertake review of the HFMA Improving NHS financial sustainability checklist | Complete the review self assessment completing the 72 question adding a score and evidence or improvement actions with timescales | Complete the review and arrange MIAA review by the 30/11/22 | Forkgen, Alice | 30.11.2022 | |

# Board Assurance Framework

| Risk ID: | 1134 | Executive Lead: | Cloney, Michelle |
|---|---|---|---|
| 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 see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. | |

| Rating | |
|---|---|
| Initial: | 20 (4x5) |
| Current: | 20 (4x5) |
| Target: | 8 (4x2) |

**Assurance Details:**

- 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.
- Overall absence rate was 6.25% for June 2022, 7.38% for July 2022, 5.54% for August 2022 and August 2021 absence rate was 6.28% against a target of 4.25%.
- New Supporting Attendance Policy has been live since February 2022.
- 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 N&M sickness and low compliance RTW 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. The group workplan aims to focus attention in September on stress awarenessThe groups membership has been reviewed along with the TOR and a work plan. The first meeting was held in August 2022 with a schedule populated for the remainder of the calendar year.
- 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 is also plans to produce a flipping book versions of the Supporting Attendance Policy once the interim policy review has taken place in September 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
- Reliance on bank and agency staff increased to 15.44% in August 2022 compared to a peak of 23.3% in Jan 2021, or 14.72% in May-22.
- The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust received national recognition from NHS Employers, for our Check In Conversation and local recognition for our Health and Wellbeing Hub.
- 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
- Rugby League Cares have been supporting WHH since July 2021, providing a range of physical and mental fitness offers to our workforce.

# Board Assurance Framework

| | |
|---|---|
| | • Grief and Menopause cafes continue to be delivered to offer guided support sessions both virtually and face to face<br>• Updated and refreshed  COVID Risk Assessment process has been implemented to align to the Living with COVID principles and the updated COVID vulnerabilities:<br>  o Blood cancer (Leukaemia or Lymphoma)<br>  o Weakened immune system due to treatment (such as steroid medication, biological therapy, chemotherapy or radiotherapy)<br>  o Organ or bone marrow transplant<br>  o A condition that means that individuals have a high risk of getting infections<br>  o Down's syndrome<br>  o Sickle Cell disease<br>  o Pregnancy<br>  o Chronic kidney disease<br>  o Severe liver disease<br>  o Certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease)<br>  o HIV or AIDs<br>  o A condition affecting the brain or nerves (such as Multiple Sclerosis, Motor Neurone Disease, Huntingdon's, Myasthenia Gravis)<br>• Only staff who are both vulnerable to COVID and working with Aerosol Generated Procedures, are required to consider reasonable adjustments, all other staff can return to their full duties, within their substantive role. | |
| **Assurance Gaps:** | • Continued lack of national/regional clarity of the management of long Covid in the context of the national agreement.<br>• Administrative & Clerical are experiencing 0.8% absence rate related to COVID-19 in Jun-22<br>• Estates & Ancillary staff are experiencing over 1% absence rate related to COVID-19 in Jun-22<br>• Additional Clinical Services are experiencing 2.4% absence rate related to COVID-19 in Jun-22<br>• Nursing & Midwifery staff experiencing 1.8% absence rate related to COVID-19 in Jun-22<br><br>This impacts requirements for temporary staffing. | |

| Recommendation | | | | | Completion Date |
|---|---|---|---|---|---|
| In line with "Living with COVID-19" and absences relating to COVID-19 is 1.2% of all absence, recommendation is to review this risk with a review to reducing the risk. | Undertake a full review of People Directorate risks. | • Review  People Directorate risks Undertake analysis of workforce data to understand any trends | Dwerryhouse, Jennie | 31/10/2022 | |

# Board Assurance Framework

| | 1114 | **Executive Lead:** | Fitzsimmons, Paul | | |
|---|---|---|---|---|---|
| **Strategic Objective:** | Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience. | | | | |
| **Risk Description:** | FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.. | | | **Initial:** | 20 (5x4) |
| | | | | **Current:** | 20 (5x4) |
| | | | | **Target:** | 8 (2x4) |

| **Assurance Details:** | **Assurance:** |
|---|---|
| | <ul><li>Risks for Cyber on risk register in line of national requirements of the DSPT & NHS Digital</li><li>**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).</li><li>**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.</li><li>**Trust benchmarking** activities including Use of Resources reviews (Model Hospital).</li><li>ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.</li><li>Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021)</li><li>Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital (December 21)</li><li>WHHT return for assurance re cyber security to NHS England (March 22)</li><li>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.</li></ul><br>**Controls:**<ul><li>**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.</li><li>Active membership of the **Sustainability Transformation Partnership Cyber Group.**</li><li>**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.</li><li>**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.</li><li>**Cyber Training** for the Trust Exec Board</li><li>The use of automatic patching software to rollout security updates to devices.</li><li>Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links.</li><li>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).</li></ul> |

Chart data points: 20, 16, 20, 8

INITIAL  PREVIOUS  CURRENT  TARGET

# Board Assurance Framework

|  |  |  |
|---|---|---|
|  | • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated)<br>• Secondary secure backup at Halton Data Centre<br>• Remote devices no longer bypassing the web proxy<br>• Active Directory password set to expire again (covid working from home-related).<br>• Fully recruit to the Digital Service restructure Phase 1 restructure<br>• Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness. |  |
| **Assurance Gaps:** | **Gaps In Assurance:**<br>• 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)<br>**Gaps In Controls:**<br>• No real-time early warning of zero-day attacks due to the lack of network pattern matching software.<br>• Current performance of Lorenzo and whether migration to the cloud will provide any benefit.<br>• Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic.<br>• Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need).<br>• Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.)<br>• No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls<br>• Using generic logins staff usernames and passwords are stored in browser when selecting "remember me"<br>• No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21)<br>• Using no longer supported Exchange 2010 email system for mail archive<br>• Using SharePoint 2010 for the Hub<br>• Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21)<br>• Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security)..<br>• No controls in place for Bluetooth connectivity.<br>• No agreed patching schedule for network equipment with the Trust.<br>• Temporarily Uninstalled Mcafee on PACS servers for 1 week (10/03/22)<br>• The extension of the mainstream support for SQL Server 2012 will end on 12 July 2022<br>• Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS |  |

| Recommendation |  |  |  |  | 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.<br><br>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.<br>• Migrate the servers to Windows Server 2016<br>• Extend Support for Windows Server 2008 until Feb 2022<br><br>NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22.<br><br>[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).<br><br>[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.] | | | |
| Turn on device firewalls, to help limit a spread of an infected device infected other devices on the internal network | Turn on local device firewalls | Prioritise workload to look at turning on personal firewalls<br>Create a test group<br>Phase turn on / turn on<br><br>[Meeting set up for 03/09/21] | Deacon,  Stephen | 31/01/2023 | |
| Cisco Phase 2 upgrade to replace aging network equipment | Approve the business case<br>Complete mini tender<br>Place orders in advance<br>Delivery of equipment<br>Install and configure equipment | New equipment has been installed and used. | Waterfield,  Tracie | 31/03/2023 | |
| Enable Anti-Virus on PACS Cluster Nodes | Enable Anti-Virus on PACS Cluster Nodes | Work with Phillips on getting a working anti-virus on the PACS Cluster Nodes | Waterfield,  Tracie | 31/08/2022 | |
| 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 | 31/08/2022 | |
| 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.<br><br>We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system. | Migrate/decommsion Server 2012 servers | • Engage with the CBU's/Departments regarding migration and potential costs and plan migration.<br>• Migrate the servers to the latest Windows Server operating system or decommission them. | Waterfield,  Tracie | 31/10/2023 | |

# 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: | 16 (4x4) | |
| | | | | Target: | 12 (4x3) | |

| Assurance Details: | • Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas.<br>• Redeployment of staff (consideration of skill mix) and review allocation of NHS Professional pool staff as part of the agreed escalation process. Shifts added to the system, communications sent to all NHS Professional staff to fill shifts.<br>• If required Executive authorisation for off framework agency usage – Greenstaff or Thornbury.<br>• Staffing numbers, skill mix and moves are stored in 'gold command' file for assurance of clinical decision making.<br>• Site Manager and Matron on site until 8pm (Warrington and Halton site). On weekends this is a full day shift.<br>• Rolling recruitment for RN and HCA posts. 2- 4 weekly interviews.<br>• Part of National Recruitment Programme and Care Support Worker Development Programme for HCAs.<br>• Workforce Group in place for monitoring and assurance.<br>• Retention – Transfer policy in place for staff.<br>• Workforce plan/ strategy under review. |
|---|---|

Rating chart: INITIAL 20, PREVIOUS 25, PREVIOUS 20, CURRENT 16, TARGET 12

| 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, CAU and Cath lab).<br>• Increased staffing pressures anticipated due to winter surge.<br>• Time to post when recruiting new staff. |
|---|---|

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities. | Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans. | Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include:<br>• Domestic and international nursing recruitment<br>• Position and plans for staff retention.<br>• Planning for the future – succession planning and staff development.<br>• 6/12 establishment reviews.<br>• Triangulation of staffing position alongside patient safety measures. | Kennah, Ali | 30/09/2022 | |

# 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:<br>• A revised OBC is being progressed for August 2022 Trust Board approval in line with emerging guidance on managed convergence.<br>• Trust Board approved ceasing procurement process a relaunch complying with Managed Convergence is being planned to start November 2022<br>• EPR Project Board (and escalation/assurance through Digital and Trust Boards)<br>• Regular, documented conference calls with the ICS NHSE and NHSD – external partners supportive of managed convergence relaunch.<br>Controls:<br>• 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<br>• Trust financial modelling includes 3-year Lorenzo costs<br>• 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<br>• Procurement relaunch to start November 2022<br>• Senior Programme Manager assigned.<br>• Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs<br>• Identification of further realistic cash releasing benefits | Rating graph: INITIAL 12, CURRENT 16, TARGET 8 |
|---|---|---|
| Assurance Gaps: | Gaps In Assurance:<br>• Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC<br>• ICS strategic approach to delivering managed convergence remains unclear<br>Gaps In Controls:<br>• Lorenzo is at end of life and is unlikely to see significant future development or enhancements | |

| 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 | 30/09/2022 | |

# 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 rwduction 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 |

Rating chart:
20 16 15 4
INITIAL PREVIOUS CURRENT TARGET

| **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 Warringotn Hospital. An improvement plan in place to progress | Complete upgrade of kitchen facilities | Ian Wright | 31/12/2022 | |
| 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 | Ian Wright | 31/03/2023 | |

# Board Assurance Framework

| | | | | | |
|---|---|---|---|---|---|
| | | and in turn improve compliance against recommended guidelines and internal KPIs | | | |
| Complete premises Assurance Model for 22/23 | Complete and submit PAMS to NHSEEI | Identify gaps and workplan for 22/23 compliance improvement plan | Ian Wright | 31/10/2022 | |

# 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 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 programme and proceed with OBC development.

- Regular Strategy updates are provided to the Council of Governors & Trust Board
- Clinical strategies at Specialty level are in the processess of being refreshed
- Breast Centre of Excellence opened. Bid for targetting investment fund (TIF) to further develop the elective offer at Halton has been prioritised by Cheshire & Merseyside
- 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.
- Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. 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
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.
- 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.
- 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. Submission to Government due in August 2022
- Strategy refresh completed and approved at Trust Board to confirm 2022/23 priorities.

**Rating chart:** INITIAL 20, PREVIOUS 15, CURRENT 12, TARGET 8

# Board Assurance Framework

| | |
|---|---|
| | - 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.<br>- The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers.<br>- The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations.  It is one of only two organisations in Cheshire & Merseyside to receive the award.<br>- £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.<br>- WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution.  Initial work recognised as the exemplary within Cheshire & Merseyside.<br>- Consistent Trust representation within Cheshire & Merseyside ICS to support transition to 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.<br>- 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.<br>- Discussions with neighbouring Trusts to accelerate collaboration taking place<br>- 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<br>Self assessments of both Warrington & Halton hospitals 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 | 30/09/2022 | 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 | |

# Board Assurance Framework

| Risk ID: | 1579 | Executive Lead: | Daniel 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 North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm | | | Initial: | 16 (4 x 4) | |
| | | | | Current: | 12 (3 x 4) | |
| | | | | Target: | 8 (2 x 4) | |

| Assurance Details: | • LHCH PPCI pathways have been adjusted to give guidance for patients not being transferred for more than 120 minutes.<br>• UEC are following the escalation process to the ROC/NWAS Control room to discuss patients transfer needs on an individual basis.<br>• All SMOCs and Silver Command are aware of the escalation process.<br>• With regards to trauma issues, UEC have raised this at the regional network meeting. For assurance a high level paper is presented to Trust Wide Trauma Group and Patient Safety and Clinical Effectiveness Sub Committee.<br>• Trust continues to perform well against the ambulance handover times thus supporting the ambulance service<br>• Implementation of a new handover escalation process in times of high demand went live in April 2022 with support from AQuA |
|---|---|

Chart:
- 16 INITIAL
- 12 CURRENT
- 8 TARGET

| Assurance Gaps: | NWAS assess there response times based upon current active and waiting calls when there regional activity is high. However, there is still significant delays. |
|---|---|

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Implement new escalated ambulance handover process | Work with NWAS to support the development of a regional escalated handover process. | Implement new escalated ambulance handover process | Sharon Kilkenny | 30.04.2022 | 05.04.2022 |

**Report to the Board of Directors**

| AGENDA REFERENCE: | BM/22/09/115 | |
|---|---|---|
| **SUBJECT:** | **COVID-19 Situation Report** | |
| **DATE OF MEETING:** | 28th September 2022 | |
| **AUTHOR(S):** | Phil Ainscough, Business & Performance Manager<br>Kerry Benjamin, Business & Performance Manager<br>Jessica Phillips, Senior Business Planning Manager | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Simon Constable, Chief Executive | |
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>*(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)* | **#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<br>**#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.<br>**#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 robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where available. This report is part of the continuing development and understanding of demand, capacity and outcomes and will determine future strategic planning. Data up to 21st September 2022 is included. | |

| **PURPOSE:** *(please select as appropriate)* | Information | Approval | To note<br>X | Decision |
|---|---|---|---|---|

| **RECOMMENDATION:** | The Trust Board is asked to:<br>1. Note the contents of this report. | |
|---|---|---|
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Choose an item. |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |

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**REPORT TO THE BOARD OF DIRECTORS**

| SUBJECT | COVID-19 Situation Report | AGENDA REF: | |
|---------|---------------------------|-------------|--|

## 1. BACKGROUND/CONTEXT

The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where available. This report is part of the continuing development and understanding of demand, capacity and outcomes and will determine future strategic planning. Data up to 21st September 2022 is included.

## 2. KEY ELEMENTS

**2.1 Number of Reported Cases**



Number of COVID 19 Cases - England

## Number of COVID 19 Cases - Warrington and Halton



## Number of COVID 19 Cases - North West and Cheshire & Mersey
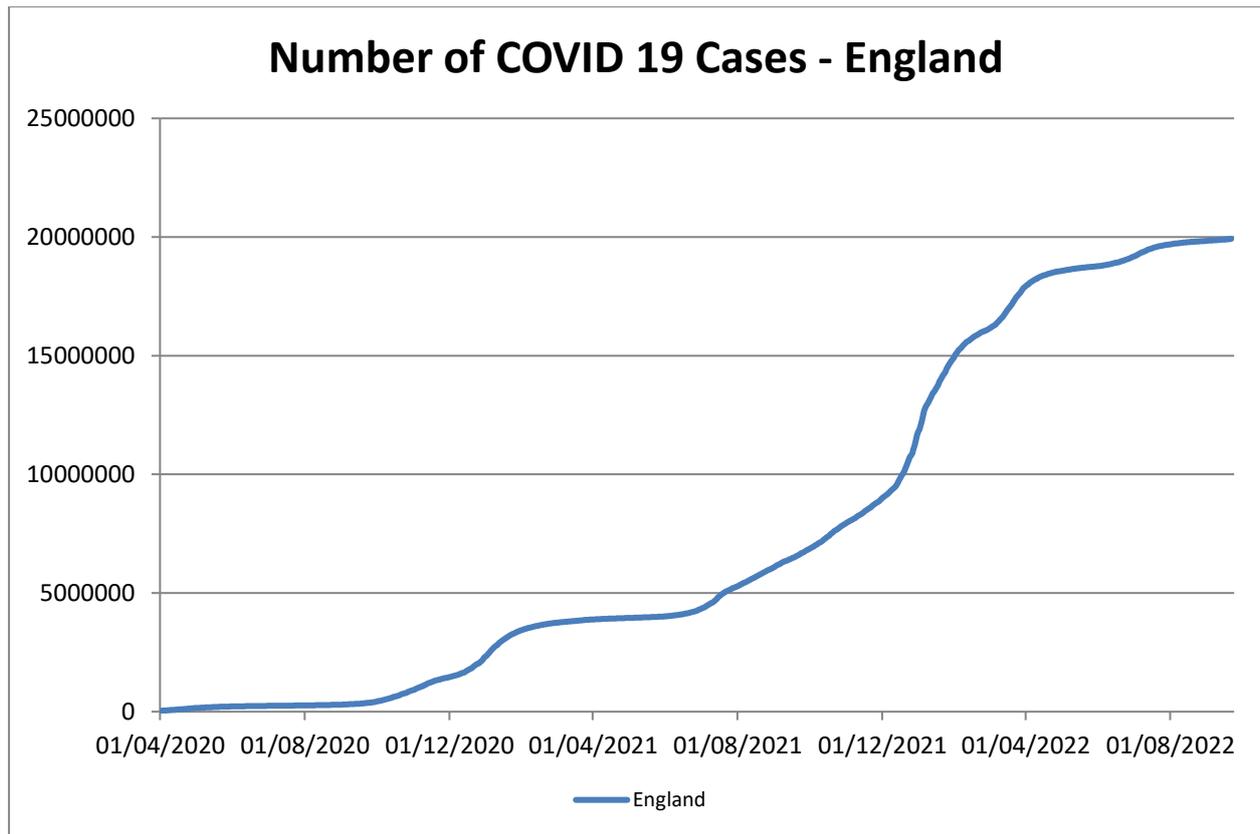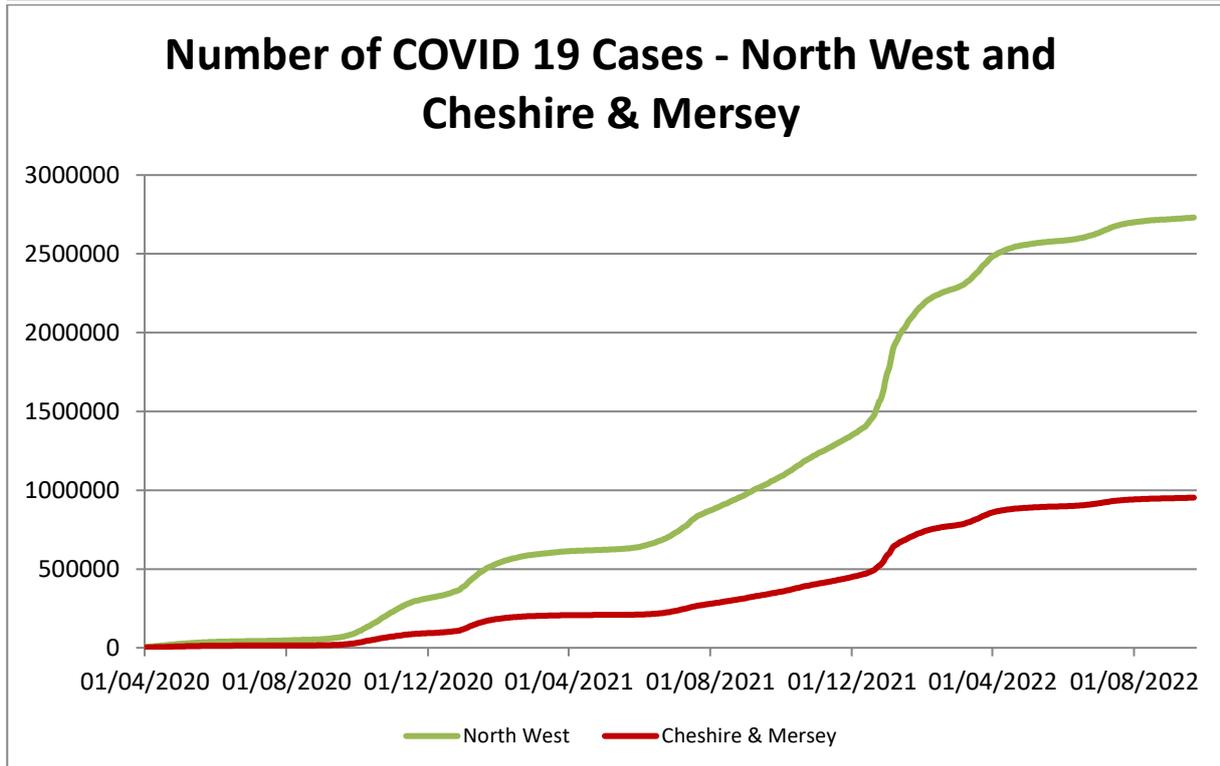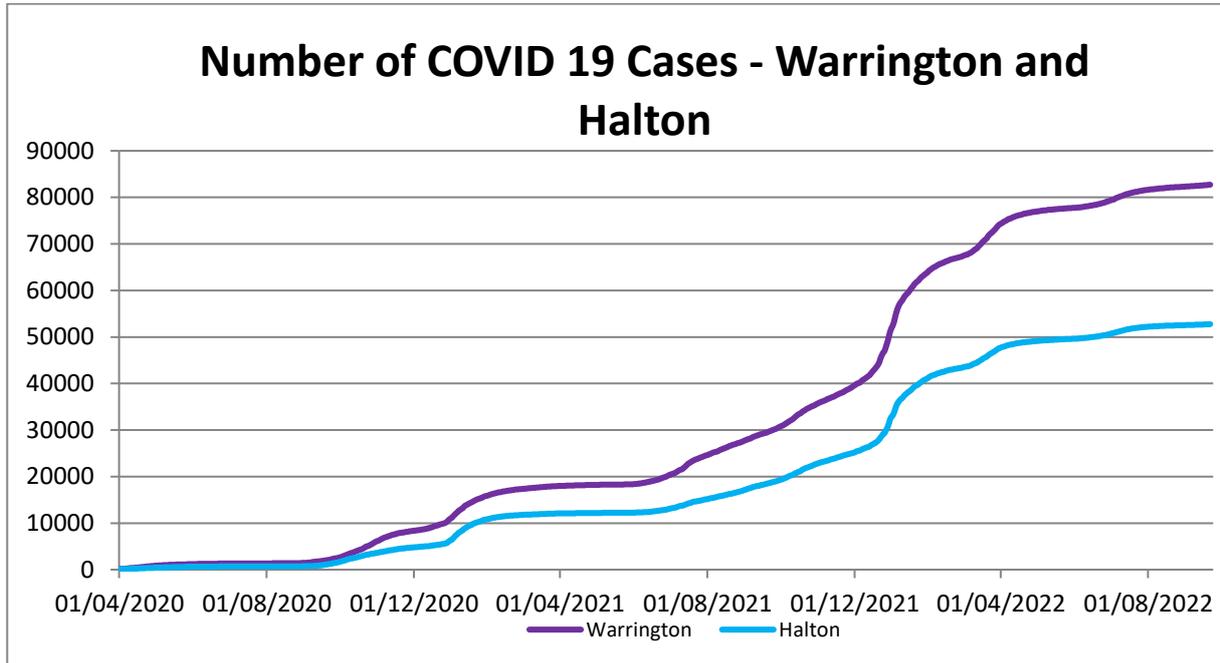


**Narrative:** As of 21/09/2022, there were 82,714 cases of confirmed COVID-19 reported in Warrington and 52,756 cases reported in Halton. The Trend is in line with the England, Cheshire & Mersey and the North West positions.

**Source:** https://coronavirus.data.gov.uk/

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to make a difference

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

**2.2 Infection Rates in the Community (per 100k population – Rolling 7 days)**

**Number of COVID 19 Cases - Cheshire & Mersey (Rolling 7 Days)**



**Number of COVID 19 Cases - Cheshire & Mersey (Rate per 100k population - Rolling 7 days)**
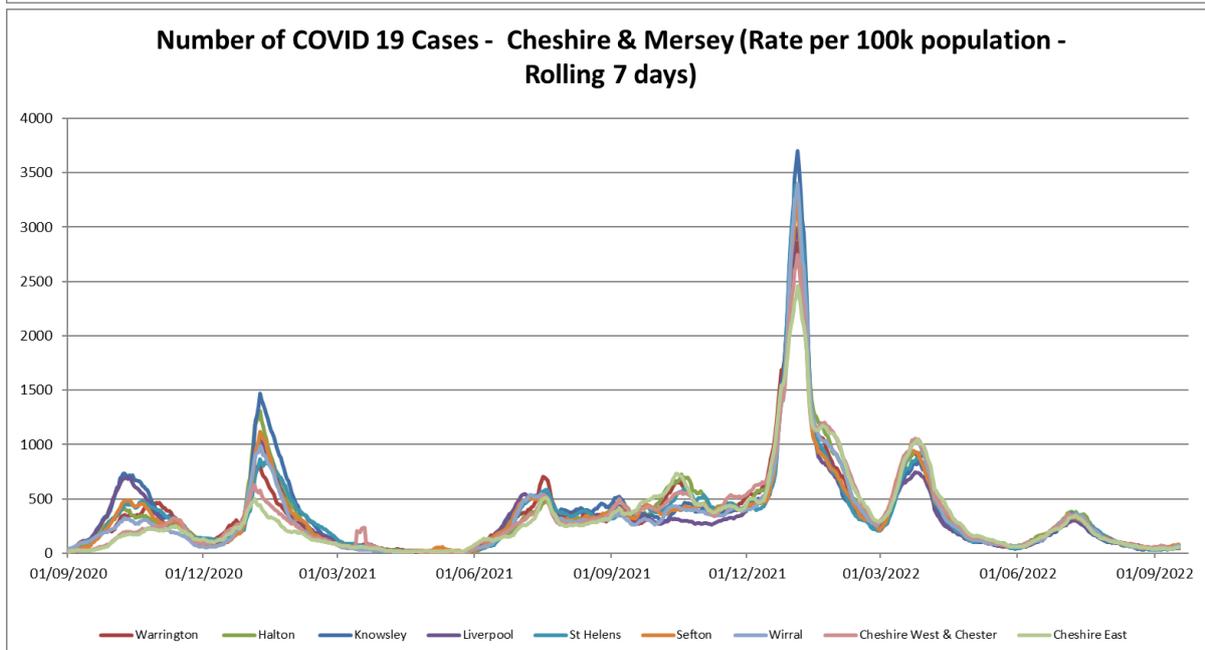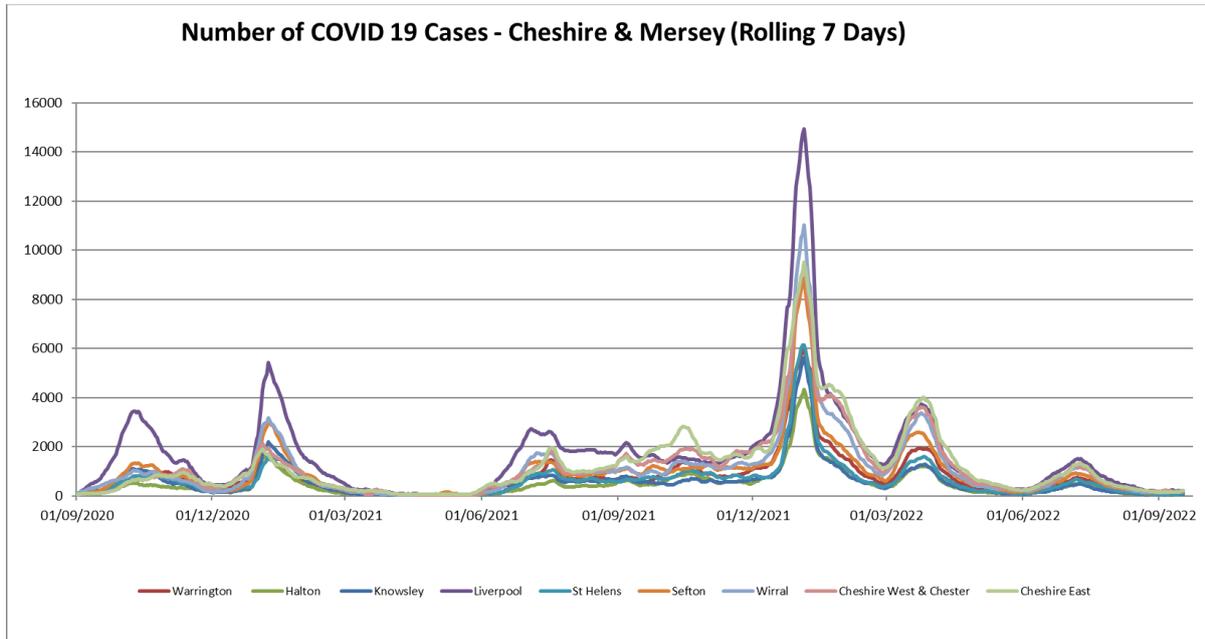


**Narrative:** The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a more accurate comparison than total number of cases due to the differences in population. The data shows the latest "Omicron" peak came in early January 2022 with the highest number of infections than at any other point of the pandemic. As at 17/09/2022, (the latest data period for this indicator) Warrington had 66 cases per 100k population and Halton had 59 cases per 100k population which is higher than the North West position (47 cases/100k population) and the England position (50 cases/100k population).

**Source:** https://coronavirus.data.gov.uk/

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**2.3 Number of People in Hospital**



Number of People in Hospital (England & North West England)



Number of People in Hospital (Warrington & Halton)
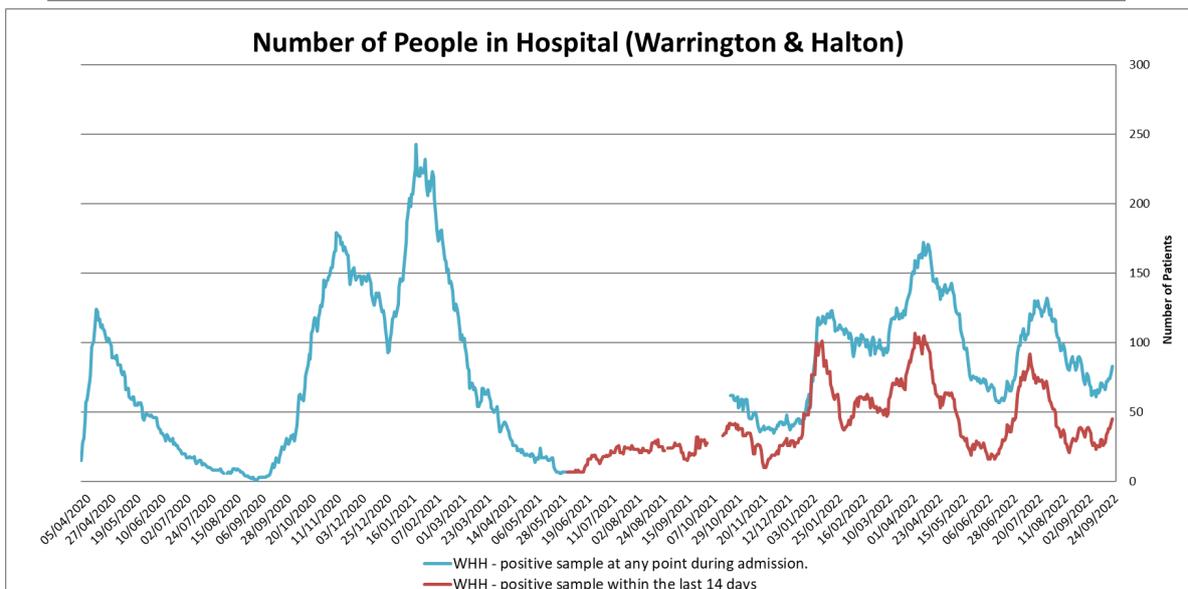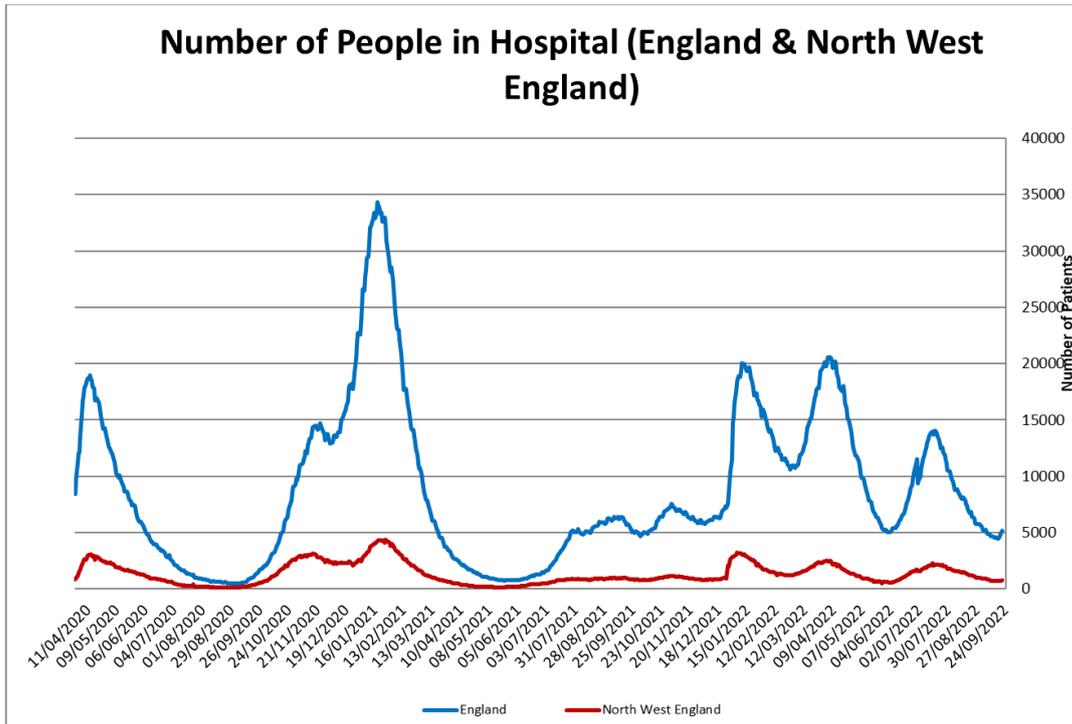
**Narrative:** As 21/09/2022, there were 45 inpatients being treated by the Trust with confirmed COVID-19 (with a positive COVID-19 sample within the last 14 days) and 83 patients (with a positive COVID-19 test at any point during admission).

**Source:** https://www.gov.uk/government/collections/slides-and-datasets-to-accompany-coronavirus-press-conferences (England & North West) and Trust Data (Warrington & Halton).

**Please note:** For Wave 1, 2 and 3 up to 31st May 2021, the data included patients with a positive COVID-19 sample at any point during their inpatient episode. For Wave 4 from 1st June 2021, the

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data includes patients with a positive COVID-19 sample during the last 14 days, in line with national guidance.

## 2.4 Number of Patients Requiring Critical Care

**Number of Patients - Requiring Critical Care (WHH)**



WHH Critical Care - Positive sample at anytime during the admission
WHH Critical Care - Postive sample within the last 14 days
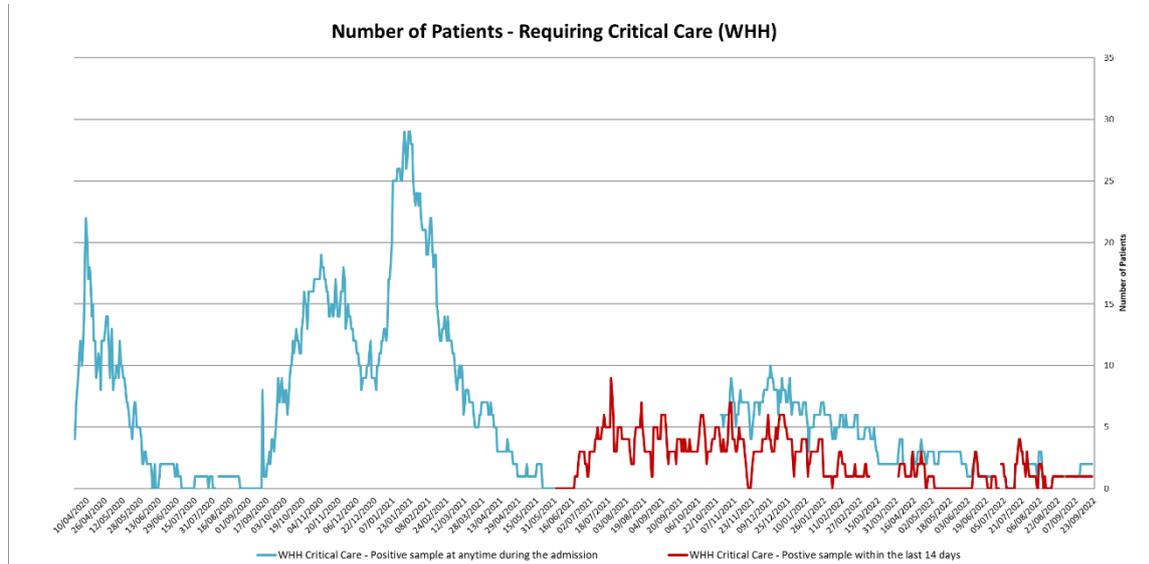
**Narrative:** As of 21/09/2022, there is 1 inpatient with confirmed COVID-19 (positive sample within the last 14 days) requiring critical care and 2 patients in critical care (positive sample at any point during admission).
**Source:** Trust Data (Warrington & Halton).

**Please note:** For Wave 1, 2 and 3 up to 31st May 2021, the data included patients with a positive COVID-19 sample at any point during their inpatient episode. For Wave 4 from 1st June 2021, the data includes patients with a positive COVID-19 sample during the last 14 days, in line with national guidance.

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**2.5.1 Number of In-Hospital Deaths**



In Hospital Deaths - England, North West & Cheshire & Mersey



In Hospital Deaths - by Trust
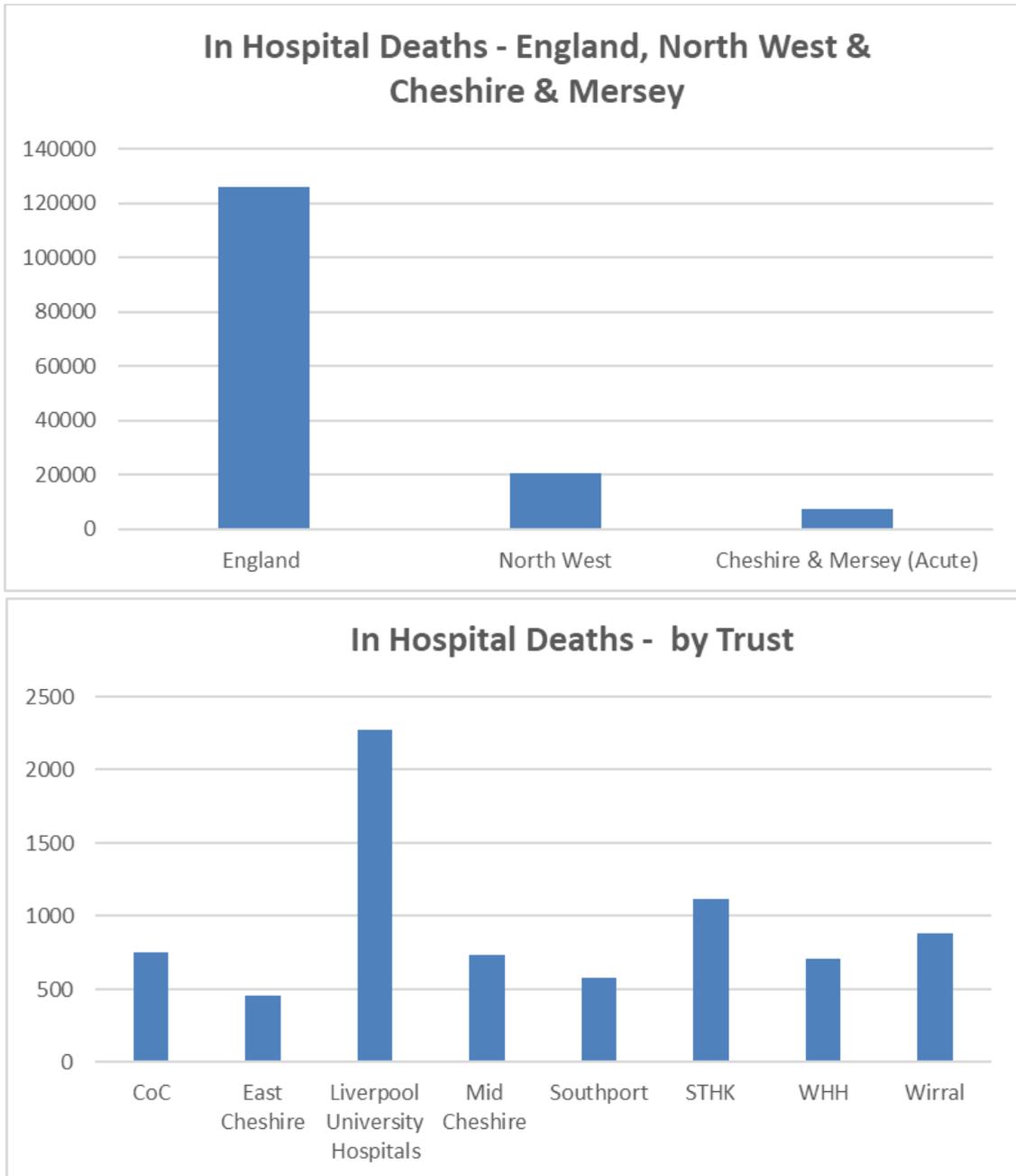
**Narrative:** As of 21/09/2022, the Trust had reported 709 deaths of inpatients with confirmed COVID-19. The trend is in line with the North West and Cheshire & Mersey positions.

**Notes:** There is a time lag between the date that the death was reported and actual date of death for national data.

**Source:** https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ and Trust Data.

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### 2.5.2 Crude Mortality

| August | 2020 | 2021 | 2022 |
|---|---|---|---|
| August (All Deaths) | 55 | 72 | 94 |
| August (Non COVID) | 52 | 62 | 76 |
| August (COVID) | 3 | 10 | 18 |
| % COVID Deaths (of all deaths) | 5.5% | 13.9% | 19.1% |
| Discharges | 4441 | 5287 | 5148 |
| Crude Mortality (deaths divided by deaths+discharges) | 1.2% | 1.4% | 1.8% |

| | Wave 1 Apr-Aug 2020 | Wave 2 Sept-Dec 2020 | Wave 3 Jan 2021 - May 2021 | Wave 4 June 2021 -February 2022 | Wave 5 March 2022 - June 2022 | Wave 6 July 2022 - Present |
|---|---|---|---|---|---|---|
| All Deaths | 405 | 402 | 478 | 760 | 331 | 229 |
| Non-COVID | 272 | 227 | 293 | 624 | 270 | 189 |
| COVID | 133 | 175 | 185 | 136 | 61 | 40 |
| % COVID Deaths (of all deaths) | 32.8% | 43.5% | 38.7% | 17.9% | 18.4% | 17.5% |
| Discharges | 19325 | 17241 | 23509 | 45561 | 20343 | 12902 |
| Crude Mortality (deaths divided by deaths+discharges) | 2.1% | 2.3% | 2.0% | 1.7% | 1.6% | 1.8% |
| Crude Mortality COVID-19 ( COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges) | 25.2% | 20.3% | 16.9% | 10.1% | 6.2% | 8.8% |

**Narrative:** Crude mortality in August 2022 was 1.8% compared with 1.4% in August 2021 and 1.2% in August 2020.  Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 and 2.0% in wave 3 and 1.7% in wave 4, 1.6% in wave 5 and 1.8% in Wave 6 (to date) with Crude mortality for COVID-19 patients 25.2% in wave 1, 20.3% in wave 2, 16.9% in wave 3 and 10.1% in wave 4, 6.2% in wave 5 and 8.8% in wave 6 (to date).
**Source:** Trust Data.

**2.5.3 Number of In Hospital Deaths (Ethnicity)**



**Trust Deaths by Ethnicity**

Legend:
- White British
- White Irish
- Any other White background
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background
- Caribbean
- African
- Any other Black background
- Chinese
- Any other ethnic group
- Not stated/Not Known
- No match
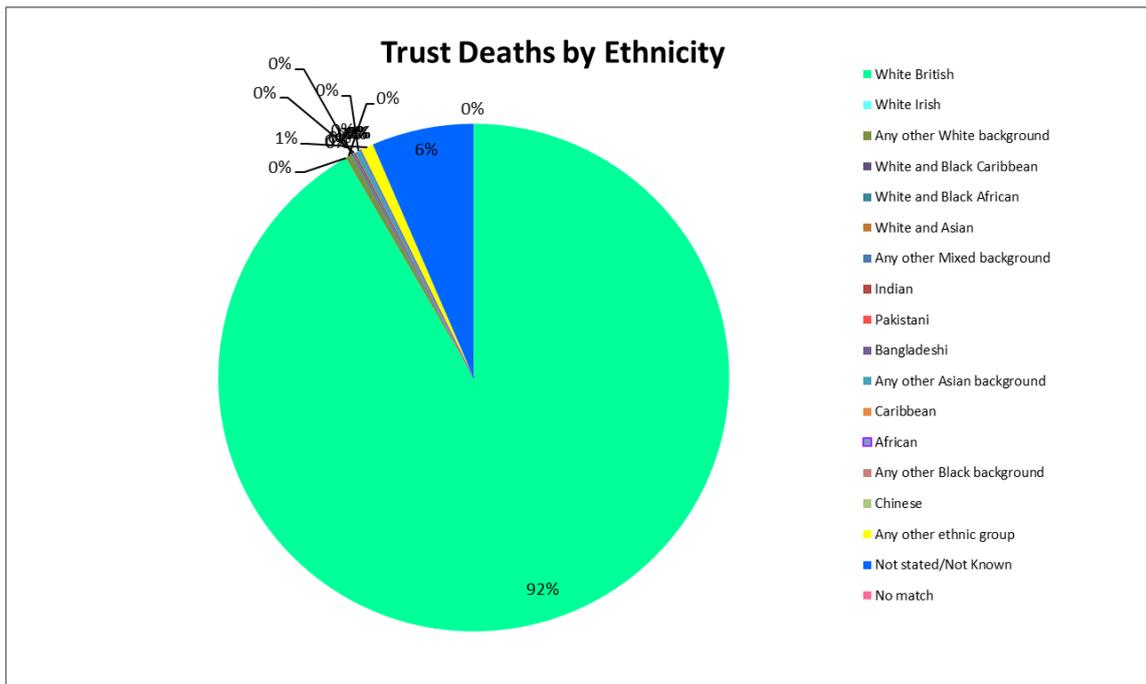
**Narrative:** As of 21/09/2022, 92% of reported deaths were patients who identified as "White British", with 6% patients' ethnicity "Not Stated/Not Known", <1% patients' ethnicity stated as "Any Other Ethnic Group", <0.5% patients stated as "Asian" or "Asian British", <1% Indian and <1% patient identified as "White Any Other Background". The proportion of White British patient deaths is greater than the national position, however this is as expected when comparing the population of Warrington (96.00% White British) & Halton (98.00% White British).

**Notes:** National data for COVID-19 deaths by ethnicity was not available at the time of writing, having previously been made available on the NHSE website.

**Source:**https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/
(England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

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**2.5.4 Number of In Hospital Deaths (Age Range)**

**Trust Deaths by Age Range**
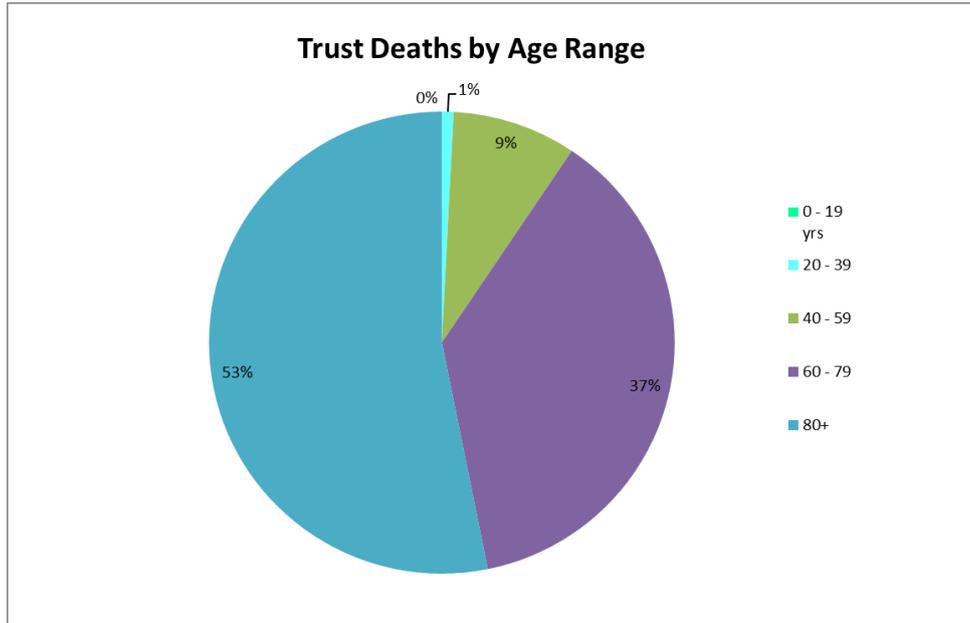


**Narrative:** As at 21/09/2022, 90% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position.  The average age of death was 77.9 years.

**Notes:** Data utilised is for the date each death was reported, not the date that the death occurred and therefore there is a 3-5 day time lag for national data.

**Source:**https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/

(England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

**2.5.5 Number of In Hospital Deaths (Gender)**

### Trust Deaths by Gender
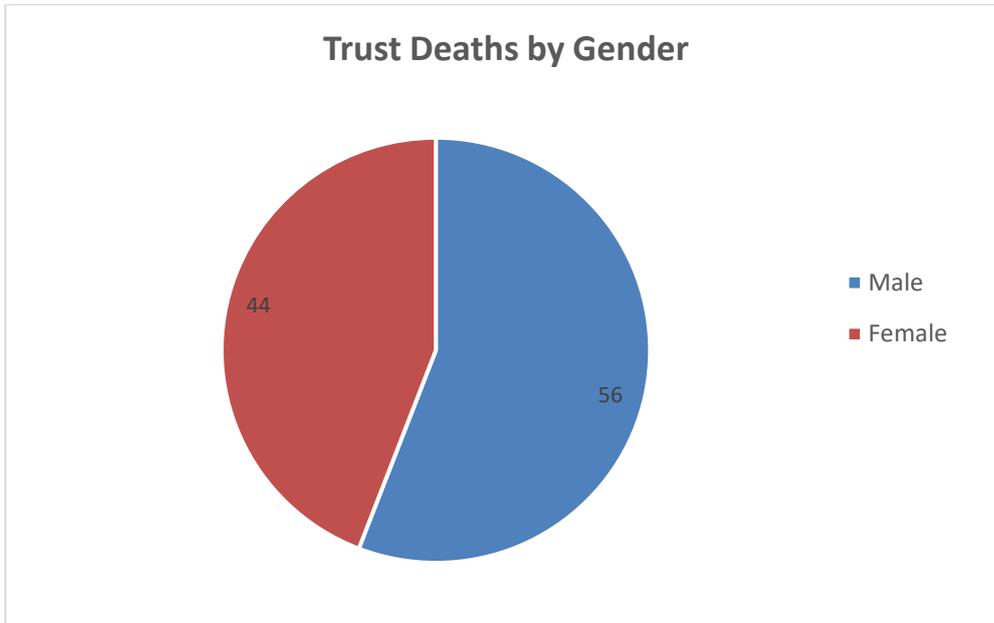


**Narrative:** As at 21/07/2022, 56% of COVID-19 deaths were male patients and 44% of COVID-19 deaths were female patients.

**Notes:** National data for COVID-19 deaths by gender was not available at the time of writing, having previously been made available on the NHSE website.

**Source:**https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/

(England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

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**2.5.6 In Hospital Deaths - Pre-Existing Medical Conditions**



**Trust Pre-Existing Medical Conditions**

Legend:
- Mental Health (inc Dementia, Alzheimer's, Schizophrenia)
- Thyroid (inc Hypothyroidism, Thyrotoxicosis)
- Lung Problems (in COPD, Asthma, Bronchiectasis, PHTN, Cancer, Pulmonary fibrosis, CPAP, Asbestosis)
- Heart/Circulation Problem (in AF, HF, PVD, MI, CCF, CHF, IHD, STEMI, ICD)
- Diabetes (NIDDM, IDDM)
- Hypertension (HTN)
- Renal (inc CKD)
- Epilepsy
- MSK (inc OA, Arthritis, Gout, RA)
- Gastro Problem (inc GORD, Coeliac Disease, IBD, Bowel/Bladder Cancer)
- Neuro Problem (inc Stroke, CVA TIA, ALD, Parkinsons)
- Prostate (inc BPH)
- Hypercholesterolemia
- Cancer (Other)
- Liver (Cirrhosis)
- Bariatric
- Abdominal (inc AAA, Abdominal Mets)
- Multi-System (inc DM1, Sarcoidosis)
- Blood (inc Pancytopenia, Sepsis, Anaemia, Thrombocytopenia, Hypercalaemia, Hep B, Hep B)

**Narrative:** As at 22/09/2022, 88.98% of inpatients whom have died with a confirmed COVID-19 positive sample had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions and Diabetes.

**Notes:** The majority of patients had more than one pre-existing medical condition and are therefore counted multiple times in the data.

This data was obtained from a review of free text fields in Lorenzo which is not coded data, therefore there may be some omissions.

**Source:** Trust Data (Warrington & Halton)

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## 2.6 Trust Outcomes

**Trust Discharges & Deaths - COVID-19 and Non COVID-19 from 02/03/2020 - 21/09/2022**

- COVID-19 Positive Discharges
- COVID-19 Negative/Not Tested Discharges
- COVID-19 Positive Deaths
- COVID-19 Negative/Not Tested Deaths
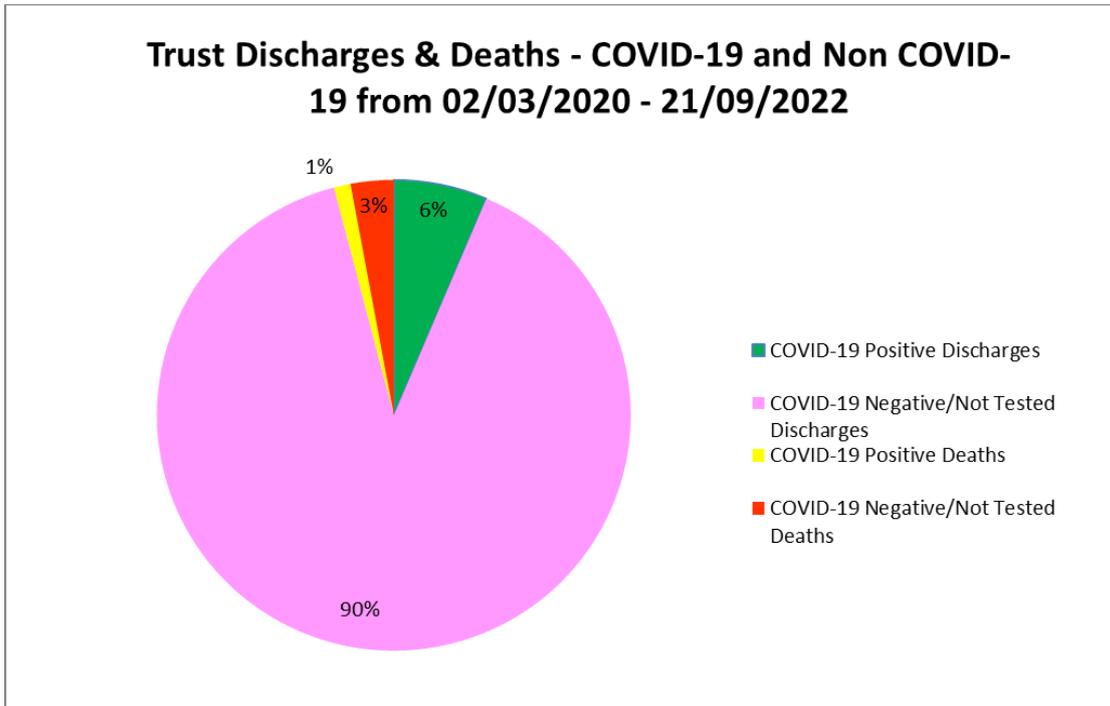
**Narrative:**

- Between 02/03/2020 – 23/09/2022, the Trust treated 64,830 inpatients (any patient with at least 1-night stay)

- 4,144 (7.53%) inpatients had tested positive for COVID-19

- 95.93% of all patients were discharged from hospital (COVID-19 and Non COVID-19)

- There was a total of 2,636 inpatients (all causes) who have died; this represents 4.07% of all inpatients

- 736 inpatient deaths were related to COVID-19 which represented 1.14% of all inpatients and 15.08% of inpatients with COVID-19

- 140 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 2.87% of all COVID-19 positive inpatients and 19.02% of inpatients who have died with a positive COVID-19 sample

**Source:** Trust Data

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## 2.6.1 Average Length of Stay



Average Length of Stay (Trust) - 02/03/2020 - 21/09/2022
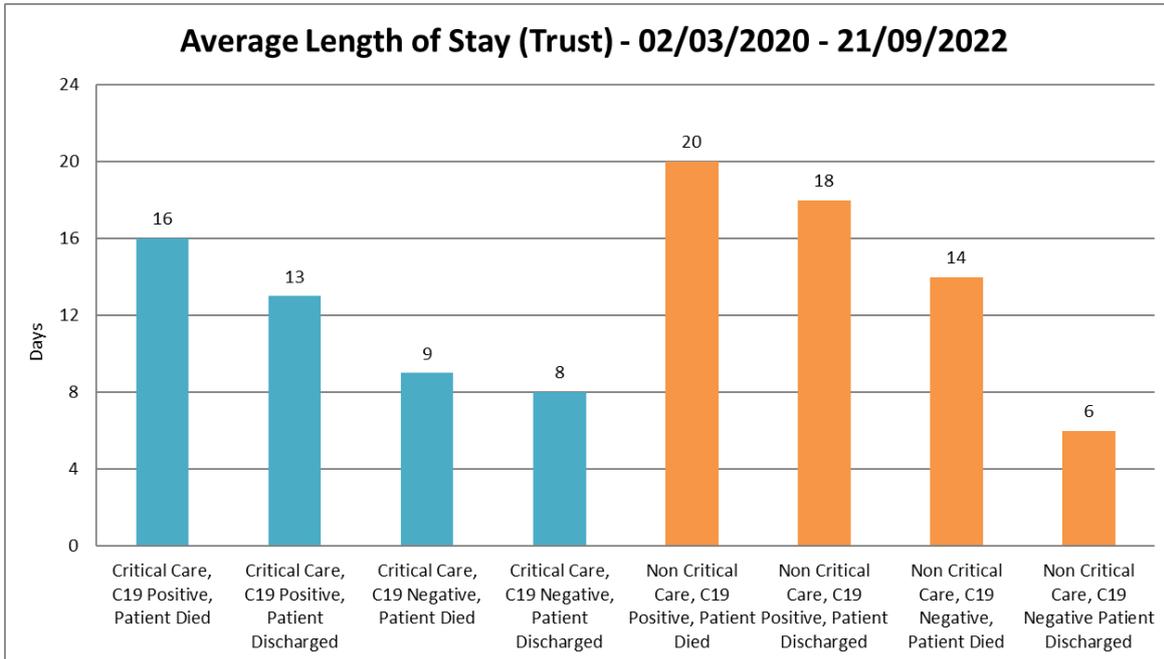
**Narrative:** From 02/03/2020 – 21/09/2022, the average length of stay for patients who had tested positive for COVID-19 was 15 days in critical care and 19 days in non-critical care.

**Source:** Trust Data

## 2.6.2 Critical Care Outcomes



Critical Care Outcomes (02/03/2020 - 21/09/2022)
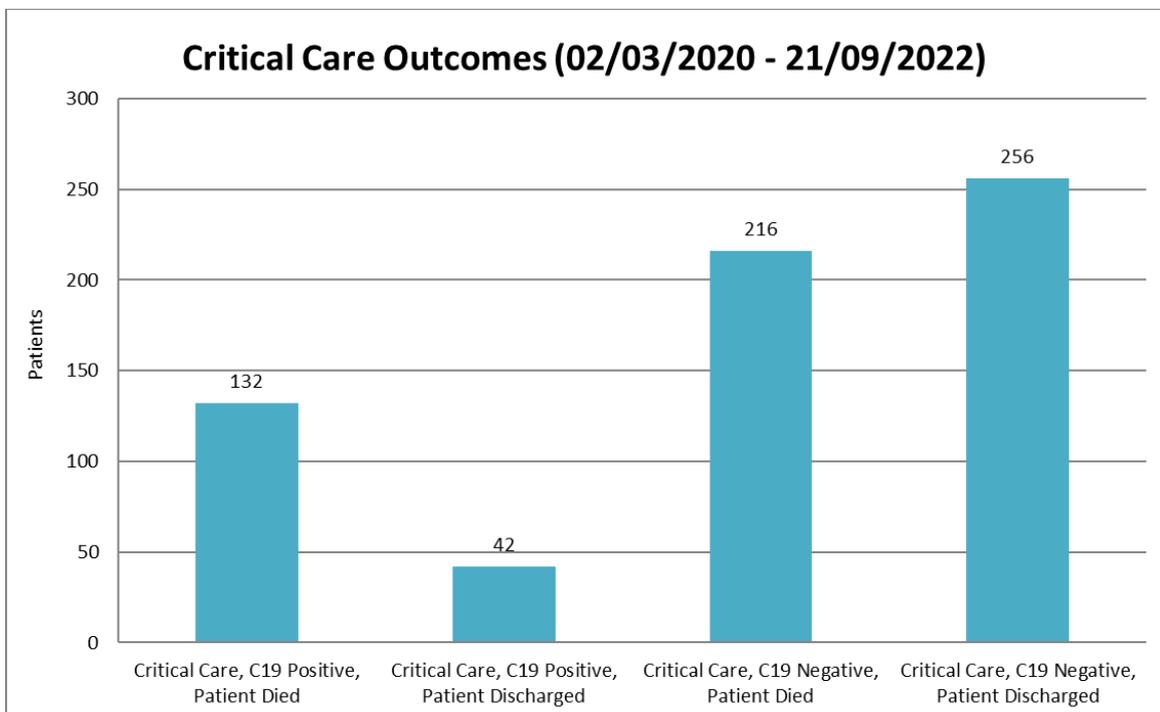
**Narrative:** From 02/03/2020 – 21/09/2022, there were 348 critical care inpatient deaths (132 COVID-19, 216 non-COVID-19) and 298 critical care inpatient discharges (42 COVID-19, 256 non-COVID-19).

**Source:** Trust Data

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**2.8 Outbreaks**

An outbreak of COVID-19 is defined as two or more people experiencing a similar illness that are linked in time and or place. Where there are endemic rates of a specific infection it can also be considered to be where there is a greater than expected incidence of infection compared to the background rate for the infection. For the purposes of hospital onset COVID-19 infection, the definition of an outbreak is for two or more cases to occur within the same ward environment within 14 days.
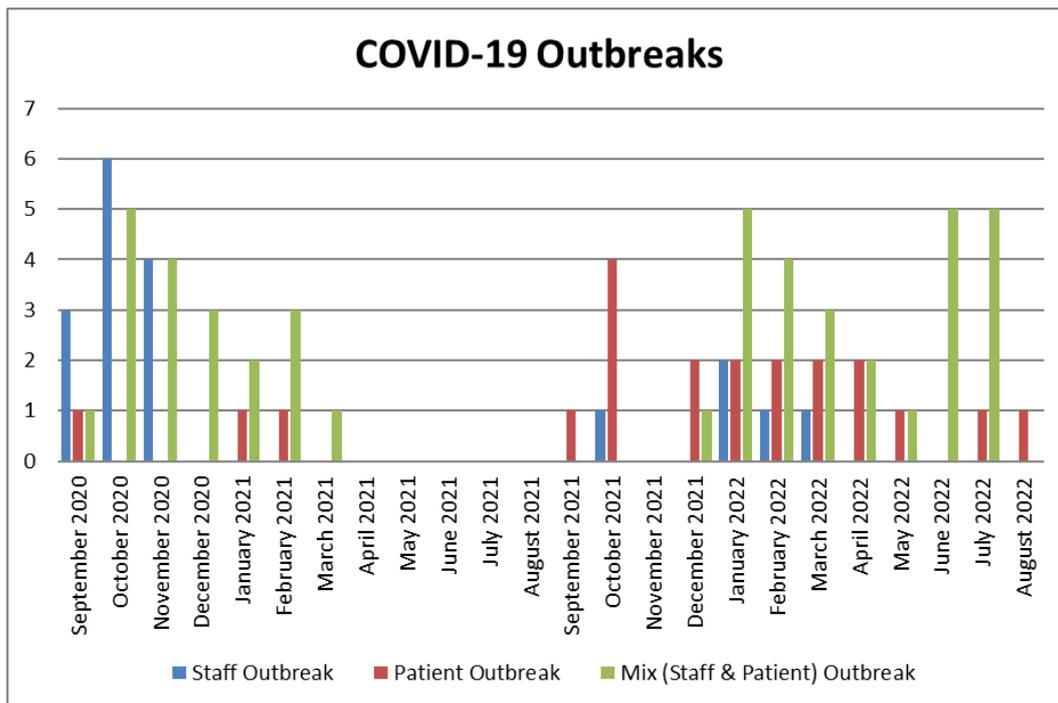


**Narrative:** In August 2022, there was 0 staff outbreaks and 1 patient outbreaks and 0 mixed staff and patient outbreaks at the Trust.

**Source:** Trust Data

## 3.  CONCLUSION

The Trust continues to respond to developments as the situation changes.

## 4.   RECOMMENDATIONS

The Trust Board is asked to:
1.   Note the contents of this report.

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We are WHH & We are
PROUD
to make a difference

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

## REPORT TO BOARD OF DIRECTORS

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/22/09/116** |
| **SUBJECT:** | **Integrated Performance Report** |
| **DATE OF MEETING:** | 28 September 2022 |
| **AUTHOR(S):** | Marie Garnett – Head of Contracts, Performance and Commercial Development |
| **EXECUTIVE DIRECTOR SPONSOR:** | Paul Fitzsimmons, Executive Medical Director<br>Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive<br>Michelle Cloney – Chief People Officer<br>Andrea McGee - Chief Finance Officer and Deputy Chief Executive<br>Dan Moore - Chief Operating Officer |

| **LINK TO STRATEGIC OBJECTIVE:**<br><br>(*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):**<br>(*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.<br>**#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<br>**#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.<br>**#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.<br>**#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<br>**#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.<br>**#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. |

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| EXECUTIVE SUMMARY *(KEY ISSUES):* | The Trust has 79 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: 26 |
| | |
| | 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, Staffing Care Hours Per Patient Day, RTT 18 Weeks, A&E 4 Hour Standard, Out Patient 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 % of patients within emergency setting who receive antibiotics administered within 1 hour of diagnosis. |
| | |
| | The Trust has submitted a £6.1m deficit plan for 2022/23. This includes achieving £7.9m ERF (Elective Recovery Fund), £15.7m CIP and a £3.0m income efficiency target.  The month 5 position is a £6.5m deficit year to date which is slightly worse than plan by £0.2m. |

| PURPOSE: *(please select as appropriate)* | Information | Approval<br>X | To note<br>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.  Approve the capital requests set out in Section 2.5 |
| | 3.  Approve 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<br>Finance and Sustainability Committee |
|---|---|---|
| | **Agenda Ref.** | |
| | **Date of meeting** | 20th September 2022<br>21st September 2022 |

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| | Summary of Outcome | <ul><li>Capital Requests Supported</li><li>Changes to include new KPIs and update existing KPIs supported</li><li>Removal of KPIs no longer included within the Oversight Framework supported</li></ul> |
|---|---|---|
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** *(if relevant)* | Choose an item. | |

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**REPORT TO BOARD OF DIRECTORS**

| SUBJECT | Integrated Performance Report | AGENDA REF: | BM/22/09/116 |
|---------|------------------------------|-------------|--------------|

## 1. BACKGROUND/CONTEXT

**1.1 IPR Indicators**

All 79 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 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 include a new set of oversight metrics. Section 2-6 of this paper sets out the suggested amendments to the Trust IPR in order 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 |
|---|---|---------|---------------------|--------|-------------------------|
| P | Consistently Passes the Target (based on the last 6 months) | 8 | 4 | 3 | 1 |
| F | Consistently Fails the Target (based on the last 6 months) | 5 | 13 | 7 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| ? | **Inconsistently Passes/Fails the Target** | 4 | 3 | 2 | 2 |
| No SPC | **No SPC/Not Enough Datapoints/Not Applicable** | 10 | 12 | 1 | 3 |
| **Total** | | 27 | 32 | 13 | 7 |

*based on the last 6 months performance.

**Table 2: Variation Categories**

| | | Quality | Access & Performance | People | Finance & Sustainability |
|---|---|---|---|---|---|
| | **Common Cause Variation** | 7 | 16 | 6 | 2 |
| L / H | **Special Variation of an Improving Nature** | 3 | 1 | 1 | 1 |
| L / H | **Special Variation of a Concerning Nature** | 4 | 4 | 3 | 0 |
| No SPC | **No SPC/Not Enough Datapoints/Not Applicable** | 13 | 11 | 3 | 4 |
| **Total** | | 27 | 32 | 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 5 Quality indicators which are consistently failing the target, these are:
- 10. Medication Reconciliation within 24 hours – the Trust achieved 58.00% in August, against a target of 80.00%
- 12. CHPPD – the Trust achieved 7.2 hours against a target of 7.9 hours.
- 18. Friends & Family Test (Urgent & Emergency Care) – the Trust achieved 72.00% in August, against a target of 87.00%.
- 21. Sepsis Screening (Emergency Patients) – the Trust achieved 76.00% in August, against a target of 90.00%.
- 23. Sepsis Antibiotics Administration (Emergency Patients) – the Trust achieved 69.00% in August, against a target of 90.00%.

There are 4 Quality indicators which are inconsistently passing/failing the target, these are:
- 3. Healthcare Acquired Infections – MRSA – the Trust reported 0 case of MRSA in August, against a target of 0. Therefore, this target was achieved in August.
- 7. VTE Assessment – the Trust achieved 95.39% in August, against a target of 95.00%. Therefore, this target was achieved in August.

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- 22. Sepsis Screening (Inpatients) – the Trust achieved 51.00% in August, against a target of 90.00%. This target was last achieved in June 2022.
- 24. Sepsis Antibiotics Administration (Inpatients) – the Trust achieved 63.00% in August, against a target of 90.00%.

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

- 11. Staffing Average Fill Rate – the average staffing fill rate for all four groups combined was 87.15% in August, against a target of 90.00%
- 26. Acute Kidney Injury – there were 182 AKIs reported in the Trust in August, against a target of less than 152 AKIs (reported in July)

**Variation**

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

- 3. Healthcare Acquired Infections - MRSA
- 7. VTE Assessment
- 10. Medicines Reconciliation within 24 hours
- 12. CHPPD

## 2.3 ACCESS AND PERFORMANCE

**Assurance**

There are 13 Access & Performance indicators which are consistently failing the target, these are:

- 28. Diagnostics 6 Week Waiting Times – the Trust achieved 78.54% in August, against a target of 99.00%
- 29. Referral to Treatment – 18 Weeks – the Trust achieved 62.45% in August, against a target of 92.00%
- 30. Referral to Treatment – 104 Week Waits – there were 8 patients waiting over 104 weeks in August, 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 72.10% in August, against a target of 95.00%
- 35. Cancer 14 Days – the Trust achieved 86.54% in July, against a target of 93.00%.
- 36. Breast Symptoms 14 Days – the Trust achieved 88.24% in July, against a target of 93.00%
- 41. Cancer 62 Day Urgent – the Trust achieved 70.75% in July, against a target of 85.00%
- 43. Ambulance Handovers within 15 minutes – the Trust achieved 34.31% in August, against a target of 65.00%
- 44. Ambulance Handovers within 30 minutes – the Trust achieved 59.24% in August, against a target of 95.00%
- 45. Ambulance Handovers within 60 minutes – the Trust achieved 72.92% in August, against a target of 100%
- 46. Discharge Summaries (24 Hours) – the Trust achieved 90.06% in August, against a target of 95.00%

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- 55. % Outpatient Activity Delivered Remotely – the Trust achieved 10.73% in August, against a target of 25.00%
- 56. % Patients seen in the Fracture Clinic within 72 hours – the Trust achieved 52.39% in June, against a target of 95.00%

There are 3 Access & Performance indicators which are inconsistently passing/failing the target in the last 6 months, these are:
- 37. Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 77.17% in July, against a target of 75.00%.
- 42. Cancer 62 Days Screening – the Trust achieved 94.74% in July, against a target of 90.00%
- 47. Discharge Summaries (7 Days) – there were 23 discharge summaries not sent within 7 days to meet the requirement, against a target of 0

SPC Assurance cannot be determined for the following indicators which have failed to meet the target in month:
- 33. A&E Waiting Times (12 Hours) – the Trust achieved 16.84% in August, against a target of 2.00% or less
- 52. COVID-19 Recovery (Inpatient/Daycase) – the Trust achieved an average of 87.17% for inpatient/daycases combined in August, against a target of 104%
- 53. COVID-19 Recovery (Diagnostics) – the Trust achieved an average of 111.27% across all diagnostic modalities combined in August, against a target of 104%. Therefore, this target was achieved in August
- 54. COVID-19 Recovery (Outpatients) – the Trust achieved 95.81% of outpatient activity in August, 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, these are:
- 60. Supporting Attendance – the Trust achieved 5.54% in August, against a target of 4.20% or less.
- 61. Welcome Back Conversations – the Trust achieved 56.33% in August, against a target of 85.00%
- 62. Recruitment Time to Hire – time to hire average days was 77 in August, against a target of 65 days or less
- 63. Vacancy Rate – the Trust achieved 11.81% in August, against a target of 9.00% or less
- 64. Retention – the Trust achieved 83.05% in August, against a target of 86.00%

- 65. Turnover – the Trust achieved 16.35% in August, against a target of 13.00% or less
- 66. Bank & Agency Reliance – the Trust achieved 15.44% in August, against a target of 9.00% or less

There are 2 People indicators which are inconsistently passing/failing the target, these are:
- 67. Monthly Pay Spend – monthly pay spend was £20.3m in August, against a budget of £19.7m
- 72. PDR Compliance – the Trust achieved 62.96% in August, against a target/trajectory of 79.00%

SPC Assurance cannot be determined for the following indicator which has failed to meet the target in month:
- 70. Safeguarding Training – the Trust achieved 71.35% in August, against a target/trajectory of 83.00%

**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, this indicator is:
- 76. Better Practice Payment Code – the Trust achieved 93.00% (cumulative), against a target of 95.00%

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 -£6.5m against a plan of £6.3m
- 75. Capital Spend – the Trust capital spend as at the end of month 5 was £3.6m against a plan of £5.5m.

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 August 2022 is attached in **Appendix 5**.

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The Trust has agreed a control total of £6.1m deficit with Cheshire & Merseyside ICS. There are a number of risks to the achievement of the planned £6.1m deficit, with the current likely forecast to be a deficit of £12.2m. The Key risks to achievement of the plan are:

- CIP delivery
- Additional bed capacity (ward B3)
- Achievement of ERF - during August 2022 all elective activity has underperformed against plan. The position also shows an under performance against all elective activity to date
- A&E staffing pressures

**Cash**

The cash balance at the end of month 5 is £40.7m, which is £18.9m higher than plan (£21.8m), with several contributing factors, e.g., timing difference in the payment of trade creditors.

**CIP**

At month 5 the Trust has delivered a CIP of £4.1m, and is on plan year to date, against a target of £15.7m. There remain several high-risk schemes to be delivered, with only £2.2m recurrent CIP identified presenting a risk to the financial position in this and future years.

**Forecast**

A best, worse and likely case has been developed, which factors risks such as CIP, energy costs, ERF, pay award and B3, resulting in a likely forecast of £12.2m deficit. The finance team is working with clinical and operational teams to improve the likely case through cost reduction, productivity, and income opportunities.

**Capital Programme**

The Trust has a capital programme of £22.7m (£12.5m CDEL and £10.2m externally funded). As of August 2022, the year to date capital spend is £3.59m, a variance of £1.9m compared to plan.

**Table 4: Capital Expenditure by category as at 31 August 2022**

| | Annual Plan | Plan YTD | Actual YTD | Variance against Plan YTD |
|---|---|---|---|---|
| | £ 000 | £ 000 | £ 000 | £ 000 |
| Estates | 7,794 | 4,141 | 3,020 | 1,121 |
| IM&T | 2,175 | 650 | 264 | 386 |
| Medical Equipment | 2,525 | 296 | 455 | - 159 |
| Contingency | - | - | - 495 | 495 |
| Sub total | 12,494 | 5,087 | 3,244 | 1,843 |
| | | | | |
| External Funded | 10,187 | 434 | 350 | 84 |
| Total | 22,681 | 5,521 | 3,594 | 1,927 |

**Table 5** highlights the current contingency.

**Table 5: Capital Contingency**

| DETAIL | £'000 | £'000 |
|---|---|---|
| **Contingency balance start of month 5** | | **587** |
| | | |
| **Emergency requests approved by the CFO/ Deputy CEO** | | |
| Chiller Compressor - Daresbury Theatres | -7 | |
| TV Transducer | -6 | |
| Curvilinear Transducer | -7 | |
| Roof Leaks Halton | -59 | |
| **Sub Total** | | **-79** |
| | | |
| **VAT rebate** | | **451** |
| | | |
| **Return estates backlog maintenance schemes to capital plan** | | |
| Appleton Fire doors final phase | -200 | |
| Repairs to roads & footpaths across both sites | -150 | |
| Appleton Wing fire dampers final phase | -100 | |
| CCTV Upgrade site wide | -50 | |
| Replacement of AVSU's - part 2 | -40 | |
| Safe surface temperatures (radiators) final part | -30 | |
| **Sub Total** | | **-570** |
| | | |
| **Additional funds requested from CPG** | | |
| Upper Limb Articulated Surgical Positioning Attachment | | **-19** |
| | | |
| **Contingency as at end of month 5** | | **370** |

**Appendix 6** contains the updated Capital Programme.

**Capital Requests**
**The Trust Board is asked to:**

- **Note the Capital requests of £79k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive**
- **Approve the return of the estates backlog maintenance schemes to the capital plan totalling £570k**
- **Approve the funds requested from the Capital Planning Group (CPG) for the Upper Limb Articulated Surgical Positioning Attachment - £19k**

**2.6 NHSE Oversight Framework Changes to KPIs**

**Table 1** outlines the suggested amendments to the IPR supported by the Clinical Recovery Oversight Committee on 20th September 2022. If approved by the Trust Board these changes would mean that the number of Access & Performance KPIs would increase from 32 to 34.

**Table 1: Suggested Amendments to the IPR**

| Amendment | Detail | Rationale |
|---|---|---|
| Amendment to current KPI (Oversight Metric 9) | **KPI Name:** RTT <br> **Target:** N/A <br> **Amendment:** To include 78 week waits in addition to 52 & 104 week waits. | Included as a new KPI on the 2022/23 NHSE Oversight Framework. |
| New KPI (Oversight Metric 101) | **KPI Name:** Reduction in Outpatient Follow Ups <br> **Target:** N/A <br> **Amendment:** To include a specific KPI to outline the reduction in Outpatient follow up activity. <br><br> The purpose of this is to measure the reduction in outpatient follow up appointments as per the operational planning guidance. <br><br> 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 <br> **Target:** N/A <br> **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. | Included as a new KPI on the 2022/23 NHSE Oversight Framework. |

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| | Target: 100% | |
|---|---|---|
| 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. |
| New KPI (Oversight Metric 117) | **KPI Name:** % patients referred to long COVID service not assessed within 15 weeks. **Target:** Zero | Included as a new KPI on the 2022/23 NHSE Oversight Framework. |
| Removal of KPI | **KPI Name:** Advice & Guidance **Removal of KPI:** This is replaced with the reduction in Outpatient follow up indicator. | Removed as a new KPI on the 2022/23 NHSE Oversight Framework. |
| Removal of KPI | **KPI Name:** Patient Initiated Follow Ups **Removal of KPI:** This is replaced with the reduction in Outpatient follow up indicator. | Removed as a new KPI on the 2022/23 NHSE Oversight Framework. |

**Table 2** outlines the suggested amendments to the IPR supported by the Finance & Sustainability Committee on 21st September 2022. If approved by the Trust Board, inclusion of these indicators would increase the number of Finance & Sustainability KPIs from 7 to 9.

**Table 1: Suggested Amendments to the IPR**

| Amendment | Detail | Rationale |
|---|---|---|
| New KPI | **KPI Name:** Agency Spend vs Price Cap **Target:** Price Cap | Included as a new KPI on the 2022/23 NHSE Oversight Framework. |
| New KPI | **KPI Name:** Agency Spend vs Ceiling **Target:** Agency Ceiling | Included as a new KPI on the 2022/23 NHSE Oversight Framework. |

Please note that the NHSE Oversight Framework contains a financial stability indicator which measures the Trust against its agreed financial plan as well as against a break even position. It is not proposed to include the breakeven position as an indicator on the IPR as the Trust has a deficit plan and it would not make sense to measure performance against a breakeven position.

The Trust Board is asked to approve the changes to the KPIs in the IPR. If approved, the changes will take effect from the November's Trust Board report (October's data).

## 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:

6. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive
7. Approve the capital requests set out in Section 2.5
8. Approve the amendments to the KPIs set out in section 2.6
9. Note the contents of this report

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# Statistical Process Control - Assurance & Variation

**Appendix 1**

Key:

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

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Teaching Hospitals
NHS Foundation Trust

| | QUALITY | Latest | | | | Previous | | Assurance |
|---|---|---|---|---|---|---|---|---|
| | | Plan/Target | Actual | Period | Variation | Actual | Period | |
| 1 | Incidents (over 40 days old) | 0 | 0 | Aug-22 | L | 0 | Jul-22 | P |
| 2 | Duty of Candour (serious incidents) | 100.00% | 100.00% | Aug-22 | | 0% | Jul-22 | P |
| 3 | Healthcare Acquired Infections - MRSA | 0 | 0 | Aug-22 | H | 1 | Jul-22 | ? |
| 4 | Healthcare Acquired Infections – CDI | Less than 37 for 2022/23 | 4 | Aug-22 | | 8 | Jul-22 | No SPC |
| 5 | Healthcare Acquired Infections – Gram Negative (E.coli) | Less than 57 for 2022/23 | 5 | Aug-22 | | 4 | Jul-22 | No SPC |
| 6 | Healthcare Acquired Infections - COVID-19 Outbreaks | N/A | 1 | Aug-22 | No SPC | 6 | Jul-22 | No SPC |
| 7 | VTE Assessment | 95.00% | 95.39% | Aug-22 | L | 92.16% | Jul-22 | ? |
| 8 | Inpatient Falls & Harm Levels | 20.00% annual reduction based on 590 in 2021/22 | 78 | Aug-22 | | 67 | Jul-22 | No SPC |
| 9 | Pressure Ulcers (Total) | 10.00% reduction based on 91 in 2021/22 | 10 | Aug-22 | | 11 | Jul-22 | No SPC |

# Statistical Process Control - Assurance & Variation

**Appendix 1**

Key:

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

**Common Cause (Normal Variation).**

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

**Consistently passes the target***

**Inconsistently passes and fail the target***

**Consistently fails the target***
*based on the last 6 datapoints/months*

**NHS**
**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10 | Medication Safety (24 Hours) | 80.00% | 58.00% | Aug-22 | L | 53.00% | Jul-22 | F |
| 11 | Staffing – Average Fill Rate (Combined) | 90.00% | 87.15% | Aug-22 | No SPC | 86.04% | Jul-22 | No SPC |
| 12 | Staffing – Care Hours Per Patient Day | 7.9 | 7.2 | Aug-22 | L | 7.0 | Jul-22 | F |
| 13 | Mortality ratio - HSMR | N/A | 89.02 | Aug-22 | No SPC | 86.28 | Jul-22 | No SPC |
| 14 | Mortality ratio - SHMI | N/A | 97.26 | Aug-22 | No SPC | 98.50 | Jul-22 | No SPC |
| 15 | NICE Compliance | 90.00% | 92.02% | Aug-22 | H | 91.15% | Jul-22 | P |
| 16 | Complaints (open over 6 months) | 0 | 0 | Aug-22 | Common Cause | 0 | Jul-22 | P |
| 17 | Friends & Family – Inpatients & Day cases | 95.00% | 96.00% | Aug-22 | No SPC | 97.00% | Jul-22 | P |
| 18 | Friends & Family – ED and UCC | 87.00% | 72.00% | Aug-22 | No SPC | 70.00% | Jul-22 | F |
| 19 | Mixed Sex Accommodation Breaches (Non ITU Breaches Only) | 0 | 0 | Aug-22 | No SPC | 0 | Jul-22 | P |
| 20 | Continuity of Carer | 51.00% | 86.40% | Aug-22 | H | 85.41% | Jul-22 | P |

# Statistical Process Control - Assurance & Variation

**Appendix 1**

Key:

- (L) (H) **Special Cause Variation of a improving nature.**
- **Common Cause (Normal Variation).**
- (L) (H) **Special Cause Variation of a concerning nature.**

- (P) **Consistently passes the target***
- (?) **Inconsistently passes and fail the target***
- (F) **Consistently fails the target***
  *based on the last 6 datapoints/months

**NHS Warrington and Halton Teaching Hospitals**
**NHS Foundation Trust**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 21 | Sepsis - % screening for all emergency within 1 hour. | 90.00% | 76.00% | Aug-22 | No SPC | 62.00% | Jul-22 | F |
| 22 | Sepsis - % screening for all inpatients within 1 hour. | 90.00% | 51.00% | Aug-22 | No SPC | 74.00% | Jul-22 | ? |
| 23 | Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis. | 90.00% | 69.00% | Aug-22 | No SPC | 64.00% | Jul-22 | F |
| 24 | Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis. | 90.00% | 63.00% | Aug-22 | No SPC | 66.00% | Jul-22 | ? |
| 25 | Ward Moves between 10:00pm and 06:00am | N/A | 101.00 | Aug-22 | No SPC | N/A | N/A | No SPC |
| 26 | Number of Hospital Acquired Acute Kidney Injuries | Less than previous month | 182 | Aug-22 | No SPC | 152 | Jul-22 | No SPC |
| 27 | Number of CAS Alerts Actions Breached | 0 | 0 | Aug-22 | (common cause) | 0 | Jul-22 | P |

# Statistical Process Control - Assurance & Variation

**Appendix 1**

**NHS**
**Warrington and Halton Teaching Hospitals**
**NHS Foundation Trust**

**Key:**

🔵 L / H — Special Cause Variation of a improving nature.

⚪ — Common Cause (Normal Variation).

🟠 L / H — Special Cause Variation of a concerning nature.

🔵 P — Consistently passes the target*

⚪ ? — Inconsistently passes and fail the target*

🟠 F — Consistently fails the target*
\*based on the last 6 datapoints/months

| ACCESS & PERFORMANCE | Plan/Target | Actual | Period | Variation | Actual | Period | Assurance |
|---|---|---|---|---|---|---|---|
| | | **Latest** | | | **Previous** | | |
| 28 Diagnostic Waiting Times 6 Weeks | 99.00% | 78.54% | Aug-22 | H (blue) | 85.10% | Jul-22 | F |
| 29 RTT - Open Pathways (18 Weeks) | 92.00% | 62.45% | Aug-22 | L (orange) | 62.72% | Jul-22 | F |
| 30 RTT – Number of Patients Waiting 104+ Weeks | 0 | 8 | Aug-22 | (common cause) | 9 | Jul-22 | F |
| 31 A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. | 95.00% | 72.10% | Aug-22 | L (orange) | 70.10% | Jul-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 | 16.84% | Aug-22 | No SPC | 14.39% | Jul-22 | No SPC |
| 34 Average time in department ED (mins) | N/A | 339 | Aug-22 | No SPC | 322 | Jul-22 | No SPC |
| 35 Cancer 14 Days* | 93.00% | 86.54% | Jul-22 | (common cause) | 90.63% | Jun-22 | F |
| 36 Breast Symptoms 14 Days* | 93.00% | 88.24% | Jul-22 | (common cause) | 96.97% | Jun-22 | F |

# Statistical Process Control - Assurance & Variation

**Appendix 1**

| | | | | | Variation | | | Assurance |
|---|---|---|---|---|---|---|---|---|
| 37 | Cancer 28 Day Faster Diagnostic* | 75.00% | 77.17% | Jul-22 | (Common Cause) | 75.28% | Jun-22 | ? |
| 38 | Cancer 31 Days First Treatment* | 96.00% | 98.57% | Jul-22 | (Common Cause) | 98.88% | Jun-22 | P |
| 39 | Cancer 31 Days Subsequent Surgery* | 94.00% | 100.00% | Jul-22 | (Common Cause) | 100.00% | Jun-22 | P |
| 40 | Cancer 31 Days Subsequent Drug* | 98.00% | 100.00% | Jul-22 | (Common Cause) | 100.00% | Jun-22 | P |
| 41 | Cancer 62 Days Urgent* | 85.00% | 70.75% | Jul-22 | (Common Cause) | 63.25% | Jun-22 | F |
| 42 | Cancer 62 Days Screening* | 90.00% | 94.74% | Jul-22 | (Common Cause) | 100.00% | Jun-22 | ? |
| 43 | Ambulance Handovers within 15 minutes | 65.00% | 34.31% | Aug-22 | (Common Cause) | 45.01% | Jul-22 | F |
| 44 | Ambulance Handovers within 30 minutes | 95.00% | 59.24% | Aug-22 | (Common Cause) | 63.86% | Jul-22 | F |
| 45 | Ambulance Handovers within 60 minutes | 100% | 72.92% | Aug-22 | (Common Cause) | 72.34% | Jul-22 | F |
| 46 | Discharge Summaries - % sent within 24hrs | 95.00% | 90.06% | Aug-22 | (Common Cause) | 90.86% | Jul-22 | F |
| 47 | Discharge Summaries – Number NOT sent within 7 days | 0 | 23 | Aug-22 | (Common Cause) | 0 | Jul-22 | ? |

# Statistical Process Control - Assurance & Variation

**Key:**

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target*

Inconsistently passes and fail the target*

Consistently fails the target*
*based on the last 6 datapoints/months

**NHS**
**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

| # | Indicator | Target | Value | Month | Variation | Value | Month | Assurance |
|---|---|---|---|---|---|---|---|---|
| 48 | Cancelled Operations on the day for a non-clinical reasons | | | | | | | No SPC |
| 49 | Cancelled Operations– Not offered a date for readmission within 28 days | Please note: Validation for this indicators was in progress at the time of reporting. | | | | | | No SPC |
| 50 | Urgent Operations – Cancelled for a 2nd time | 0 | 0 | Aug-22 | Common Cause | 0 | Jul-22 | P |
| 51 | Super Stranded Patients | Trajectory TBC for 2022/23 | 146 | Aug-22 | H concerning | 139 | Jul-22 | No SPC |
| 52 | COVID-19 Recovery Elective (Inpatient/Daycase) - (Average) | 104% | 87.17% | Aug-22 | No SPC | 81.44% | Jul-22 | No SPC |
| 53 | COVID-19 Recovery Diagnostic Activity - (Average) | 104% | 111.27% | Aug-22 | No SPC | 80.27% | Jul-22 | No SPC |
| 54 | COVID-19 Recovery Outpatient Activity | 104% | 95.81% | Aug-22 | No SPC | 79.39% | Jul-22 | No SPC |
| 55 | % Outpatient Appointments delivered remotely | 25.00% | 10.73% | Aug-22 | L concerning | 11.93% | Jul-22 | F |
| 56 | % of Patients seen in the fracture clinic within 72 hours | 95.00% | 52.39% | Aug-22 | Common Cause | 62.54% | Jul-22 | F |
| 57 | Advice & Guidance (A&G) Activity Levels | N/A | 491 | Aug-22 | No SPC | 497 | Jul-22 | No SPC |
| 58 | Patient Initiated Follow Up (PIFU) Activity Levels | N/A | 41 | Aug-22 | No SPC | 21 | Jul-22 | No SPC |

# Statistical Process Control - Assurance & Variation

**Key:**

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target*

Inconsistently passes and fail the target*

Consistently fails the target*
*based on the last 6 datapoints/months

**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

| 59 | % of zero-day length of stay admissions (as a proportion of total) | N/A | 86% | Aug-22 | No SPC | 83% | Jul-22 | No SPC |
|---|---|---|---|---|---|---|---|---|

| | | Latest | | | | Previous | | |
|---|---|---|---|---|---|---|---|---|
| **WORKFORCE** | | **Plan/Target** | **Actual** | **Period** | **Variation** | **Actual** | **Period** | **Assurance** |
| 60 | Supporting Attendance | 4.20% | 5.54% | Aug-22 | (common cause) | 7.38% | Jul-22 | F |
| 61 | Welcome Back Conversations | 85.00% | 56.33% | Aug-22 | L (concerning) | 67.97% | Jul-22 | F |
| 62 | Recruitment Time to Hire (Days) | 65 | 77 | Aug-22 | (common cause) | 78 | Jul-22 | F |
| 63 | Vacancy Rates | 9.00% | 11.81% | Aug-22 | H (concerning) | 11.03% | Jul-22 | F |
| 64 | Retention | 86.00% | 83.05% | Aug-22 | L (concerning) | 83.04% | Jul-22 | F |
| 65 | Turnover | 13.00% | 16.35% | Aug-22 | (common cause) | 16.34% | Jul-22 | F |
| 66 | Bank & Agency Reliance | 9.00% | 15.44% | Aug-22 | (common cause) | 14.09% | Jul-22 | F |
| 67 | Monthly Pay Spend (Contracted & Non-Contracted) | £19,657,809.00 | £20,282,194.81 | Aug-22 | (common cause) | £19,820,097.35 | Jul-22 | ? |

# Statistical Process Control - Assurance & Variation

**Key:**

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target*

Inconsistently passes and fail the target*

Consistently fails the target*
*based on the last 6 datapoints/months

**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 68 | Core/Mandatory Training | 85.00% | 85.57% | Aug-22 | H | 85.25% | Jul-22 | P |
| 69 | Role Specific Training | 85.00% | 91.62% | Aug-22 | No SPC | 91.60% | Jul-22 | P |
| 70 | Safeguarding Training | 83.00% | 71.35% | Aug-22 | No SPC | 70.80% | Jul-22 | No SPC |
| 71 | % Workforce carrying out an Apprenticeship Qualification | 2.30% | 2.56% | Aug-22 | No SPC | 2.43% | Jul-22 | P |
| 72 | PDR Compliance | 79.00% | 62.96% | Aug-22 | | 62.53% | Jul-22 | ? |

# Statistical Process Control - Assurance & Variation

**Appendix 1**

**Key:**

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target*

Inconsistently passes and fail the target*

Consistently fails the target*
*based on the last 6 datapoints/months

**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

| | FINANCE & SUSTAINABILTY | Latest | | | | Previous | | Assurance |
|---|---|---|---|---|---|---|---|---|
| | | Plan/Target | Actual | Period | Variation | Actual | Period | |
| 73 | Trust Financial Position £m (Cumulative) | -6.28 | -6.53 | Aug-22 | | -5.56 | Jul-22 | |
| 74 | Cash Balance £m | 21.76 | 40.70 | Aug-22 | H | 22.95 | Jul-22 | P |
| 75 | Capital Programme Spend £m (Cumulative) | 5.521 | 3.59 | Aug-22 | No SPC | 3.77 | Jul-22 | |
| 76 | Better Payment Practice Code (Cumulative) | 95% | 93% | Aug-22 | | 93% | Jul-22 | F |
| 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 | Jun-22 | No SPC | 1.20 | May-22 | No SPC |
| 79 | Cost Improvement Programme – Forecast (Recurrent) £m | 6.50 | 2.10 | Jun-22 | No SPC | N/A | N/A | No SPC |

Key:

System Oversight Framework

Care Quality Commission

SOF    Risk Register    RR116

CQC    Trust Strategy    ⭐

## Quality Improvement - Trust Position

**Appendix 2**
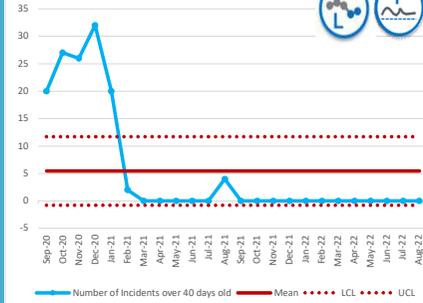
**Trust Performance**

**Trend**

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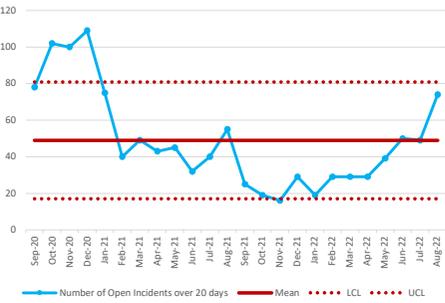
**What are the reasons for the variation and what is the impact?**

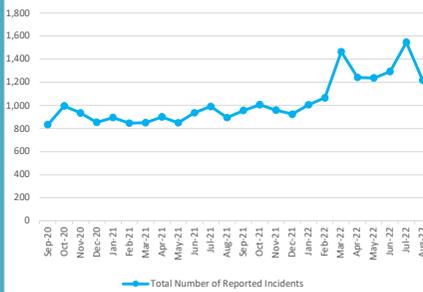**How are we going to improve the position (Short & Long Term)?**

SOF  CQC

**1. Incidents**

**Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**

There were 0 incidents over 40 days old and 74 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.

### Open Incidents - 40 Days

L  P

(chart: Number of Incidents over 40 days old — Mean — LCL — UCL)

### Open Incidents - 20 Days

(chart: Number of Open Incidents over 20 days — Mean — LCL — UCL)

### Total Incidents Reported

(chart: Total Number of Reported Incidents)

### Serious Incidents & Never Events

(chart: Serious Incidents — Mean — LCL — UCL — NEVER EVENTS)

### Serious Incidents Actions Breached

(chart: Serious Incidents Actions breached — Mean — LCL — UCL)

Incident reporting remains within range with little variance across the Trust.

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

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

TThere are 0 incidents over 40 days-sustained position

There were 7 serious incidents reported in August 2022. An increase of 5 compared to previous month.

There were 12 breached serious incident actions in August 2022.

The Report to Improve Campaign continues with close weekly monitoring of incident reporting Trust wide, CBU and speciality specific. A weekly overview is provided to the Executive Team in the form of a governance dashboard. The governance team continue to monitor and escalate themes and trends.

Weekly CBU monitoring supports with timely escalation to the Associate Director of Governance to ensure the position is sustained.

This is within statistical control

Weekly monitoring continues with appropriate escalation to the CBU leads. This has been contributed to by staffing deficits across the Integrated Medicine CBU. This position has now improved with 4 actions open.

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**Key:**

System Oversight Framework    SOF    Risk Register    RR116

Care Quality Commission    CQC    Trust Strategy

**Appendix 2**

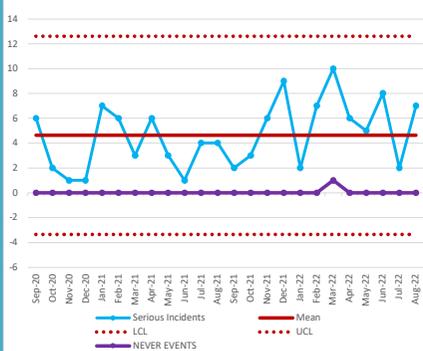| Trust Performance | Trend | Statistical Narrative | What are the reasons for the variation and what is the impact? | How are we going to improve the position (Short & Long Term)? |
|---|---|---|---|---|

CQC

**2. Duty of Candour**

**Target: 100%**

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

### Duty of Candour (DoC) - Moderate Incidents

Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22

—— % Compliance rate with DoC (moderate incidents)

### Duty of Candour (DoC) - Serious Incidents

Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22

—— % Compliance rate with DoC (serious incidents)

**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.**

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**Key:**

System Oversight Framework | SOF | Risk Register | RR116

Care Quality Commission | CQC | Trust Strategy | ⭐

## Quality Improvement - Trust Position
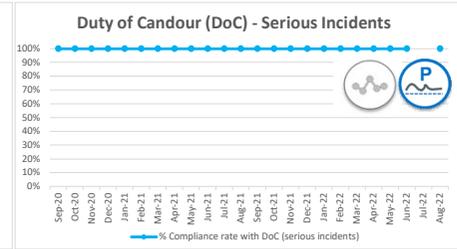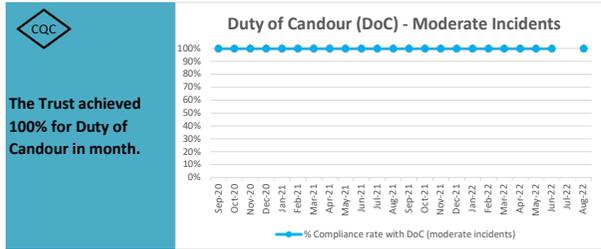
**Appendix 2**

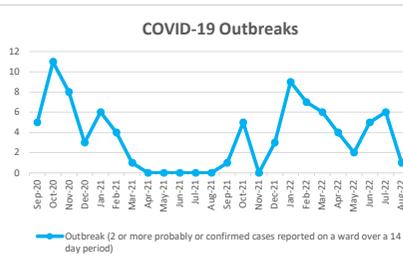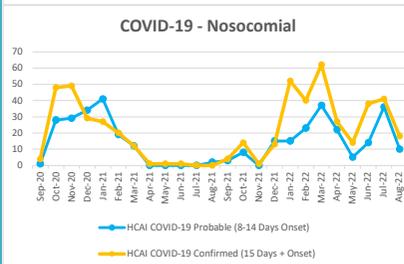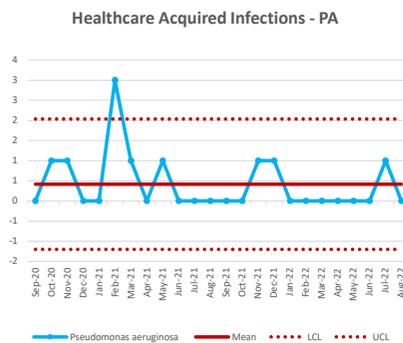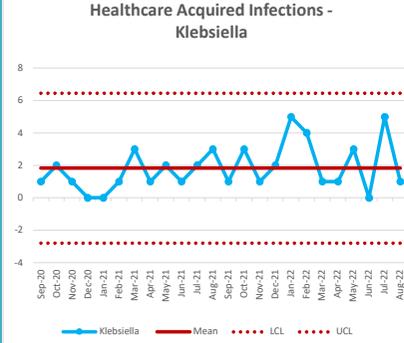| Trust Performance | Trend | Statistical Narrative | What are the reasons for the variation and what is the impact? | How are we going to improve the position (Short & Long Term)? |
|---|---|---|---|---|

SOF  CQC  S

**3. Healthcare Acquired Infections (MRSA)**

**Target: ZERO**

**4. Healthcare Acquired Infections (CDI)**
Target: Less than 37 -annual

**5. Healthcare Acquired Infections (Ecoli)**
Target: less than 57 - annual
**(Klebsiella)**
Target: Less than 19 - annual
**(PA)**
Target: Less than 6 - annual
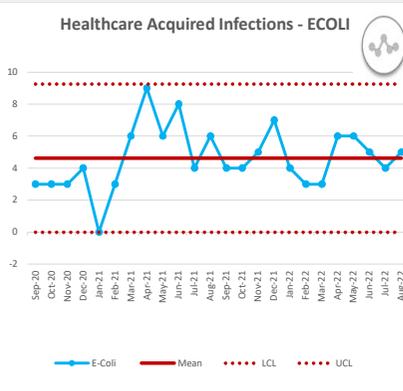
**6. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)**
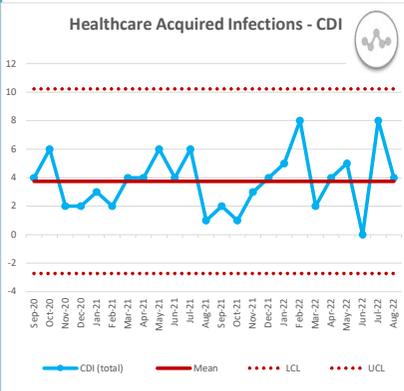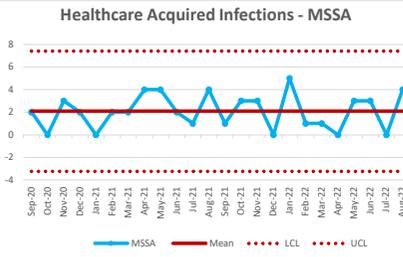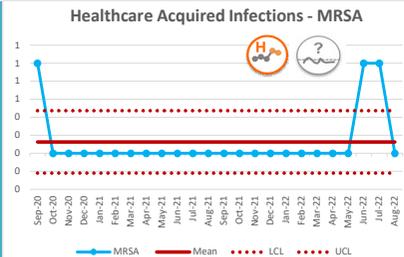
RR1275

**MRSA 2 cases over threshold**
**MSSA 10 cases YTD - no threshold set**
**CDI 21 cases YTD, above trajectory**
**E. coli 26 cases YTD (3 cases over trajectory)**
**Klebsiella spp. 10 cases YTD (on trajectory)**
**P. aeruginosa 1 case YTD (1 case under trajectory)**
**COVID-19:**
**87 day 8-14 cases probable healthcare associated cases YTD**
**138 day 15+ cases definite healthcare associated YTD**
**1 COVID-19 outbreaks**

### Healthcare Acquired Infections - MRSA



### Healthcare Acquired Infections - MSSA



### Healthcare Acquired Infections - CDI



### Healthcare Acquired Infections - ECOLI



### Healthcare Acquired Infections - Klebsiella



### Healthcare Acquired Infections - PA



### COVID-19 - Nosocomial



### COVID-19 Outbreaks



**(MRSA) Assurance:** The Trust inconsistently passes/fails the target.
**(MRSA) Variation:** Special Cause Variation of a concerning nature.

**(CDI) Assurance: N/A Annual Target**
**(CDI) Variation: Common Cause (Normal) variation.**

**(ECOLI) Assurance: N/A Annual Target**
**(ECOLI) Variation: Common Cause (Normal) variation.**

**N/A - No target.**

Both cases thought to be Urinary tract infection associated. Case 1 avoidable. Case 2 under review.

Higher incidence of C. difficile across the northwest and 18 acute Trusts were above last years set threshold. Increase in antibiotic prescribing associated with respiratory infections & COVID-19.

The change in the apportionment rule has increased the number of GNBSI cases apportioned to the Trust.
Work has been carried out with the Quality Academy to implement improvements in patient care.

Increase in numbers cases in the community and patients being admitted with COVID-19

Action plans are in place for the prevention of HCAIs with a focus on invasive device management. Additional training provided on IV device management to areas identified with opportunities for improvement.

CDI prevention strategy and and a review of proton pump inhibitor medication with the Gastroenterology Team continues
Focus on environmental hygiene and use of HPV. Hand Hygiene promotion strategy for patients and revise education plan for staff. Root cause analysis investigations to identify learning. Awareness raising campaign in production and programme of work being undertaken with regard to redcing antibiotic prescribing.

Quality Academy support is in place with 8 wards engaged in a collaborative. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. The UTI pathway was launched at Grand Round in May 2022. An audit of Klebsiella spp. cases identified missed blood culture sampling opportunities and care of urinary catheter as areas for care improvement.

Close liaison with the operational teams to support patient placement. Risk assessments in place to prevent vulnerable patient contact with Covid exposed patients. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients and staff.

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**Key:**

System Oversight Framework

Care Quality Commission

| SOF |
| CQC |

Risk Register | RR116

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)? |

SOF ☆

**7. VTE Assessment**

**Target: 95% (quarterly position)**

The Trust achieved the required target at 95.39% for VTE assessments in August 2022.

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

**Variation: Special cause variation of a concerning nature.**

Trust target of 95% was achieved in August 2022. Year to date performance has improved to 95.17 % at end of August 2022.

**Current systems in place to improve VTE compliance:**
**1. Use initial clinical assessment and ward round forms incorporated with VTE risk assessment (RA)form for compliance within 14 hours of admission - launched Trust-wide with new intake of August 2022 trainees.**
**2. Monthly CBU VTE RA compliance data has been distributed to all CBU Governance Meetings since April 2022 on monthly basis for feedback and improvement plans.**
**3. All doctors responsible for non-completion of VTE risk assessment within 14 hours are emailed directly to raise the awareness of the importance of completion of VTE RA for learning purposes.**

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**Key:**

System Oversight Framework

Care Quality Commission

| SOF | | Risk Register | RR116 |
| CQC | | 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)? |
|---|---|---|---|---|

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

**104 total falls were reported in August 2022. 78 of these were inpatient falls. There were 4 inpatient falls with harm: 1 on ACCU, 1 on A7 and 2 on A8 (these falls affected the same patient on A8). All 4 falls with harm are being investigated through the governance process: the fall on A7 as an SI and the remainder as concise RCAs.**



Inpatient Falls

All Falls

Falls - All Harm

Falls Per 1000 Bed Days

Falls - Avoidable Harm
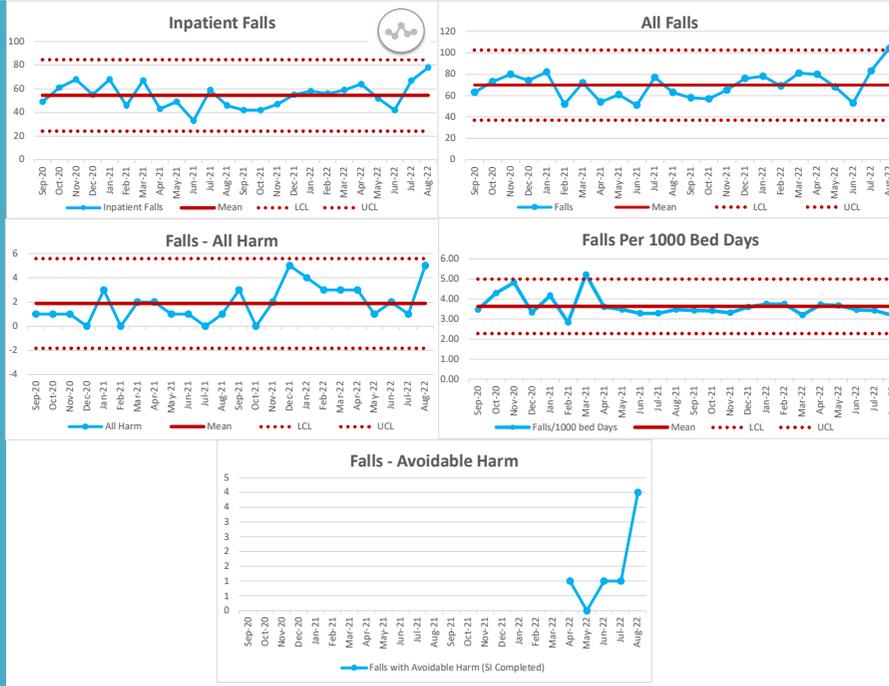
**Assurance: N/A Annual Target.**

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

**Higher demand of patients with enhanced care requirements have been identified as a contribution to increased inpatient falls.**

**A focussed piece of work to reduce patient deconditioning is underway. Falls Week will be held week commencing 19th September with training events reinforcing the use of falls prevention equipment. Weekly Falls Review meeting continue with shared learning. The Associate Chief Nurses have improvement plans for areas with higher numbers of falls. The Quality Improvement Team are supporting the nursing teams to reduce falls and subsequent harm. It is recognised that the number of super stranded patients at risk of deconditioning will increase the risk of patient falls.**

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

**There were 10 hospital acquired category 2 pressure ulcers in August 2022.**



Pressure Ulcers - Category 2

Pressure Ulcers - Category 3

Pressure Ulcers - Category 4

Community Acquired Pressure Ulcers
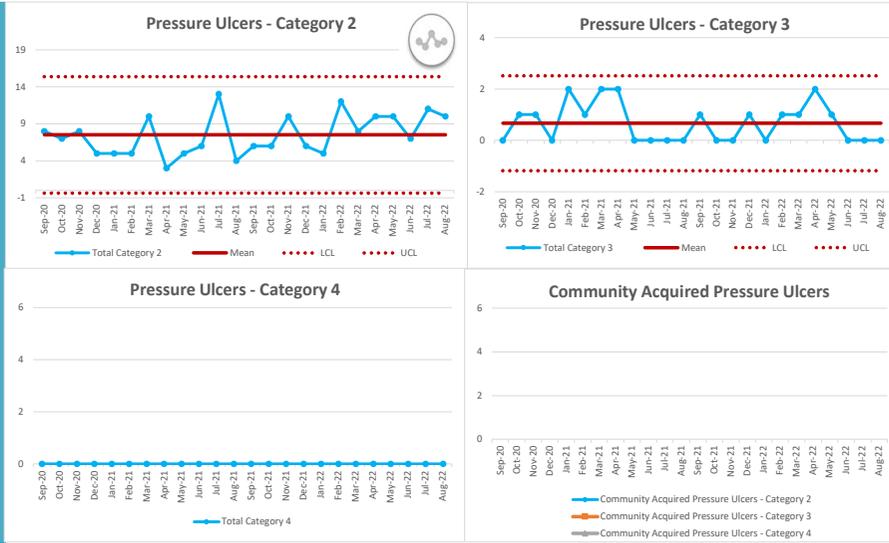
**Assurance: N/A Annual Target.**

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

**Lack of recognition of risk and the prolonged length of time on trolleys in the Emergency Department have been identified as themes. Variation in the frequency of prescribed pressure prevention care on the wards has contributed to the incidence of pressure ulcers.**

**Work is ongoing in the Emergency Department to improve risk recognition. A Quality Improvement Programme Change Package to spread and sustain improvements has been launched. A dedicated study day for the ward champions was held in September with good attendance. Training is in place with compliance across the wards improving. Root cause analysis meetings continue on a monthly basis chaired by the Deputy Chief Nurse. Improvement action plans are in place in local areas. No category 3 pressure ulcers have been recorded in the Trust since May 2022**

**NHS**
**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

## Quality Improvement - Trust Position
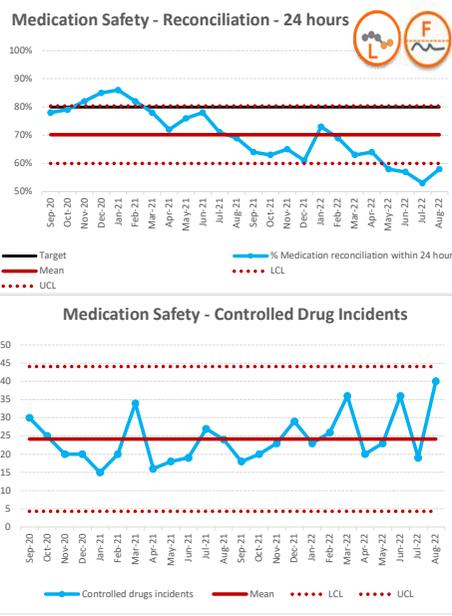
**Appendix 2**

| 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 58% for medicines reconciliation within 24 hours and 85% for overall medicines reconciliation.

There were 40 controlled drug incidents, this is higher than the 2 preceding months.



Medication Safety - Reconciliation - 24 hours

Medication Safety - Reconciliation - Overall

Medication Safety - Controlled Drug Incidents

Medication Safety - Incidents with Harm

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

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

% medicines reconciliation achieved within 24 hours continues to be adversely impacted by the need for a focus on managing system pressures. Training of new members of staff and staff absences within the team that have resulted in gaps in rotas have also had an impact.

Controlled drug incident reporting increased following the CD audits undertaken in month. The majority of controlled drug incidents are documentation, policy or administration related, action plans for improvement are developed with each area and shared.

With staff in post and use of real time data (new database), work will focus on undertaking MRs closer to the front door and raising overall % in Surgical Specialties & Women's & Children's. Review of patients who did not receive a medicines reconciliation is undertaken to assess/report risk/harm. Ongoing recruitment.

Monthly self-assessment and quarterly CD audits continue, with support in place for areas highlighted for improvement. Medicines Improvement Group membership includes the Senior AHP Manager & Senior Nurse Manager, Planned Care for oversight of process in their areas of responsibility.

**11. Staffing - Average Fill Rate**
Target: 90%

RR115   RR1108

In August 2022, the average staffing fill rates were:
Day (Nurses/Midwife) 84%
Day (Care Staff) 85%
Night (Nurses/Midwife) 92%
Night (Care Staff) 87%



Staffing - Average Fill Rate - Day Nurses/Midwives

Staffing - Average Fill Rate - Day Care Staff

Staffing - Average Fill Rate - Night Nurses/Midwives

Staffing - Average Fill Rate - Night Care Staff
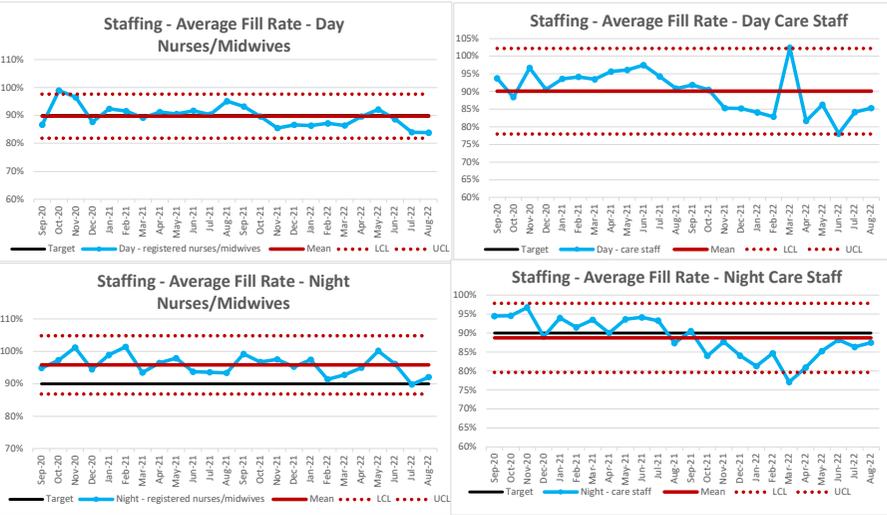
**Assurance:** N/A Grouped Indicator

**Variation:** N/A Grouped Indicator

Additional beds in use across the Trust due to increased demand through the Emergency Department, increased sickness rates, increased acuity and a large number of super stranded are contributing factors to the reduction of fill rates across the Trust.

Staffing is reviewed twice daily by the Senior Nursing Team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. The Safe Care tool is completed daily to determine whether the right amount of staff are in place in accordance with acuity and dependency. Robust recruitment for both RN's and HCSW's is in place and work to review agency/core staffing ratios is underway. Buddy programmes for new starter RN's and HCSW's are being finalised for Autumn start

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Path : P:\Performance-Framework\Executive\Reports\Integrated Dashboard\202223\5. August 2022\ File - IPR-MASTER-202223-August-22FINAL.xlsx Tab - [Tab]    Page 15 of 39    Printed on 22/09/2022 at 12:49

**Key:**

System Oversight Framework    SOF    Risk Register    RR116

Care Quality Commission    CQC    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)? |
|---|---|---|---|---|

### Staffing - CHPPD - Overall



### Staffing - CHPPD - Cumulative



### Staffing - CHPPD - by Staff Group



### Staffing - CHPPD - Benchmarking



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

In August 2022, the average CHPPD were:
Nurse/Midwife: 4.2 hours
Care Staff: 3.0 hours
Overall: 7.2 hours

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

**Variation:** Special Cause Variation of an Concerning Nature.

The CHPPD August data is higher than noted for July. CHPPD for August 2022 is at the lower end of normal variation, the themes identified for this are due to higher sickness rates and the necessity to staff extra beds opened due to increased activity and higher numbers of super stranded patients.

Work continues to reduce vacancies, increase NHSP shift fill and reduce agency usage through the NHSP CAMS project.
Cohort 6 and 7 of the overseas recruits are now in the country with 15 RN's due on wards in September a further 15 in December.

---

### HSMR



### SHMI



**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 89.02. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 97.26.

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

The CHPPD August data is higher than noted for July. CHPPD for August 2022 is at the lower end of normal variation, the themes identified for this are due to higher sickness rates and the necessity to staff extra beds opened due to increased activity and higher numbers of super stranded patients.

Work continues to reduce vacancies, increase NHSP shift fill and reduce agency usage through the NHSP CAMS project.
Cohort 6 and 7 of the overseas recruits are now in the country with 15 RN's due on wards in September a further 15 in December.

**Key:**

System Oversight Framework

Care Quality Commission

SOF    Risk Register    RR116

CQC    Trust Strategy

## Quality Improvement - Trust Position

**Appendix 2**

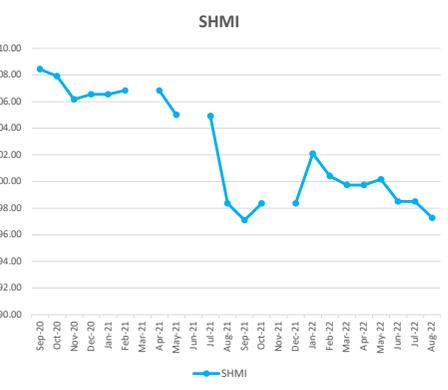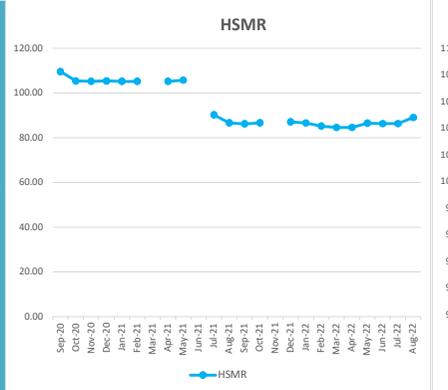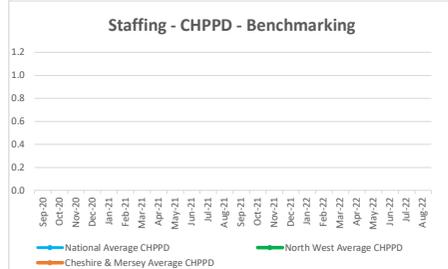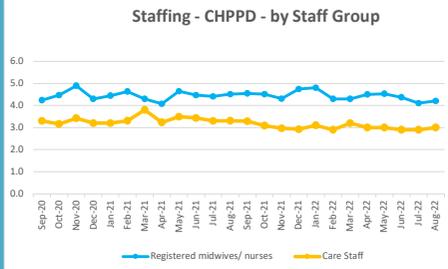| Trust Performance | Trend | Statistical Narrative | What are the reasons for the variation and what is the impact? | How are we going to improve the position (Short & Long Term)? |

### NICE Compliance



**15. NICE Compliance**

**Target: 90%**

The Trust achieved 92.02% in month.
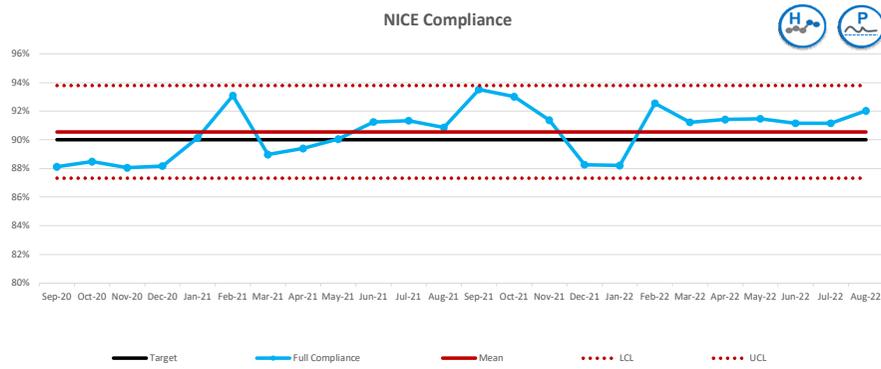
**Assurance:** The Trust consistently passes the target.

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

The Trust has met the target of achieving over 90% compliance. Sustained position.

The Clinical Effectiveness Manager is working closely with leads to complete the outstanding guidelines, and a review of partial compliant guidance is ongoing to ensure action plans are in place and regularly monitored through CBU Governance meetings.

---

### Complaints - Over 6 months old



### Complaints - Closed in Month



### Complaints - Responded in Timeframe



### Complaints - Open 1st Response



### Complaints - Received in Month



### Complaints - PHSO



**16. Complaints**

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

In August, 32 new complaints were received to the Trust which was an increase of 7 from the previous month. There were 2 dissatisified received in month, which is an increase from the previous month.
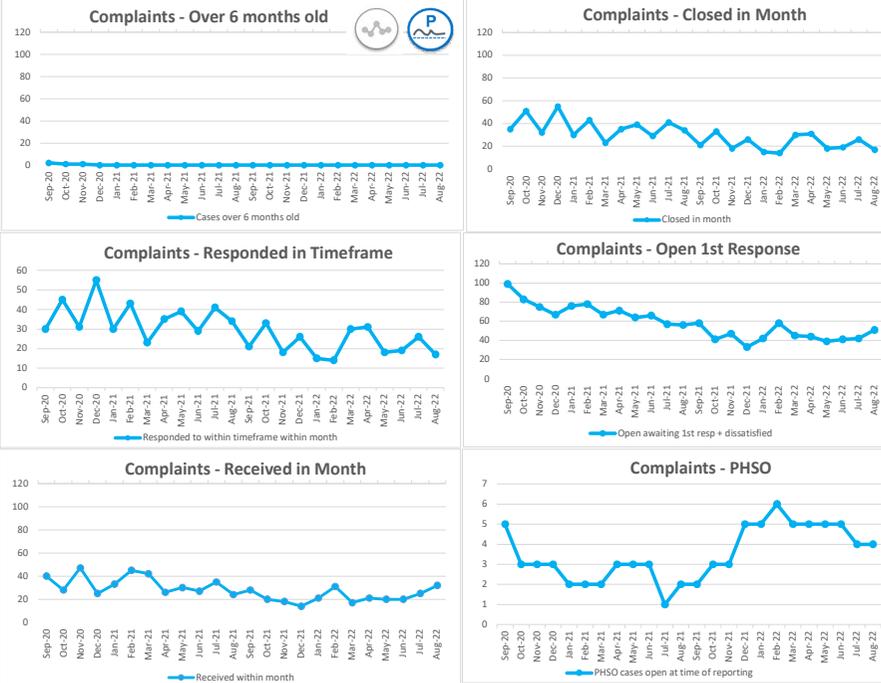
**Assurance:** The Trust consistently passes the target.

**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 within timeframes.

All complaints continue to be monitored to ensure timely response. PALS continues to offer effective and timely resolve. All complainants continue to be offered a meeting as an initial measure of resolution. The Complaints Team are currently developing a process mapping tool to further improve the efficiency of the complaints process. Formal complaints training sessions have been held in August 2022 with further dates scheduled for September 2022.

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## Quality Improvement - 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)? |
|---|---|---|---|---|

**17. Friends and Family (Inpatients & Day cases)**

Target: 95%

**18. Friends and Family (ED and UCC)**

Target: 87%

The Trust achieved 96.00% in month for Inpatient & Day case FFT and 72.00% for ED/UCC FFT.



Friends and Family (Inpatients & Daycase)



Friends and Family (ED and UCC)



FFT Inpatients/Day Case - National, Regional, Cheshire & Mersey



FFT Emergency Department - National, Regional, Cheshire & Mersey

**(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 72.00% positive feedback in Friends and Family Test results in August 2022 which is a 2% improvement from the previous month and mirrors ED FFT performance across the Cheshire and Merseyside footprint.

Inpatient/Day Case - The Trust achieved 96.00% positive recommendation rate in August 2022.

ED/UCC - Action plans in place with key themes for improvement being wait times and communication. Measures taken in month to improve patient experience within the emergency department include but are not limited to:
- Observational and support visits from Patient Experience and Inclusion Team.
- Scoping exercise underway to enhance volunteer support for the dept

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 August 2022. There were 7 MSA incidents within the ITU.



Mixed Sex Accommodation Breaches - Non ICU



Mixed Sex Accommodation Breaches - ICU

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

**Variation:** N/A - not enough datapoints.

There were 7 mixed sex accommodation breaches reported in August 2022 in the Intensive Care Unit. There were zero breaches within any other ward area. Themes identified are due to increased demand for medical beds from the Emergency Department.

A focussed piece of work is being completed in the Unplanned Care Group to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each bed meeting.

**NHS**
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NHS Foundation Trust

**Key:**

System Oversight Framework

Care Quality Commission

SOF

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**Quality Improvement - Trust Position**

**Appendix 2**

**Trust Performance**

**Trend**

**Statistical Narrative**

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

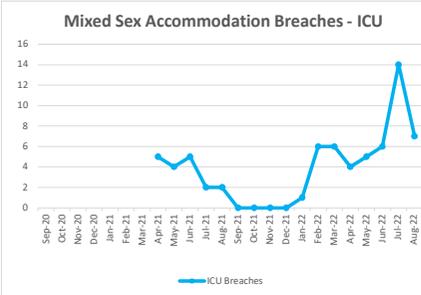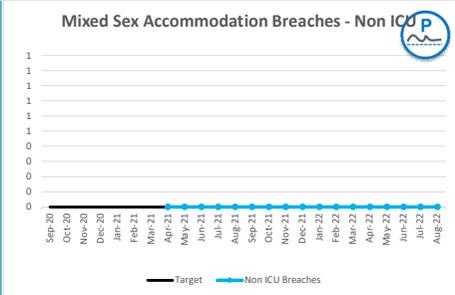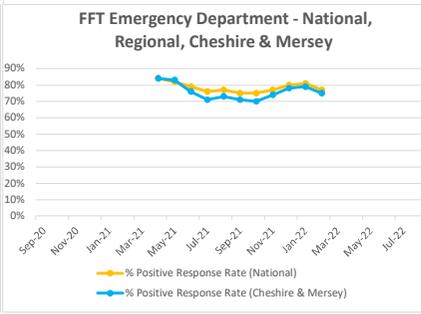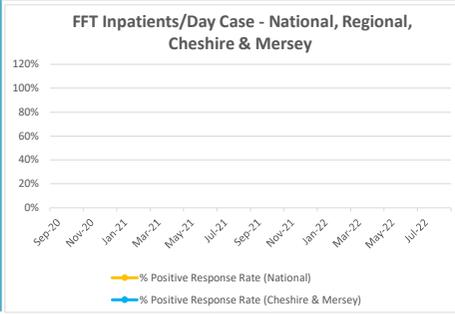**How are we going to improve the position (Short & Long Term)?**

**20. Continuity of Carer Target: 51%**
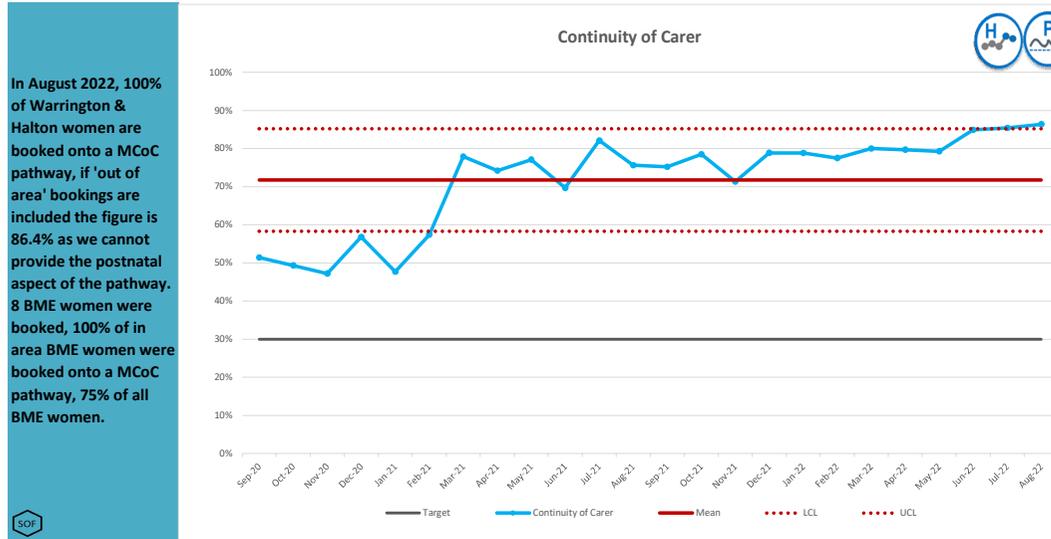
In August 2022, 100% of Warrington & Halton women are booked onto a MCoC pathway, if 'out of area' bookings are included the figure is 86.4% as we cannot provide the postnatal aspect of the pathway. 8 BME women were booked, 100% of in area BME women were booked onto a MCoC pathway, 75% of all BME women.

### Continuity of Carer



Target — Continuity of Carer — Mean ····· LCL ····· UCL

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

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

The Trust achieved 86.4% onto a CoC pathway (including intrapartum care) in August 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 2021 in relation to Continuity of Carer and a revised action plan has been agreed and submitted to the LMNS and national team.

Key:

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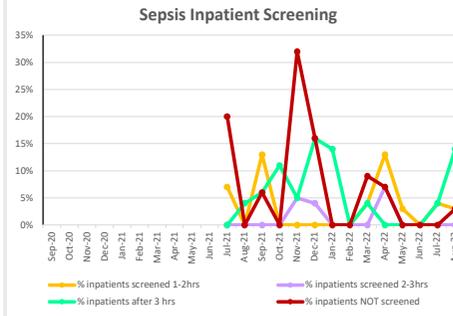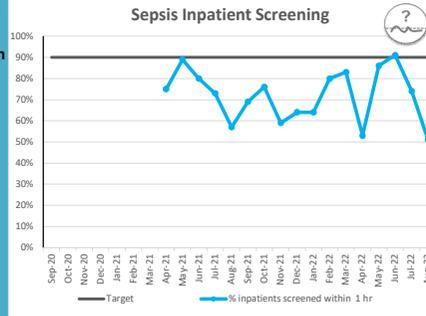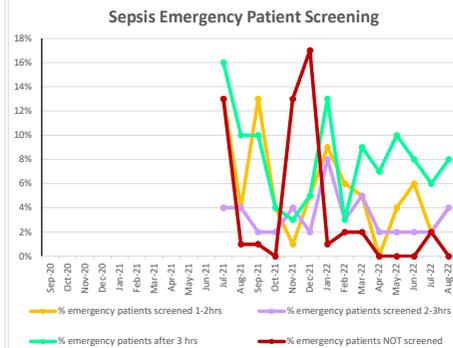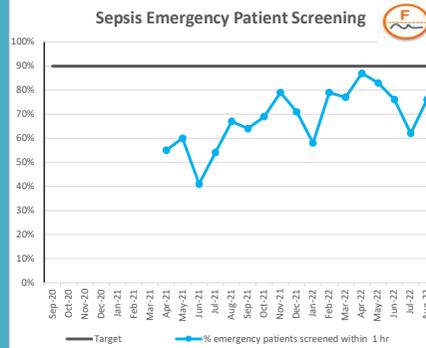
**21. Sepsis - % screening for all emergency patients. Target: 90%**

**22. Sepsis - % screening for all inpatients Target: 90%**

**The Trust achieved:**
**• 76.00% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.**
**• 51.00% screening for all inpatients with suspected sepsis within 1 hour.**

### Sepsis Emergency Patient Screening

F

Target — % emergency patients screened within 1 hr

### Sepsis Emergency Patient Screening

— % emergency patients screened 1-2hrs — % emergency patients screened 2-3hrs
— % emergency patients after 3 hrs — % emergency patients NOT screened

### Sepsis Inpatient Screening

?

Target — % inpatients screened within 1 hr

### Sepsis Inpatient Screening

— % inpatients screened 1-2hrs — % inpatients screened 2-3hrs
— % inpatients after 3 hrs — % inpatients NOT screened

**(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 overcrowding and corridor care in the Emergency Department has contributed to the inability to screen all patients with suspected sespis within 1 hour.**

**Sepsis awareness events held in September for World Sepsis Day and one week of daily Hot Topics supported by the Infection Prevention and Control and Acute Care Team. Sepsis Improvement Groups continue for both Emergency and in patients with support from the Quality Improvement Teams. Sepsis management is part of Safety Huddles in the clinical areas. Training compliance continues to improve at 78%. Training for FY1 doctors is in place. Awaiting appointment of medical lead for the Trust.**

**NHS**
**Warrington and Halton Teaching Hospitals**
NHS Foundation Trust

Key:

System Oversight Framework | SOF | Risk Register | RR116

Care Quality Commission | CQC | Trust Strategy | ★

## Quality Improvement - Trust Position

**Appendix 2**

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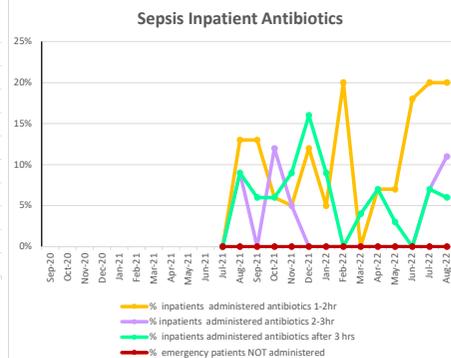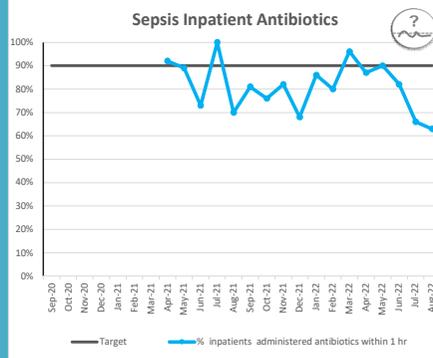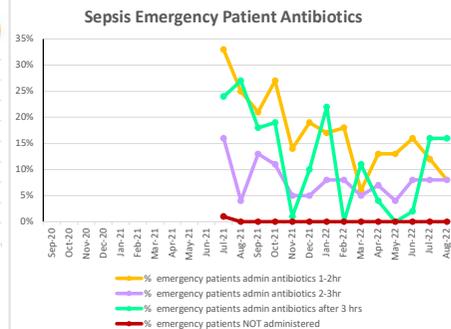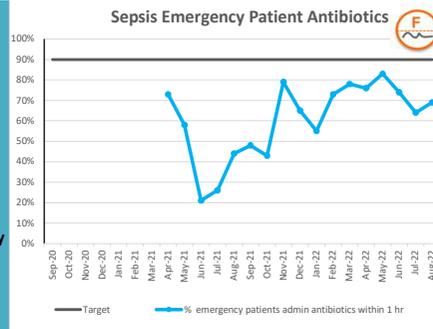
**23. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag Target: 90%**

**24. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis Target: 90%**

The Trust achieved:
• **69.00% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.**
• **63.00% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**



Sepsis Emergency Patient Antibiotics



Sepsis Emergency Patient Antibiotics

— Target
— % emergency patients admin antibiotics within 1 hr

— % emergency patients admin antibiotics 1-2hr
— % emergency patients admin antibiotics 2-3hr
— % emergency patients admin antibiotics after 3 hrs
— % emergency patients NOT administered



Sepsis Inpatient Antibiotics



Sepsis Inpatient Antibiotics

— Target
— % inpatients administered antibiotics within 1 hr

— % inpatients administered antibiotics 1-2hr
— % inpatients administered antibiotics 2-3hr
— % inpatients administered antibiotics after 3 hrs
— % emergency patients NOT administered

**(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 increased number of attendances within the Emergency Department has contributed to the reduction in patients recieving antibiotics within 1 hour of suspected sepsis diagnosis.**

**A mapping exercise is planned for the Quality Improvement Team to undertake to determine barriers to timely administration of antibiotics on inpatient wards. The Patient Safety Nurses review NEWS 2 scores for inpatients daily and follow up any triggers for Sepsis. Sepsis awareness events held in September for all staff. Sepsis recognition and management review by Senior nurses was undertaken in August accompanied by the Trust Chair, good compliance was noted.**

![NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust]

**Key:**

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|---|---|---|---|---|

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

There was a total of 101 ward moves between 10pm-6am in August 2022 compared to 77 in August 2021.

### Ward Moves 10:00pm - 06:00am



Number of Ward Moves – August 2022 ·····  Number of Ward Moves - August 2021
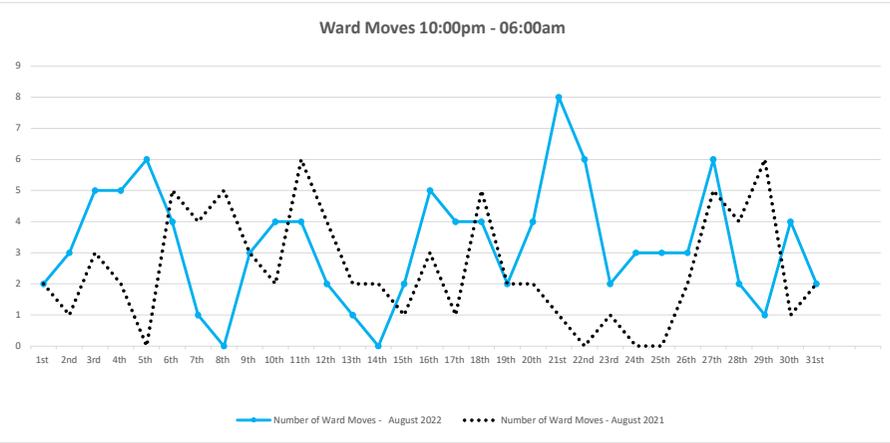
N/A - Monthly/Annual Comparison.

The reason for the increase in ward moves after 10pm for this reporting period compared to August 2021 is as a result of the increased attendances the requirement to place patients onto wards to support flow through the Emergency Department and the high number of super stranded patients in the Trust.

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 182 acute kidney injuries reported in month.

### Acute Kidney Injury



Number of Hospital Acquired Acute Kidney Injuries Reported

### Average Length of Stay AKI Patients



Average Length of Stay (Days)
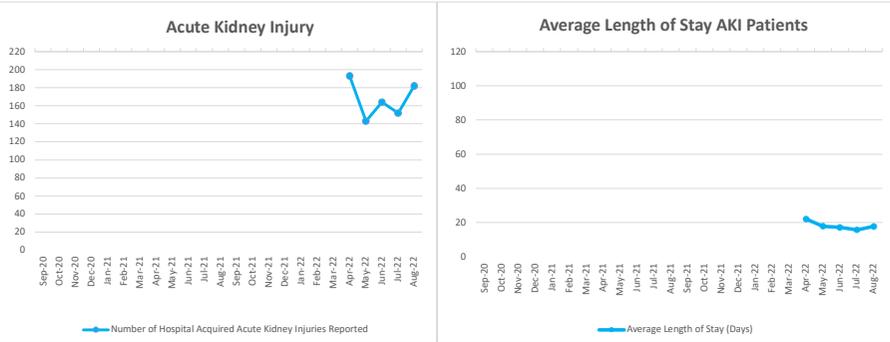
N/A - Not enough datapoints.

The increased length of Stay (LOS) across the Trust has been identified as a contributory factor to the development of AKI.

AKI Hot Clinic commenced in August 2022 along with a new AKI role within the Acute Care Team.

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**27. CAS Alerts -**
Target: All relevant CAS Alerts actioned within timescales

There were 0 CAS alerts with breached actions in month.
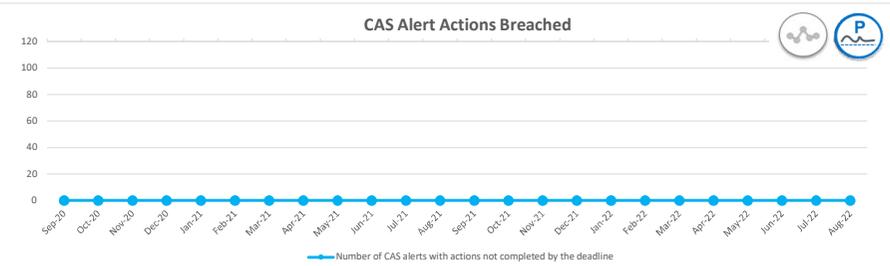
### CAS Alert Actions Breached



Number of CAS alerts with actions not completed by the deadline

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

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

There is no variance from the previous month as no alerts have been breached.

CAS alerts are monitored via the Trusts Health Safety Sub-Committee and Medical Devices Group. Action plans and monitoring arrangements are reviewed weekly by the Health & Safety Department.

**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)? |
|---|---|---|---|---|

SOF CQC

**28. Diagnostic Waiting Times 6 Weeks**

**Target: 99%**

RR1215 RR1125

The Trust achieved 78.54% in month.
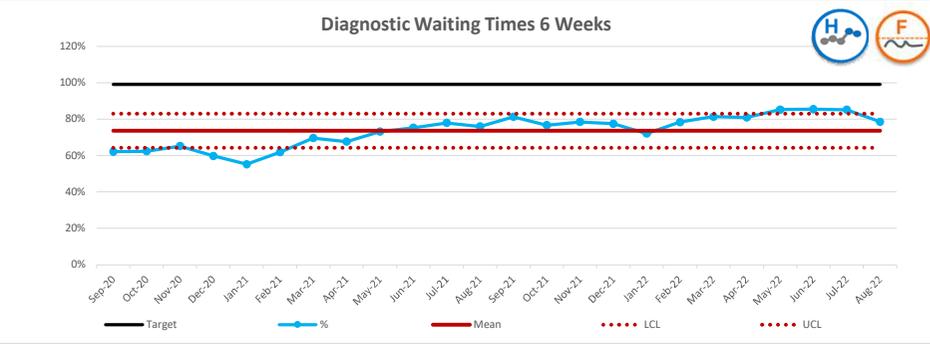
### Diagnostic Waiting Times 6 Weeks



Legend: Target, %, Mean, LCL, UCL

**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 Endoscopy, Cardiorespiratory and Cystoscopy

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SOF CQC

**29. Referral to treatment Open Pathways**

**Target: 92%**

**30. RTT - Number of patients waiting 104+ weeks Target: ZERO**

RR1125 RR1215

The Trust achieved 62.45% in month. There were 1448, 52 week breaches and 8, 104 week breaches in August 2022.
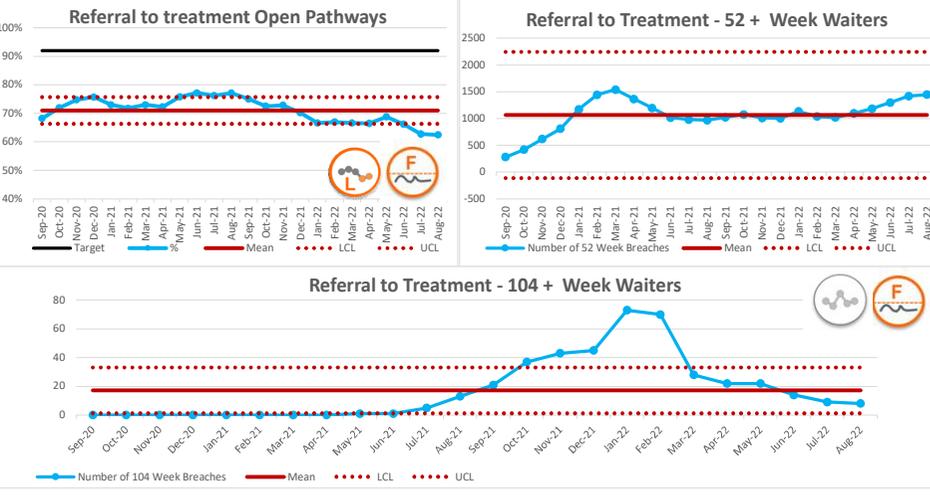
### Referral to treatment Open Pathways



Legend: Target, %, Mean, LCL, UCL

### Referral to Treatment - 52 + Week Waiters



Legend: Number of 52 Week Breaches, Mean, LCL, UCL

### Referral to Treatment - 104 + Week Waiters



Legend: Number of 104 Week Breaches, Mean, LCL, UCL

**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 August 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 8 104 breaches were a combination of patient choice (P6) COVID positive and not medically fit for surgery.

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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)? |
|---|---|---|---|---|

**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**

The Trust achieved 72.10% excluding Widnes walk ins in month.

### A&E Waiting Times - 4hr target



Legend: Improvement Trajectory — % (Excluding Walk-In) — Mean — LCL — UCL

**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. A Norovirus outbreak in August leading to ward closures had a significant impact on flow.

• 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.
• Same Day Emergency Care Centre opens July 2022.

**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**

17.00% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 339 minutes.

### % of Patients Waiting Longer than 12 Hours in A&E



Legend: Target

### Average Time in Department



Legend: Average Time in Department (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.

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Path - P:\Performance-Framework\Executive\Reports\Integrated Dashboard\202223\5. August 2022\ File - IPR-MASTER-202223-August-22FINAL.xlsx Tab - [Tab]   Page 24 of 39   Printed on 22/09/2022 at 12:49

# Warrington and Halton Teaching Hospitals
## NHS Foundation Trust

## Access & Performance - Trust Position

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

**SOF  CQC**

**35. Cancer 14 Days**

Target: 93%

**36. Breast Symptoms 14 Days**

Target: 93%

RR1125

**The Trust achieved 86.54% in July 2022 for Cancer 14 days and 88.24% in July 2022 for Breast Symptomatic.**

### Cancer 14 Days



### Breast Symptoms 14 Days
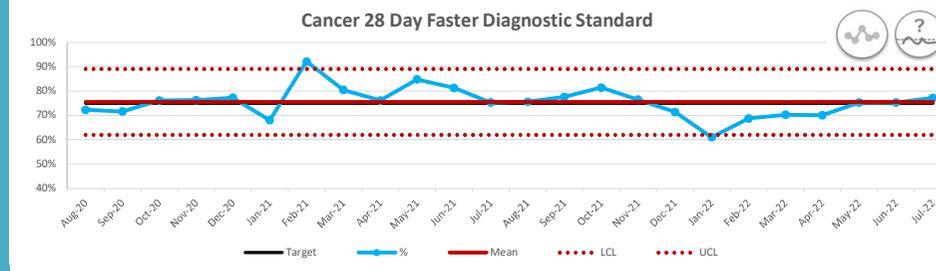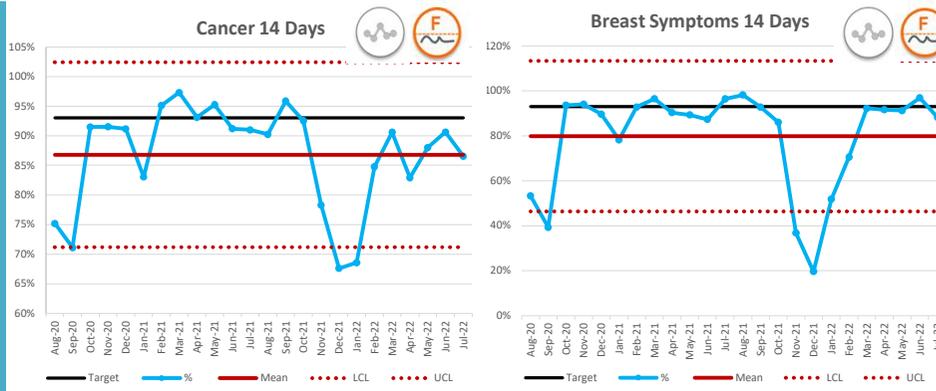


**(C14) Assurance:** The Trust consistently fails the target.
**Variation:** Common Cause (normal) variation.

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

**Overall the 2 Week Wait narrowly missed the target in July with the continued impact of Wave 7 over this period. 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.**

**SOF**

**37. 28 Day Faster Cancer Diagnosis Standard**
Target: 75%

**The Trust achieved 77.17% in July 2022**

### Cancer 28 Day Faster Diagnostic Standard



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

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

**This indicator is still being impacted by waves of COVID-19 and an increase in referrals seen as a result of the pandemic and an increase awareness of certain cancer groups.**

**The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and the KPI Sub-Committee.**

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# Access & Performance - Trust Position

**Key:**

| | | |
|---|---|---|
| Risk Register | RR116 | System Oversight Framework |
| | | Care Quality Commission |

SOF

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)? |
|---|---|---|---|---|

SOF  CQC

**38. Cancer 31 Days First Treatment**

Target: 96%

**39. Cancer 31 Days Subsequent Surgery**

Target: 94%

**40. Cancer 31 Days Subsequent Drug**

Target: 98%

RR1125

The Trust achieved 98.57% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in July 2022.

### Cancer 31 Days First Treatment



### Cancer 31 Days Subsequent Surgery



### Cancer 31 Days Subsequent Drugs



**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 July 2022. 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.

SOF  CQC

**41. Cancer 62 Days Urgent**

Target: 85%

**42. Cancer 62 Days Screening**

Target: 90%

RR1125

The Trust achieved 70.75% for Cancer 62 Day Urgent and 100% for Cancer 62 Day Screening in July 2022.

### Cancer 62 Days Urgent



### Cancer 62 Days Screening



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

**(Screening) Assurance:** The Trust inconsistently passes/fails the target.
**Variation:** Common Cause (Normal) variation.

The 62 day urgent target was not achieved in July 2022 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.

Risk Register | RR116 | System Oversight Framework | SOF

Care Quality Commission | CQC

# Access & Performance - Trust Position

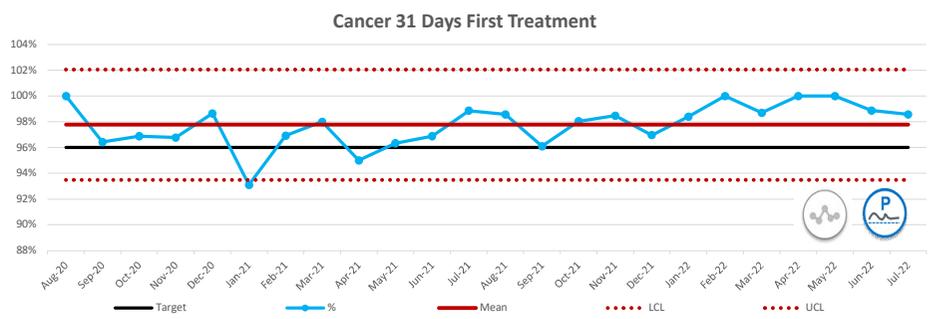| Trust Performance | Trend | Statistical Narrative | What are the reasons for the variation and what is the impact? | How are we going to improve the position (Short & Long Term)? |

**43. Ambulance Handovers within 15 minutes**

Target: 65%

**44. Ambulance Handovers within 30 minutes**

Target: 95%

**45. Ambulance Handovers within 60 minutes**

Target: 100%

**In month 34.31% of patients were handed over within 15 minutes, 59.24% were handed over within 30 minutes and 72.92% were handed over within 60 minutes.**

### Ambulance Handovers within 15 minutes

### Ambulance Handovers within 30 minutes

### Ambulance Handovers 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.**

**46. Discharge Summaries - % sent within 24hrs**

Target: 95%

**47. Discharge Summaries - Number NOT sent within 7 days**

Target: ZERO

**The Trust achieved 90.06% in month. There was 1 discharge summary not sent within 23 days required to meet the 95.00% threshold.**

### Discharge Summaries

### Discharge Summaries - NOT sent within 7 days
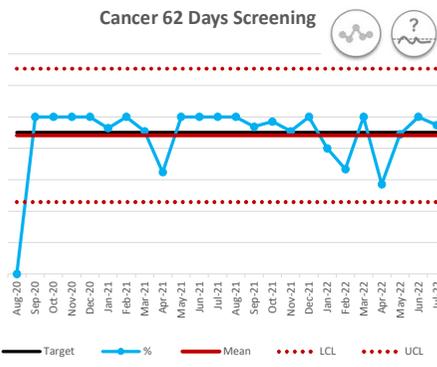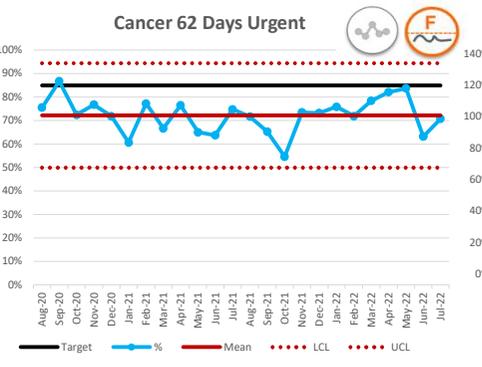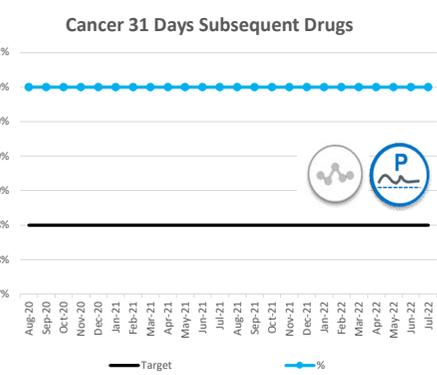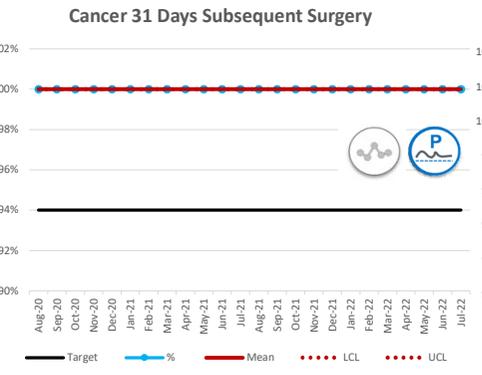
**(24 hrs)**
**Assurance: The Trust consistently fails the target.**
**Variation: Common Cause (Normal) variation.**

**(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 Wave 7 challenges. The reporting logic for this metric has now been agreed.

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

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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)? |
|---|---|---|---|---|

**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 August is in progress.**

### Cancelled operations on the day for non-clinical reason



Legend: Target — % of Cancelled Operations — Mean ···· LCL ···· UCL

### Urgent Operations - Cancelled for a 2nd Time



Legend: Target — No. of Patients

### Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days



Legend: Target — Number of Patients (validated & unvalidated) — Mean ···· LCL ···· UCL

**(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).**

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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 303 stranded and 146 super stranded patients at the end of June 2022. A Superstranded Patient Trajectory has not yet been agreed for 2022/23.

### Super Stranded Patients



Legend: Super Stranded Patients Trajectory; Number of Super Stranded Patients; Mean; LCL; UCL

### Stranded Patients



Legend: Number of Stranded Patients

**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 August 2022, the Trust achieved the following % of activity against August 2019. This included 102.49% of Daycase Procedures and 71.84% of Inpatient Elective Procedures.

### COVID-19 Recovery Daycase



Legend: Target; Daycase Procedures Achieved

### COVID-19 Recovery Inpatient



Legend: Target; Inpatient Elective Procedures Achieved
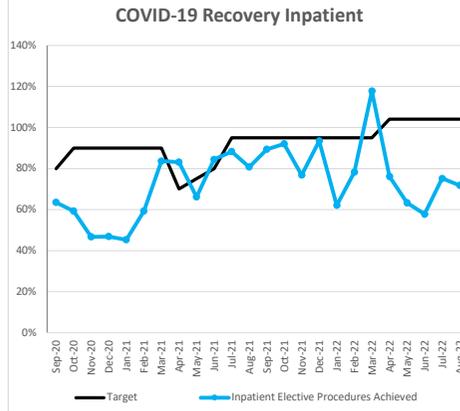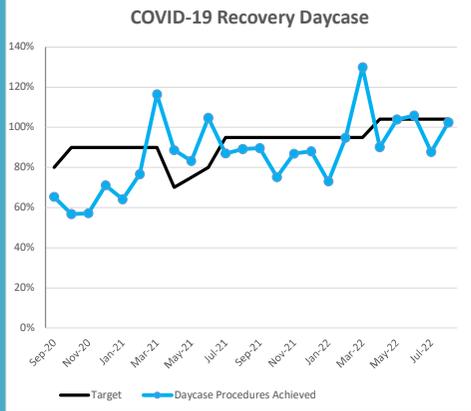
**N/A - Grouped indicator.**

Inpatient activity for August below the Trajectory due to the continued impact of COVID and the Norovirus outbreak.

The Trust monitors progress weekly via PRG and Clinical Services Oversight Group (CSOG)

SOF

RR1125

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NHS
Warrington and Halton
Teaching Hospitals
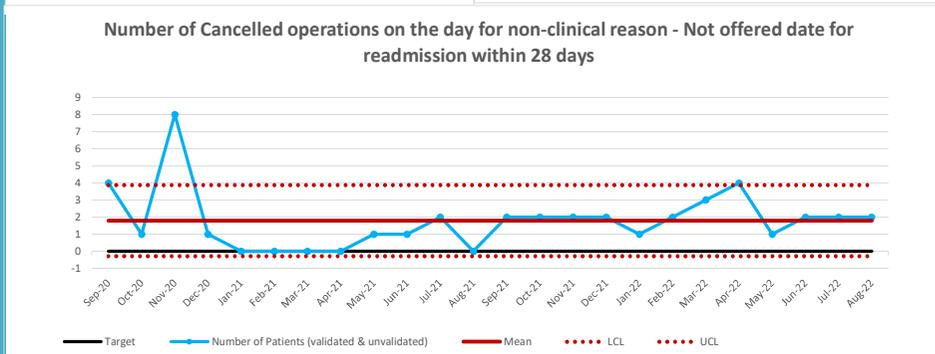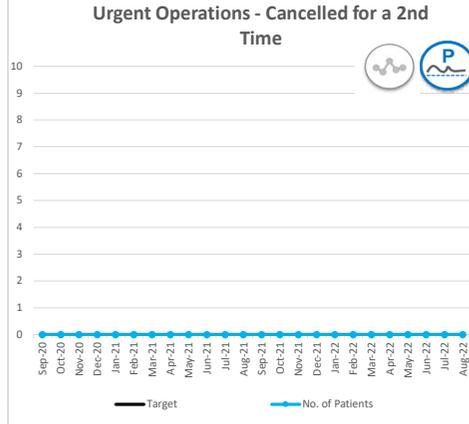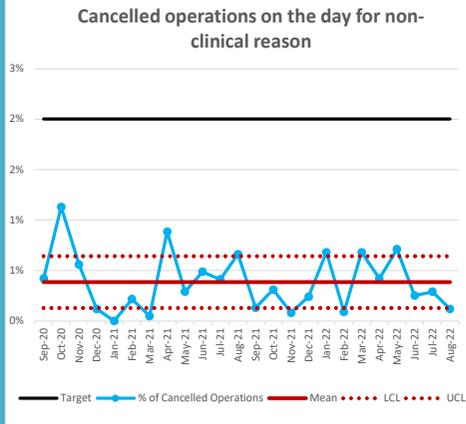NHS Foundation Trust

| 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 August 2022, the Trust achieved the following % of activity against August 2019. This included:
100.11% of MRI
119.08% of CT
121.09% of Non-Obstetric Ultrasound
48.89% of Flexi Sigmoidoscopy
179.82% of Colonoscopy
157.98% of Gastroscopy

RR1125

**COVID-19 Recovery Diagnostics - MRI**



**COVID-19 Recovery Diagnostics - US**



**COVID-19 Recovery Diagnostics - CT**



**COVID-19 Recovery Diagnostics - Colo**



**COVID-19 Recovery Diagnostics - Gastro**



**COVID-19 Recovery Diagnostics - Flexi**



N/A - Grouped indicator.

The Trust did not meet the diagnostic activity recovery trajectories for August 2022 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 Ultrasound remain the most challenged areas although now improving.

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

---

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

SOF | RR1125

In August 2022, the Trust achieved 95.81% of Outpatient activity against August 2019.

**COVID-19 Recovery Outpatient Activity**



N/A - Grouped indicator.

The Trust achieved 100.87% of New activity and 98.49% of follow up activity against the 19/20 position for consultant led services

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

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

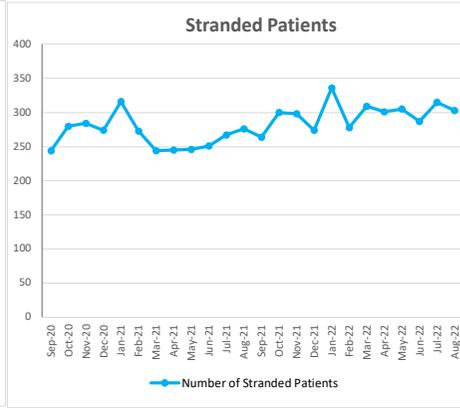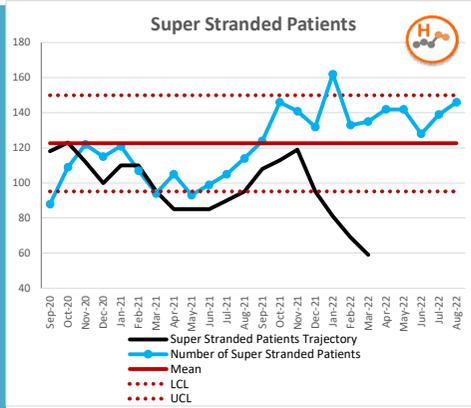| Risk Register | RR116 | System Oversight Framework | SOF |
| | | Care Quality Commission | CQC |

| 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)? |

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**55. Outpatient Activity Delivered Remotely Target: 25%**

**10.73% of Outpatient Appointments were delivered remotely in month.**
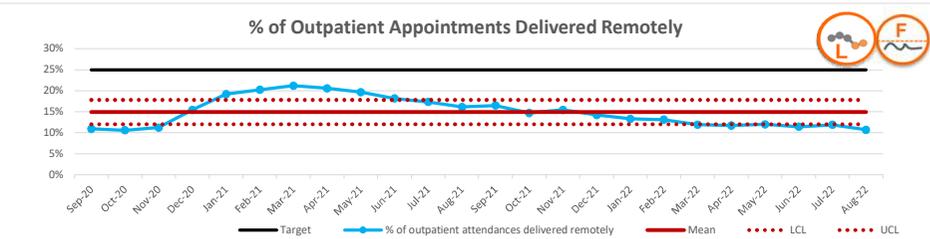
### % of Outpatient Appointments Delivered Remotely



Target — % of outpatient attendances delivered remotely — Mean — LCL — UCL

**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.

The Trust continues to identify opportunities to deliver additional outpatient activity remotely.

---

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

**52.39% of patients were seen in the Fracture Clinic within 72 hours in month.**
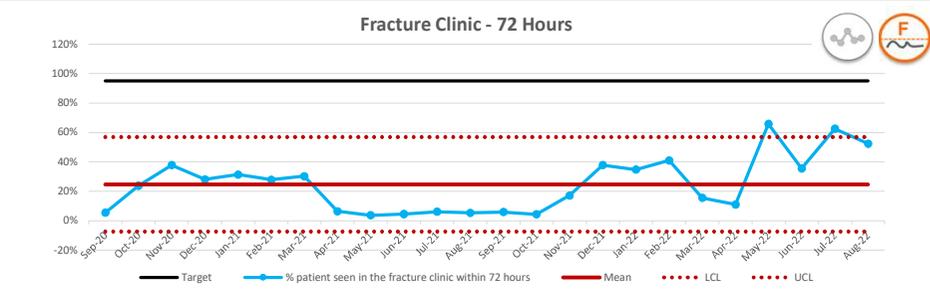
### Fracture Clinic - 72 Hours



Target — % patient seen in the fracture clinic within 72 hours — Mean — LCL — UCL

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

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

Performance against the 72 hour standard deteriorated slightly in August due to the pressures on Trauma services.

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 in the coming weeks.

---

**57. Advice & Guidance (A&G) Activity Levels No Target**

**58. Patient Initiated Follow Up (PIFU) Activity Levels No Target**

**The Trust completed 491 Advice & Guidance Contacts and 41 Patient Initiated Follow Ups in month.**

### Advice & Guidance Activity



Number of Advice & Guidance Contacts

### Patient Initiated Follow Up



Number of Patient Initiated Follow Ups (PIFU)
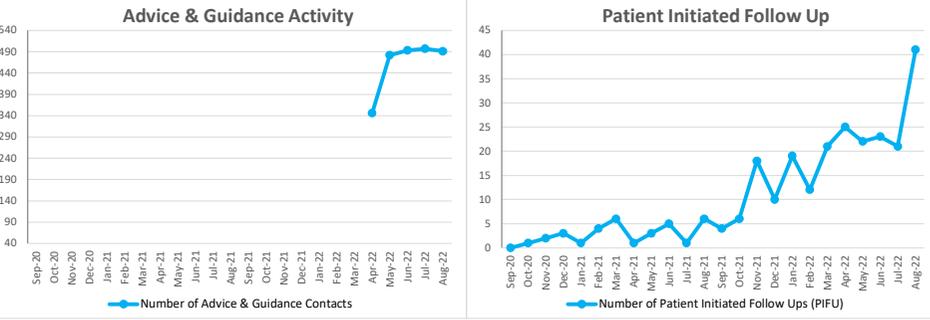
**N/A - Not enough datapoints.**

The number PIFU and Advice & Guidance contacts continues to increase in line with the 2022-23 operational plan.

The Trust monitors progress weekly via PRG.

---

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

**86.00% of SDEC Emergency Admissions had a zero day length of stay.**

### SDEC - % of Zero Length of Stay Admissions



% of zero-day length of stay admissions (SDEC)
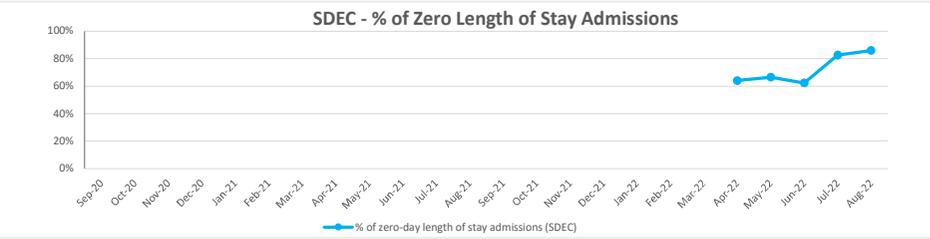
**N/A - Not enough datapoints.**

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## Workforce - Trust Position

**Key:**

System Oversight Framework — SOF

Use of Resources Assessment — UoR

Risk Register — RR200

Care Quality Commission — CQC
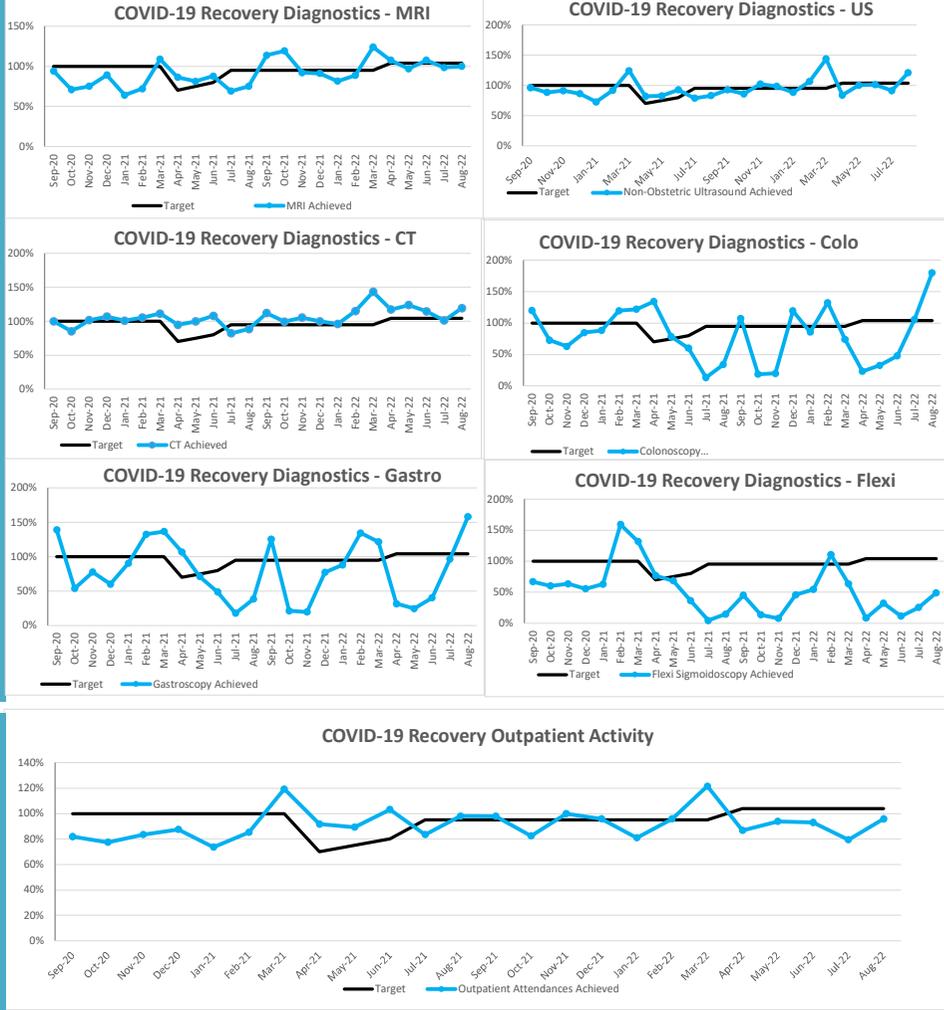
Trust Strategy — ★

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

**UoR** **SOF** **S**
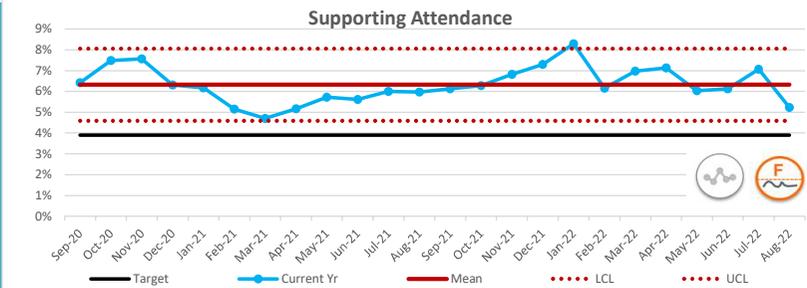
**60. Supporting Attendance**

**Target: Below 4.2%**

**The Trust's sickness absence rate was 5.54% in month. There were 8,066 calendar days lost to sickness in month.**

**RR200** **RR1108** **RR1134**

### Supporting Attendance

Legend: Target, Current Yr, Mean, LCL, UCL

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

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

**Sickness absence is 5.54% for August 2022, it was last reported as 6.25% in June 2022.**

**Short term absence is 2.58%, and long-term absence 2.96%.**

**Sickness absence in August 2021 was 6.28%.**

**Anxiety, Stress and Depression is the highest reason for sickness absence, followed by Chest and Respiratory problems.**

The Trust implemented an updated Supporting Attendance policy in February 2022 and transitioned existing employees under attendance management to the policy in April 2022 making the new framework fully operational. Part of the new policy was the amalgamation of trigger points in order to manage long term and short-term sickness absence. Consequently, the Trust has seen a significant improvement in long term sickness absence rates from 4.19% in April 2022 to 2.96% in August 22.

Short term sickness absence levels for the Trust have been challenging due to the spikes of infection of covid. In July 2022, a national directive was announced that covid sickness absence was no longer ring fenced and would be managed within existing contractual sick pay arrangements and also under the Trust's Supporting Attendance policy. The short-term sickness absence rate for August 2022 was 2.58% which is down from 3.74% in July 2022.

In July 2022, a 'Supporting Attendance Reset' was undertaken with a series of activities being completed to promote the policy and training across the organisation, this was run alongside the summer wellbeing campaign to ensure staff had the necessary wellbeing support with the aim of decreasing sickness absence. Overall, the sickness absence rate has reduced from 7.38% in July 2022 to 5.54% in August 2022.

The Prioritising Health and Wellbeing Strategy Group is aligned to People Promise 1 of the Trust's People Strategy. The group are actively in progress with the workplan covering a broad view of matters related to employee health and wellbeing. 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, Care Groups and service leads to identify patterns and implement support interventions to assist in preventing absences and support staff wellbeing.

**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)? |
|---|---|---|---|---|

**61. Welcome Back Conversations**

Target: 85%

Welcome Back Conversation compliance was 56.33% in August 2022.
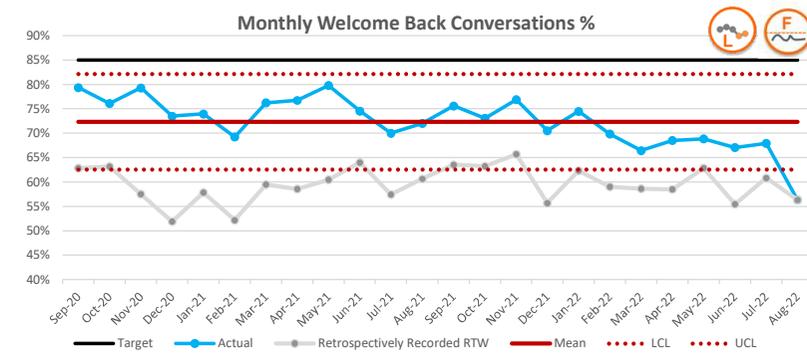


**Monthly Welcome Back Conversations %**

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

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

Welcome Back Conversations (WBC) compliance is 56.33% in August 2022.

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

The 12-month WBC compliance is 69.89%.

Further to a pilot that took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE, the HR Business Partnering team are supporting improvements in WBCs through the introduction of a coaching focused WBC review with CBUs. HR will be reviewing WBC data monthly and reaching out to individual managers with offers of support, signposting to training and seeking to understand reasons for either non-compliance and/or under reporting.

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.

**62. Recruitment**

Target: 65 days or below

The average number of working days to recruit is 75 days, based on the last 12 months average.
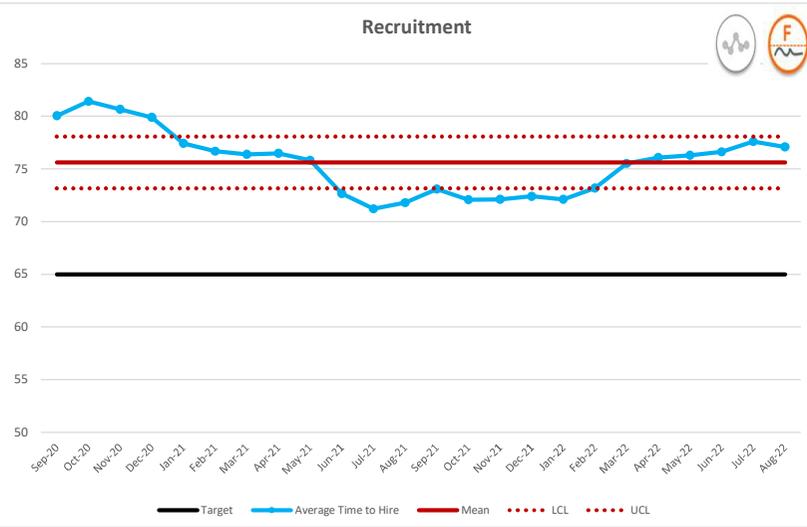


**Recruitment**

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

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

Recruitment time to hire for August 2022 is 77 working days, compared to 72 working days in August 2021. This includes notices periods.

In line with the implementation of NHS Jobs 3, the end-to-end recruitment process is currently 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.

The Recruitment team are undertaking a survey of new starters to feedback on their recruitment experience. These will support refining our services based on staff experience. Actions to reduce time to hire from the survey will be identified and implemented to streamline the process.

A new Occupational Health system implementation is underway which will digitise new stater pre-employment checks, management referrals and the digitisation of staff records relating to occupational health with the aim of reducing time to hire as well as improving the candidate experience.

A review of time to hire for current recruitment is in progress to identify areas to address to minimise delays to recruitment.

**63. Vacancy Rates**

Target: 9% or Below

The Trust's vacancy rate was 11.81% in August 2022.
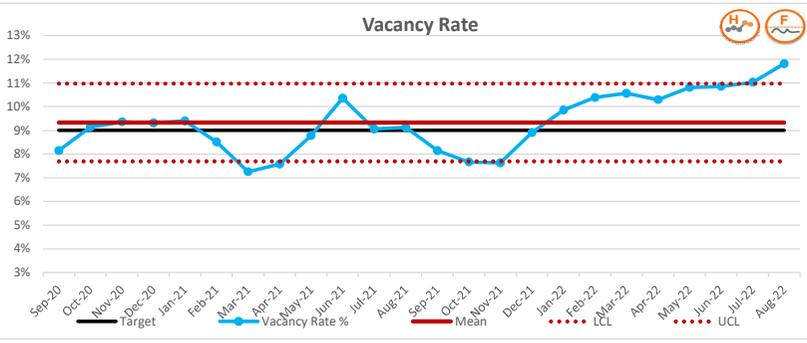


**Vacancy Rate**

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

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

Trust Headcount is currently 4461 (3,940 FTE) compared to 4,485 (3,955 FTE) in August 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 are 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.

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![NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust]

# 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)? |
|---|---|---|---|---|

**Retention of all staff was 83.05% and Retention of Permanent staff only was 86.39% in month.**

S   CQC

SOF   UoR

**Turnover of All staff was 16.35% and Turnover of Permanent staff only was 15.46% in month.**

65. Turnover

Target: Below 13%
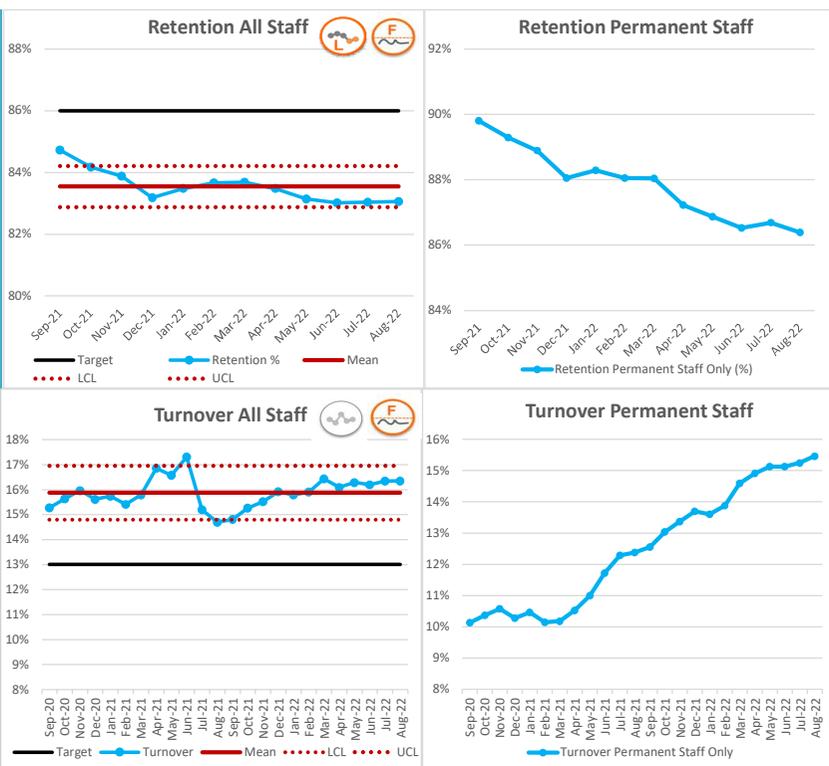
### Retention All Staff


### Retention Permanent Staff


### Turnover All Staff


### Turnover Permanent Staff


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

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

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

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

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.

**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.

**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.

**Health, Wellbeing & Development**

The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work.  The Trust received national recognition from NHS Employers, for our Check In Conversation and local recognition for our Health and Wellbeing Hub.

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**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)? |
|---|---|---|---|---|

### 66. Bank and Agency Reliance

Target: 9% or Below

**UoR**

Bank and Agency Reliance was 15.44% in month.

**Bank & Agency Reliance**



Target — Bank/Agency % — Mean — LCL — UCL

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

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

Bank and Agency reliance is 15.44% in Aug 2022, in Aug 2021 it was 13.26%.

There is currently work underway to establish clear actions that the Trust needs to undertake to reduce agency expenditure. This includes assessment against a Best Practice Toolkit for controlling agency spend and the development of recommendations and approaches to bring down agency costs.

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.

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.

### 67. Pay

Target: On or Less than Budget

**UoR** **CQC** **S**

Total pay spend in August 2022 was £20.2m against a budget of £19.6m.

**Pay Spend vs Budget**



Total Pay Spend — Budget — Mean — LCL — UCL

**Pay Spend vs Budget**



Contracted — Overtime — Bank — Agency — WLI

**UoR**

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

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

Total pay spend in August 2022 is £20.4m against a budget of £19.6m. In August 2021, pay spend was £18.6m against a budget of £18.3m.

The total pay spend for August 2022 is made up of the following elements:
- £16.6m contracted
- £1.9m Bank
- £1.1m Agency
- £0.38m WLI
- £0.26m Overtime

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.

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**Workforce - Trust Position**

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

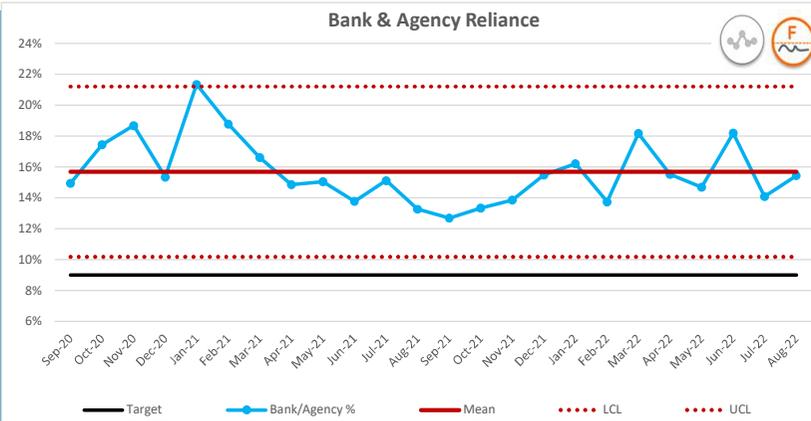| Trust Performance | Trend | Statistical Narrative | What are the reasons for the variation and what is the impact? | How are we going to improve the position (Short & Long Term)? |
|---|---|---|---|---|

CQC

**68. Core/Mandatory Training**

Target: 85%

Core/Mandatory training compliance was 85.57% in month.

**Core/Mandatory Training Compliance**

Target/Trajectory — Core/Mandatory Training % — Mean — LCL — UCL

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

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

In August 2022, CSTF Mandatory Training compliance is 85.57%, this now excludes Safeguarding Training (Children's and Adults); Safeguarding compliance is 70.67%, and Role Specific Training compliance is 91.62%.

In August 2021, CSTF was 77.02% and Role Specific 88.34% (Safeguarding was included in CSTF).

Mandatory Training compliance is now split by Mandatory, Safeguarding and Role Specific Training.

The CBUs and SMEs have been supported to develop trajectories to improve compliance, these are monitored through workforce governance structures and QPS

The organisation continues to support staff to access training safely with virtual offers where possible.

The Mandatory and Role Specific Group are currently reviewing all training offered by the Trust, specifically to review:
•Accessibility
•Training Needs Analysis
•Justification for Mandatory Status

**69. Role Specific Training**

Target: 85%

Role Specific Training compliance was 91.62% in month.

**Role Specific Training Compliance**

Target/Trajectory — Actual

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

**Variation:** N/A Not enough datapoints.

**70. Safeguarding Training**

Target: Trajectory

Safeguarding Training compliance was 71.00% in month.

**Safeguarding Training**

Target/Trajectory — Safeguarding Training %

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

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

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## Workforce - Trust Position

Key:
System Oversight Framework — SOF
Use of Resources Assessment — UoR
Risk Register — RR200
Care Quality Commission — CQC
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)? |
|---|---|---|---|---|

### 71. Workforce carrying out an Apprenticeship Qualification

Target: 2.3% or above

2.56% of staff were carrying out a qualification in month.



**Workforce Carrying out a Apprenticeship Qualification**

**Number of Learners by Qualification Level**

**Apprenticeship Funding**
Aug-22 — Funding Utilised / Funding Under Utilised

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

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

In August 2022, 2.56% of the workforce is carrying out a qualification (previous year comparator data not available)

Utilisation of the apprenticeship levy in August 2022 was 59.4%% (previous year comparator data not available)

The new Levy measures provide greater detail on how the Trust is spending the Levy by demonstrating both the range of course levels, and a summary on the spent and unspent Levy. This detail will enable targeted actions to be developed and reported on in future reports. Levy that is unspent for 24 months is returned to the Government.

The ECF Panel, supported by the Trusts Apprentice Team, continue to challenge all vacancies and support managers to supplement the vacancy with an external development offer, paid for by the Levy. This supports the Trust achieving above the 2.3% target of the percentage of the workforce carrying out a qualification.

There is also a well-developed communications programme to promote the Levy, including educating managers and staff about the various courses/development offers available through the levy.

### 72. PDR

Target: 85%

PDR compliance was 62.96% in month.



**PDR Compliance**

Target/Trajectory — Actual — Mean — LCL — UCL

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

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

In August 2022, PDR compliance was 62.96%

Currently PDR rates are below the trajectories.

In August 2021, PDR compliance was 50.64%

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

The PDR talent management tool, Scope for Growth, is being trialled in three areas using a test of change approach – Digestive Diseases CBU, People Directorate and Finance Directorate. The pilot will run from July 2022 to September 2022. Outcomes of this test of change will then be reviewed to generate recommendations on a Trust wide roll out programme with the aim to improve compliance.

A campaign is also being developed to focus on the benefits for staff and managers of having effective PDR discussions including staff examples of where an effective PDR has supported career development. The campaign will also include 'PDR snack packs' for managers and staff and identification of areas that can be accessed for PDR discussions to be held.

The Pay Progression policy which was paused during the Covid pandemic is being reviewed for implementation. A delivery plan is being developed which will firstly focus on identifying areas of poor performance for PDRs, the impact if pay progression was implemented and recovery plans required to ensure the parameters of the pay progression policy can be positively achieved.

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# Finance & Sustainability - Trust Position

Key:

System Oversight Framework

Use of Resources Assessment

Risk Register

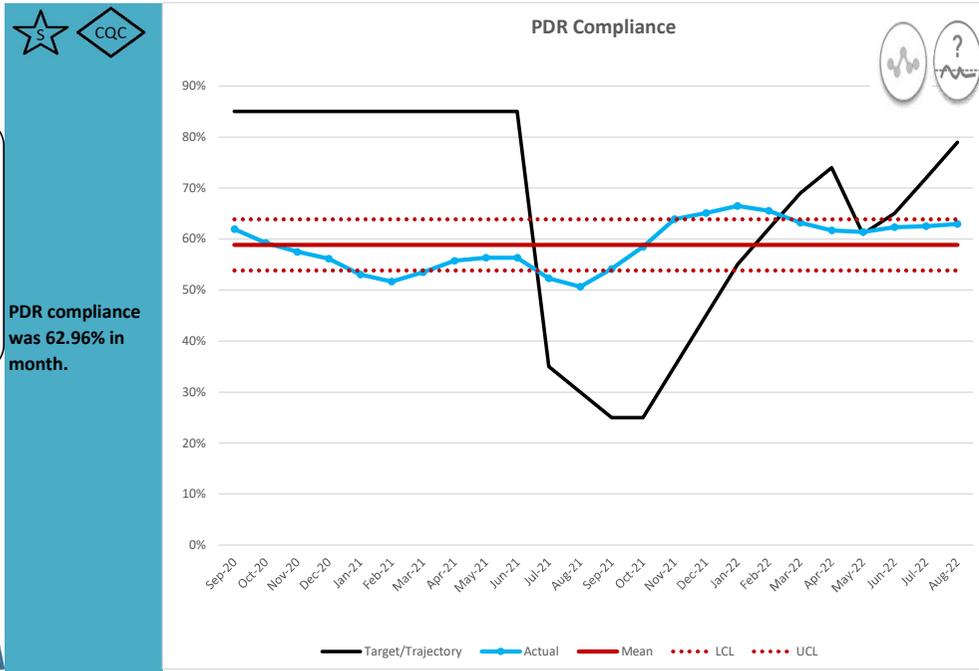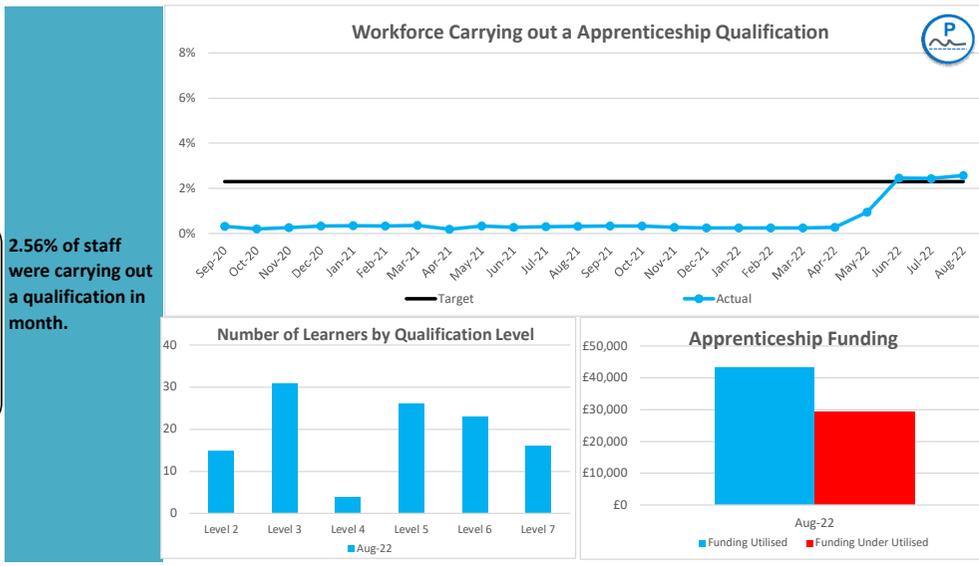| SOF | Care Quality Commission | CQC |
| UoR | Trust Strategy | S |
| RR116 | | |

| 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)? |
|---|---|---|---|---|---|

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**UoR SOF S**
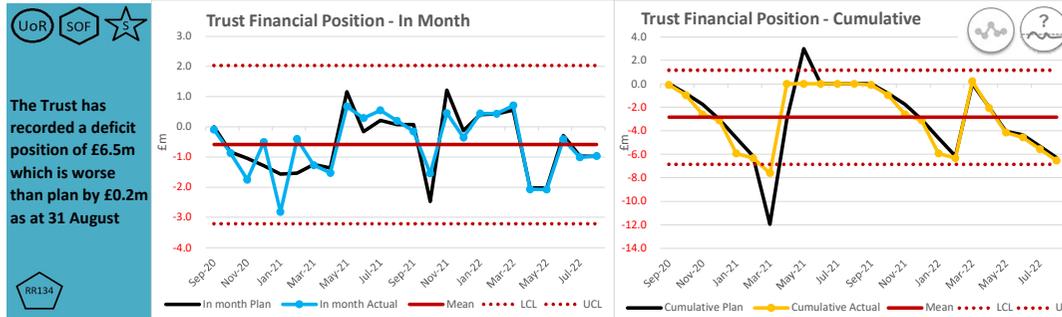
**73. Trust Financial Position**

**Target: Plan**

RR134

The Trust has recorded a deficit position of £6.5m which is worse than plan by £0.2m as at 31 August


Trust Financial Position - In Month


Trust Financial Position - Cumulative

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

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

For the period ending 31 August 2022, the Trust has recorded a deficit of £6.5m, against a planned deficit of £6.3m. The position includes £3.3m ERF.

Investment in a clinical and financial GIRFT post will support acceleration of GIRFT schemes. Weekly Exec and Senior Leadership focus on aactivity delivery and CIP/GIRFT delivery.

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**UoR**
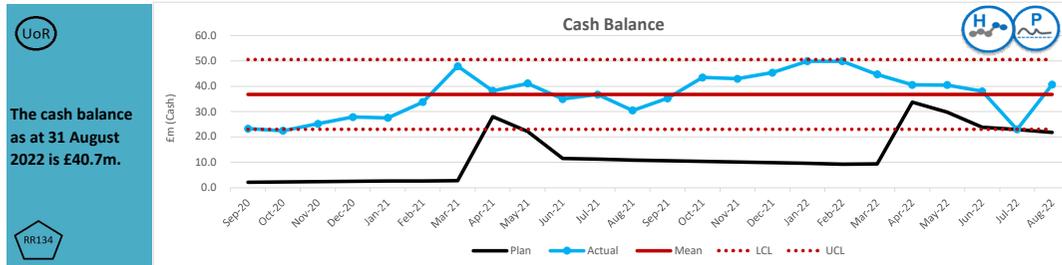
**74. Cash Balance**

**Target: On or better than plan**

RR134

The cash balance as at 31 August 2022 is £40.7m.


Cash Balance

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

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

The current cash balance is £38.0m which is £14.2m better than the initial cash plan. In the main this relates to a timing difference in the payment of trade creditors (£6.1m), a timing difference in the payment of capital creditors (£5.2m), additional income from contracts (£2.3m) and additional VAT recovery (£0.4m).

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**UoR**
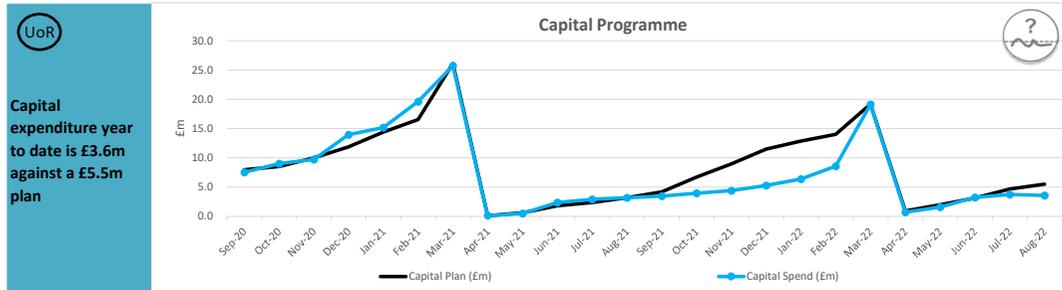
**75. Capital Programme**

**Target: On plan 90%-100%**

Capital expenditure year to date is £3.6m against a £5.5m plan


Capital Programme

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

The Trust funded annual capital plan is £12.5m of which £2.8m is the ED Plaza monies brokered to the C&M system in 2021/22. There are a further £10.2m of schemes planned which will be funded from external sources, bring the total capital plan to £22.7m. Capital expenditure year to date is £3.6m against a £5.5m plan.

The underspend year to date relates to a VAT rebate of £0.5m, delayed final invoices from ED Plaza, along with some delay on starting some backlog maintenance schemes which will catch up. There is an anticipated slippage on the catering scheme of 8 weeks which will require mitigation. The Trust will consider bringing slipped 'must do' items forward to 2022/23 to manage any in year slippage.

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**Finance & Sustainability - Trust Position**

Key:

System Oversight Framework

Use of Resources Assessment

Risk Register

| SOF | Care Quality Commission | CQC |
| UoR | Trust Strategy | S |
| RR116 | | |

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

**UoR**

**76. Better Payment Practice Code**

Target: Cumulative performance 95%

**The Better Payment Practice Code performance based on volume for NHS is 83% and non-NHS is 93%. The Better Payment Practice Code performance based on value for NHS is 85% and non-NHS is 93%.**

Better Practice Payment Code (Month)

Better Practice Payment Code (Cumulative)

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

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

Cumulative performance is 93.00% which is below the national target of 95.00%.

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

**UoR**

**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.**

**UoR**

**78. Cost Improvement Programme (recurrent & non recurrent) - In year performance to date**
Target: >90% Plan delivered YTD

**The year to date CIP plan is £2.1m and £2.1m has been delivered.**

N/A - Not enough datapoints.

In year savings identified are £14.1m 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.

**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 has a recurrent CIP target of £6.5m, as at month 5, the forecast for delivery is £2.1m**

N/A - Not enough datapoints.

**Appendix 3 – Trust IPR Indicator Overview**

| | Indicator | Detail |
|---|---|---|
| | **Quality** | |
| 1. | **Incidents** | • Number of incidents reported in month.<br>• Number of incidents open over 20 days and 40 days.<br>• Number of serious incidents reported in month.<br>• Number of serious incidents where actions have breached the timescale.<br>• 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.<br>4.<br>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.<br>• MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.<br>• Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.<br>• Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.<br>• 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.<br>• 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.<br>• 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.<br>• Falls per 1000 bed days in month.<br>• Total number of inpatient falls which have occurred in month.<br>• Levels of harm reported as a result of a fall in month.<br>• 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.<br>22.<br>23.<br>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.<br>• 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.<br>30. | **RTT Open Pathways and 52 & 104 week waits** | • Percentage of incomplete pathways waiting within 18 weeks.<br>• Number of patients waiting over 52 weeks.<br>• Number of patients waiting over 104 weeks. |
| 31.<br>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 2$^{nd}$ Time | • Number of urgent operations which have been cancelled for a 2$^{nd}$ time. |
| 51. | Super Stranded Patients | • Stranded Patients are patients with a length of stay of 7 days or more.<br>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). |

| | **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**
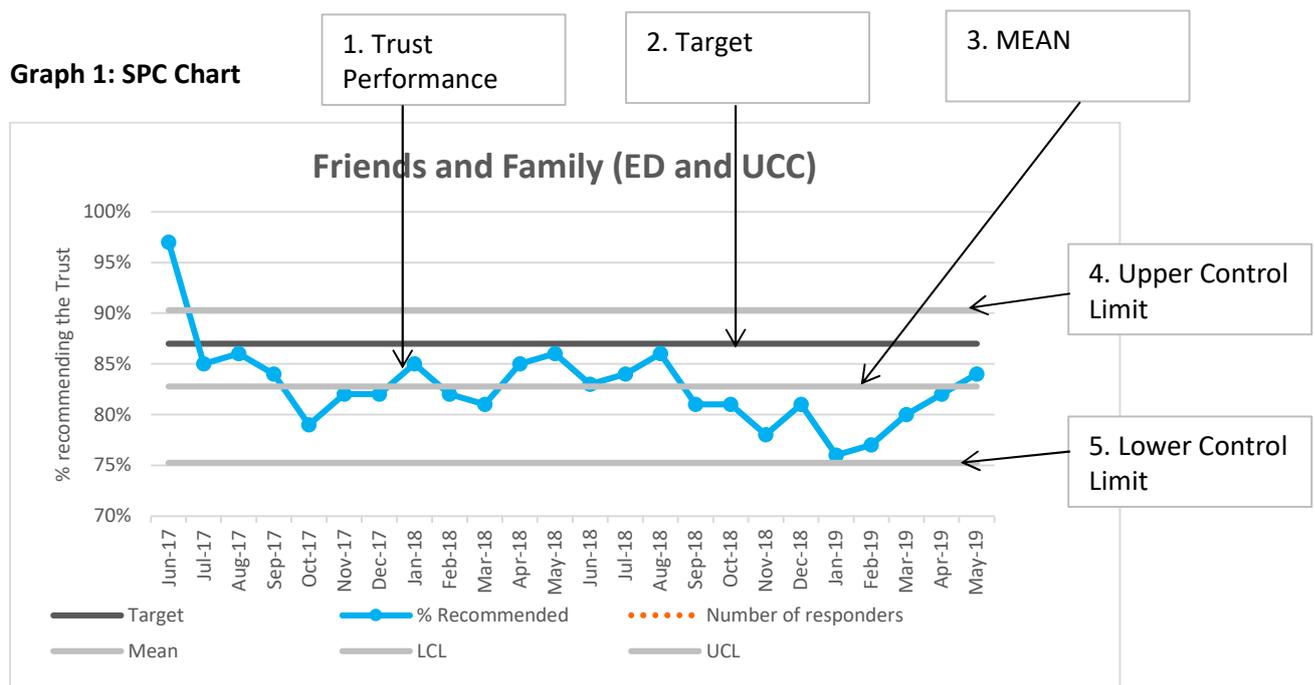
## 2.1 Interpreting a SPC Chart

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**
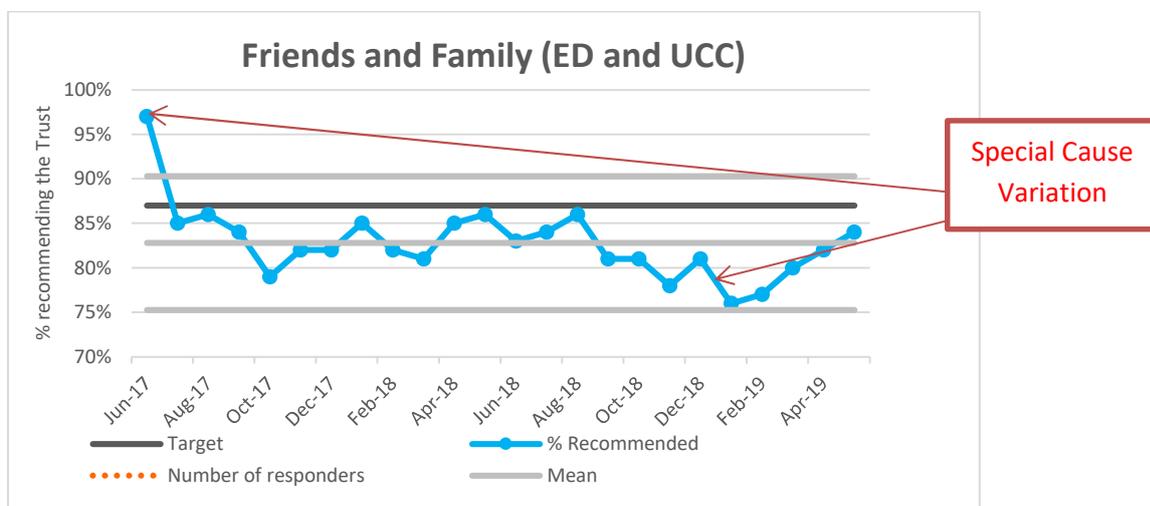


In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

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 | | |
|---|---|---|---|---|---|
| (?) | (P) | (F) | (∿) | (H)(L) | (H)(L) |
| 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.

(No SPC)

- 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.

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

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

| | Annual | Month | | | Year to date | | |
|---|---|---|---|---|---|---|---|
| **Income Statement** | Budget £000 | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 |
| **Operating Income** | | | | | | | |
| | | | | | | | |
| **NHS Clinical Income** | | | | | | | |
| Elective Spells | 31,873 | 2,213 | 2,649 | 436 | 13,034 | 12,015 | -1,019 |
| Elective Excess Bed Days | 336 | 22 | 4 | -18 | 142 | 22 | -120 |
| Non Elective Spells | 73,559 | 6,115 | 4,493 | -1,622 | 29,017 | 26,703 | -2,314 |
| Non Elective Bed Days | 2,015 | 173 | 109 | -64 | 796 | 1,146 | 351 |
| Non Elective Excess Bed Days | 2,882 | 247 | -17 | -264 | 1,138 | 785 | -354 |
| Outpatient Attendances | 45,340 | 2,500 | 2,611 | 111 | 18,365 | 15,900 | -2,465 |
| Accident & Emergency Attendances | 17,871 | 1,441 | 1,688 | 247 | 7,893 | 8,388 | 495 |
| Other Activity | 76,602 | 7,995 | 9,100 | 1,105 | 33,147 | 39,383 | 6,236 |
| ERF | 7,887 | 657 | 533 | -124 | 3,286 | 3,162 | -124 |
| COVID Block Income (Liverpool CCG) | 34,842 | 2,904 | 2,875 | -28 | 14,518 | 14,509 | -8 |
| **Sub total** | **293,208** | **24,267** | **24,046** | **-221** | **121,336** | **122,014** | **678** |
| | | | | | | | |
| **Non NHS Clinical Income** | | | | | | | |
| Private Patients | 0 | 0 | 1 | 1 | 0 | 4 | 4 |
| Non NHS Overseas Patients | 0 | 0 | 3 | 3 | 0 | 56 | 56 |
| Other non protected | 996 | 83 | 49 | -34 | 415 | 321 | -94 |
| **Sub total** | **996** | **83** | **53** | **-30** | **415** | **381** | **-34** |
| | | | | | | | |
| **Other Operating Income** | | | | | | | |
| Training & Education | 9,093 | 758 | 709 | -49 | 3,789 | 3,954 | 165 |
| Donations and Grants | 2,910 | 77 | 0 | -77 | 307 | 350 | 43 |
| Miscellaneous Income | 13,248 | 1,021 | 1,951 | 930 | 5,104 | 6,337 | 1,233 |
| **Sub total** | **25,251** | **1,856** | **2,660** | **804** | **9,200** | **10,641** | **1,441** |
| | | | | | | | |
| **Total Operating Income** | **319,456** | **26,206** | **26,759** | **553** | **130,951** | **133,036** | **2,085** |
| | | | | | | | |
| **Operating Expenses** | | | | | | | |
| Employee Benefit Expenses | -233,200 | -19,620 | -20,104 | -484 | -99,329 | -99,594 | -265 |
| Drugs | -17,585 | -1,471 | -1,452 | 19 | -7,385 | -8,333 | -948 |
| Clinical Supplies and Services | -20,415 | -1,721 | -1,959 | -238 | -8,726 | -9,444 | -717 |
| Non Clinical Supplies | -32,995 | -2,755 | -2,769 | -15 | -13,797 | -14,485 | -688 |
| Depreciation and Amortisation | -13,760 | -1,147 | -1,142 | 5 | -5,733 | -5,665 | 69 |
| 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** | **-26,714** | **-27,427** | **-713** | **-134,970** | **-137,520** | **-2,550** |
| | | | | | | | |
| **Operating Surplus / (Deficit)** | **1,501** | **-508** | **-668** | **-160** | **-4,019** | **-4,484** | **-465** |
| | | | | | | | |
| **Non Operating Income and Expenses** | | | | | | | |
| Profit / (Loss) on disposal of assets | 0 | 0 | 2 | 2 | 0 | 4 | 4 |
| Interest Income | 166 | 14 | 50 | 36 | 69 | 195 | 125 |
| Interest Expenses | -192 | -16 | 17 | 33 | -80 | -61 | 19 |
| PDC Dividends | -4,863 | -405 | -405 | 0 | -2,026 | -2,026 | 0 |
| **Total Non Operating Income and Expenses** | **-4,889** | **-407** | **-337** | **71** | **-2,037** | **-1,888** | **149** |
| | | | | | | | |
| **Surplus / (Deficit) - as per Accounts** | **-3,388** | **-916** | **-1,005** | **-89** | **-6,057** | **-6,373** | **-316** |
| | | | | | | | |
| **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 | -77 | 0 | 77 | -307 | -350 | -43 |
| Add Depreciation on Donated & Granted Assets | 192 | 16 | 39 | 23 | 80 | 197 | 117 |
| **Total Adjustments to Financial Performance** | **-2,718** | **-61** | **39** | **100** | **-227** | **-153** | **74** |
| | | | | | | | |
| **Adjusted Surplus / (Deficit) as per NHSI Return** | **-6,106** | **-977** | **-965** | **11** | **-6,284** | **-6,526** | **-242** |

**Appendix 6: Capital Programme**
**As at 31 August 2022**

| Scheme Name | Approved Programme | Budget Amendments Mths 1-4 | Emergency Requests Mth 5 | Proposed Budget Adjustments in Mth 5 | PDC/External Funding Adjustments in Mth 5 | Total Revised Budget |
|---|---|---|---|---|---|---|
| | 2022/23 | 2022/23 | 2022/23 | 2022/23 | 2022/23 | 2022/23 |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **ESTATES** | | | | | | |
| ED Plaza | 2,859 | | | | | 2,859 |
| Paeds (Childrens Outpatients) | 130 | | | | | 130 |
| Urology (Estates) | 240 | | | | | 240 |
| ED Plaza further slippage | 115 | | | | | 115 |
| L Shaped Roof | 129 | 37 | | | | 166 |
| Nurse Call Minor injuries | 25 | | | | | 25 |
| CMTC Replacement Emergency Lighting | 72 | | | | | 72 |
| ED Plaza - Dr Mess room (Exec Lead) | 141 | (141) | | | | 0 |
| Breast Relocation of Breast Equipment (Kendrick to Bath Street) | 30 | | | 39 | | 69 |
| Shopping City 21/22 underspend | 35 | | | 128 | | 163 |
| Shopping City Retension of 2.5% | 18 | | | | | 18 |
| Appleton Ventilation Upgrade | 300 | | | | | 300 |
| Fire schemes deferred from 21/22 | 300 | (100) | | | | 200 |
| Estates Capital Staffing | 260 | | | | | 260 |
| Appleton Fire doors final phase | 200 | (200) | | | | 0 |
| Dementia & Accessibility - Site Wide | 200 | | | | | 200 |
| Repairs to roads & footpaths across both sites | 150 | (150) | | | | 0 |
| Fixed electrical testing site wide | 150 | 100 | | | | 250 |
| Emergency lighting to stairwells and exits | 115 | | | | | 115 |
| Appleton Wing fire dampers final phase | 100 | (100) | | | | 0 |
| CCTV Upgrade site wide | 50 | (50) | | | | 0 |
| 6 Facet Annual Survey Review | 55 | | | | | 55 |
| Replacement of AVSU's - part 2 | 40 | (40) | | | | 0 |
| Safe surface temperatures (radiators) final part | 30 | (30) | | | | 0 |
| Annual Asbestos Site Management survey | 30 | | | | | 30 |
| ED Fire Barrier (actual work for above - added 28/02/2022) | 125 | | | | | 125 |
| Catering Upgrade | 1,800 | | | | | 1,800 |
| Removal of C21 Bathroom and installation of storage | 24 | | | | | 24 |
| Induction of Labour Ward (Lucy Gartside) | 300 | | | | | 300 |
| Replacement Hot Water Cylinder CSTM | 0 | 13 | | | | 13 |
| Boiler Block 1 | 0 | 21 | | | | 21 |
| Fire - Relocate and replace medical gas AVSU's to clinical wards | | 8 | | | | 8 |
| CSTM Ward Modification | | 47 | | | | 47 |
| Corporate Offices Decoration | | 14 | | | | 14 |
| Chiller Compressor - Daresbury Theatres | | | 7 | | | 7 |
| Roof Leaks - Halton | | | 59 | | | 59 |
| | | | | | | |
| **Estates Total** | **8,023** | **-571** | **66** | **167** | **0** | **7,685** |

| Scheme Name | Approved Programme | Budget Amendments Mths 1-4 | Emergency Requests Mth 5 | Proposed Budget Adjustments in Mth 5 | PDC/External Funding Adjustments in Mth 5 | Total Revised Budget |
|---|---|---|---|---|---|---|
| **IM&T** | | | | | | |
| 005 Cisco Refresh (Phase 1) | 22 | (22) | | | | 0 |
| 007 IP Telephony | 27 | (27) | | | | 0 |
| EPMA 1-4 | 8 | | | | | 8 |
| Electronic Patient Record Procurement | 50 | | | | | 50 |
| Patient Flow (Tif) | 10 | | | | | 10 |
| Cisco Refresh Phase 2 | 817 | | | | | 817 |
| IT Staffing | 316 | | | | | 316 |
| Tech Refresh 22/23 | 85 | | | | | 85 |
| Halton SAN Refresh (DR site) | 200 | | | | | 200 |
| Network Switches - reduced network switches to £49k per HG 16. | 49 | | | | | 49 |
| Programme and Benefits Resource/Phase 2 Structure | 165 | | | | | 165 |
| EPR | 155 | | | | | 155 |
| New Maternity System - Extended Project Management Support | 109 | | | | | 109 |

| | | | | | | |
|---|---:|---:|---:|---:|---:|---:|
| Comms Cabinets (Phase 3) | 100 | | | | | 100 |
| | | | | | | 0 |
| **Information Technology Total** | **2,113** | **-49** | **0** | **0** | **0** | **2,064** |

| **MEDICAL & OTHER EQUIPMENT** | | | | | | |
|---|---:|---:|---:|---:|---:|---:|
| Image Intensifer | 78 | | | | | 78 |
| Urology Equipment - Bladder Scanner | 10 | (10) | | | | 0 |
| Video Laryngoscope | 13 | | | | | 13 |
| Decontamination Shelter | 2 | | | | | 2 |
| Hamilton Cold Vent | 0 | | | | | 0 |
| Radiology - Fluoroscopy Room (turnkey costs) | 105 | 16 | | | | 121 |
| Mammography Equipment Replacement (enabling works only) | 50 | | | | | 50 |
| Video Laryngoscopes | 77 | | | | | 77 |
| Neonatal Scanner | 104 | | | | | 104 |
| Security - NEST/neonatal unit/C23/Paediatrics | 50 | | | | | 50 |
| Obstetric Portable Ultrasound Machine | 27 | | | | | 27 |
| UCC X-ray Turnkey costs | 80 | | | | | 80 |
| Microtomes and slide writers | 25 | 3 | | | | 28 |
| Platelet Incubator / Agitator | 8 | | | | | 8 |
| Audiology ABR replacement | 22 | | | | | 22 |
| Resuscitaires | 91 | | | | | 91 |
| Replacement of the Pharmacy Automated Dispensing System | 1,084 | | | (744) | | 340 |
| Boiling Pan - Estates and Facilities | 0 | 8 | | | | 8 |
| A3 Dishwasher | 0 | 6 | | | | 6 |
| Spine Coil | 0 | 19 | | | | 19 |
| CT Scanner | 0 | 200 | | | | 200 |
| V60 Machine - V800 | 0 | 130 | | | | 130 |
| Ophthamology | 0 | 308 | | | | 308 |
| Echo Machines | 0 | 500 | | | | 500 |
| Concealment Trolley | 0 | 6 | | | | 6 |
| TV Transducer | | | 6 | | | 6 |
| Curvilinear Transducer | | | 7 | | | 7 |
| **Medical Equipment Total** | **1,826** | **1,186** | **13** | **-744** | **0** | **2,281** |

| **Total Trust Funded Capital** | **11,962** | **566** | **79** | **-577** | **0** | **12,030** |
|---|---:|---:|---:|---:|---:|---:|

| **CONTINGENCY** | | | | | | |
|---|---:|---:|---:|---:|---:|---:|
| Prior Year Adjustments (VAT Rebates) | 0 | | | | | 0 |
| Contingency | 802 | (600) | (79) | (12) | | 111 |
| Slippage fron Schemes | 0 | (236) | | | | (236) |
| **Contingency Total** | **802** | **(836)** | **(79)** | **(12)** | **0** | **(125)** |

| **Total Trust Funded Capital** | **12,764** | **(270)** | **0** | **(589)** | **0** | **11,905** |
|---|---:|---:|---:|---:|---:|---:|

| **Schemes that can only go ahead if Externally Funded** | | | | | | |
|---|---:|---:|---:|---:|---:|---:|
| Warrington Town Deal Health and Wellbeing Hub- Capital Works* | 2,560 | | | | | 2,560 |
| Shopping City 21/22 underspend (added 04/02/2022) | 350 | | | | | 350 |
| 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 |
| **Total Externally Funded** | **10,187** | **0** | **0** | **0** | **0** | **10,187** |
| **Schemes that can only go ahead if further funding identified** | | | | | | |
| Appleton Fire doors final phase | 0 | 200 | | | | 200 |
| Repairs to roads & footpaths across both sites | 0 | 150 | | | | 150 |
| Appleton Wing fire dampers final phase | 0 | 100 | | | | 100 |
| CCTV Upgrade site wide | 0 | 50 | | | | 50 |
| Replacement of AVSU's - part 2 | 0 | 40 | | | | 40 |
| Safe surface temperatures (radiators) final part | 0 | 30 | | | | 30 |
| ED Plaza - Dr Mess room (Exec Lead) | 0 | 141 | | | | 141 |
| **Total of additional schemes if funding available** | **0** | **711** | **0** | **0** | **0** | **711** |
| **Grand Total** | **22,951** | **441** | **0** | **(589)** | **0** | **22,803** |

**REPORT TO TRUST BOARD**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/21/07/116a** |
| **SUBJECT:** | **Safe Staffing Assurance Report – June & July 2022** |
| **DATE OF MEETING:** | 28th September 2022 |
| **AUTHOR(S):** | Ali Kennah, Deputy Chief Nurse |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive |
| **LINK TO STRATEGIC OBJECTIVE:** *(Please select as appropriate)* | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. |
| **LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):** *(Please DELETE as appropriate)* | **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. |
| **EXECUTIVE SUMMARY** *(KEY ISSUES):* | This paper details ward staffing data for the months of June and July 2022. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safely staffed. Mitigation was provided and associated actions put in place when a ward was below 90%, minimum staffing percentage of planned staffing levels.<br><br>A positive reduction in the vacancy figures for Health Care Support Workers (HCSW) has been seen as a result of collaborative system working with Cheshire and Mersey Workforce Teams and focussed internal recruitment processes.<br><br>The increase in registered nurse vacancies within the Trust is due to the successful approval of B19 business case, recruitment is underway with over 50 new starters within the recruitment pipeline and 30 overseas nurses to join the Trust in 2022.<br><br>Maternity services have recruited a midwife to focus on retention plans and vacancies will reduce from September/October when staff commence in post.<br><br>Across Cheshire and Merseyside WHH have led on the expansion of student capacity for the last 2 years with an overall increase across Cheshire and Mersey of 87% of which 29% is at WHH, which equates to over 2000 hours per annum.<br><br>In the month of June 13 of the 21 wards were above 90% target fill rate and in the month of July there were 9 wards. To ensure safe staffing levels are maintained, mitigation and responsive plans were implemented to ensure that there is safe delivery of patient care. Care hours per patient day (CHPPD) in June was 7.2 and 7.0 in July, with a year-to-date rate 7.3. |

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Safe staffing plans are monitored, amended, and reviewed by senior nursing teams via twice daily staffing meetings and staffing escalation processes are followed to ensure mitigation plans are in place such as the use of temporary staffing

Registered nurse and midwife sickness absence in the month of June was recorded at 7.73% with an increase in July to 8.81%. Health care support worker sickness absence in the month of June was recorded at 8.42% with an increase in July to 9.63%.

Turnover for Nursing and Midwifery staff is 16.59% which is an increase from 15.67% in July and 14.95% in June. Main reason for leaving is work-life balance. Joined Integrated Care Board (ICB) Retention Strategy workstream.

A review of non-registered and registered nurse staffing in the Emergency Department will be completed in September 2022 with a report to be presented to Strategic People Committee in November 2022.

This report forms part of the agenda pack for Strategic People Committee (21st September 2022) and is presented to Trust Board as per the National Quality Board (NQB) guidance 2016, 2018. The guidance states that Trust Boards should have oversight of the workforce plans in place for sufficient and sustainable staffing capacity and the capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.

This report provides assurance of safe staffing levels and the mitigation plans in place to maintain this.

The report is for noting as a requirement of the above.

| PURPOSE: *(please select as appropriate)* | Information x | Approval | To note x | Decision |
|---|---|---|---|---|
| RECOMMENDATION: | The Trust Board is asked to receive and note the content of this report. | | | |
| PREVIOUSLY CONSIDERED BY: | **Committee** | | Strategic People Committee | |
| | **Agenda Ref.** | | | |
| | **Date of meeting** | | 21st September 2022 | |
| | **Summary of Outcome** | | | |
| FREEDOM OF INFORMATION STATUS (FOIA): | Release Document in Full | | | |
| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None | | | |

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*REPORT TO BOARD OF DIRECTORS*

| SUBJECT | Safe Staffing Assurance Report – June and July 2022 | AGENDA REF: | BM/22/09/116 a |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

**Safe Staffing Assurance Report – June and July 2022.**

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of June and July 2022. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

The safe staffing report with the 6-month acuity review was presented to the Quality Assurance Committee in August 2022 which provided an overview of the current nursing/midwifery staffing workforce data, recruitment and retention plans and Care Group updates.

This paper provides assurance that shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. Substantial evidence exists which demonstrate nurse staffing levels significantly contribute to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery and therefore essential that the Trust delivers the right staff, with the right skills, in the right place at the right time.

## 2. KEY ELEMENTS

All Trusts are required to submit staffing data to NHS England via the Unify Safe Staffing return, which is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. In addition, assurance is provided to Trust Board of Directors via the Chief Nurse and Deputy Chief Executive.

During the months of June and July 2022 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels.

The safer staffing data consists of the 'actual' numbers of hours worked by registered nursing and health care support staff on a shift-by-shift basis, measured against the numbers of 'planned' hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and within the Trust, when fill rates are below 90%, the ward staffing is reviewed at the daily staffing meeting considering acuity and activity and where necessary staff are moved from other areas to support.

In the month of June 2022 13 of the 21 wards were above their planned 90% target of registered nursing staff for the day shift and in July 2022 9 of the 21 wards (Appendix 1&2). To ensure safe staffing levels, mitigation and responsive plans were implemented by the senior nursing team based on acuity and activity for the areas that did not meet 90%.

**Care Hours Per Patient Day (CHPPD)**

CHPPD was developed, tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting staff redeployment on all inpatient wards across all healthcare settings. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The data is valuable because it consistently shows how well patient care requirements are met alongside outcome measures and quality indicators. The June and July 2022 Trust wide staffing data has been analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse and Lead Nurses. The senior nursing team currently collects and reports CHPPD data monthly.

Table 1 illustrates the monthly CHPPD data. In the month of June 2022 CHPPD was recorded at 7.2 and July 2022 recorded at 7.0 with a 2022/23 YTD figure of 7.3.

*Table 1 – CHPPD Data*

| Financial Year | Month | Cumulative count over the month of patients at 23:59 each day | CHPPD - Registered | CHPPD - Care Staff | CHPPD All |
|---|---|---|---|---|---|
| 2021/22 | April | 13769 | 4.4 | 3.3 | 7.7 |
| | May | 13645 | 4.6 | 3.5 | 8.1 |
| | June | 13134 | 4.5 | 3.4 | 7.9 |
| | July | 13964 | 4.4 | 3.3 | 7.6 |
| | August | 13479 | 4.7 | 3.3 | 8.0 |
| | September | 13428 | 4.5 | 3.3 | 7.8 |
| | October | 14131 | 4.5 | 3.1 | 7.6 |
| | November | 14726 | 4.3 | 3.0 | 7.3 |
| | December | 14448 | 4.7 | 2.9 | 7.7 |
| | January | 14174 | 4.8 | 3.1 | 7.9 |
| | February | 13901 | 4.3 | 2.9 | 7.2 |
| | March | 15320 | 4.3 | 2.8 | 7.1 |
| 2021/22 Total | | 168119 | 4.5 | 3.1 | 7.6 |
| 2022/23 | April | 14461 | 4.5 | 3.0 | 7.5 |
| | May | 15060 | 4.5 | 3.0 | 7.5 |
| | June | 14903 | 4.4 | 2.9 | 7.2 |
| | July | 15446 | 4.1 | 2.9 | 7.0 |
| 2022/23 Total | | 59869 | 4.4 | 2.9 | 7.3 |

Cross reference of CHPPD and Unify fill rates supports the Trust internal assurance oversight of staffing.

**Sickness**

Existing evidence indicates that reducing nurse staffing and/or skill mix adversely affects care quality. A presentation to Quality Assurance Committee in May 2022 demonstrated the correlation between lower numbers of staff and increasing harm. Table 2 shows the consistently increased rates in staff sickness across the nursing, midwifery and HCSW staff groups.

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*Table 2 – Sickness Data*

| Month | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | July-22 |
|---|---|---|---|---|---|---|---|---|---|---|
| N&M Registered | 7.87% | 7.89% | 9.06% | 10.61% | 7.98% | 8.56% | 9.08% | 7.38% | 7.73% | 8.81% |
| Band 2 HCSW | 12.93% | 13.71% | 14.10% | 12.56% | 9.93% | 11.58% | 12.36% | 9.39% | 8.42% | 9.63% |

**Red Flags**

Staffing levels are reviewed twice daily in the staffing meeting with all areas. Red flags are created by areas where staffing levels drop below the planned establishment. A process has been put in place where red flags are reviewed, resolved, and closed at the staffing meetings which has shown a reduction in open/unresolved red flags and provides assurance of safe staffing levels to meet the patient's needs. All open flag areas are reviewed by the site manager and matron to ensure the area is safe and staffing is reviewed and modified where necessary with appropriate closure of red flags if actions put in place.

A weekly red flag report has been created which is shared with the deputy chief nurse and associate chief nurses alongside the lead nurses. This also shows were staffing levels were escalated as red on gold command nurse staffing and the narrative behind the actions taken to ensure safety.

**Staffing Levels and Harm**

A monthly report is produced and shared with the senior nursing team to enable them to triangulate staffing red flags, gold command nurse staffing red status, falls, pressure ulcer development against staffing incidents for each of their areas. Table 3 and 4 shows the overall data for each of these elements for June and July 2022.

*Table 3 – June 2022*

| | |
|---|---|
| Total number of red flags rasied | 297 |
| Total number of gold command red status | 281 |
| Total number of falls with harm | 2 |
| Total number of pressure ulcer development | 7 |
| Total number of staffing incidents | 62 minor |

The falls with harm occurred on ward A9. When triangulated against red flags raised in month and red staffing status it shows a correlation, there were no days during June reported as green for staffing for A9. Ward A9 also reported a pressure ulcer as did A6,A7 and A8 all areas with high reporting numbers for red flags and red rag status. All areas have harm improvement action plans and due to the level of enhanced care requirements request additional staff to support the wards. Progress is monitored by the senior nursing teams.

*Table 4 – July 2022*

| | |
|---|---|
| Total number of red flags rasied | 436 |
| Total number of gold command red status | 195 |
| Total number of falls | 1 moderate |
| Total number of pressure ulcer development | 11 |

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| Total number of staffing incidents | 32 minor |
| | 1 moderate |

When traingulated against staffing numbers, red flags and red status, the harms that occurred in July show a correlation between reduced staffing and increased red flag escalation. The increased requirement for enhanced monitoring of patients due to their dependancy means more staff are required on some wards. Plans are made to mitigate utilising temporary staffing. Senior nurse oversight is in place and the wards where harm has occurred have local action plans in place for improvement.

**Vacancy Summary**

Table 5 below shows Registered Nursing (Band 5) and Health Care Support Worker Vacancies (Excluding Theatres)

*Table 5 – RN and HCSW vacancies (excluding Theatres)*
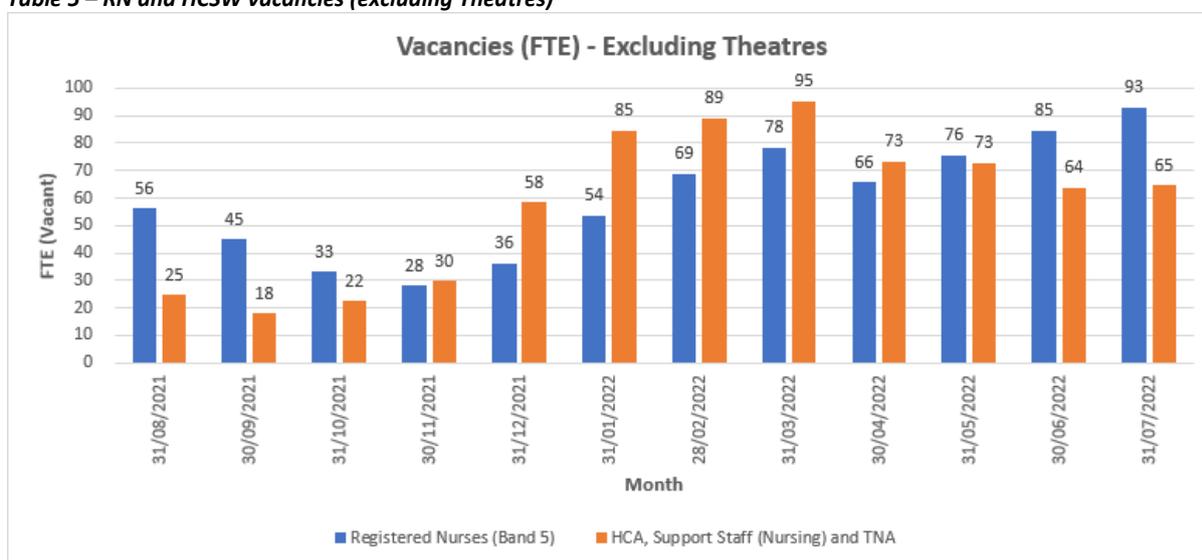


**Health Care Support Worker (HCSW) Vacancies**
July vacancy data shows a very small increase in HCSW vacancies, but a reducing trajectory which has been supported by WHH successful collaborative work with NHSE/I in the HCSW Recruitment Programme. Monitoring by NHSEI of WHH progress with this workstream has reduced due to the improvement shown in successful recruitment, demonstrated in the table across Q1 and Q2 2022/2023.
Approval of the business case for B19 has increased HCSW vacancies for August. Table 6 below demonstrates the various stages of the recruitment pipeline and the remaining number of vacancies out to advert.

*Table 6 – HCSW vacancy data and recruitment data on 30th August 2022*

| Overall Vacancy | 72 | Figure reported externally to NHSEI |
| Induction September | 23 | Next induction 5th and 19th September |
| In recruitment process | 42 (Pre- Induction) | Weekly tracking meetings with recruitment in place. |
| **Total remaining vacancies** | **7.0** | **Rolling advert and recruitment ongoing** |

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WHH continues to utilise the NHSP Care Support Worker Development (CSWD) programme and are currently supporting 10 completing their 6-month training programme in September 2022 with a further 11 who have commenced their 6-month training in July and August 2022. The next planned cohort of 15 will commence their training in October 2022.

**Registered Nursing Vacancies**

Registered nurse vacancies have increased due to a successful business case approval in relation to B19 and further increased in August with the successful approval of the B3 business case, resulting in 11 wte extra funded band 5 staff. Of the vacancies, 56 are in the recruitment pipeline.

Recruitment and retention remain a priority at WHH. Collaborative working with the ICB Workforce and Education Transformation Lead is underway to support retention planning. A workforce plan is being developed supported by the Trust HR Team so we can forecast workforce needs going forward. As part of the Trust Workforce Planning Group, the deputy chief nurse is working with the deputy medical director across CBU's to complete a forecasting piece of work across all staff groups.

*Table 7 below shows Band 2 and Band 5 Vacancies – Theatres Only*
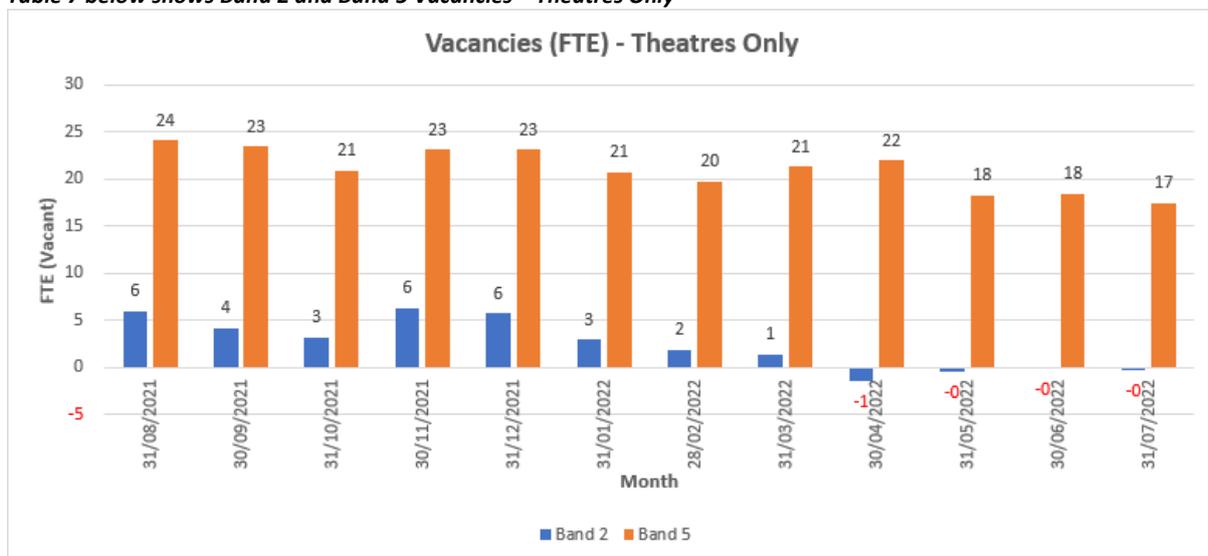


Theatres have seen a small reduction in the number of band 5 vacancies, the senior nursing team in planned care are working closely with the theatre manager and the Trust workforce lead to improve recruitment in that area.

*Table 8 - Maternity Vacancies*



Vacancies (FTE) - Maternity
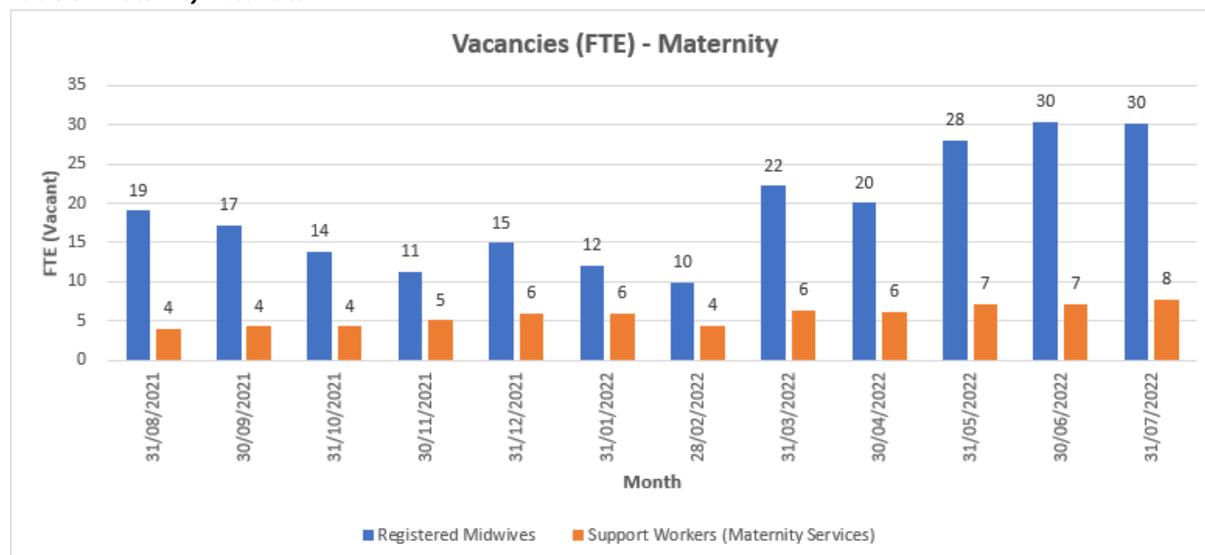
Of the vacancies within the maternity department 18 of those are in the recruitment pipeline with 9 starters due by end of October, high turnover rates (28%) in maternity have contributed to these figures, 22% of those staff are retire and return. Close working with senior midwives to ensure safe staffing of the maternity unit is ongoing, flexibility within the teams is utilised to ensure safe cover is maintained. When this has not been possible due to acuity the Maternity Unit have diverted activity elsewhere, this has happened on 5 occasions this year with no harm to mother or baby.

**Turnover**

Turnover for Nursing and Midwifery staff stands at 16.59% which is an increase from 15.67% in July and 14.95% in June. Main reason cited for leaving is work-life balance, and work is underway with HR colleagues to gain a greater understanding of reasons for leaving. WHH has recently joined the Integrated Care Board (ICB) Retention Strategy workstream.

**Unplanned Care Group**

The costings for the Enhanced Care Unit on AMU are currently being calculated after the repurposing of those beds, with a wider review of nurse staffing establishments across Unplanned Care. This review includes ITU in relation to how WHH compares with the Guidelines for the Provision of Intensive Care Services (GPICS) standards for ITU staffing levels. This remains under review. A7, A8, A9 have seen an increase in the number of enhanced care patients and those with no right to reside, the dependency of these patients has impacted on the delivery of safe care and is reflected within the SNCT indicative data (reported to Quality Assurance Committee August 2022) a further professional judgment review is being undertaken looking at the enhanced care requirements for patients on these wards as part of a safe staffing review for those areas. A review of registered and non-registered staffing in ED will be completed in September 2022.

**Planned Care Group**

Ward B3 remains open at Halton as a facility to step down patients from Warrington site, who meet the criteria as less acute. Recruitment is underway following the recent successful approval of the business case for staffing. Currently until staff are in post it will continue to be supported by staff from across other areas within the Trust   provide safe levels of care leaving areas reliant on temporary staffing.

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The cohorting of Orthopaedic patients within CSTM as a result of Infection Prevention and Control (IPC) precautions has resulted in an increased use of temporary staffing.

**Overseas recruitment**

The first cohort of international nurses who joined WHH from 2020 have now been given permanent contracts, work is underway to support the extension of visa's to enable them to apply for UK residency. 30 international nurses will join the Trust in 2022.

**Escalation Beds**

It is important to note that the Trust continues to be extremely challenged with increased activity and as a result additional beds have been opened during June and July. Extra beds have been opened in the following areas:
- Extra beds opened on B3, in addition to the original 27 already opened as escalation.
- Ward A4
- Catheter Laboratory
- Ward B18
- Ready for discharge (RFD) (Old CAU unit)

**Temporary staffing**

The Trust continues to work with NHS Professionals (NHSP) and the Comprehensive Agency Managed Service (CAMS) which moved to a permanent contract on the 1st August 2022. The aim is to remove the responsibility of managing agencies from NHS Trusts, drive performance, efficiency, and cost reduction. No off-framework agency staff have been utilised in the Trust since May 2022.

An agency spend reduction plan is being developed to review areas with higher agency usage across the Trust, such as the Emergency Department. As planned with the CBU during the COVID-19 pandemic, a review of registered and non-registered nurse staffing in the ED will commence in September 2022, the review will be completed by an external subject matter expert with a draft report expected in October 2022. Close working with colleagues from NHSP continues to encourage staff to join the NHSP bank with a month-on-month improvement in staff numbers who join thus, reducing the reliance on agency staff.

**Sickness Absence – June and July 2022**

Registered nurse and midwife sickness absence in the month of June was recorded at 7.73% with an increase in July to 8.81%. Health care support worker sickness absence in the month of June was recorded at 8.42% with an increase in July to 9.63%.
The cost of bank/agency cover of Registered Nursing and Midwifery staff sickness (at usual bank/agency fill rates) was £360,660 in June and £302,194 for July 2022.

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*Table 9 – Sickness Absence Rate*

**Sickness Absence Rate**

| Month | Additional Clinical Services (Band 2) | Nursing and Midwifery Registered |
|---|---|---|
| July 2022 | 9.63% | 8.81% |
| June 2022 | 8.42% | 7.73% |
| May 2022 | 9.58% | 7.31% |
| April 2022 | 12.32% | 8.99% |
| March 2022 | 11.50% | 8.43% |
| February 2022 | 9.74% | 7.81% |
| January 2022 | 12.37% | 10.37% |

*Tables 10 and 11 - Registered nurse and midwifery sickness cover – June / July 2022*

**Jun-22**

| | |
|---|---|
| Contracted Nursing WTE (Band 5 to 7) | 900.65 |
| % Sickness | 7.73% |
| WTE Equivalent of Sickness | 69.62 |
| NHSP Fill Rate | 93% |
| WTE Covered by Temporary Staffing | 65.03 |

| | |
|---|---|
| Cost at Average NHSP Rates | 360,660 |

**Jul-22**

| | |
|---|---|
| Contracted Nursing WTE (Band 5 to 7) | 898.26 |
| Nursing & Midwifery % Sickness | 8.81% |
| WTE Equivalent of Sickness | 79.14 |
| NHSP Fill Rate | 94% |
| WTE Covered by Temporary Staffing | 74.47 |

| | |
|---|---|
| Cost at Average NHSP Rates | 413,032 |

**Update from Specialist Areas**

**Paediatrics and Neonatal Unit**

- Paediatric Outpatients Department open with 2 x new HCSW's enrolled to support the increase in activity.
- Daily sitreps continue to be submitted to the Cheshire and Mersey Paediatric Network, this report notes acuity and staffing levels as well as HDU capacity, Covid 19 and RSV admissions. There is a focus across the network on the increase of children being admitted to children's wards requiring mental health support.
- As part of a recent workforce meeting with the Northwest Neonatal Operational Delivery Network The Trust is undertaking a staffing review to move our workforce and skill mix to an

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optimal and compliant model. Outcome of the review will be presented at Quality Assurance Committee in October 2022.

- The child health matron continues to represent WHH at the Silver command meetings for the Cheshire and Mersey Network.
- Recruitment within Neonatal Units continues to be a challenge across the region.  The WHH NNU has successfully recruited 5 Band 5 staff nurses.
- Challenges remain in ensuring those recruited commence work at WHH as, despite a robust recruitment keep in touch process, candidates have chosen to commence alternative employment at specialist hospitals prior to their start dates.

## Theatres

- Recruitment and retention on a national scale demonstrates shortfalls in theatre staff due to retirement or staff leaving to join an agency. Theatre managers across the Northwest come together to discuss for future workforce planning.
- Focussed work within the Care Group for recruitment, retention and succession planning is underway
- Overseas recruitment for theatres.
- Due to gaps in ODP staffing, alternative staffing models are being explored such as skilling up anaesthetic nurses which requires training. The recruitment team are supporting theatres with this work.
- Structure for progression from band 2 upwards is in place with a theatre hierarchy model to support this.

## Therapy

- Successful approval of business case for overseas recruitment and the collaborative bid to NHSE/I to recruit 3 international occupational therapists.
- Possibility of new roles including advanced clinical practitioners and apprenticeships.
- AHP Strategic Workforce Plan approved.
- AHP Return to Practice Policy being reviewed.
- AHP Workforce Supply Project, Preceptorship for all new AHP Preceptees.
- Career conversations and cascading development opportunities offered by WHH.
- Active management of absent and sickness, supported by the review of therapies supervision policy to embed a check in conversation culture.
- High level brief report feeds into Workforce Review Group for assurance and escalation.
- Daily workforce reviews across inpatient therapy services to support shortfalls due to vacancies and escalation beds
- Total vacancies across therapy groups for both inpatient and outpatient services are 44.16 wte. Close monitoring of this process is maintained by the AHP lead, head of therapy services with joint working underway between nursing and AHP recruitment.
- Plan for AHP staff to join NHSP which will encourage fill of staffing gaps and support recruitment.

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**Maternity**

- Annual sickness rate for Maternity is 11.45%, in month figure is 9.89% (in month), 2.98% short term, 8.45% long term, this is an improving picture.
- Figures for registered staff is lower 8.11% (in month) and is reducing compared to the previous month. Of this 6.22% % was long term and 1.89% was short term.
- In total there are six long term sickness case (One Covid related, one bereavement), three have return to work dates in place.
-  Cases are being effectively calculated total workforce requirement for WHH is 116.70 wte, which includes an additional 10% for non-clinical roles. The overall ratio for Warrington & Halton Teaching Hospitals NHS Foundation Trust of 24.6 births to WTE in line with NICE guidelines.
- Vacancy rate 22.94%, recruitment underway with a number of posts due to be filled October.
- Escalation of areas of concern through a monthly high level briefing paper via the Workforce Review Group.
- Overseas recruitment.
- Daily staffing review and monitoring of safe staffing levels.
- Proactive management of sickness and absence.
- Reinstatement of the attendance management surgeries to assist line managers with effective management of long-term sickness absence cases.

Implementation of several initiatives to support recruitment and retention.

## 3. RECOMMENDATIONS

Members of the Trust Board are asked to receive and note the content of this report.

## Appendix One – Monthly Staffing Data – June 2022

| CBU | Ward | Day Planned RN hours | Day Actual RN hours | Day Planned HCA hours | Day Actual HCA hours | Day %RN fill rate | Day %HCA fill rate | Night Planned RN hours | Night Actual RN hours | Night Planned HCA hours | Night Actual HCA hours | Night %RN fill rate | Night %HCA fill rate | Cumulative count over the month of patients at 23:59 each day | CHPPD RN | CHPPD HCA | CHPPD RNA | CHPPD AHP | CHPPD Overall |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | |
| DD | Ward A4 | 1725.0 | 1467.3 | 1380.0 | 1449.0 | 85% | 105% | 1380.0 | 1334.0 | 1380.0 | 1334.5 | 97% | 97% | 989 | 2.8 | 2.8 | 0.1 | 0.0 | 5.7 |
| DD | Ward A5 G | 1035.0 | 1000.5 | 1035.0 | 869.5 | 97% | 84% | 690.0 | 690.0 | 1035.0 | 851.0 | 100% | 82% | 736 | 2.3 | 2.3 | 0.0 | 0.0 | 4.7 |
| DD | Ward A5 E | 690.0 | 747.5 | 690.0 | 536.5 | 108% | 78% | 713.0 | 713.0 | 690.0 | 402.5 | 100% | 58% | 244 | 6.0 | 3.8 | 0.0 | 0.0 | 9.8 |
| MSK | Ward A6 | 1725.0 | 1558.0 | 1725.0 | 1682.0 | 90% | 98% | 1035.0 | 1276.5 | 1725.0 | 1552.5 | 123% | 90% | 1017 | 2.8 | 3.2 | 0.0 | 0.0 | 6.0 |
| MSK | CMTC | 966.0 | 1086.5 | 644.0 | 586.5 | 112% | 91% | 575.0 | 575.0 | 552.0 | 207.0 | 100% | 38% | 152 | 10.9 | 5.2 | 0.0 | 0.0 | 16.2 |
| W&C | C20 | 1035.0 | 1058.0 | 690.0 | 714.0 | 102% | 103% | 690.0 | 690.0 | 0.0 | 780.0 | 100% | N/A | 496 | 3.5 | 3.0 | 0.0 | 0.3 | 6.8 |
| W&C | Ward C23 | 1380.0 | 1092.5 | 690.0 | 667.0 | 79% | 97% | 690.0 | 529.0 | 690.0 | 575.0 | 77% | 83% | 594 | 2.7 | 2.1 | 0.0 | 0.0 | 4.8 |
| W&C | Birth Suite | 2070.0 | 1644.5 | 345.0 | 299.0 | 79% | 87% | 2070.0 | 1794.0 | 345.0 | 172.5 | 87% | 50% | 228 | 15.1 | 2.1 | 0.0 | 0.0 | 17.1 |
| W&C | The Nest | 345.0 | 287.5 | 345.0 | 241.5 | 83% | 70% | 345.0 | 230.0 | 345.0 | 230.0 | 67% | 67% | 5 | 103.5 | 94.3 | 0.0 | 0.0 | 197.8 |
| W&C | Ward B11 | 2980.8 | 2520.0 | 862.5 | 817.0 | 85% | 95% | 1596.0 | 1519.0 | 322.4 | 322.4 | 95% | 100% | 316 | 12.8 | 3.6 | 0.1 | 0.0 | 16.8 |
| W&C | NNU | 1725.0 | 1138.5 | 345.0 | 276.0 | 66% | 80% | 1725.0 | 1020.0 | 345.0 | 345.0 | 59% | 100% | 301 | 7.2 | 2.1 | 0.0 | 0.0 | 9.2 |
| UEC | Ward A1 | 2249.0 | 2392.7 | 2824.2 | 1826.5 | 106% | 65% | 1606.3 | 1892.8 | 1271.1 | 948.7 | 118% | 75% | 974 | 4.4 | 2.8 | 0.0 | 0.0 | 7.2 |
| UEC | Ward A2 | 1506.2 | 1226.7 | 1872.0 | 1629.6 | 81% | 87% | 964.6 | 943.2 | 956.4 | 926.8 | 98% | 97% | 816 | 2.7 | 3.1 | 0.0 | 0.0 | 5.8 |
| UEC | ED | 6967.2 | 7007.8 | 2837.2 | 2603.5 | 101% | 92% | 4681.4 | 5571.1 | 2142.1 | 1824.5 | 119% | 85% | 0 | | | | | |
| MC | ACCU | 2415.0 | 2171.0 | 1035.0 | 989.0 | 90% | 96% | 1725.0 | 1775.5 | 1035.0 | 1037.0 | 103% | 100% | 796 | 5.0 | 2.5 | 0.0 | 0.0 | 7.5 |
| MC | ICU | 5520.0 | 4887.5 | 1035.0 | 621.0 | 89% | 60% | 5520.0 | 5037.0 | 1035.0 | 736.0 | 91% | 71% | 491 | 20.2 | 2.8 | 0.0 | 0.0 | 23.0 |
| MC | B18 | 2415.0 | 2006.0 | 1380.0 | 1359.0 | 83% | 98% | 2070.0 | 2124.5 | 1380.0 | 1034.5 | 103% | 75% | 868 | 4.8 | 2.8 | 0.0 | 0.0 | 7.5 |
| IM&C | Ward A7 | 1725.0 | 1608.0 | 1725.0 | 1381.0 | 93% | 80% | 1426.0 | 1402.0 | 1380.0 | 1230.5 | 98% | 89% | 1020 | 3.0 | 2.6 | 0.0 | 0.1 | 5.6 |
| IM&C | Ward C21 | 1380.0 | 1322.5 | 1380.0 | 1168.5 | 96% | 85% | 1035.0 | 1035.0 | 1035.0 | 1012.0 | 100% | 98% | 750 | 3.1 | 2.9 | 0.0 | 0.0 | 6.1 |
| IM&C | Ward B14 | 1035.0 | 1121.5 | 1725.0 | 1310.0 | 108% | 76% | 690.0 | 724.5 | 1035.0 | 1012.0 | 105% | 98% | 720 | 2.6 | 3.2 | 0.0 | 0.0 | 5.8 |
| IM&C | Ward B12 | 1035.0 | 1035.0 | 2484.0 | 222.3 | 100% | 9% | 690.0 | 701.5 | 1794.0 | 1817.0 | 102% | 101% | 630 | 2.8 | 3.2 | 0.1 | 0.0 | 6.2 |
| IM&C | Ward B19 | 1380.0 | 1035.0 | 1380.0 | 1111.5 | 75% | 81% | 1035.0 | 952.5 | 1035.0 | 1010.5 | 92% | 98% | 720 | 2.8 | 2.9 | 0.0 | 0.0 | 5.9 |
| IM&C | Ward A8 | 1725.0 | 1483.5 | 1725.0 | 1407.0 | 86% | 82% | 1380.0 | 1314.0 | 1380.0 | 1161.5 | 95% | 84% | 1020 | 2.7 | 2.5 | 0.0 | 0.0 | 5.3 |
| IM&C | Ward A9 | 1782.5 | 1433.5 | 1782.5 | 1544.5 | 80% | 87% | 1380.0 | 1561.0 | 1725.0 | 1127.0 | 113% | 65% | 1020 | 2.9 | 2.6 | 0.1 | 0.0 | 5.7 |
| | Total | 46811.7 | 42331.4 | 31936.3 | 25311.4 | 90% | 79% | 35712.3 | 35405.1 | 24633.0 | 21650.4 | 99% | 88% | 14903 | 4.4 | 2.9 | 0.0 | 0.0 | 7.3 |
| | | = above 100% | | = above 90% | | | = above 80% | | | = below 80% | | | | | | | | | |

# Appendix Two – Monthly Staffing Data – July 2022

| | | Day | Day | Day | Day | Day | Day | Night | Night | Night | Night | Night | Night | | CHPPD | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CBU | Ward | Planned RN hours | Actual RN hours | Planned HCA hours | Actual HCA hours | % RN fill rate | % HCA fill rate | Planned RN hours | Actual RN hours | Planned HCA hours | Actual HCA hours | % RN fill rate | % HCA fill rate | Cumulative count over the month of patients at 23:59 each day | RN | HCA | RNA | AHP | Overall |
| DD | Ward A4 | 1782.5 | 1507.5 | 1426.0 | 1437.5 | 85% | 101% | 1426.0 | 1368.5 | 1426.0 | 1403.0 | 96% | 98% | 1000 | 2.9 | 2.8 | 0.0 | 0.0 | 5.7 |
| DD | Ward A5 G | 1069.5 | 904.0 | 1069.5 | 954.5 | 85% | 89% | 713.0 | 713.0 | 1069.5 | 954.5 | 100% | 89% | 606 | 2.7 | 3.2 | 0.1 | 0.0 | 5.9 |
| DD | Ward A5 E | 713.0 | 713.0 | 713.0 | 574.0 | 100% | 81% | 713.0 | 701.5 | 690.0 | 310.5 | 98% | 45% | 244 | 5.8 | 3.6 | 0.0 | 0.0 | 9.4 |
| MSK | Ward A6 | 1782.5 | 1487.0 | 1782.5 | 1573.0 | 83% | 88% | 1069.5 | 1230.5 | 1782.5 | 1588.0 | 115% | 89% | 1051 | 2.6 | 3.0 | 0.1 | 0.0 | 5.7 |
| MSK | CMTC | 1069.5 | 1133.0 | 713.0 | 705.0 | 106% | 99% | 713.0 | 713.0 | 713.0 | 345.0 | 100% | 48% | 228 | 8.1 | 4.6 | 0.0 | 0.0 | 13.1 |
| W&C | C20 | 1069.5 | 966.0 | 690.0 | 564.0 | 90% | 82% | 713.0 | 713.0 | 0.0 | 292.0 | 100% | N/A | 434 | 3.9 | 2.0 | 0.0 | 0.3 | 6.1 |
| W&C | Ward C23 | 1426.0 | 1155.8 | 713.0 | 598.0 | 81% | 84% | 713.0 | 563.5 | 713.0 | 644.0 | 79% | 90% | 794 | 2.2 | 1.6 | 0.0 | 0.0 | 3.7 |
| W&C | Birth Suite | 2139.0 | 1707.8 | 356.5 | 299.0 | 80% | 84% | 2139.0 | 1828.5 | 356.5 | 230.0 | 85% | 65% | 324 | 10.9 | 1.6 | 0.0 | 0.0 | 12.5 |
| W&C | The Nest | 356.5 | 270.3 | 356.5 | 207.0 | 76% | 58% | 356.5 | 270.3 | 356.5 | 149.5 | 76% | 42% | 3 | 180.2 | 118.8 | 0.0 | 0.0 | 299.0 |
| W&C | Ward B11 | 3050.0 | 2563.5 | 877.5 | 807.8 | 84% | 92% | 1596.0 | 1508.8 | 322.4 | 322.4 | 95% | 100% | 290 | 14.0 | 3.9 | 0.0 | 0.0 | 18.2 |
| W&C | NNU | 1782.5 | 1091.5 | 356.5 | 290.0 | 61% | 81% | 1782.5 | 985.5 | 356.5 | 304.0 | 55% | 85% | 291 | 7.1 | 2.0 | 0.0 | 0.0 | 9.2 |
| UEC | Ward A1 | 2323.3 | 2350.3 | 2850.5 | 1747.3 | 101% | 61% | 1652.2 | 1703.6 | 1321.8 | 944.9 | 103% | 71% | 944.93 | 4.3 | 2.8 | 0.0 | 0.0 | 7.1 |
| UEC | Ward A2 | 1568.1 | 1381.1 | 1951.5 | 1514.8 | 88% | 78% | 977.0 | 923.1 | 984.8 | 945.7 | 94% | 96% | 945.7 | 2.4 | 2.6 | 0.0 | 0.0 | 5.0 |
| UEC | ED | 7213.8 | 7185.1 | 2942.6 | 2439.1 | 100% | 83% | 4817.9 | 5698.7 | 2221.9 | 1802.2 | 118% | 81% | 0 | | | | | |
| MC | ACCU | 2495.5 | 2268.5 | 1069.5 | 1055.0 | 91% | 99% | 1782.5 | 1460.5 | 1058.0 | 1081.0 | 82% | 102% | 823 | 4.5 | 2.6 | 0.0 | 0.0 | 7.1 |
| MC | ICU | 5704.0 | 4283.8 | 1069.5 | 793.5 | 75% | 74% | 5704.0 | 4094.0 | 1069.5 | 598.0 | 72% | 56% | 498 | 16.8 | 2.8 | 0.0 | 0.0 | 19.6 |
| MC | B18 | 2495.5 | 2025.5 | 1426.0 | 1369.7 | 81% | 96% | 2139.0 | 2231.0 | 1426.0 | 1102.0 | 104% | 77% | 895 | 4.8 | 2.8 | 0.0 | 0.0 | 7.5 |
| IM&C | Ward A7 | 1782.5 | 1514.0 | 1782.5 | 1518.0 | 85% | 85% | 1426.0 | 1426.0 | 1426.0 | 1345.5 | 100% | 94% | 1054 | 2.8 | 2.7 | 0.0 | 0.1 | 5.6 |
| IM&C | Ward C21 | 1426.0 | 1288.0 | 1426.0 | 1381.5 | 90% | 97% | 1069.5 | 1069.5 | 1069.5 | 1081.1 | 100% | 101% | 775 | 3.0 | 3.2 | 0.0 | 0.0 | 6.2 |
| IM&C | Ward B14 | 1069.5 | 1036.5 | 1782.5 | 1168.0 | 97% | 66% | 713.0 | 724.5 | 1069.5 | 943.0 | 102% | 88% | 744 | 2.4 | 2.8 | 0.0 | 0.0 | 5.2 |
| IM&C | Ward B12 | 1035.0 | 967.0 | 2495.5 | 2063.5 | 93% | 83% | 713.0 | 736.0 | 1782.5 | 1817.0 | 103% | 102% | 651 | 2.6 | 6.0 | 0.2 | 0.0 | 8.9 |
| IM&C | Ward B19 | 1426.0 | 1100.0 | 1426.0 | 1201.5 | 77% | 84% | 1069.5 | 1023.5 | 1069.5 | 1028.0 | 96% | 96% | 742 | 2.9 | 3.0 | 0.0 | 0.0 | 6.0 |
| IM&C | Ward A8 | 1782.5 | 1464.0 | 1782.5 | 1550.5 | 82% | 87% | 1426.0 | 1322.5 | 1426.0 | 1345.5 | 93% | 94% | 1054 | 2.6 | 2.7 | 0.0 | 0.0 | 5.5 |
| IM&C | Ward A9 | 1782.5 | 1364.4 | 1782.5 | 1789.0 | 77% | 100% | 1426.0 | 1437.5 | 1782.5 | 1305.5 | 101% | 73% | 1054 | 2.7 | 2.9 | 0.2 | 0.0 | 5.8 |
| | Total | 48344.7 | 41727.4 | 32841.1 | 27601.2 | 86% | 84% | 36850.0 | 34446.4 | 25493.4 | 21882.3 | 93% | 86% | 15445.63 | 4.2 | 3.0 | 0.0 | 0.0 | 7.3 |
| | | = above 100% | | = above 90% | | | = above 80% | | | = below 80% | | | | | | | | | |

# BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

| AGENDA REFERENCE: | BM/22/09/116 a | | Trust Board | DATE OF MEETING | 28 September 2022 |
|---|---|---|---|---|---|

| | |
|---|---|
| Date of Meeting | 2 August 2022 |
| 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/22/08/198 | Patient Story – Communication in its many Forms | The Committee heard about the experience of a patient who is a member of the deaf community and their associated obstacles experience when trying to communicate.<br><br>The patient has subsequently signed up to be an Expert by Experience with the Trust to help support improvements.<br><br>The Committee noted that future work would include commissioning basic skills, and deaf awareness training, and brilliant basics associated with interpretation and translation as part of the staff guide.  There had been also been a relaunch of the Accessible Information Standards policy to ensure communication needs would be recorded, shared, and acted on | **The Committee discussed the presentation and received good assurance** | n/a |
| QAC/22/08/199 | Hot Topic – Human Tissue Authority (HTA) | The Committee received a presentation relating to a recent HTA inspection on 18 May 2022, directed at mortuary services and the following was highlighted from the inspection.<br>• 1 critical, 5 major and 4 minor findings<br>• The Trust had responded to the report and was still awaiting the official report | **The Committee noted and discussed the presentation, receiving moderate assurance, and it was agreed a further update be presented to the November meeting.** | 01.11.2022 |

| | | | | |
|---|---|---|---|---|
| | | • Critical findings required immediate action, major within 1-2 months and minor within 3 – 4 months. | | |
| QAC/22/08/200 | Deep Dive – ED Wait Times | The Committee received a presentation which focused on ED Wait times and the escalation processes, along with challenges and issues.  The following was highlighted as part of the presentation.<br>• Data included 4 hour performance and 12+ hour delays<br>• There had been an increase in 12+ hour delays during 2022/23 with a significant increase from January 2022, tapering off slightly in May.<br>• Up until the end of June 12+ hour breaches had been reviewed with no harm identified<br>• Early evaluation of the opening of SDEC had been positive with further development work planned<br>• The challenges experienced are reflected on the BAF & Risk Registers | **The Committee discussed the highlights from the presentation and received moderate assurance.** | **Quality Assurance Committee (monthly)** |
| QAC/22/08/203 | Violence, Prevention & Reduction Strategy | The Committee approved the Violence, Prevention & Reduction Strategy that ensured measures had been put in place to better protect staff against deliberate violence and aggression from patients, their families and the public, and to prosecute offenders more easily. | **The Committee approved the Strategy** | **Trust Board 28.09.2022** |

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

*Matters for Approval*
QAC/22/08/201 – Strategic Risk Register & BAF
QAC/22/08/202 – Health & Safety Annual Report
QAC/22/08/204 – Food & Drink Strategy

*Papers to Discuss and Note for Assurance*
QAC/22/08/206 – Quality Dashboard
QAC/22/08/207 – 6 Monthly Staffing & Acuity Reviews
QAC/22/08/208 – Maternity Update

2

**Papers to Note for Assurance**

QAC/22/08/209 – Serious Incidents & Complaints – Q1

QAC/22/08/210 – Learning from Experience – Q1

QAC/22/08/211 – Quality Priorities – Q1

QAC/22/08/212 – Learning from Deaths Review – Q1

QAC/22/08/213 – Clinical Audit Update – Q1

QAC/22/08/214 – DIPC Infection Control – Q1

QAC/22/08/215 – Dementia Strategy Update – Q1

QAC/22/08/216 – Quality Improvement Progress Report – Q1

*High Level Briefing Report*

QAC/22/08/217 – Clinical Recovery Oversight Committee

QAC/22/08/218 – Patient Safety & Clinical Effectiveness Sub Committee

QAC/22/08/219 – Health & Safety Sub Committee

QAC/22/08/220 – Risk Review Group

QAC/22/08/221 – Complaints Quality Assurance Group

QAC/22/08/222 – Patient Experience Sub Committee

QAC/22/08/223 – Equality, Diversity & Inclusion Sub Committee

QAC/22/08/224 – Infection Control Sub Committee

**Closing**

It was noted the 6 monthly Committee Effectiveness Review would be circulated and presented in October

3

**BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT**

| AGENDA REFERENCE: | BM/22/09/116 a | | Trust Board | DATE OF MEETING | 28 September 2022 |
|---|---|---|---|---|---|

| Date of Meeting | 6 September 2022 |
|---|---|
| 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/22/09/232 | Hot Topic – Maternity Diverts | The Committee received a presentation to Maternity Diverts which covered the period January – July 2022. The following was highlighted.<br>• 5 Maternity diverts occasions with 3 occasions during January – December 2021<br>• Information was provided in relation to the SI investigations and the reasons for the diverts<br>• Updated Divert Policy launched on 19 August 2022 | **The Committee noted and discussed the presentation, receiving good assurance** | n/a |
| QAC/22/09/233 | Deep Dive – Medicines Reconciliation | The Committee received a presentation which focused Medicines Reconciliation and the process identifying medication taken by a patient and reconciling against clinical status to ensure it is appropriate.<br><br>The data presented showed the average percentage over a 12 month period, and it was noted the data did not include emergency medication due to an issue with data quality.<br><br>Assessment of harm due to delayed medication was highlighted and this identified a number of occasions causing minor harm. | **The Committee discussed and noted the presentation receiving moderate assurance. It was agreed that a further update be presented to the meeting in January 2023.** | QAC 10.01.2023 |

| QAC/22/09/235 | Safeguarding Annual Report | The Committee received the Safeguarding Annual Report describing the structures, responsibilities and activity of the Trust in ensuring that patients and staff are appropriately safeguarded.<br>The Committee particularly noted:<br>• 17% increase in notifications to the Safeguarding Children Team<br>• 150% increase in Female Genital Mutilation<br>• 44% increase in notifications to the Adult Safeguarding Team | **The Committee approved the report receiving moderate assurance and noted a further update would be presented to the Committee in November** | QAC 01.11.2022 |
| --- | --- | --- | --- | --- |
| QAC/22/09/239 | Strategy Highlight Programme | The Committee received a report providing a progress update on the key strategic projects and initiatives that underpin the Trust's QPS aims and objectives.<br><br>The Committee noted that three enabling strategies remained overdue. The Committee felt it was not fully assured of the potential impact. | **The Committee discussed the update receiving moderate Assurance. A further update will be presented to the next meeting.** | QAC 04.10.2022 |

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

*Papers for Approval*
QAC/22/09/234 – Board Assurance Framework

*Papers to Discuss and Note for Assurance*
QAC/22/09/236 – Infection & Prevention Control BAF
QAC/22/09/237 – Q1 Quality Impact Assessment for CIP Plans
QAC/22/09/238 – Maternity Update
QAC/22/09/239 – Strategy Programme Highlight Report

*High Level Briefing Report*
QAC/22/09/240 – Clinical Recovery Oversight Committee
QAC/22/09/241 – Patient Safety & Clinical Effectiveness Sub Committee
QAC/22/09/242 – Palliative End of Life Care
QAC/22/09/243 – Risk Review Group
QAC/22/09/244 – IG & Corporate Records
QAC/22/09/245 – Infection Control Sub Committee

**Closing**

2

It was noted the 6 monthly Committee Effectiveness Review would be circulated and presented in October

**BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT**

| AGENDA REFERENCE: | BM/22/09/116 b | MEETING: | Trust Board | DATE OF MEETING | 28th September 2022 |
|---|---|---|---|---|---|

| Date of Meeting | 21st Sept 2022 |
|---|---|
| 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/22/09/87 | **Matters Arising** | Chair's action was completed in July 2022 to approve the Trade Union Facilities report which was submitted on the Government portal and published on the Trust's website | **Report approved for submission.** | **Not applicable** |
| SPC/22/09/88 | **BAF & Risk Register - Staff** | The Committee review the Workforce Risks overseen by the Strategic People Committee. Change to the current BAF risk was discussed and approved with the recommendation to add in reference to the impact on the workforce related to unplanned bed capacity. All current corporate risks were reviewed and 8 additional new corporate risks identified.

The Committee agreed to bring to the attention of the Trust Board the new Corporate Risk regarding potential industrial action from October 2022 for up to 6 months, involving one or more Trade Unions. The Committee were assured that the Trust has plans in place to mitigate the impact of industrial action, and that this is currently a Corporate Risk but may be escalated to a BAF risk in the event that statutory balloting results indicate a legal intention of Trade Unions to enact discontinuous strike action. | **The Committee approved the changes to the risks proposed.**

**Escalation to Trust Board: Corporate Risk – Potential Discontinuous Industrial Action for up to 6 months** | **Not applicable** |

1

| SPC/22/08/89 | Hot Topic – Health & Wellbeing (Anxiety, Stress & Depression) | The Committee received a detailed presentation and assurance regarding the People Directorate actions to support staff presenting with anxiety / stress / depression.

The Committee discussed the requirement of the organisation to reduce the underlying causes for anxiety / stress acknowledged the adverse impact on the wellbeing of the workforce from the current operational pressures and regular use of additional unplanned bed capacity. Agreed organisation to raise impact of length of stay and super stranded and the impact on people within the organisation to the ICB.

The Committee reviewed the Health and Well-Being Guardian report and was joined in the discussions by Cliff Richards as the well-Being Guardian | The Committee discussed the presentation and received good assurance of the support mechanisms and good offer in place for staff suffering from anxiety and stress. Moderate assurance in relation to addressing some of the underpinning causal factors. | Not applicable |
|---|---|---|---|---|
| SPC/22/09/90 | Deep Dive – AHPs Strategic Workforce Plan | The Committee received a presentation which focussed on the Trusts' approach to developing an AHP strategic workforce plan and actions taken to develop and grow the WHH AHP workforce | The Committee discussed the presentation and received good assurance on the plan. | Not applicable |
| SPC/22/09/91 | Chief People Officer Report | The Committee received and discussed a paper summarising a number of key people related topics.

The Committee noted the impact of the pay award on pension bandings, particularly for staff on the first increment of band 8a which may result in staff members owing pension arrears. Staff are being supported to repay pension arrears over 6 months.

The Committee were assured regarding planning for industrial action. | The Committee received good assurance on the topics. | Not applicable |
| SPC/22/09/92 | Move to Outstanding Red Flags Report | The Committee received and discussed the Moving to Outstanding Red Flags Report. | The Committee received moderate assurance due to queries regarding the data from CQC. | Not applicable |

2

| | | The report was noted. Improvements have been made on the reporting of the CQC data and RAG rating. Further work required to align the CQC RAG rating and internal data. There was an action to address this. | | |
|---|---|---|---|---|
| SPC/22/09/93 | On-Call Harmonisation | The Committee received and discussed the On-Call Harmonisation report further to the request from the Audit Committee to monitor the outcomes from the Task and Finish group and the Decision Making panel. | **The Committee received good assurance of the process for moving to Harmonisation and noted the requirement to monitor the outcomes of the project. Moderate assurance on the likely outcomes because of the sensitivity of the project which is being delivered at a difficult time for staff relations.** | **SPC November 2022** |
| SPC/22/09/94 | Freedom to Speak Up Annual report | The Committee received and discussed the annual FTSU report.

The Committee approved the new national FTSU policy. | **The Committee received good assurance on the FTSU process.** | **Not applicable** |
| SPC/22/09/99 | GMC National Trainee Survey | The Committee noted the report for assurance.

The Committee noted the positive actions to support the Trust in exiting 'Enhanced Monitoring' stage. | **The Committee received good assurance on the actions to address.** | **Not applicable** |
| SPC/22/09/100 | GMC Revalidation Annual report | The Committee noted the report for assurance.

The Committee noted that the Chief Executive and Medical Director revalidation recommendation are submitted by the RO at LUFT to manage the conflict of interest of the WHH RO being the Deputy Medical Director. | **The Committee received good assurance on the process.** | **Not applicable** |

3

The Committee also received the following items:

***Matters to Discuss for Assurance***
SPC/22/09/95 – WHH Annual Seasonal Influenza Vaccine Plan 2022-23

***Matters for Approval***
SPC/22/09/96 - Policies and Procedures Report – Polices ratified / extended:
- Annual Leave Policy, Maintaining High Professional Standards Policy, On-Call Policy, Pay Progression Policy, Professional Clinical Registration Policy, Recovery of Employee Related Overpayments Policy

***Matters to Note for Assurance***
SPC/22/09/97 – Equality Delivery System (EDS) – EDS2 moving to EDS 2022
SPC/22/09/98 – Bi-Annual Health & Wellbeing Guardian Report
SPC/22/09/101 – Q1 Guardian Safe Working Hours Junior Doctors in Training
SPC/22/09/102 – Staffing Assurance Report June 7 July 2022 – Key Issues

***Sub-Committee Minutes/Notes***
SPC/22/09/103 - Operational People Committee (18.08.2022)
SPC/22/09/104 - Workforce Recovery Subgroup (16.08.2022)
SPC/22/09/105 - Workforce Equality Diversity & Inclusion Sub-Committee (12.08.22)
SPC/22/09/106 – Committee Effectiveness Review

**BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT**

| AGENDA REFERENCE: | | TRUST BOARD OF DIRECTORS | DATE OF MEETING | 17 August 2022 |
|---|---|---|---|---|

| Date of Meeting | **17 August 2022** |
|---|---|
| Name of Meeting + Chair | **Finance and Sustainability Chaired by Terry Atherton** |
| 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/22/08/133 | Pay Assurance | The Committee considered and reviewed the report noting: -<br>• Reduction in FTE worked (180 below funded compared to 96 below last month), acknowledged that this is mainly due to staffing challenges in nursing<br>• Establishment control – 30% compliance rate for Medical and Dental, review of process underway to improve this<br>• Work continues on the medical rate card and review of compliance is ongoing<br>• Tighter controls around agency spend are to be implemented from 1 September 2022, awaiting further guidance on the detail of these controls<br>• Annual leave management – reviewed at Executive Team meeting with the Care Groups to understand if there are any issues which will prevent annual leave to be fully utilised, deep | The Committee **noted** the report | FSC September 2022 |

| | | dive to take place with care groups as well as a medical staff review | | |
|---|---|---|---|---|
| FSC/22/08/134 | CIP & GIRFT | The Committee considered and reviewed the monthly CIP & GIRFT report noting: -<br>• Delivered £3.1m against a plan of £3.1m<br>• Identified £14.4m to date however £5.6m high risk and £12.3m non recurrent<br>• Care groups are owning their plans and identifying how this will be delivered<br>• Level of financial risk is £9.9m this month, reduction from £10.4m last month therefore although still a high number, moving in the right direction<br>• Unplanned care most challenged area, planned care planning beyond their target to help bridge the gap<br>• Clinical GIRFT lead and finance support are to be appointed | The Committee **noted** the report. | FSC September 2022 |
| FSC/22/08/135 | Medical Staffing Review | The Committee considered the report noting: -<br>• £4.6m cost pressure in 2022/23 (£2.7m recurrent) mainly due to issues around recruitment, sickness and gaps in HEE rotations<br>• Delay in business case preparation is of concern as prolonging dependency on high cost bank and agency as well as delays in recruitment | The Committee **noted** the report | FSC November 2022 |
| FSC/22/08/136 | Benefits Realisation Q1 | The Committee noted the quarterly report:<br>• Noted the progress<br>• Acknowledged clearance of long outstanding items that had been delayed due to the impact of COVID-19 | The Committee **noted** the quarterly report | FSC November 2022 |

2

| FSC/22/08/137 | Digital Services Report | The Committee considered the report noting:-<br>• Moderate assurance for Vendor Management, IT Services, Clinical Safety and Risk Review and Regional "place" Digital Programme (Warrington Together)<br>• Issues with PACs performance still undergoing investigation and technical changes with the external company<br>• Dedalus – ongoing review of all projects given that Lorenzo will not be further developed as their core EPR product | The Committee **noted** the update | FSC September 2022 |
|---|---|---|---|---|
| FSC/22/08/138 | WLI MIAA Audit Review | The Committee noted the update:-<br>• Five recommendations in total of which three fully implemented<br>• Two partially implemented relating to WLI payments now being made through payroll rather than Patchwork, in place, to be reviewed by MIAA in September | The Committee **noted** the update | FSC September 2022 |
| FSC/22/08/139 | Monthly Finance report | The Committee considered the report and capital proposals. Key points to note included:<br>• Month 4 position £5.55m deficit, slightly worse than plan<br>• All Trusts off plan to meet monthly with ICB, CEO and CFO, letter received alludes to systemwide controls on expenditure<br>• Indications are that the pay award will be fully funded<br>• High DNA rates in outpatients main driver of nonachievement of ERF<br>• May 2022 ERF achieved following freeze position<br>• NHS E have advised that ERF income is recognised within the position – expectation this will not be returned later in the year<br>• Pay – pressure in A&E nursing, being investigated but currently forecasting an overspend of £2.7m, pressure from temporary Ward B3 of £2.5m as unable to close as planned at the end of June 2022 due to capacity challenges outside of hospital<br>• Capital contingency – shortfall from year end accruals supported<br>• Supported CPG Terms of Reference updates<br>• Note the items escalated from CPG | The Committee **noted** the update<br>The Committee **supported** the changes to the capital contingency and the changes to the CPG Terms of Reference | FSC September 2022<br><br>Trust Board August 2022 |

3

| FSC/22/08/140 | Capital Expenditure Update | The Committee considered and reviewed the presentation noting: -<br>• Capital plan amended to match £12.5m CDEL in line with NHSE I plan<br>• Month 4 position underspent by £890k due to finalisation of the ED Plaza scheme and a delay in commencement of backlog maintenance<br>• Two additional capital requests to be funded from contingency (Shopping City £128k and Breast to Bath Street £39k)<br>• Pharmacy robot slippage returned to contingency (£744k), reduction through procurement (£362k) and second robot to be purchased in 2023/24 (£382k) – to be ring fenced from 2023/24 capital programme<br>• The progress of the schemes over £500k<br>• ED Plaza, build completed, final cost report expected in August to finalise the scheme<br>• Urology & Paeds – expected to complete on time, final QS report expected to indicate overspend on both schemes but not yet substantiated, to be brought to FSC and Trust Board in September. | The Committee **noted** the update and **supported** the changes to the capital contingency to be presented to Board | FSC September 2022<br><br>Trust Board August 2022 |
| --- | --- | --- | --- | --- |
| FSC/22/08/141 | Shopping City – Capital Addendum | The Committee considered and supported the presentation noting: -<br>• Additional capital request of £128k (inclusive of 10% contingency and worst case)<br>• Lessons learnt highlighted<br>• Supported capital request for presentation to Board for approval<br>• Request for external review of lessons learnt from the scheme | The Committee **noted** the presentation and **supported** the capital request to be presented to Board for approval and external review of lessons learnt to take place | Trust Board August 2022 |
| FSC/22/06/105 | B3 Staffing Business Case | The Committee considered and reviewed the business case noting: - | The Committee **noted** the update and **supported** the | Trust Board August 2022 |

| | | | | |
|---|---|---|---|---|
| | | • The need to retain 27 beds on B3 to support patient flow, A&E performance and elective recovery supported by a substantive model<br>• ICB support to capacity bid coupled with repurpose of CAU which supports costs in year however provides a sustainability challenge going into 2023/24 if the Trust is unable to close the ward<br>• Cost pressure for future financial years, interim review planned for December 2022 to review progress and exit strategy<br>• Supported for review at Trust Board | business case for review at Trust Board. Interim review to be reviewed at FSC in December 2022 | FSC December 2022 |
| FSC/22/06/110 | Risk Register & BAF | The Committee considered the report noting: -<br>• There are no new risks or changes to the current risk ratings<br>• The titles of two risks have been updated | The Committee **noted** the Risk Register and BAF report | FSC September 2022 |

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**BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT**

| AGENDA REFERENCE: | BM/22/09/116 c | | TRUST BOARD OF DIRECTORS | DATE OF MEETING | 28 September 2022 |
|---|---|---|---|---|---|

| Date of Meeting | **21 September 2022** |
|---|---|
| Name of Meeting + Chair | **Finance and Sustainability Chaired by Terry Atherton** |
| 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/22/09/149 | BAF & risk register | The committee considered the BAF report noting:- <br> No changes in terms of risks added, deleted or amended <br> Full details of the risks included in the report. <br> The Committee came back to the BAF at the end of the meeting to reflect after discussing the papers and issues raised during the meeting whether the current risk score was appropriate and concluded it was. | The Committee **noted** the report | FSC October 2022 |
| FSC/22/09/150 | Pay Assurance | The Committee considered and reviewed the report noting: - <br> • Amendment needed to report relating to medical vacancies, the report will be recirculated <br> • Annual leave continues to be monitored for agenda for change staff looking at booked and utilised. Medical and Dental workforce reporting is also being reviewed and a new system is being implemented which will support this <br> • Agency staffing controls have been reviewed and additional enhanced controls are being implemented | The Committee **noted** the report | FSC October 2022 |

1

| | | • WLI policy clarifies when it is appropriate to use WLI | | |
|---|---|---|---|---|
| FSC/22/09/151 | CIP & GIRFT | The Committee considered and reviewed the monthly CIP & GIRFT report noting: -<br>• Delivered £4.1m against a plan of £4.1m<br>• Identified £14.4m to date however £5.4m high risk, £1.3m unidentified and £3m Income giving a £9.7m risk<br>• £2.2m recurrent CIP highlighted<br>• Clinical GIRFT lead and finance support have been appointed<br>• Key areas being reviewed:-<br>• Pre op clinic<br>• Theatre productivity<br>• Daycase rates<br>• Unplanned care focus on Length of stay limited financial impact<br>• Reduce cancellation, PIFU and radiology reporting<br><br>The Committee considered the significant risk and how this will be progressed with the ICS and Place colleagues. | The Committee **noted** the progress achieved so far but noted the risk to the financial position. | FSC October 2022 |
| FSC/22/09/152 | Digital Strategy Group Report | The Committee considered the report noting items to escalate to FSC include:<br>• Unplanned outage 16 September due to Dedalus issue. The Trust managed with continuity plans and did not class as major incident.<br>• Data quality and reporting problems related to the Maternity Services Dataset (MSDS)<br>• An unplanned outage of the LiON portal (business intelligence reports)<br>• PACS system Antivirus update<br>• Cancellation of the "Patient Aide" project<br>• A Task & Finish Group to be established for trust wide Print Reduction CIP schemes | The Committee **noted** the report | FSC October 2022 |

| FSC/22/09/153 | WLI | The Committee noted the report:<br>• Noted the progress<br>• The two partial recommendations expected to be closed this month<br>• Committee chair to consider whether a quarterly update would be required | The Committee **noted** the report | FSC October 2022 |
|---|---|---|---|---|
| FSC/22/09/155 | Monthly Finance report | The Committee considered the report and capital proposals.  Key points to note included:<br>• Month 5 position £6.5m deficit, slightly worse than plan £0.2m<br>• Highlight the year to date plan and full year plan shows a significant proportion of the CIP is in the second half of the year.<br>• C&M month 4 position is a year to date deficit of £44m with a forecast outturn plan of £30m deficit<br>• May 2022 ERF achieved however all other months have not NHSE/I advice is to assume ERF monies achieved for month 1 to 5<br>• Pay award funding is showing a shortfall of £1.3m<br>• CDC phase 1 bid supported  excluding the CT scanner and the Trust is waiting to hear on phase 2<br>• Peer to peer – pay run rate and wte presented demonstrating the reasons for increases such as PACU. WHH growth from 2019/20 is 7%, C&M average is 14%<br>• Debtors and creditors noted One to One Midwives and independent report to be presented to Trust Board<br>• Pay pressures noted – A&E nurse staffing due to increased demand and additional inpatient capacity in Ward B3<br>• Capital behind plan £1.9m year to date, considered capital proposals, and requested further information due to a potential over spend on 2 projects<br>• 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£6m from plan | The Committee **noted** the update<br>The Committee **requested** further scenarios on the suggested capital changes before presenting to the Trust Board | FSC October 2022<br><br>Trust Board September 2022 |

| FSC/22/09/156 | Capital Expenditure Update | The Committee considered and reviewed the presentation noting: -<br>• Capital plan amended to match £12.5m CDEL in line with NHSE I plan<br>• Month 5 position underspent by £1.9m due to finalisation of the ED Plaza scheme and a delay in commencement of backlog maintenance and VAT rebate<br>• Emergency requests totalling £79k noted for equipment and roof leaks<br>• Contingency is currently at £959k which would mean that potentially the schemes slipped back to 2023/24 could be managed in year. However highlight reports of the schemes over £500k revealed some risk:-<br>• Urology & Paeds –completed on time, however there is currently a risk of a £500k overspend<br>• Catering has an expected slippage of 8 weeks and potential £500k move to 2023/24<br>• ED plaza underspend of circa £300k | The Committee **noted** the update and **requested** further scenarios on the suggested capital changes before presenting to the Trust Board | FSC October 2022<br><br>Trust Board September 2022 |
|---|---|---|---|---|
| FSC/22/09/157 | Revenue Request | The Committee considered and supported Tier 3 premium cover of vacancies acute medical consultants revenue case: -<br>• The funds were ringfenced in budget setting and the investment will switch off premium rate cost pressures | The Committee **supported** the revenue request | Trust Board September 2022 |
| FSC/22/09/158 | Private Patients | The Committee considered the report noting: -<br>• The pause in April 2020 and an independent review was undertaken in November 2021 with an agreement to review in September 2022<br>• Currently there is no clear guidance regarding restarting private patient work<br>• Further guidance expected and given the restoration challenge no national appetite to restart Private patient work. | The Committee **noted** the update and **supported** the recommendation to be presented to Trust Board. | Trust Board September 2022 |

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| | | • Recommendation to continue with the current arrangements until the end of March 2023, ie a pause with some minor exceptions<br>• | | |
| FSC/22/09/159 | Overseas Visitor Policy | The Committee considered the revision to the policy relating to latest national guidance for Ukrainian residents. | The Committee **approved** the policy subject to checking the national guidance on all asylum seekers | |
| FSC/22/09/160 | Amendments to IPR | The Committee asked to support the changes to the IPR<br>• Adding two new KPIs Agency spend vs price cap and Agency spend vs ceiling | The Committee **supported** the changes | Trust Board September 2022 |
| FSC/22/09/161 | Committee Terms of reference annual review | The Committee noted the report and approved the changes namely:-<br>• Amendments to the and Duties & Responsibilities and Reporting Groups sections | The Committee **approved** the changes | FSC September 2023 |

5

**BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT**

| AGENDA REFERENCE: | BM/22/09/116 d | TRUST BOARD OF DIRECTORS | DATE OF MEETING | 28 September 2022 |
|---|---|---|---|---|

| Date of Meeting | **20 September 2022** |
|---|---|
| Name of Meeting + Chair | **Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton** |
| Was the meeting quorate? | **Yes** |

| REF | AGENDA ITEM | ISSUE AND LEAD OFFICER | Recommendation / Assurance/Decision/ mandate to receiving body | Follow up/ Review date |
|---|---|---|---|---|
| CROC/22/09/105 | Board Assurance Framework / Risk Update | The committee discussed the risks on the Board Assurance Framework for which this Committee is a monitoring Committee, and the risks on Corporate Risk Register for which this Committee is a monitoring Committee.<br><br>BAF<br>• Since the last meeting there have been no new risks added.<br>• Since the last meeting there have been no amendments to the ratings of any of the risks.<br>• Since the last meeting there have been updates to the descriptions of three risks.<br>• Since the last meeting, two risks have been closed or de-escalated.<br>• Risk 1215 – added the wording " as a consequence of the ongoing (COVID-19 pandemic…) to the description (*If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics)* **because of the ongoing COVID-19 pandemic** *then there may be delayed appointments and* | The Committee noted the update | Standing agenda item |

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| | | *treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards.)* <br><br> Corporate Risk Register <br> • Since the last meeting, no news risks have been added to the Corporate Risk Register for which this committee is the monitoring Committee. | | |
| CROC/22/09/97 | Harm Profile update | • No new cases of harm were identified. <br> • There were 566 patients who have a 52+ week wait and require a harm review, which was an increase of 3 patients from the previous week. New agreed run rate of 500 due to the increase in 52 week waits. <br> • As of 6th September, 1326 patients had waited less than 52 weeks and had exceeded their P Code review in line with national guidance, and therefore require a harm review to be undertaken. T&O highest with General Surgery and Gastro next. <br> • 107 reviews have taken place over previous week.173 patients have tipped in over previous week. 63 patients have been either removed, treated or dated over previous week. <br> • Small T&F Group have met and proposed to continue: <br>     ◦ To complete harm reviews on all over 52week patients. <br>     ◦ To complete harm reviews on P2 patients that have expired by 2 months in specialties of Urology, T&O and Upper GI. <br>     ◦ Each Quarter 10% of all overdue P codes will be randomly selected for a harm review. <br>     ◦ Update the SOP. <br>     ◦ Develop communication with the patients. <br>     ◦ Briefing paper for executives for approval <br> • Total Number of Harm Reviews completed to date 5935 against 4966 separate patients. | The Committee noted the update | Standing agenda item |

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| | | • There are 2 patients over 52 weeks with a P2 code that require a harm review.<br>• There are 190 patients under 52 weeks with a P2 expired code that require a harm review.<br>• The Committee were assured that communication was open and waiting times were in the public domain. | | |
|---|---|---|---|---|
| CROC/22/09/98 | Corporate Performance Report | Key points to note for August 2022:<br><br>ED 4 Hour performance;<br>• There was an increase in performance compared to the previous month achieving 72.10% (excluding Widnes Walk-in activity).  Overall attendance rates decreased in comparison to the previous month..<br>• The Trust is still experiencing delays in discharges for patients who do not meet the criteria to reside, this has contributed to a high over all bed occupancy and impacted on urgent care flow from ED.<br>• Ward B3 on the Halton site continues to be utilised to release capacity on the Warrington site, in addition the area that used to house CAU has been used to support further capacity. This is both to support urgent care flow and provide Covid capacity.<br>• The number of Super Stranded on the last day of the month was 150, a significant increase on the previous month. This is in correlation with gaps in the domiciliary workforce market.<br>• The Trust did not achieve the 18-week Referral to Treatment standard in August 2022<br>• Decrease in Ambulance handover performance – the position being validated.<br>• Issue noted with the scheduling in PACU following the work to address the SSI in T&O at CSTM. | The Committee noted the assurance provided on the mitigations and plans to achieve performance standards. | Standing agenda item |

| CROC/2022/09/99 | Waiting List updates | DM highlighted the key points.<br><br>RTT updates;<br>• All elective lists are now focussed on cancer and urgent cases and being undertaken at both Warrington and Halton sites. The performance in month is better than the forecast trajectory as part of the clinical service recovery programme.<br><br>Priority code and Waiting Time<br>• In August 2022 the waiting list size saw an increase in the total number although the increase has started to plateau. This is attributed to the increase in referrals and new patients being added to the waiting list and workforce constraints.<br>• Compliant against meeting the 104 week Standard since June.<br>• Forecasted issue with hitting the 78 week standard – action plans being drawn up.<br><br>Cancer:  Key Points;<br>• 62-day performance for June is 62.3%.<br>• The Trust is currently on track and meeting the trajectory for patients 104+ days on the cancer PTL.  Patients waiting over day 62 is currently 11 patients over trajectory as a result of continued diagnostic delays and is also representative of larger numbers of referrals into the Trust and the PTL.<br>• There is also increased focus on the delivery of the 28-day FDS which is showing improvement but particularly challenged in the colorectal and prostate pathways which are also a focus for a national CQUIN<br><br>Diagnostics<br>• Good recovery on CT & MRI | The Committee noted the report. | Standing agenda item |
| --- | --- | --- | --- | --- |

- 100% compliance for over 16 weeks.
- WHH have experienced high sickness over recent weeks running into AL high demand.
- Outsourcing is being considered to improve performance, but cost is high due to high regional demand for outsourcing.
- Overall performance is now improving.

*ECHO*
- 1 x Band 7 started in post September
- 1WTE Band 7 starting October
- TOC in progress to increase capacity on lists from (am sessions)
- Plan to provide mutual aid to Mid Cheshire from October 22 – c.80/month
- Forecasting improvement >70% in September
- Locum agency support remains in place

Endoscopy:
- Current Waiting List = 1247 patients waiting against target of 700 patients.
- Current In month decrease of 118 patients.
- Total number of patients waiting over 13 weeks = 418
- In month increase of 8 patients.
- August - 56 ahead of target.

Outpatients:
- 14 specialties are currently live with PIFU but use within these is very variable.
- We will also work with specialities successfully using PIFU (e.g. Trauma & Ortho) to share any learning.
- In order to reach the 5% target by end of financial year, we will raise awareness of PIFU with the existing specialties and work directly with others to be added, including respiratory & diabetic medicine.

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| | | • 13 services live with Advice and Guidance.<br>• Discussions with Digestive Diseases CBU ongoing to introduce Advice and Guidance for Pain Management.<br>• Virtual attendances - August 20.82% - Target 25%. | | |
| CROC/2022/09/100 | 78 Week Wait Analysis | Deferred to the next meeting | | |
| CROC/2022/09/101 | 2022-2023 Plans | DM reported that no adjustments to the plan so far this year. | The Committee noted the update | Standing agenda item |
| CROC/2022/09/102 | Access to recovery fund update | Verbal report by the Chair. | The Committee noted the update | Standing agenda item |
| CROC/2022/09/103 | EPRR Assurance Letter/Compliance Statement | The Annual EPRR self-assessment was presented – a rating of Substantial performance was noted. | The Committee noted the update | |

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**BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT**

| AGENDA REFERENCE: | BM/22/09/116 3 | COMMITTEE OR GROUP: | Trust Board | DATE OF MEETING | 28 September 2022 |
|---|---|---|---|---|---|

| Date of Meeting | 18 August 2022 |
|---|---|
| Name of Meeting & Chair | Audit Committee, Chaired by Michael O' Connor |
| Was the meeting quorate? | Yes |

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

| Agenda Reference | Agenda Item | Issue and Lead Officer | Recommendation / Assurance/mandate to receiving body | Follow up/ Review date |
|---|---|---|---|---|
| AC/22/08/56 | Renewal/Refresh of External Audit Contract | The Committee received a report in relation to the extension of the External Auditor Contract for Grant Thornton LLP, which was due to expire on 30th September 2022. | The Committee noted the approval by the Council of Governors to extend the Contract with the Trust's External Auditors | Council of Governors, Aug 2024 |
| AC/22/08/57 | Progress Report on Internal Audit Follow Up Actions | The Committee received a report detailing the progress on internal audit follow up actions. It was particularly noted that there two audits with four overdue management actions, one of which was partially complete and one which had been paused.<br><br>• In relation to the Discharge Patient Review for 2021/22 extensions had been requested until 31 October in relation to Clinical Criteria Led Discharge, Discharge Checklist had been requested to be extended until 31 August and the Audit Trail extended until 31 October.<br>• Assurance Framework Phase 2, this action had been paused due to the current external Well-Led review currently underway. | The Committee discussed the update and received good assurance. | Audit Committee 17.11.2022 |
| AC/22/08/60 | Value for Money – Annual Auditors Report | The Committee received the External Auditors Annual report considering whether the Trust had put in place proper arrangements to secure economy, | The Committee approved the report subject receiving good assurance | n/a |

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| | | efficiency and effectiveness in it use of resources against three criteria: Financial Stability, Governance and Improving economy, efficiency and effectiveness.<br><br>No significant weaknesses were identified and two improvement recommendations were made. | | |
| AC/22/08/66 | **On Call Harmonisation Update** | The Committee received an update on the On-Call Harmonisation implementation status, setting out a new timetable for the review of the original costings and service impact. | **The Committee discuss the update and requested that an update was presented to the next Strategic People Committee** | SPC 21.09.2022 |

Other items included on the agenda were:

**AC/22/08/54** – Update from Chairs – FSC, SPC, QAC, CFC and CROC
**AC/22/08/55 –** Changes and updates to the BAF
**AC/22/08/59** - Internal Audit Progress Report
**AC/22/08/61** – Counter Fraud Progress Report
**AC/22/08/62** - Review Losses and Special Payments 01.01.22 – 31.03.22
**AC/22/08/63** – Review of Quotation & Tender Waivers 01.01.22 – 31.03.22
**AC/22/08/64** – Disposals and Condemnation of Assets
**AC/22/08/65** - Risk Management Annual Report Update
**AC/22/08/67** – NW Skills Development Agency Bi-Annual Report
**AC/22/08/68** – ICON Programme Bi-Annual Report
**AC/22/08/69** – Committee Effectiveness Review
**AC/22/08/70** – Terms of Reference
**AC/22/08/71** – Committee Chair's Annual Report

**REPORT TO BOARD OF DIRECTORS**

| AGENDA REFERENCE: | BM/22/09/117 | |
|---|---|---|
| **SUBJECT:** | **Moving to Outstanding Update** | |
| **DATE OF MEETING:** | 28 September 2022 | |
| **AUTHOR(S):** | Layla Alani, Director of Integrated Governance and Quality and Interim Deputy Chief Nurse. Margaret Armstrong Compliance and Improvement Manager | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive | |
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>(*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):** | **#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.<br>**#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<br>**#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.<br>**#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.<br>**#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks<br>**#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.<br>**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.<br>**#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. | |

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| | **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain |
| | **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g., cyber defences), new technology skillsets (e.g., Cloud), unfit solutions (e.g., Maternity), end-of-life solutions (e.g., Telephony), poor performance (e.g., Lorenzo EPR) RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g., Civil Contingency measures) and subsequent reputational damage. |
| | **#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 |
| | **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. |
| | **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. |
| | **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. |
| **EXECUTIVE SUMMARY** *(KEY ISSUES):* | **1) CQC Insight Position and Red Flags Report**<br><br>This report provides a high-level analysis of the individual indicators that are 'much better', 'better', 'much worse', and 'worse' when compared nationally and also against the Trusts own performance (this is in accordance with the terminology referenced by the CQC). The updated position from the CQC Insight report released on 15 June 2022 notes the following across 77 Trust wide indicators:<br><br>• 9 (12%) noted as better.<br>• 3 (4%) noted as worse: staff doing paid overtime, enhanced GMC monitoring and staff view of learning.<br>• 1 (1%) noted as much worse : Proportion of staff appraised<br><br>CQC Insight report declining indicators remain across:<br>• Staff sickness.<br>• Staff turnover.<br>• Constitutional standards (excluding ED).<br>• Effectiveness of care provision.<br><br>**2) Internal Mock Inspections**<br>The last mock inspection was undertaken in July 2022 for the Emergency Department (ED) **(See Section 2.2).** An action plan has been developed and actions identified to reduce their impact and progress is being made to mitigate the risks for all actions which are on track. When inspected, there is high risk of remaining in regulatory breach as a result of system |

pressures and the very high number of patients who are super stranded within WHH, resulting in patients being cared for on the corridor frequently. Care of patients at risk of clinical deterioration has shown signs of improvement through measures implemented to support triage alongside evidence of improved compliance with NEWS2 with the frequency of observations clinically led.

3) **External Reviews, Assessments and Accreditations**
The report also provides a progress update on:

- **The Human Tissue Authority Inspection**. A Corrective and Preventive Action Plan (CAPA) has been submitted following a factual accuracy exercise. The main factor outlines additional measures with regard to care of the deceased. An action plan is in place to track progress overseen by the Associate Director of Clinical Support Services.

- **The UK Accreditation Service (UKAS)** A report will be provided by UKAS when all reviews have been completed (**Section 2.14.2**).

- **The Royal College of Paediatric and Child Health Diabetes Peer Review final report** has been received. The report describes the service as 'award winning' with a team that displayed 'an extremely positive attitude towards the review'. The report highlighted one concern which related to dietetic provision. This was addressed the day after the visit and the dietetic vacancy is out for advert.

  The Neonatal Unit received Amber 'Working Towards' accreditation in the **Northwest Neonatal Operational Delivery Network FiCare Accreditation Scheme**.

**The Ockenden 1 Insight visit** from NHSE/I was undertaken on 29 July 2022. Very positive feedback was received and the report is under review. One indicator for improvement referenced monitoring of fetal well-being with a recommendation to appoint a Consultant Lead for Fetal Medicine and the introduction of a Failsafe Officer **(Section 2.14.4).** Discussions are underway regarding these posts.

The format of this report is currently under review in terms of content and structure.

| PURPOSE: *(please select as appropriate)* | Information | Approval | To note x | Decision |
|---|---|---|---|---|
| **RECOMMENDATION:** | The Board of Directors is asked to discuss and note this report. | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | | M20 22 September 2022. | |
| | **Agenda Ref.** | | | |
| | **Date of meeting** | | 22 September 2022 | |
| | **Summary of Outcome** | | To share with the Trust Board | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED:** | None | | | |

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**REPORT TO BOARD OF DIRECTORS**

| SUBJECT | Moving to Outstanding Action Plan Update | AGENDA REF: | BM/22/09/117 |
|---------|------------------------------------------|-------------|--------------|

## 1. BACKGROUND

The Moving to Outstanding Steering Group provides an updated position on key performance metrics monitored by the Care Quality Commission (CQC) enabling focused improvement and assurance of compliance across a number of CQC domains.

The Care Quality Commission (CQC) released the latest version of their Insight report on the 15 June 2022, and this was discussed at the Moving to Outstanding Steering Group meeting held on 21 July 2022. There was no meeting held in August 2022 and therefore the updated internal position (end July 2022) will be discussed at the next Moving to Outstanding Steering Group meeting on 22 September 2022.

The report provides a high-level analysis of the individual indicators that are 'much better', 'better', 'much worse', and 'worse' ( this terminology is used by the CQC) when compared nationally and also against the Trusts own performance.

The data from the CQC Insight Report received in June 2022 is being shared alongside Internal Red Flag data for July 2022. The Trust has not received a further insight report at this stage.

The report also provides information about new CQC Methodology, an update on the WHH plans for CQC preparedness, and an update on internal mock inspections. The Trust has not had an engagement meeting with the CQC since July 2022 due to sickness at the CQC and staff turnover. The Director of Governance has contacted the CQC to ensure a proactive position in engagement with the CQC.

## 2. KEY ELEMENTS

### 2.1 CQC Insight Position and Red Flags Report
#### 2.1.1 CQC Insight Report
The updated position from the CQC Insight report received in June 2022 notes 77 Trust wide indicators including a number of additional indicators for core services (An increase of 6).

The previous CQC Insight reporting period, March 2022, notes 71 Trust wide indicators monitored by the CQC. The number of indicators change month by month depending on data assessed by the CQC in each CQC Insight report. Overall, Trust wide performance remained stable. Of the 77 indicators reported in the latest version of the Insight report released on 15 June 2022 these indicated:

- 9 (12%) noted as better.
- 3 (4%) noted as worse: staff doing paid overtime, enhanced GMC monitoring and staff view of learning.
- 1 (1%) noted as much worse : Proportion of staff appraised

**Table 1** shows the performance of the indicators categorised as better, worse, and much worse compared to the national average position. Narrative regarding indicators noted as worse and much worse is detailed within the paper with comparison to red flag internal data.

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**Table 1 – Summary of Trust wide Indicators from CQC Insight Report June 2022 (including Staff Survey Results from 6 April 2022)**

| Indicator | Latest Performance | National Average | Variance |
|---|---|---|---|
| **CQC Insight Report June 2022** | | | |
| Sick days for medical and dental staff [set target 3.5%] (%) | 2.23% (Apr 21 - Mar 22) | 1.75% | + 0.48% |
| GMC - Enhanced monitoring | Status: no concern with progress May 22 | No enhanced monitoring | N/A |
| Proportion of staff appraised (%) | 67.36% (Sep 21 - Dec 21) | 79.08% | - 11.72% |
| **Staff Survey Results from 6 April 2022** | | | |
| Flexible working | 6.1 (Sep 21 - Dec 21) | 6.0 | + 0.1 |
| Morale | 5.9 (Sep 21 - Dec 21) | 5.7 | + 0.2 |
| Proportion of staff that believe they have adequate materials and resourcing, and that they have adequate staff (%) | 59.36% (Sep 21 - Dec 21) | 55.46% | + 3.9% |
| Proportion of staff who have felt burnt out due to work (%) | 31.25% (Sep 21 - Dec 21) | 35.33% | + 4.08% |
| Proportion of staff who would feel secure raising concerns about unsafe clinical practice (%) | 77.52% (Sep 21 - Dec 21) | 73.57% | + 3.95% |
| Recognised and rewarded | 6.1 (Sep 21 - Dec 21) | 5.8 | + 0.3 |
| Safe and healthy | 6.1 (Sep 21 - Dec 21) | 5.9 | + 0.2 |
| Sick days for medical and dental staff [set target 3.5%] (%) | 2.23% (Apr 21 - Mar 22) | 1.75% | + 0.48% |
| Voice that counts | 6.9 (Sep 21 - Dec 21) | 6.7 | + 0.2 |
| Proportion of Staff Doing Paid Overtime (%) | 43.15% (Sep 21 - Dec 21) | 38.15% | - 5% |
| We are always learning | 5.1 (Sep 21 - Dec 21) | 5.2 | - 0.1 |

**Key:**

| Colour | Categorisation |
|---|---|
| | Better than national average |
| | Worse than national average |
| | Much worse than national average |

In relation to the indicators categorised as worse and much worse these relate to the following:

- GMC Enhanced Monitoring has been a Red Flag Indicator for over a year whilst improvement work has been undertaken. The GMC trainee survey results have been received with the following feedback noted:
  - Continued improvements in Geriatrics, Cardiology, Paediatrics, Obstetrics and Gynaecology and Acute Medicine
  - Positive results in Anaesthesia, Radiology, Intensive Care
  - Action plans have been requested for Gastro, ED, General Medicine, Diabetes and Endocrinology
  - All other specialities have balanced results with no negative outliers

A GMC Enhanced Monitoring meeting was held with Patch Dean, and it has been suggested and agreed to review progress on all actions given to the Trust during the Quality Visit, for removal of GMC Enhanced Monitoring.

### 2.1.2 Red Flags Report

The CQC Insight report identifies indicators for which metrics are determined as 'much worse' (MW), 'worse' (W) than national average or declining performance in accordance with the CQC descriptors. Operational Leads have been notified to request the rationale for the statistical differences noted when compared to the national average and areas of declining performance.

In July 2022 there were 40 Red Flag indicators, a decrease from June 2022 when there were 46 Red Flag indicators. **Table 2** identified that six Red Flag indicators were closed at the Moving to Outstanding Steering Group meeting on 21 July 2022 relating to Staff Survey themes which are no longer monitored by the CQC. This will be reviewed as part of the new inspection methodology. Table 2 also highlights where sustained improvement can be evidenced:

| Table 2: | Six Red Flag indicators were closed at the Moving to Outstanding Steering Group | |
|---|---|---|
| 1. | W3 Immediate managers PICKER NHS staff survey themes and questions | No longer monitored by the CQC – last monitored performance above national average |
| 2. | W3 Team Working PICKER NHS staff survey themes and question | No longer monitored by the CQC – last monitored performance in line with national average |
| 3. | E2 In- hospital mortality: Acute bronchitis | Sustained improvement following introduction of correct coding card |
| 4. | E2 Risk adjusted posterior capsule rupture rate | The Trust's latest audit (1 Sep 20 – 31 Aug 21) shows performance above the national average |
| 5. | E2 Stabilised and risk adjusted extended perinatal mortality rate (per 1,000 births) | The Trust's latest audit (2021) shows performance above the national average |
| 6. | E2 Stabilised and risk adjusted extended perinatal mortality rate excluding congenital anomalies (per 1,000 births) | The Trust's latest audit (2021) shows performance above the national average |

In June 2022 there were 27 (58.5%) Red Flag indicators showing a decline. This position declined in July 2022 to 24 (60%) Red Flag indicators, including the 8 staff survey indicators. Areas of decline have remained the same in previous reporting periods and are detailed in **Table 3.** The thematic cluster remains the same with a focus on:

- Sickness

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- Staff turnover
- Constitutional standards (excluding ED)
- Effectiveness of care provision.

Effectiveness of care provision means patients' care and support achieves good outcomes. Actions to address these themes are denoted in **Appendix 1.**

**Table 3 – Red Flag Indicators showing a deterioration in performance based on internal data**

| Indicator declining | Performance reported June 2022 | Performance reported July 2022 | Variance |
|---|---|---|---|
| **Trust wide:** Sick days for other clinical staff (%) | 7.80% | 7.88% | +0.08% |
| **Trust wide:** Sick days for non-clinical staff (%) | 6.42% | 7.06% | +0.64% |
| **Trust wide:** Sick days for nursing and midwifery staff (%) | 7.71% | 7.89% | +0.18% |
| **Trust wide:** Turnover rate for other clinical staff (%) | 17.42% | 17.80% | +0.38% |
| **Trust wide:** Turnover rate for nursing and midwifery staff (%) | 14.82% | 15.59% | +0.77% |
| **Trust wide:** Ratio of occupied beds to nursing staff | 7.2 | 7 | -0.02 |
| **Trust** wide: Ratio of ward manager nurses to senior and staff nurses | Vacancies HCA 70 WTE RNs 118 FTE | Vacancies HCA 70 WTE RNs 121 FTE | Vacancies +3 RNs FTE |
| **Surgery:** Crude proportion of patients having perioperative medical assessment (%) | 0.94 | 0.85 | -0.90% |
| **Surgery:** Crude overall hospital length of stay Royal College of Physicians - National Hip Fracture Database (NHFD) | 17 | 18 | +1 |
| **Surgery:** Crude proportion of patients having surgery on the day or day after admission %) | 23% | 18% | -5.00% |
| **Medicine**: In-hospital mortality: Fractured neck of femur (hip) | 3 deaths (Jan-Mar 22) | 6 deaths (Apr-Jul 22) | +3 deaths |
| **Cancer:** First treatment in 62 days of urgent GP/dentist referral (%) | 79.60% | 62.30% | -17.30% |
| **Outpatients:** Referral to treatment, on incomplete pathways, within 18 weeks (%) | 66.18% | 62.72% | -3.46% |
| **UEC:** Patients spending less than 4 hours in (any type of) A&E (%) | 69.50% | 70.10% | +0.6% |
| **UEC:** Ambulances remaining at hospital for more than 60 minutes (%) | 1% | 10% | +9% |
| **UEC:** A&E Attendees spending more than 12 hours | 313 | 398 | +85 |

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to make a difference

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

| Key - Colour Code | Categorisation |
|---|---|
|  | Better or on a par with national average |

The information provided in **Table 3** details the Red Flag Indicators showing a deterioration in performance from June 2022 to July 2022 based on internal data. These are monitored across all the Executives agenda. There are 5 indicators highlighted in green which are better or on a par with national average in the June 2022 CQC report. In hospital mortality  Fractured Neck of Femur has increased. In hospital mortality  Fractured Neck of Femur has increased by 3 when compared to the last reporting period. This is also reflected in the Trusts performance in the National Hip Fracture Database which has deteriorated. Following discussion at PSCESC in July 2022 an Improvement Task and Finish Group has been established, with an update due to PSCESC in September 2022. A Fractured Neck of Femur Performance and Improvement Plan is due to be presented at Quality Assurance Committee in November 2022.

**Table 4 – Indicators showing a decline based on Staff Survey Results**

| Indicator | Nat Avg. | 2020 result | 2021 result | Variance |
|---|---|---|---|---|
| **Trust wide**:  Proportion staff appraised (%) | 79.08% | N/A | 67.36% | N/A |
| **Trust wide:** Proportion staff believe they have adequate material resourcing (%) | 55.46% | 64.71% | 59.36% | -5.35% |
| **Trust wide:**  Proportion of Staff Doing Unpaid Overtime (%) | 56.44% | 48.95% | 56.37% | +7.42% |
| **Trust wide:** Proportion of Staff Doing Paid Overtime (%) | 38.15% | 39.09% | 43.15% | +4.06% |
| **Trust wide:**  Proportion staff believe the provider is adequately staffed (%) | 26.49% | 42.20% | 28.56% | -36.30% |
| **Trust wide:** Morale | 5.70% | 6.20% | 5.90% | -0.30% |
| **Trust wide:**  Staff Engagement | 6.8 | 7.1 | 6.9 | -0.02 |
| **Trust wide:**  Always Learning | 5.2 | N/A | 5.1 | N/A |

| Key - Code Colour | Categorisation |
|---|---|
|  | Better or on a par with national average |

The information provided in **Table 4** and the challenges that this creates in providing safe and effective care are a consequence of:

- Increased staffing pressures contributing to increased levels of sickness
- Increased attendances within Urgent and Emergency Care.
- Static number of patients with no right to reside as a result of wider system pressures.

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The Red Flag data triangulates with what is reported through internal intelligence in relation to incidents, complaints, PALS, and risks.

In June 2022 there were 10 indicators (21.7%) showing improvement. In July 2022 this improved to 9 indicators (22.5%). These are detailed in **Appendix 2**.

## 2.2 Emergency Department (ED) Mock Inspection

### 2.2.1 Overall ED Action Plan Compliance

The mock inspection for the Emergency Department (ED) had a total of 90 actions, 13 were identified as urgent. All 90 actions have progressed since the last update was provided. The overall action plan compliance is summarised below in **Table 5** with urgent actions are noted in **Table 5.**

**Table 5 – Emergency Department (ED) Action Plan Compliance**

| CQC Action Plan Compliance | | | | | | Performance |
|---|---|---|---|---|---|---|
| | **April** | **May** | **June** | **July** | **Aug** | |
| Red* | 1 | 1 | 1 | 1 | 1 | ba |
| Amber | 20 | 18 | 15 | 11 | 10 | h |
| Green | 69 | 71 | 74 | 78 | 79 | h |
| Overall actions | **90** | **90** | **90** | **90** | **90** | |

| Key colour code: | |
|---|---|
| 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 |

Outstanding amber action themes relate to:
- Estates works
- Mandatory Training Compliance
- Patient Experience impacted by patients being cared for on the corridor , and
- Operational Performance against Constitutional Targets

The senior team have advised that all actions were on track. Monitoring of the action plan is reported through CBU governance meetings, Care Group meetings and via the Moving to Outstanding Steering Group meetings. The Associate Director of Compliance undertakes spot checks on the completion of actions. The postholder has recently left post and this has been recruited to. In the interim oversight will be provided by the Director of Governance.

The senior team have continued to undertake daily, and weekly walk rounds to obtain assurance regarding the implementation of the completed actions detailed within the action plan. All key actions continue to be shared with all staff within UEC CBU via the Newsletter and safety huddles

### 2.2.2 Urgent Actions

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Outstanding urgent actions are focused around the privacy and dignity of patients when cared for outside cubicles and escalation measures. This has included working with the Patient Experience Team in times of extreme pressure to support the ED Team when patients are receiving care on the corridor. The SDEC has started to show signs of improved flow following its opening on 19th July 2022. Work is also ongoing with regard to ensuring timely surgical review to inform treatment plans. This is being overseen by Care Group Leads. All of these actions are significantly impacted by system pressures and a continually high number of super stranded patients averaging 125 per day. As a result of these pressures additional actions have been identified:

2.2.3    Additional Actions

- **Triage Times**
  - A Triage Escalation Tool is in place that is completed hourly to address the Triage waiting times. Challenges are escalated to the Nurse in charge and Matrons feeding through the agreed escalation process to silver command. Staffing is re-assessed to re-deploy staff to support Triage in a safe manner and this is continually reviewed. There are several actions in place to address Triage forming part of monitoring at the ED Response Group. Regular ED updates are also provided to Quality Assurance Committee.
- Intentional Rounding continues to ensure the comfort of patients.
- **NEWS2 / Escalation of the deteriorating patients**
  - Audit is ongoing with a new report developed to assure that all inclusion and exclusions are reported correctly.
  - Screens are now in every area to support escalation of the deteriorating patients.
- Alteration to practice following Decision to Admit following clinical review in accordance with ward NEWS processes, resulting in improved compliance as follows:

August data is being collated at the time of writing this report.

- **Patients being cared for on the Corridor**
  - Standard Operating Procedure is in place, alongside a Full capacity Protocol and Escalation Protocol. As a result of continued increased acuity the criteria for the standard operating procedure is being reviewed in accordance with risk.
  - Corridor care with extended waits for bed allocation continues to be escalated as a risk at relevant committees.

The ongoing workstreams will be reported to the next Moving to Outstanding Steering Group on 22 September 2022.
**Table 6**

| Pre Process Change | July 2022 | Was the patient correctly escalated NEWS 1-4 | Was the patient correctly escalated NEWS 5-6 | Was the patient correctly escalated NEWS 7+ |
|---|---|---|---|---|
| | 5th July | 89% | 100% | 50% |
| | 8th July | 89% | 33% | 50% |
| Transition of Change | 15th July | 90% | 50% | 100% |
| Following Change | 26TH July | 90% | 80% | 100% |

2.2.4    Regulatory Breaches

During the ED inspection, the 4 regulatory breaches received in 2019 following the CQC's responsive inspection were reviewed and cannot be closed ahead of the next inspection (**Table 7**). Due to current system pressures challenges remain under regulation 12. These cannot be removed ahead of another inspection and this risk remains in the current climate.

**Table 7 – Regulatory breaches**

| Regulation Breached | | Progress and Assurance |
|---|---|---|
| Regulation 12: Safe Care and Treatment | Crowding in the Emergency Department must be reduced so that patients do not have to wait on trolleys in corridors. Regulation 12(2)(b) | • Escalation Policy revised by Director of Operations April 2022.<br>• 12 hr Trolley breaches discussed at length in Executives, presentation at Quality Assurance Committee and in collaboration with PLACE.<br>• Paper presented to Executive Team to stand process down and dip sample being undertaken.<br>• Weekly Performance Review Group.<br>• Care on corridor Standard Operating Procedure in place with further review of criteria.<br>• .Ongoing work with system partners<br>• Introduction of Same Day Emergency Care.<br>• PLACE Director aware and updated monthly at Clinical Quality Focus Group (cqfg) -overall ED position. Detailed update of Trust ED position discussed at CQFG monthly meeting.<br>• BAF |
| Regulation 12: Safe Care and Treatment | Patients whose clinical condition is at risk of deteriorating must be rapidly identified and reviewed at suitable intervals. Regulation 12(2)(a)(b) | On Risk Register-<br>• Delays in ED also noted in red flag report monthly at M20 meeting.<br>• All concise and Serious Incident investigations reviewed and approved |

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| | | |
|---|---|---|
| | | at the weekly Safety Oversight meeting chaired by the Chief Nurse/Deputy Chief Executive.<br>• NEWS audit now clinically determined with improved performance.<br>• Supported by measures implemented in triage as detailed within report. |
| Regulation 17:<br>Good governance | Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team.<br>Regulation 17(2)(a) | • Performance dashboards available via Lion Portal.<br>• Weekly Performance Review Group – Update<br>• Monthly Key Performance Indicators – Update<br>• Uec Monthly SMT - disseminated to all clinical colleagues.<br>• Governance data reviewed and themes triangulated. |
| Regulation 18:<br>Safe Staffing | There are sufficient numbers of suitably qualified, skilled, and experienced doctors and nurses to meet the needs of patients in the Emergency Department.<br>Regulation 18(1) | • Ongoing recruitment for vacancies in place<br>• ED Nurse staffing review commissioned<br>• Training positions for Advanced practitioners and Physician Associates<br>• Additional Locum and Patchwork shifts<br>• International recruitment<br>• Skills review of B2 and B3 staffing underway<br>• Vacancies reviewed weekly<br>• ED Medical staffing business case complete<br>• Where required use of bank staff and agency via NHSP CAMS project to ensure patient safety<br>• Staffing escalation plans in place |

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## 2.3 Surgery
### 2.3.1 Overall Action Plan Compliance

Following the CQC inspection in 2019, 109 Moving to Outstanding actions and 14 urgent actions were identified, 3 remain outstanding (**Table 8**). The Moving to Outstanding actions are on track, as confirmed by Lead Nurse for Surgery at the Moving to Outstanding Steering Group on 21 July 2022.

Themes from all the Surgery actions relate to:
- Appraisals
- Equipment
- Estates
- Information Governance
- Infection, Prevention and Control
- Medicines management
- Patient Experience

### 2.3.2 Urgent Actions

**Table 8 – Urgent Actions**

| Actions | Update | Target date |
|---|---|---|
| IV fluid storage in the anaesthetic rooms must meet BS 2881 standards – upgrade required | Medicines cabinets have been ordered and will be installed. | 30 September 2022 |
| Medicine cupboards on PACU must meet BS 2881 to comply with medicines storage regulations | Medicines cabinets have been ordered and will be installed. | 30 September 2022 |
| There must be locked access to maternity theatres | Estates work is underway, and work is scheduled to be completed by end September 2022. | 30 September 2022 |

## 2.4 Maternity
### 2.4.1 Overall Action Plan Compliance
There are currently 7 maternity action plans in progress following the maternity reviews **Table 9** shows progress across all action plans in Maternity.

**Table 9 – Maternity Action Plan Progress**

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| Source of Action | No. of Actions | June | July | June | July | June | July | June | July | June | July |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aubrey Report | 23 | 0 | 0 | 2 | 1 | 2 | 3 | 19 | 19 | 0 | 0 |
| Ockenden Part 1(a) | 53 | 0 | 0 | 5 | 2 | 8 | 9 | 40 | 42 | 0 | 0 |
| Ockenden Part 1(b) | 121 | 0 | 0 | 2 | 8 | 4 | 4 | 115 | 109 | 0 | 0 |
| Ockenden Part 2 | 77 | 0 | 0 | 40 | 40 | 14 | 15 | 17 | 22 | 6 | 0 |
| Mock Inspection | 19 | 0 | 0 | 5 | 12 | 9 | 2 | 5 | 5 | 0 | 0 |
| M2O | 32 | 0 | 0 | 4 | 16 | 1 | 3 | 16 | 13 | 11 | 0 |
| Maternity CQC Survey | 43 | 0 | 0 | 41 | 39 | 2 | 2 | 0 | 2 | 0 | 0 |
| Total | 368 | 0 | 0 | 99 | 118 | 40 | 38 | 212 | 212 | 17 | 0 |
| % of actions completed rating | | 0.0% | 0.0% | 26.9% | 32.1% | 10.9% | 10.3% | 57.6% | 57.6% | 4.6% | 0.0% |

| Key colour code: | |
|---|---|
| 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 |

Themes for the 32 'Moving to Outstanding' Actions identified relate to:
- Estates
- Information Governance
- Patient Experience.

Monitoring of the action plan continues through the CBU governance meetings, Care Group meetings, via the Moving to Outstanding Steering Group and monthly Compliance Team reviews.

2.4.2    Urgent Actions

19 urgent maternity actions were identified at the time of the mock inspection. 5 urgent actions remain outstanding including mandatory training compliance and cultural improvements. Plans and trajectories are in place.

**Table 10** compares training and appraisal compliance for Maternity from the time of the inspection (April 2021) compared to June and July 2022.

**Table 10 – Maternity Training and Appraisal Compliance**

| Area | April -2021 | Compliance - reported June 2022 | Compliance - reported July 2022 | Trend |
|---|---|---|---|---|
| Appraisals* | 65.77% | 57.30% | 61.31% | *h |
| Role Specific training | 83.02% | 88.92% | 91.62% | *h |
| Core Skills training | 76.56% | 85.15% | 85.37% | *h |
| Adults Level 2 Safeguarding | 60.90% | 74.52% | 70.61% | *i |

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\* Amber is below trajectory – Green indicates compliant with trajectory

Appraisal compliance was below the Trusts target at the time of the inspection and below the Trust's recovery trajectory of 65% for April 2022. A trajectory is in place to achieve compliance by the end of November 2022. This is being overseen by the Director of Midwifery. The appointment of a Safeguarding Midwife will offer additional compliance and training support. The service is on trajectory to achieve compliance by November 2022.

### 2.5    Outpatients
2.5.1    Urgent Action
Following the mock inspection of Outpatients, one urgent action was identified which was completed at the time of the inspection. This related to staff using clinical treatment rooms as a corridor whilst they were in use.

2.5.2    Moving to Outstanding Initial Actions
At the time of the inspection a further 26 Moving to Outstanding actions were agreed. There are a total of 51 actions to progress the service to a level considered to be CQC outstanding**.**

### 2.6    Mock inspection programme
In line with the mock inspection schedule, no inspections have taken place in the last month. The Compliance Team have focused on:
- Developing further Moving to Outstanding actions in Surgery and Outpatients to support the services target outstanding practice.
- A compliance review of the Surgery action plan.
- An ED action plan review with the CBU Team and Unplanned Care Triumvirate to prioritise areas for improvement.

Plans are in place as part of the mock inspection programme to undertake unannounced inspections in the following areas:

- Medical Care
- Critical Care
- End of Life Care
- Children and Young People
- Diagnostics
- Gynaecology
- Urgent Care Centre at the Halton Hospital site.

### 2.7    CQC Enquiries
Since July 2022, the Trust has received 1 CQC enquiry, this was for a copy of a complaint response, and this will be provided to the CQC when finalised shortly. The request for the Ockenden 2 action plan and NHSE/I report following the Ockenden Insight visit scheduled for 29 July 2022 has now been actioned:
- The Ockenden 2 action plan and the Ockenden Insight visit report has now been shared with the CQC.

There are no concerns to escalate to this Committee in relation to CQC enquiries. The Director of Governance has contacted the CQC to request that engagement meetings be arranged. Due to staff sickness and turnover within the CQC the last engagement meeting was in July 2022.

### 2.8    CQC Methodology Changes
2.8.1 **Background**

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The CQC are changing their methodology and approach in line with their new Strategy from 2021 ([https://www. A new strategy for the changing world of health and social care)](https://www.)

This new Strategy strengthens their commitment to deliver our purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. Key points to note are:

- The domains (safe, effective, caring, responsive and well-led) will remain. However, they will be called **Key Questions** instead of domains.
- The Key Lines of Enquiry (KLOEs) will be replaced by **Quality Statements** that set out **expectations of care which will be based on a 'good' rating. The quality statements will be laid out as 'I' and 'We' statements,' 'I' for patients and 'We' for providers e.g. I receive safe care and treatment; We provide** safe care and treatment.
- There will be **Six Evidential Categories** for each Quality Statement:
    1. People's experiences
    2. Feedback from staff and leaders
    3. Observations of care
    4. Feedback from partners
    5. Processes
    6. Outcomes of care

- Evidence required will be set out at service type (i.e., Medicine) and for each Quality Statement so providers are clear what minimum levels of evidence will be collated for each quality statement.
- Structure and consistency are key for the new methodology. The key point to note is that there will be minimum evidential requirements for each Quality Statement. Each evidence type will be scored feeding into the overall CQC rating for the key question.
- Ongoing evidence collections will be set out and this will include the CQC collating information the Trust already provides to other external bodies (e.g., A&E Sitreps/ NHS Digital) to reduce the burden on the Trust. This will build on the information collated from the CQC Insight report). The frequency for this is to be determined.
- The process for judgments is:
    - **Set** – A timetable for evidence collection is decided based on national and local risk priorities. The information is then collated and reviewed.
    - **Score** – Evidential Categories for Quality Statements are scored (between 1-4 for each Evidence Category).
    - **Publish** – Scores with a narrative and direction of travel are published including any change in the CQC rating.

**2.8.2 Next Steps**
Further details on the new methodology and approach are planned to be shared by the Trust's allocated CQC Relationship Manager in Quarter 3 (October - December) 2022/23.

**2.9     Coroner Regulatory 28 Prevention of Future Deaths Reports**
The Trust has had no Regulatory 28 Reports issued since 2018.

**2.10    Well-led**
WHH has commissioned the Good Governance Institute to undertake a 'Well-led' review. The review commenced 11 July 2022 and a schedule has been agreed.  This will be followed by an internal well-led review for additional assurance.

**2.11    Communications**
The Communication Plan has three domains and forms part of the Well Led Framework that requires support from the Communications Department and the Patient Experience Team:
- Domain 1 - The production of patient information
- Domain 2 - Compliance with the accessible information standards

- Domain 3 - The engagement, participation and involvement of service users, wider stakeholders, and our community in the development of our services.

At the Moving to Outstanding Steering Group meeting held in July 2022, the Senior Communications and Involvement Manager confirmed that all actions in the underpinning workstreams for each domain are on track. Actions are also reported into the Patient Experience Sub-Committee.

**2.12    Mandatory Training Compliance**
An overview of trajectories for Mandatory Training, Role Specific Training, Safeguarding and Appraisal is shown below in **Table 13**

**Table 11 – Overview of Mandatory Training Compliance**

| Training | June 2022 position | July 2022 position | Trajectory |
|---|---|---|---|
| Core Skills Training Framework (CSTF) | 85.25% | 86.23% | 85% |
| Role Specific Training (RST) | 91.48% | 91.84% | 85% |
| Safeguarding | *70.67% | *71.11% | *86% |

* Amber is below trajectory – Green indicates compliant with trajectory

**2.13    Appraisal Compliance**
The information detailed in Table 14 below shows appraisal compliance across the Trust comparing June 2022 to July 2022.

**Table 12 – Appraisal Compliance**

| Training | June 2022 position | July 2022 position | Trajectory |
|---|---|---|---|
| **Appraisals** | *59.86% | *60.63% | *85% |

* Amber is below trajectory

There has been an improvement in appraisal compliance of 0.77%. Compliance and plans for improvement are being monitored through the Operational People Committee.

**2.14    Use of resources**
The Use of Resources Assessment is suspended whilst a new framework is developed. Internal work continues to be completed ahead of further direction from NHSE. There are no concerns to escalate to this Committee.

**2.15 External Reviews, Assessments and Accreditations**

2.15.1   Human Tissue Authority (HTA) Inspection
- A Corrective and Preventive Action Plan (CAPA) has been submitted following a factual accuracy exercise. The main factor outlines additional measures with regard to care of the deceased.

2.15.2   UKAS inspections

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The UK Accreditation Service (UKAS) has completed 3 out of 4 inspections of the Trust's laboratories at Warrington. The remaining inspection is scheduled to take place on 29 September 2022. Following completion of the inspections, a full report will be provided to the Trust.

The inspections are being led by the Pathology Quality Manager with support from the Associate Director of Clinical Support Services. Fortnightly meetings are in place for oversight of progress.

### 2.15.3   Royal College of Paediatrics and Child Health (RCPCH) Peer Review

The final report has been received from the RCPCH. The report describes the service as 'award winning' with a team that displayed 'an extremely positive attitude towards the review'. It noted that 'the team were praised by the parent representatives who described the service as 'incredible'. The report highlighted one concern which related to dietetic provision. This was addressed the day after the visit and the dietetic vacancy is out for advert.

### 2.15.4   Ockenden 1 Insight visit

An Ockenden 1 Insight review visit from NHSE/I was undertaken on 29 July 2022. Positive feedback was received, and the summary report below indicates one area that was RAG rated Amber. This related to 'Monitoring fetal well-being' and a recommendation was that the Trust must appoint a Consultant Lead for Fetal Medicine without delay. This is being monitored through the Ockenden Oversight Group. An Obstetrics and Gynaecology (O&G) Consultant Away Day is scheduled for 10 October 2022 when a Consultant Lead will be agreed. Executive oversight is provided at fortnightly Ockenden part 2 meetings

## Summary of Insight Visit Review of Ockenden IEAs Status

| IEA | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1)   Enhanced safety | Q1 Dashboards | Q2 – External review of SIs | Q3 – SIs to Board/LMNS | Q4 - PMRT | Q5 - MSDS | Q6 - HSIB | Q7 - PCQSM | Q8 – SIs to Board/LMNS |
| 2) Listening to women and families | N/A | N/A | Q11 – NED | Q12 - PMRT | Q13 – Service user feedback | Q14 – Bimonthly safety champ meetings | Q15 – Service user feedback | Q16 – NED |
| 3) Staff training and working together | Q17 – MDT Training | Q18 – Cons. Ward Rounds | Q19 – Ring-Fenced Funding | Q20 – workforce planning | Q21 – 90% MDT Training | Q22 – Cons Ward Rounds | Q23 – MDT Training Schedule | |
| 4) Managing complex pregnancy | Q24 – MMC Criteria | Q25 – Named Consultant | Q26 – Complex Pregnancies | Q27 – SBLCBv2 | Q28 – Named Cons/Audit | Q29 – MMC | | |
| 5) Risk assessment throughout pregnancy | Q30 – Risk assessment | Q31 – Place of Birth RA | Q32 – SBLCBv2 | Q33 – RA recorded with PCSP | | | | |
| 6) Monitoring fetal well-being | Q34 – Leads in post | Q35 – Leads expertise | Q36 – SBLCBv2 | Q37 – 90% MDT Training | Q38 – Leads in post | | | |
| 7) Informed consent | Q39 – Accessible Information, Place of Birth | Q40 – Accessible Information, All Care | Q41 – Decision making and Informed Consent | Q42 – Women's Choices Respected | Q43 – Service User Feedback | Q44 - Website | | |
| Workforce Planning | Q45 – Clinical Workforce Planning | Q46 – Midwifery Workforce Planning | Q47 – D/HoM Accountable to Exec Dir | Q48 – Strengthening Midwifery Leadership | | | | |
| Guidelines | Q49 - Guidelines | | | | | | | |

## 3.0 ASSURANCE COMMITTEE

This paper will continue to be provided on a bi-monthly basis to the Quality Assurance Committee.

## 4.0   RECOMMENDATIONS

The Board of Directors is asked to note the contents of this paper.

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**Appendix one – Indicators showing improvement**

| Indicator improving | Performance reported June 2022 | Performance reported July 2022 | Variance |
|---|---|---|---|
| **UEC**: Patients spending less than 4 hours in majors A&E | 53.40% | 60.20% | +6.80% |
| **UEC**: Admissions waiting 4-12 hours from the decision to admit (%) | 58.90% | 44.70% | -14.20% |
| **Surgery**: Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%) | 62.28% | 62.87% | +0.59% |
| **Surgery**: Patients consented to have personal details included in the NJR National Joint Registry | - | 98.0% | - |
| **Medicine**: Emergency readmissions: Urinary tract infections | 84.20% | 66.40% | -17.80% |
| **Medicine**: In-hospital mortality: Urinary tract infections - | 20 deaths (Jul 20 - Jun 21) | 12 deaths (Jul 21 - Jun 22) | - 8 deaths |
| **Medicine**: Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%) | 90.10% | 95.74% | +5.64% |
| **Cancer**: Cancer - First treatment in 62 days of urgent national screening referral (%) | 88.90% | 100% | +11.10% |
| **Cancer**: Seen by specialist in 14 days of urgent GP/dentist referral (%) | 88.00% | 90.80% | +2.80% |

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**REPORT TO TRUST BOARD**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/22/09/118** |
| **SUBJECT:** | **Maternity Update Report** |
| **DATE OF MEETING:** | 28th September 2022 |
| **AUTHOR(S):** | Catherine Owens, Director of Midwifery/Associate Chief Nurse |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive |

| | | |
|---|---|---|
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>*(Please select as appropriate)* | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. | x |
| | SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future | |
| | SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. | |

| | |
|---|---|
| **LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):**<br><br>*(Please DELETE as appropriate)* | **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken.<br>**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.<br>**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.<br>**#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<br>**#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**<br>*(KEY ISSUES):* | Maternity Incentive Scheme (MIS) Year 4 and Ockenden recommendations require the Trust Board to be informed of and has oversight of maternity safety updates.<br><br>This paper aims to provide the Trust Board oversite of the maternity safety agenda and assurance of how Warrington and Halton Materntiy Services are implementing the national maternity and neonatal recommendations. The information within this paper has previously been shared with the Quality Assurance Committee and findings discussed. |

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The content of this report has been embedded into the Cheshire and Mersey Local Maternity and Neonatal System (LMNS) Board reporting template. In summary Warrington and Halton Teaching Hospital (WHH) is:

- 95% compliant with Ockenden Part 1 and on trajectory to be fully embedded by 30th September 2022.
- 86.89% compliant with Ockenden Part 1 phase 2 and on trajectory to be fully compliant by 30th September 2022.
- WHH is 32 .04% compliant with Ockenden Part 2 with action plans in place.
- All 10 Safety Actions recommended by MIS Year 4 Guidance is on track to be completed by 30th November 2022 prior to national submission date of 5th January 2022.
- WHH stillbirth rate for Q1 2022/23 was 5.23 per 1000 births. WHH annual Mean stillbirth rate is 3.06 per 1000 births which is below the MBRRACE-UK national rate 3.51 per 1000 births.
- WHH Neonatal mortality rate Q1 2022/2023 was 1.74 per 1000 live births. MBRRACE-UK national rate 1.64/1000 live births.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards met.
- Current Quarter 1 Avoiding Term Admission into Neonatal Units (ATAIN) rate is 4.5%. National target 6% Northwest Operational Development Network (NWODN) target 5.6%.
- 10 babies received transitional care in Q1
- Birth Rate Plus ratio is 1:24. July midwifery workforce update reports a Midwifery vacancy of 15.3% equating to 21.17 Whole Time Equivalent (WTE) of which 19.12 WTE appointed to and will commence in September/October.
- All maternity and obstetric mandatory training on tract to be completed by 30th November 2022.
- The maternity team were the regional winners for the Nursing and Midwifery Parliamentary Award for the implementation of Continuity of Care work.
- '15 Steps Event' with service users and stakeholders undertaken on 8th July 2022; positive feedback received while awaiting the final report.
- 250 incidents reported in Q1. 245 incidents noted as negligible /no harm, 5 as moderate harms.  4 Serious Incidents have been reported. All have followed the governance process.
- 2 Serious Incidents (SI) have been completed. 1 was related to a maternal death, where the root cause identified no concerns in which care impacted on the outcome. The second SI related to a maternity divert where all care was noted as appropriate. Root cause noted as reduced staffing levels due to sickness and increased acuity.
- WHH  have a higher than average number of  3rd and 4th degree tears across the Northwest Coast. WHH statistics

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| | |
|---|---|
| | under national rate of 3 in 100. An audit of the data is being undertaken to understand any themes or trends. This will be reported to Quality Assurance Committee in November 2022. |
| | • WHH notes a higher than average number of babies born under 3rd centile in Northwest Coast. A positive detection rate will ensure small babies are born at the right time and risk of stillbirth and co morbidities associated with small babies reduced. |
| | • No completed Health Care Safety Investigation Branch (HSIB) cases to report. |
| | • Jayne Downy, Non Executive Director has been appointed to the role of Maternity Safety Champion. |
| | • WHH has 7 Continuity of Carer (CoC) teams across Warrington and Halton. Previously Lorenzo did not capture this data does it now? How? Badgernet?. An update including data analysis will be provided in November 2022. |

| PURPOSE: *(please select as appropriate)* | Information | Approval | To note X | Decision |
|---|---|---|---|---|

| RECOMMENDATION: | The Trust Board is asked to note the findings of this paper as per MIS and Ockenden recommendations. |
|---|---|

| PREVIOUSLY CONSIDERED BY: | **Committee** | Quality Assurance Committee |
|---|---|---|
| | **Agenda Ref.** | |
| | **Date of meeting** | 2nd August and 6 September 2022 |
| | **Summary of Outcome** | Discussed and noted for information |

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

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**REPORT TO BOARD OF DIRECTORS**

| SUBJECT | Maternity Update | AGENDA REF: | BM/22/09/118 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

The following report will update the Trust Board of Quarter 1 Maternity Update for the reporting period from 1st April 2022 to 30th June 2022.

The findings within this report has embedded within the Cheshire and Mersey Local Maternity and Neonatal Board reporting template to provide the Trust Board with oversight of all maternity and neonatal services in-line with the Maternity Transformation Programme, Ockenden Reports and Maternity Incentive Scheme (MIS) Year 4 recommendations.

## 2. KEY ELEMENTS

**2.1 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 (IEAs) 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

Warrington and Halton Teaching hospitals (WHH) has embedded the recommendations of Ockenden Part 1 and reported **95% compliance** to Cheshire and Mersey Local Maternity and Neonatal System (C&M LMNS) on 15th April 2022. To date the action plan and remain 95% compliant.

The remaining actions are in relation to:
- Completion of a Maternity and Neonatal Safety Improvement Programme which WHH is due to commence in September 2022.
- Cheshire and Mersey LMNS have extended the deadline of an action in relation to the establishment of maternal medicine centres until September 2022.

**Ockenden Part 1 phase 2**
Following the initial evidence submission to the National Maternity Team, the returned provider report identified a further 122 actions were identified. **WHH is currently 95.90%**

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**compliant**. The action plan is on track to be completed by 30th November 2022. Outstanding actions are related to:

IEA 2    Trust Safety Champions share minutes with LMNS: currently awaiting a process to be established with LMNS to share Safety Champions minutes of Bi Monthly meetings.

IEA 4    Implementation of a maternal medicine's pathway. This is an action for the LMNS.

IEA 4    This action assesses compliance with all elements of Saving Babies Lives Version 2 care bundle (SBLV2). WHH has implemented all elements of the care bundle. Amber status has been assigned whilst data assurance is achieved.

Data is submitted on a monthly basis to the Cheshire and Mersey Region. Previously reporting of (SBLV2) data has been impacted by inter-operability issues with the previous maternity data system. This made it difficult to demonstrate compliance.

A new BadgerNet system was implemented in May 2022 which is it anticipated will improve data quality and provide the necessary data assurance. Data is reported monthly. WHH is awaiting confirmation from the Maternity Services dashboard (NHS Digital platform) to report assurance of the data.

IEA 6    Consultant Lead for fetal surveillance: WHH does have a named consultant for fetal Surveillance, however due to competing clinical demand is unable to completely fulfil all elements of this role. The Women's and Children's Clinical Business Unit is recruiting to this role through a process of work plan reconfiguration. The timeline for this role to be appointed to is 30st November 2022. In the interim this essential action will be included on the Risk Register.

IEA 7    Completion of an Out of Guideline audit: WHH recruited a Consultant Midwife in April 2022 who has set up Out of Guideline Clinics from June 2022. This action will be completed by 30th September 2022.

Ockenden Part 1 phase 2 action plan is on trajectory to be completed by 30th November 2022.

**Ockenden Part 2 Report**

Ockenden Part Two 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.

The report concluded by recommending all Trust's embed a further 15 Immediate and Essential Actions (IEA's) which encompass 92 actions:

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1. Workforce Planning & Sustainability
2. Safe Staffing
3. Escalation & Accountability
4. Clinical Governance Leadership
5. Clinical Governance Learning from Clinical Incidents & Complaints
6. Learning from Maternal Death
7. Multidisciplinary Training
8. Complex Ante Natal Care
9. Pre-Term Birth
10. Labour & Birth
11. Obstetric Anaesthesia
12. Post Natal Care
13. Bereavement Care
14. Neonatal Care
15 Supporting Families

As per regional trajectory WHH Ockenden Part Two action plan was shared with C&M LMNS on 30th June 2022. This action plan was also shared with the Executive Team on the 12th of July 2022.  WHH is currently 32.04% compliant with all 78 local actions:

| Key | Action |
|---|---|
| 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 |
| Grey | National Actions |

| Key | Action | Number of actions | WHH % | National % |
|---|---|---|---|---|
| Purple | Action not initiated | 6 | 7.69 | 6.5 |
| Red | Action initiated but risk to achieving completion date | 1 | 1.28 | 1.08 |
| Amber | On track to achieve completion date | 46 | 58.96 | 23.9 |
| Green | Complete but assurance embedded not received | 13 | 16.66 | 13.54 |
| Blue | Complete, assurance evidence embedded, received and passed to CBU for monitoring | 12 | 15.38 | 12.5 |
| Total | WHH Actions to complete | 78 | | |
| | WHH Overall Compliance | 25 | 32.04 | |
| Grey | National Action | 11 | | 15.21 |
| Total | | 89 | | 100% |

An Ockenden Part Two Oversight Group was established in May 2022 to oversee the implementation of all IEA's. The group members include the Chief Nurse/Deputy Chief

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Executive Officer and Director of Governance. This action plan is also monitored by Women's and Children's Governance meetings. This action plan is on trajectory to be 100% compliant by 31$^{st}$ January 2023.

The previous one red action relates to Birth Suite Coordinators being trained in high dependency care. This has now moved to amber as the training programme has been identified.

Currently there are no national timelines in which to submit Ockenden Part Two evidence or complete actions.

**No risks have been identified which will inhibit WHH from implementing all 15 IEAs**

**2.2 WHH Ockenden Insight Visit**

Cheshire and Mersey Local Maternity and Neonatal System (C&MLMNS) undertook an Insight Visit at WHH on 29$^{th}$ July. The purpose of the visit was to provide assurance against the seven Immediate and Essential Actions from the interim Ockenden report.

As part of the preparation for the visit Team Talk sessions were held with staff alongside posters and other communication to ensure staff were fully informed of the purpose and expectations of the visit. An example of a poster presentation is included in Appendix One.

The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the interim Ockenden recommendations were embedded in practice. Conversations were held with various members of the senior leadership team and various frontline staff ranging in job roles.

Emerging themes from conversations were organised under the Immediate and Essential Actions headings.

WHH received the Insight Visit feedback on 11$^{th}$ August 2022.  Key headlines from the feedback report are as follows:

- The Trust offered an open and transparent view of its services.
- The Trust had implemented and embedded the Birmingham System Specific Obstetric Triage System (BSOTS) model for triage.
- There was a culture of cohesive and Multidiscerplinary Team  working at all levels.
- The Trust formed part of the MVP and worked collaboratively with the Materntiy Voice Partnership (MVP) and MVP Chair, the Trust should continue engaging the MVP and Chair early in service design to ensure true coproduction.
- Due to activity levels on the day, the Insight Team were unable to speak to as many staff as they would have liked, despite the activity levels the Insight Team observed teams working together in a calm and organised manner.

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- The Safety Champion meetings were returning to pre-pandemic arrangements, the Insight Team heard how these had led to positive improvements.
- The Trust did not have a Failsafe Clerk, the Insight Team felt this should be considered as it is good practice. A Failsafe Clerk supports systems and processes in relation to the antenatal and newborn screening pathway to prevent missed screening opportunities.
- The Trust estates offered challenges to the provision of services, the Insight Team heard a place and space review was planned.
- The neonatal unit offered Family Integrated (Fi)Care, the Insight Team felt this was good practice.
- The Trust had adopted BadgerNet a system of electronic patient records, the Insight Team felt this was good practice.

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## Summary of Insight Visit review Of Ockenden IEAs Status

| IEA | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1) Enhanced safety | Q1 Dashboards | Q2 – External review of SIs | Q3 – SIs to Board/LMNS | Q4 - PMRT | Q5 - MSDS | Q6 - HSIB | Q7 - PCQSM | Q8 – SIs to Board/LMNS |
| 2) Listening to women and families | N/A | N/A | Q11 – NED | Q12 - PMRT | Q13 – Service user feedback | Q14 – Bimonthly safety champ meetings | Q15 – Service user feedback | Q16 – NED |
| 3) Staff training and working together | Q17 – MDT Training | Q18 – Cons. Ward Rounds | Q19 – Ring-Fenced Funding | Q20 – workforce planning | Q21 – 90% MDT Training | Q22 – Cons Ward Rounds | Q23 – MDT Training Schedule | |
| 4) Managing complex pregnancy | Q24 – MMC Criteria | Q25 – Named Consultant | Q26 – Complex Pregnancies | Q27 – SBLCBv2 | Q28 – Named Cons/Audit | Q29 – MMC | | |
| 5) Risk assessment throughout pregnancy | Q30 – Risk assessment | Q31 – Place of Birth RA | Q32 – SBLCBv2 | Q33 – RA recorded with PCSP | | | | |
| 6) Monitoring fetal well-being | Q34 – Leads in post | Q35 – Leads expertise | Q36 – SBLCBv2 | Q37 – 90% MDT Training | Q38 – Leads in post | | | |
| 7) Informed consent | Q39 – Accessible Information, Place of Birth | Q40 – Accessible Information, All Care | Q41 – Decision making and Informed Consent | Q42 – Women's Choices Respected | Q43 – Service User Feedback | Q44 - Website | | |
| Workforce Planning | Q45 – Clinical Workforce Planning | Q46 – Midwifery Workforce Planning | Q47 – D/HoM Accountable to Exec Dir | Q48 – Strengthening Midwifery Leadership | | | | |
| Guidelines | Q49 - Guidelines | | | | | | | |

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**Recommendations/ Points for Consideration**

- The Insight Team felt the Trust should consider employing a Failsafe Clerk.
- The place and space review for maternity should be undertaken without delay in partnership with the MVP and MVP Chair. The estate for the Antenatal Day Unit must be a priority.
- The Trust should without delay work with the commissioners to enable the offer of nicotine replace therapy as part of the midwifery offer.
- The Trust must appoint a Consultant Lead for Fetal Medicine without delay.
- The Safety Champions should be supported in returning to pre-Covid activity to demonstrate positive engagement from Board to floor.
- The Trust should review the website and seek a solution to offer all information in the language of choice.
- The Trust could consider the role of the MSW within the public health function of the midwifery team.
- The Trust should continue engaging the MVP and Chair early in service design to ensure true coproduction

The visiting team expressed their thanks to all the staff who on the day of the visit were very welcoming in sharing their thoughts regarding the maternity services.

The Women's and Children's Clinical Business Unit is currently reviewing the feedback received on the 11th of August 2022 and will add the recommendations to the Ockenden action plan which will be monitored at Women's and Children's Governance meeting.

**2.3 Ockenden Summary**

- Ockenden recommends Trust Boards have oversight of the implementation of Ockenden IEAs. This paper provides the QAC of WHH current Ockenden position:
- Ockenden Part 1 WHH is 95% compliant and on track to be 100% compliant by 30th September 2022
- Ockenden Part 1 Phase 2 is 95.90% compliant and on trajectory to be 100% compliant by 30th November 2022.
- Ockenden Part 2 is 32.04% compliant on trajectory to be 100% compliant by 31st January 2023.
- WHH received an Insight Visit from the Regional C&M LMNS on 29th July and received its feedback on the 11th of August 2022. WHH received positive feedback and assurance that the majority of the initial 7 IEAs were embedded within maternity services. The outstanding action relates to the identification of an obstetric lead for fetal surveillance. W&C CBU has an action to achieve this by 30th November 2022.

**2.2 Maternity Incentive Scheme (MIS) (Formally known as Clinical Negligence Scheme for Trust-CNST)**

**Safety action 1 (SA1): 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.

Quarter 1 (Q1.) audit report has been submitted as a separate paper to September Trust Board for noting. The report notes WHH stillbirth rate is 5.3 per 1000 births. WHH mean stillbirth rate is 3.06 per 1000 births and is under the national MBRRACE stillbirth rate of 3.51 per 1000 births. WHH Neonatal mortality rate Q1 2022/2023 was 1.74 per 1000 live births. MBRRACE-UK national rate 1.64/1000 live births. WHH is awaiting the Operational Development Network to calculate the mean neonatal mortality rate for WHH. Please note in the last 12-month period WHH has reported 4 neonatal deaths 2 of which were due to extreme prematurity.

**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 October 2022

New specifications released by NHSR in March 20222 included the Trust must have a Digital Strategy related to maternity services. The auditor noted the current corporate Digital Strategy and BagerNet Strategy. The Women's and Children's Clinical Business Unit is working with the Chief Information Officer to ensure this is in place by October 2022. A draft Maternity Digital Strategy is currently being reviewed by the senior team and Maternity Voice Partnership Chair before being presented at Digital Strategy group on the 10th October.

Previously Women's and Children's Clinical Business Unit has escalated the potential risk of not meeting SA2 MSDS specifications. This was addressed by the Trust Board investing in a new Maternity Database system culminating in the implementation of Badgernet on 6th May 2022. Maternity data is always recorded 2 months in arrears and currently reporting May data. WHH May data scorecard is reporting WHH as non-compliant for the data submission of smoking data, complex social factors, continuity of carer data and Body Mass Index (BMI). This was extracted from WHH previous Lorenzo database system.

MIS MSDS submission will capture July data which will be undertaken at the end of September. In preparation Women's and Children's Digital Team continues to monitor Badgernet data compliance daily to ensure the submission of July data is compliant. Initial data submission to National Maternity Services dashboard in relation to MSDS submission has been approved. Since this information was shared with QAC the digital team has corrected the technical challenges and received successful notification from NHS Digital that WHH has been received and is compliant with MSDS metrics.
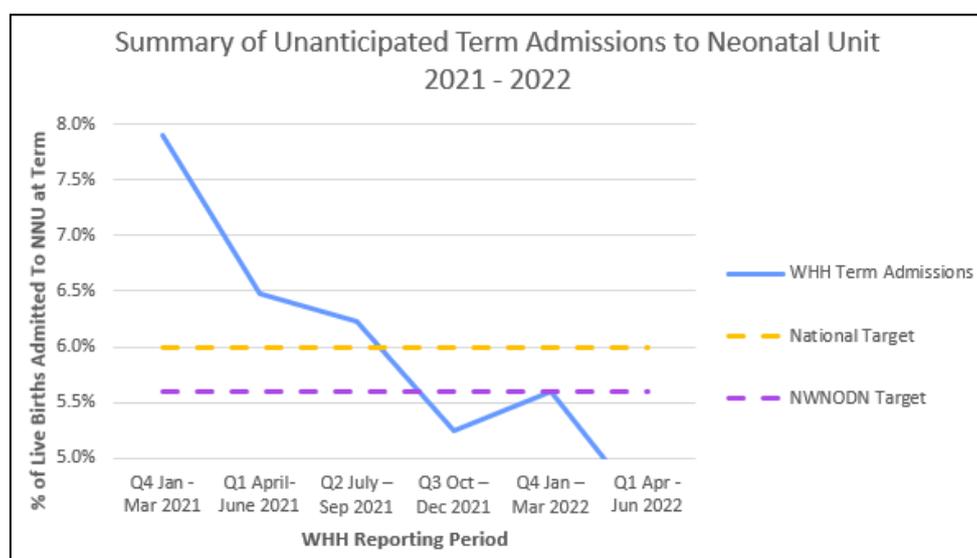
**Safety action 3: Can you demonstrate that you have transitional care (TC) services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme?**

WHH is on track to be 100% compliant.

ATAIN and TC quarterly reports have been submitted to QAC and updates are included in to the quarterly Maternity Trust Board Report. 10 Babies were reported has having received TC in Q1.

WHH is pleased to report a Q1 ATAIN Rate of 4.5% which is a significant and continued improvement since March 2021.

| 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 | 7.9% | | |
| Q1 April- June 2021 | 617 | 40 | 6.5% | | |
| Q2 July – Sep 2021 | 706 | 44 | 6.2% | | |
| Q3 Oct – Dec 2021 | 687 | 36 | 5.2% | | |
| Q4 Jan – Mar 2022 | 647 | 36 | 5.6% | | |
| Q1 Apr – Jun 2022 | 574 | 26 | 4.5% | | |



Q1 ATAIN report will be submitted to the October QAC meeting.

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

WHH is on track to be compliant by November 2022

| MIS Specification | RAG | Due date | Comments |
|---|---|---|---|
| Compliance to Royal College of Obstetricians & Gynaecologists workforce standards. | | 30/10/22 | Gathering evidence |
| Duty Anaesthetist 24 hours per day | | Complete | ACSA standard 1.7.2.1 |
| Neonatal Medical workforce review | | 30/10/22 | BAPM Standards |
| Neonatal Nursing workforce review | | 30/09/22 | Being reviewed |

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**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 will be updated in November 2022 as part of quarterly maternity update report.

**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 Lorenzo database. As previously discussed in SA2 WHH will submit July data to the national maternity dashboard in September. SBLV2 data requires a further 6months of consistent submission of SBLV2 data. The Digital Team is monitoring compliance of this data daily.

**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 to coproduce local maternity services?**

WHH is on track to be 100% compliant in all specification by 31st October

Previous challenges escalated to QAC around the Maternity Voice Chair claiming expenses has now been resolved.

Outstanding specification of SA7 relates to new MIS guidance which specifies the MVP Chair is invited to attend maternity governance meetings and actions, themes and trends from meetings are shared with the MVP chair. Women's and Children's Clinical Business Unit is working with the Trust Lead for the Patient Safety Collaborative to align this action with the role out of the Trust Patient Safety Collaborative. The trajectory for completion of thisis October 2022.

**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 30th November 2022

Current midwifery vacancies have been recruited to and newly qualified midwives due to start in September /October when their training is complete.

Training updates are monitored monthly at Women's and Children'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 30th November 2022

**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 specifications 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

Further assurance was ascertained following the findings of the MIAA external audit undertaken on 13th and 14th June 2022. The full MIAA report has been shared previously with QAC.

**MIS Next Steps and timeline:**

| Month/Date/2022 | Action | Update |
|---|---|---|
| 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. | Benchmark complete |
| 21st September | Bi monthly Triumvirate MIS review of outstanding actions | Complete |
| 28th September | The Trust Board will be updated on the MIS Trajectory | |
| 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 Final CBU Sign off | |
| November | Final CBU Sign off | |
| 24th November | Present MIS Evidence and presentation to Trust Board and Trust Board sign off | |
| December | 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 5th January 2023

**MIS Summary**

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MIS Safety Standards are on track to be compliant by November 2022.

## 3. Perinatal Quality Surveillance Model (PQSM)

The PQSM model aims to provide a consistent and methodical oversight of maternity services.

### 3.1 The Perinatal Clinical Surveillance Quality Assurance Report

The Perinatal Clinical Surveillance Quality Assurance Report includes key metrics against the following themes:

**Clinical care**

The Neonatal Unit was assessed for Family Integrated Care accreditation on 4<sup>th</sup> July 2022 where members of the Northwest Operational Delivery Network assessed WHH against a criterion which supports families being integrated into the care of their neonate. WHH was awarded 'Amber award' and highly commended the neonatal team for their integration of this pathway. Actions to achieve green status includes improving collaboration with the wider MDT team inclusive of neonatal speech and language therapists and physiotherapy. The unit will be reassessed in 6 months. The team are working collaborative with the senior management team to complete this care pathway.



**Clinical Care**

The Women's and Children's Clinical Business Unit has reviewed the North West Coast Clinical Network Dashboard and wish to inform QAC by exception:

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**Care in Labour**

| Metric | Q1 21/22 | Q2 21/22 | Q3 21/22 | Q4 21/22 | FY 21/22 |
|---|---|---|---|---|---|
| Midwife to Birth Ratio | 87 | 87 | 87 | 82 | 343 |
| Number of Women Receiving 1:1 Care in Labour | 464 | 541 | 502 | 450 | 1957 |
| Number of Women who Laboured | 471 | 556 | 511 | 469 | 2007 |
| Percentage of Women Receiving 1:1 Care in Labour | 98.51% | 97.30% | 98.24% | 95.95% | 97.51% |

1:1 care is labour is monitored continually and when this is not provided is escalated via the Red Flag WHH Safe Care system. An audit of all Red Flags captured 6 months data which identified 100% 1:1 status and 3 occasions where the Band 7 Coordinator did not have supernumerary status. This was escalated and appropriately.

**Service user and staff feedback**

The Maternity Voice Partnership (MVP) has been very Busy in the last 3 months facilitating listening events, Quarterly MVP meeting, a 15 Steps event and capturing difficult to reach voices at the Disability Awareness Day held on Sunday 17th July 2022. The MVP Chair Lisa Welch. reported the 15 Steps feedback as very positive:







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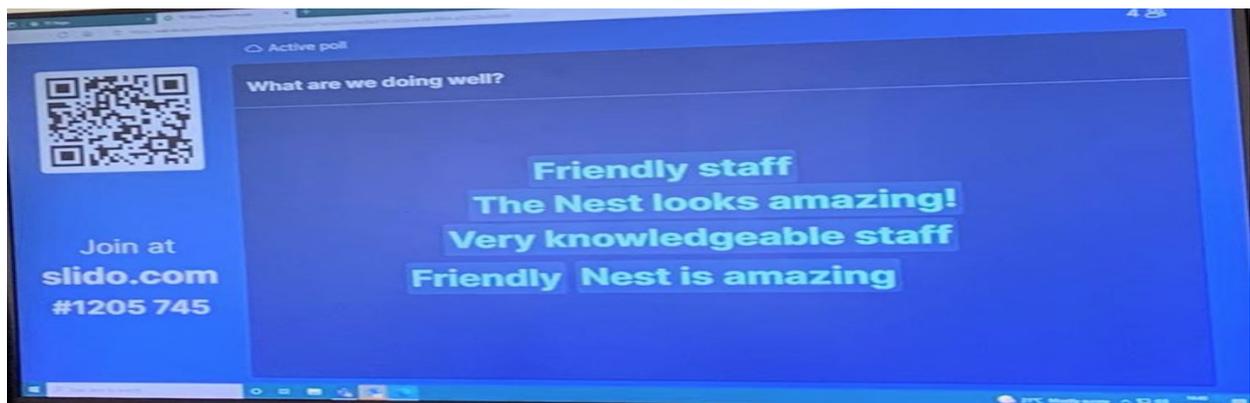
The full findings of the 15 Steps event will be shared with the Trust Board in November 2022.

**Leadership and relationships**



The Maternity Team was announced as the North West winner for the 2022 Nursing and Midwifery Parliamentary award for implementing 100% Continuity of Carer to women booking to birth their baby at WHH. The team can be seen here with Warrington MP Andy Carter when they attended the award presentation in London on 6th July.

**Incident reporting**

During Q1 WHH supported 574 women to birth their babies.
During the reporting period from 1st April 2022 to 30th June 250 maternity incidents were reported:

**Level of harm:**
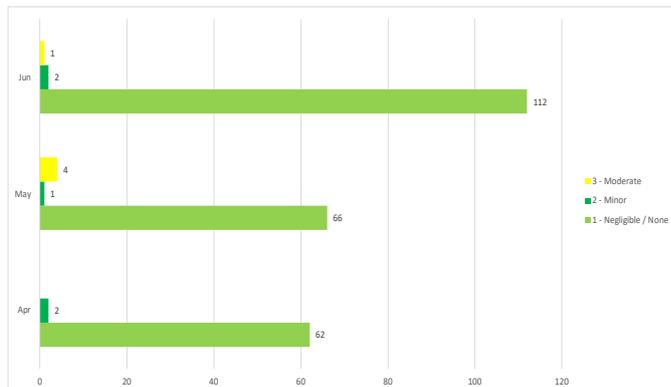


| Month | Non-Negligible Harm | Minor Harm | Moderate Harm | Grand total |
|-------|---------------------|------------|---------------|-------------|
| April | 62 | 2 | 0 | 64 |
| May | 66 | 1 | 4 | 71 |
| June | 112 | 2 | 1 | 115 |
| Total | 240 | 5 | 5 | 250 |

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**Top 5 reported incidents:**



**Top 5 Maternity Themes**

| Theme | Value |
|---|---|
| Postpartum haemorrhage > 1500ml or maternal compromised | 9 |
| Delayed ANNB Screening | 10 |
| Communication issue between staff | 17 |
| Postpartum haemorrhage 1000ml - 1500ml or maternal compromised | 26 |
| Documentation Inadequate | 42 |

**Documentation inadequate**

42 incidents reported in Q1 and noted as no/negligible harm. All have been reviewed by the senior management team and the following emerging themes identified:

Staff absence and capacity has contributed to delays in bookings being undertaken prior to their dating scan. On multiple occasion ultrasound were able to offer earlier scan appointments which preceded their booking appointment. In addition, women were referred for ultrasound from other departments without the full booking process completed. Subsequently the scan was arranged without awareness to also book a booking appointment.
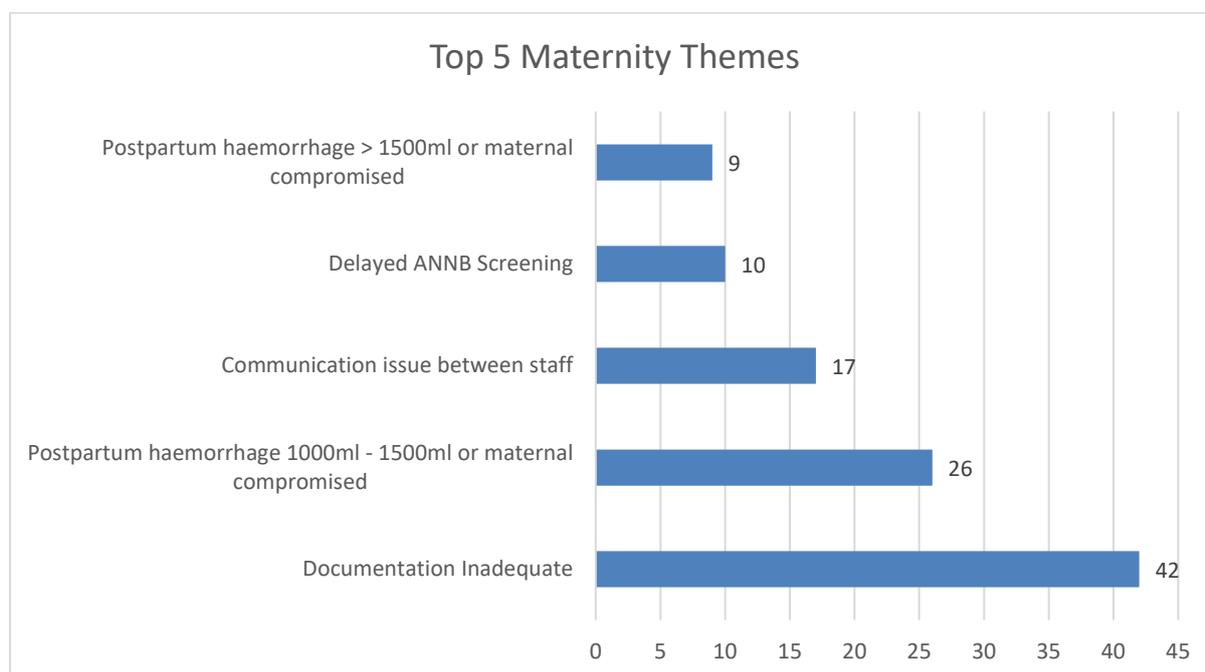
To prevent this from reoccurrence several measures have been implemented:

- Widespread communication with maternity team for all bookings to be completed prior to the dating scan.
- Communication shared re self-referring booking process with other departments (Emergency Department and Gynaecology Assessment Unit).
- The Integrated Community Manager has implemented a change in the processing of referrals to prioritise bookings by gestation and ensure these are completed in line with Key Performance Indicators (KPIs) prior to the initial dating scan.
- To further develop this, the Integrated Community Manager will be working closely with the Ultrasound department to implement a new failsafe process to prevent scans being arranged before a booking can be completed and to ensure where a late referral is received an urgent booking can be completed.

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Since the implementation of the above actions a reduction in incidents of this nature has been noted. Sharing of information and reminders to staff in relation to the new processes will continue alongside close monitoring at Women's and Children's Governance meeting.

There have also been occasions where a booking appointment had been completed on paper and had not been inputted into the electronic system pre Badgernet. This was partly due to initial migration issues with the transfer of data to Badgernet plus capacity issues within the team due to sickness.

Badgernet is now fully integrated thus will eliminate this issue. Badgernet will also increase midwifery capacity due to it facilitating direct electronic documentation and removal the previous dual system.

**Post-Partum Haemorrhage (PPH) 1000mls – 1500mls**
26 incidents reported in Q1 of which all were noted as no/negligible harm. All incidents have been reviewed by the senior team and reported all care was managed appropriately as per PPH policy.

**Communication Issue between staff**
17 incidents reported in Q1 of which all recorded as no/negligible harm. All incidents have been reviewed by the senior management team and identified all communication issues were addressed appropriately. Individual feedback has been given where indicated.

**Delayed Ante Natal and New-born (ANNB) Screening**
10 incidents were reported in Q1. All incidents were reviewed by the ante-natal Screening Lead and Manager. 4 themes were identified.

- Delay due to lack of information on the system caused by migration issues when BadgerNet was first implemented.  These have now been corrected.

- Delay in inputting screening results due to BadgerNet migration and capacity issues within community staffing due to sickness. The migration issues have been corrected which will improve capacity for midwives.

- Screening for Downs Syndrome testing undertaken when the woman had declined this test. This was human error and this element of the booking screening process had not been documented on the screening form. An apology was provided to the woman; no harm was caused. The midwife has reflected on this with her manager. The manager has also discussed the importance of ante natal screening documentation with her team.

A failsafe has been added to the daily checklist to ensure all appointments have an out-come from the previous day and follow up appointments booked. The digital team are also exploring solutions to improve connectivity in community settings.

**Post-partum Haemorrhage (PPH) greater than 1500mls**
9 incidents were reported in Q1; all noted as no/negligible harm.

All women who sustain a PPH which is 1500mls or above are reviewed using the Trust Rapid Incident Reporting system which includes Multidisciplinary Team (MDT) review of electronic and paper records within 72 hours following the incident to identify good practice, learning, need for escalation and Duty of Candour.

Following MDT review of the incidents all of the women had increased associated risk of PPH because of their mode of birth for example emergency caesarean section, complex assisted birth with shoulder

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dystocia. All care was noted as appropriate.

## Governance processes

### CQC Inspections & DHSC / NHSE/I request for support.
Nil to report.
The Cheshire and Mersey Local Maternity System undertook an Insight Visit on the 29th of July 20222 where the regional team visited the Trust to review its compliance with Ockenden Part 1 implementation.

### 3.2 The C&M Clinical Outcome / Outlier Report

The Northwest Coast Dashboard Report identifies outcomes for improvement should they be identified as an outlier. This report highlights:



**Low Birth Weight**

**Babies Born Below 3rd Centile**

Percentage of Babies Born Below 3rd Centile
June 2021 - May 2022

Data Source: NWC CN Maternity Dashboard
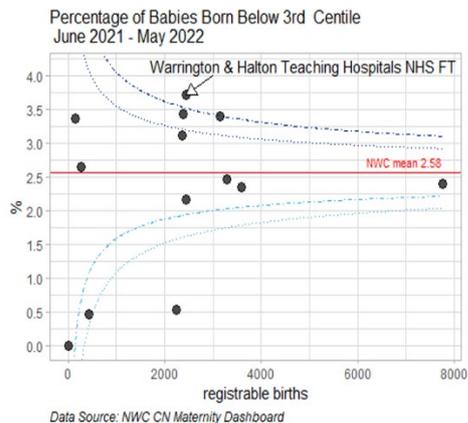
WHH is reported to have a higher-than-average number of babies whose birth weight is expected to be below the 3rd Centile.

The key information to note here is WHH detection rate of small babies in pregnancy has been reported as higher than average in Q1 by the perinatal institute for epidemiology.

Your data is now available for Q1 (April- June 2022), we are pleased to inform you that your detection rates of SGA babies is above GAP user average.

| Q1 Detection Rate | GAP User Average Q1 Detection Rate |
|---|---|
| 41.3% | 40.6% |

You can access your trust's full reports via the GROW App using the following link: https://ukaws.growservice.org/App/Reports.

WHH undertake a Growth Assessment Protocol (GAP) audit annually which is reported nationally to the Perinatal Institute of Epidemiology. The Obstetric Governance Lead and Lead Midwife for Ultrasound have reviewed the data and have taken an action to repeat the GAP audit. Both reiterated the importance of identifying those babies who have reduced growth (detection rate) as opposed to focusing on number of babies below the 3rd centile. A positive detection rate will ensure small babies are born at the right time and risk of reduced.

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**Safety**

**3rd/4th Degree Tears**

**3rd/4th Degree Tears in Vaginal Deliveries**



Percentage of 3rd/4th Tears in Vaginal Deliveries
June 2021 - May 2022

Data Source: NWC CN Maternity Dashboard
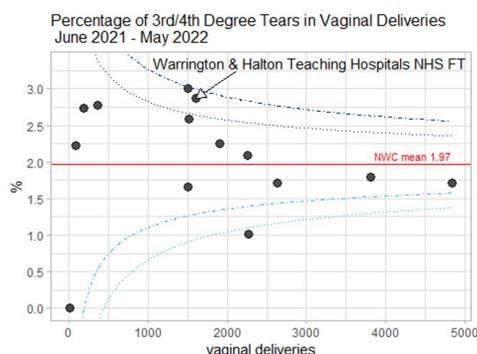
WHH is reported higher than average within the North West Coast, however WHH rate is not above national average. 3rd and 4th degree tears are where the anal sphincter has sustained injury during a vaginal birth. This occurs 6 in 100 births in first time mothers and 2 in 100 births in second time mothers (Royal College of Obstetrician and Gynaecologists). The Women's and Children's CBU will continue to monitor this incidence and undertake a clinical audit to identify learning and themes. An audit is being undertaken and findings reported in November 2022.

### 3rd / 4th Degree Tears

| Metric | Q1 21/22 | Q2 21/22 | Q3 21/22 | Q4 21/22 | FY 21/22 |
|---|---|---|---|---|---|
| Number of 3rd/4th Degree Tears | 17 | 14 | 13 | 21 | 65 |
| Percentage of 3rd/4th Degree Tears | 2.91% | 2.11% | 2.04% | 3.55% | 2.63% |
| Number of 3rd/4th Degree Tears in Vaginal Births | 13 | 11 | 10 | 16 | 50 |
| Percentage of 3rd/4th Degree Tears in Vaginal Births | 2.22% | 1.66% | 1.57% | 2.71% | 2.02% |
| Number of 3rd/4th Degree Tears in Instrumental/Unsuccessful Instrumental Vaginal Births | 4 | 3 | 3 | 5 | 15 |
| Percentage of 3rd/4th Degree Tears in Instrumental/Unsuccessful Instrumental Vaginal Births | 6.67% | 4.92% | 3.95% | 6.10% | 5.38% |

### Maternity Service Closures

| Metric | Q1 21/22 | Q2 21/22 | Q3 21/22 | Q4 21/22 | FY 21/22 |
|---|---|---|---|---|---|
| **Obstetric Unit** - number of **days** the service has closed on in reporting period | | 1 | 2 | 1 | |
| **Obstetric Unit** - number of **episodes** of closure the service has closed in reporting period | | 2 | 2 | 1 | |
| **AMU** - number of **days** the service has closed on in reporting period | | 1 | 25 | 28 | |
| **AMU** - number of **episodes** of closure the service has closed in reporting period | | 1 | 89 | 94 | |
| **FMU** - number of **days** the service has closed on in reporting period | | | | | |
| **FMU** - number of **episodes** of closure the service has closed in reporting period | | | | | |
| **Homebirth** - number of **days** the service has closed on in reporting period | | 1 | 3 | 26 | |
| **Homebirth** - number of **episodes** of closure the service has closed in reporting period | | 1 | 3 | 26 | |

All unit diverts are reported as a Serious Incident and notified to Strategic Executive Information System (StEIS)and monitored through the Trust Safety Oversight Committee. Since the introduction of the Integrated Care Systems All Serious incidents are now presented to Cheshire and Mersey LMNS Serious Incident Panel. A cluster review of all diverts is being undertaken and findings presented in November 2022.

## 3.3 Serious Incidents

Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in C&M and in Lancashire and South Cumbria. SIs are also reported to the LMNS with the Quality Safety Surveillance Group having further oversight of all SI's across the region. (A Cheshire and Merseyside SI panel has been established).

### Q1 Serious Incidents Reported
During Q1 4 incidents were reported as a serious incident.

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| Date of incident | Date StEIS reported | Theme | Level of Harm | Duty of Candour undertaken |
|---|---|---|---|---|
| 22/04/22 | 27/04/22 | Unit Divert | Negligible/None | Not applicable |
| 25/04/22 | 08/06/22 | Booked with WHH. Pre term birth at Liverpool Women's. Complaint received on 08/05/22 Antenatal pathway not followed. | Moderate | Yes |
| 14/05/22 | 13/06/22 | Baby born at home at 20 weeks gestation. RIP | Moderate | Yes |
| 29/05/22 | 07/06/22 | Unit Divert | Negligible/None | Not applicable |

**2 Serious Incidents were completed Q1**

| SBAR | Summarised findings of the SI | WHH Compliance with SI process |
|---|---|---|
| **Situation** | 8 Months following the preterm birth at 29 weeks gestation of her daughter the woman had a cardiac arrest and died. (RIP) | Maternal death is a StEIS reportable incident. A maternal death is classified as such up to 12 months following the birth of a baby. |
| **Background** | The woman had a complex history of deteriorating mental health prior to, during and following the birth of her baby.<br><br>The pregnancy was classified as high-risk due to a history of pre term birth at 30 weeks gestation, mental health issues and social needs.<br><br>Complex social needs led to all her 4 children being removed and adopted.<br><br>Intermittent engagement had with mental health agencies noted.<br><br>Duty of Candour recorded. The family liaison officer was unable to ascertain direct contact with the next of kin (NOK). Following repeated unsuccessful contact/calls NOK informed of investigation and completed investigation by letter. | Investigation was completed in line with WHH governance processes and included information from external agency of Mersey Care and the woman's General Practitioners. |
| | | |

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| | | |
|---|---|---|
| **Actions** | Early engagement with maternity services including gynaecological, Emergency Department, midwifery and obstetric care.<br><br>Appropriate referral to Mental Health services. Intermittent engagement with mental health services.<br><br>Appropriate care identified within GP services.<br><br>Following discharge from WHH, the woman returned to social services care where she reported suicidal thoughts intermittently and sought help from her GP and Mersey Care. Intermittent deterioration of physical and mental health reported. | WHH Care recorded as appropriate for most of the care provided. |
| **Recommendation** | No direct care issues were identified as a root cause and would have caused the outcome | Duty of care notified to NOK |
| | Incidental learning has been actioned and monitored by Women's and Children's Clinical Business Unit. | SI to be shared with Cheshire and Mersey LMNS on 26th July 2022 |

| SBAR | Summarised findings of the SI | WHH Compliance with SI process |
|---|---|---|
| **Situation** | Maternity Unit was diverted on 14th March for 10 hours and 25 minutes | Maternity Divert is a StEIS reportable incident. This incident was diverted in line with StEIS reporting timeline. |
| **Background** | Reduced staffing levels due to COVID impacted on the ability of the unit to remain safe if further women attended the unit. Acuity at time of Divert was minus 2.75 whole time equivalent midwives.<br><br>4 women were diverted to other units within the region.<br><br>Level of risk reported as negligible/no harm | Cheshire and Mersey Escalation and Divert Policy activated at 21:25hours on 14th March 2022. |
| | | |

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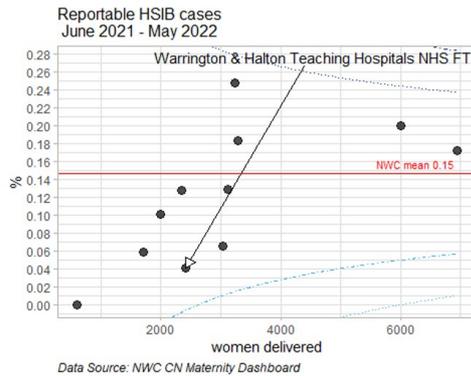| | | |
|---|---|---|
| **Actions** | Rapid incident review undertaken as per WHH governance pathway within 72 hours of incident.<br><br>Appropriate measures undertaken to mobilise midwives to where clinical activity was highest. Midwives remained on duty to support activity.<br><br>Midwives on call came in to support activity.<br><br>Cheshire and Mersey Escalation and Divert Policy followed by appropriate escalation to Executive on call and liaison with accepting neighbouring trusts.<br><br>Executive and North West Ambulance service updated 4 hourly and continued divert status approved due to continuing acuity and women presenting in labour unannounced and requiring 1:1 care.<br><br>Divert de-escalated at 08:00am on 15th March 2022 | Compliant with WHH governance process. No duty of candour reported. |
| **Recommendations** | Root cause of divert related to reduced staffing, acuity and bed capacity. | 4 women diverted to other units were sent a written apology for any distress caused during the divert as per divert policy. |
| | Incidental learning shared with team to strengthen communication during divert process. | |

**3.4 Health Care Safety Investigation Branch (HSIB)**

HSIB undertake independent investigations into incidents within maternity services which fall under defined criteria that include maternal deaths, stillbirths and babies that require cooling**.**

No completed cases returned to WHH for Q1.

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**Reportable HSIB Cases**

Reportable HSIB cases
June 2021 - May 2022

Warrington & Halton Teaching Hospitals NHS FT

NWC mean 0.15

women delivered

Data Source: NWC CN Maternity Dashboard

<table>
<tr><td colspan="2" align="center"><strong>HSIB Maternity Investigations Update</strong><br><strong>Warrington and Halton Hospitals NHS Foundation Trust</strong><br><strong>Team: North West</strong><br><strong>Team Leader: Samantha Ladd</strong><br><strong>Link MI: Karen Armsden</strong><br><strong>Week ending: 24 June 2022</strong></td><td>HSIB</td></tr>
</table>

**Executive Summary**

| Cases to date | |
|---|---|
| Total referrals | 18 |
| Referrals / cases rejected | 5 |
| Total investigations to date | 13 |
| Total investigations completed | 12 |
| Current active cases | 1 |
| Exception reporting | None |

## 3.5 Care Quality Commission CQC Review

Ockenden Part 2 action plan was submitted to CQC at their request following 30th June submission to LMNS. This action plan was shared with the Trust Executives prior to sharing.

## 3.6 Safety Champion Report

Maternity and Neonatal Safety Champions met on 12th April 2022 where an open forum was facilitated with the Non- Executive Director, Midwifery, Obstetric and Neonatal Safety Champions. The Advanced Midwifery Practitioner, Deputy Head of Midwifery and Community Midwives attended this meeting. The team discussed the progress of:

- Maternity Triage and Birmingham System Specific Obstetric Triage System (BSOTS).
- Implementation of BadgerNet and 98% of staff trained to use the system.
- Staffing levels and daily review process to identify and fill gaps.

The quarterly Maternity and Neonatal Safety Champions report was shared which informs the team of current hot topics, shared learning through incidents and updates.

Nil concerns escalated. A new Non-Executive Director has taken the role of Maternity and Neonatal Safety Champion. New meeting dates have been scheduled.

## 4. Workforce: Maternity and Neonatal Staffing

Birth Rate Plus (a nationally recognised Acuity / Staffing tool used to assess safe staffing levels in maternity services) have recently undertaken a review of midwifery staffing within the maternity service at the Trust

Current Birth Rate Plus ratio is 1 midwife :24 births. July midwifery workforce review reported the midwifery vacancy rate as 15.3 % equating to 21.17 Whole Time Equivalent (WTE) to which 19.12 WTE have been appointed to and expected to commence their post in September/October time upon qualification. WHH has also requested to appoint 2 international midwives as part of the national international recruitment programme.

Neonatal staffing is monitored by the regional Neonatal Operational Delivery Network (NODN) and

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the establishment currently aligns with the acuity, capacity, and demand of the service. A Neonatal staffing review is being undertaken and will be presented to QAC and Trust Board in November 2022.

## 5. Midwifery Continuity of Carer (MCoC)

Following on from Better Births in 2016 the Maternity Transformation Programme has supported the roll-out of a revised model of midwifery care – Continuity of Carer. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy, including the delivery and following, cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences with the woman less likely to experience postnatal illness.

WHH continues to have 7 CoC teams across Warrington and Halton. All women booked to birth at WHH will be cared for on a CoC pathway**.** This equates to approximately 85% of women. The remaining women cared for by WHH midwives provide ante natal and post-natal care to women booked to birth in another hospital or intrapartum care to women who live out of area.

CoC data is reported to QAC at 6 monthly intervals and is next due to be reported in November 2022. The previous Lorenzo system did not facilitate the requirement to extract CoC data.

## 7. Learning from maternity claims complaints and incidents

Safety Action 9 of year 4 MIS requires maternity, neonatal and Trust Board Safety Champions to review the Trusts Claims Scorecard as reported by NHS Resolution alongside incident and complaint data with the aim of targeting interventions to improve patient safety.

Maternity claims scorecard is released annually. Nil to report at this quarter.
Summary of complaints received in Maternity during Q1:

- 4 maternity complaints received in Q1
- All complaints responded to in line with WHH Governance process.
- No complaints have been breeched

| First received | Description | Grading of Risk | Current Stage |
|---|---|---|---|
| 28/06/2022 | Delay diagnosis of tongue tie | High | Under investigated |
| 06/06/2022 | Maternity Care and information given re diagnosis of birth defect | Moderate | Closed |
| 03/05/2022 | Midwifery care | High | SI Closed |
| 21/04/2022 | Delay in diagnosis of pre term birth | High | Head of complaints |

## 8. Summary

MIS Year 4 and Ockenden recommendations require the Trust Board to be informed of and has

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oversight of maternity updates. This paper aims to provide QAC oversite of the maternity safety agenda for discussion prior to sharing with the Trust Board. The content of this report has been embedded into the Cheshire and Mersey LMNS Board reporting template. In summary WHH is:

- 95% compliant with Ockenden Part 1 and on trajectory to be fully embedded by 30th September 2022.
- 86.89% compliant with Ockenden Part 1 phase 2 and on trajectory to be fully compliant by 30th September 2022.
- WHH is 32 .04% compliant with Ockenden Part 2.
- All 10 Safety Actions recommended by MIS Year 4 Guidance is on track to be completed by 30th November 2022 prior to national submission date of 5th January 2022.
- WHH stillbirth rate for Q1 2022/23 was 5.23 per 1000 births. WHH annual Mean stillbirth rate is 3.06 per 1000 births which is below the MBRRACE-UK national rate 3.51 per 1000 births.
- WHH Neonatal mortality rate Q1 2022/2023 was 1.74 per 1000 live births. MBRRACE-UK national rate 1.64/1000 live births.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards met.
- Current ATAIN rate is 4.5%. National target 5% NWODN target 5.6%.
- 10 babies received transitional care in Q1.
- Birth Rate Plus ratio is 1:24. Midwifery vacancy of 15.3% equating to 21.17 WTE of which 19.12 WTE appointed to and will commence in September/October.
- All maternity and obstetric mandatory training is on track to be completed by 30th November 2022.
- The Maternity Team was the Northwest regional winner for the Nursing and Midwifery Parliamentary Award for roll out of Continuity of Carer teams.
- '15 Steps Patient Experience event' with service users and stakeholders undertaken; positive feedback received while awaiting report.
- 250 incidents reported in Q1. 245 noted as negligible /no harm and 5 moderate harms
- 4 Serious Incidents reported.
- 2 Serious Incidents were completed in relation to a maternal death which identified no concerns in which care impacted on the outcome. The second SI related to a maternity divert where all care was noted as appropriate. Root cause noted as reduced staffing levels and increased acuity.
- WHH identified as having higher than average 3rd and 4th degree tears on the Northwest dashboard. WHH data is under the national rate of 3 in 100. WHH is undertaking an audit to analyse the data further.
- WHH identified as having higher than average number of babies under 3rd Centile on the Northwest dashboard. It is important to note the detection rate of small babies in which WHH is higher than average.
- No completed HSIB cases were reported in Q1.
- Jayne Downy commenced as the new Non-Executive Director Maternity Safety Champions
- WHH has 7 COC teams across Warrington and Halton. Previously Lorenzo did not capture this data. An update including data analysis will be provided in November 2022.

## 3. MONITORING/REPORTING ROUTES

The content and action plans narrated in this paper are monitored locally within the Women's and Children's Clinical Business Unit monthly and Quality Assurance Committee monthly and Trust Board Bi monthly.

## 4.    RECOMMENDATIONS

The Trust Board is requested to note the findings of this paper for information as per MIS Year 4 and Ockenden recommendations.

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**REPORT TO TRUST BOARD**

| AGENDA REFERENCE: | BM/22/09/118 | |
|---|---|---|
| SUBJECT: | **Quarter 1 Perinatal Mortality Review Report** | |
| DATE OF MEETING: | 28th September 2022 | |
| AUTHOR(S): | Catherine Owens, Director of Midwifery/Associate Chief Nurse | |
| EXECUTIVE DIRECTOR SPONSOR: | Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive | |
| LINK TO STRATEGIC OBJECTIVE:<br><br>*(Please select as appropriate)* | SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. | x |
| | SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future | |
| | SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. | |
| LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):<br><br>*(Please DELETE as appropriate)* | **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken.<br>**#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain.<br>**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g., cyber defences), new technology skillsets (e.g., Cloud), unfit solutions (e.g., Maternity), end-of-life solutions (e.g., Telephony), poor performance (e.g., Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g., Civil Contingency measures) and subsequent reputational damage.<br>**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.<br>**#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 | |
| EXECUTIVE SUMMARY<br>*(KEY ISSUES):* | The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025.<br><br>The Perinatal Review Tool (PMRT) has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland, and Wales.<br><br>NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 4) in September 2021 to ensure that Trust Boards receive quarterly perinatal mortality review reports.<br><br>The information in this report has been presented previously to the Quality Assurance Board and its contents discussed..<br><br>This report has been completed using the Cheshire and Mersey PMRT template which was introduced in January 2022. This details information relating to Q1 and reporting of PMRT for the period . 01/04/2022 – 30/06/2022. | |

1

During Q1 WHH reported four babies to Mothers and Babies Reducing Risk through confidential enquires across the UK (MBRRACE-UK):

**Three Stillbirths:**

- One baby born at 25 weeks gestation
- One baby born at 26 weeks gestation
- One baby born at 27 weeks gestation

**One Neonatal Death:**

- One live baby born a 36-week gestation following an emergency caesarean section for placental abruption.

WHH stillbirth rate for Q1 2022/23 was 5.23 per 1000 births. WHH annual Mean stillbirth rate is 3.06 per 1000 births which is below the MBRRACE-UK national rate 3.51 per 1000 births.

WHH Neonatal mortality rate Q1 2022/2023 was 1.74 per 1000 live births. MBRRACE-UK national rate 1.64/1000 live births.

PMRT reviews are all graded as either A B C or D as per outcome incurred.

One PMRT stillbirth panel met in Q1 where the care provided to the mother up to the point the baby had died was graded as B (care issues which would have made no difference to the outcome for the baby), and care provided to the mother following confirmation of the death of the baby graded as A (no issues with care identified from birth up to the point the baby died).

No care was identified as C (may have changed the outcome) or D (likely to have changed the outcome) for stillbirths occurring in Q1.

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

The PMRT action plan is monitored at the Women's and Children's Governance Committee.

There are two remaining actions which are on track to be completed by 30th September 2022.

| PURPOSE: *(please select as appropriate)* | Information x | Approval | To note x | Decision |
|---|---|---|---|---|
| RECOMMENDATION: | The Trust Board is asked to note this report for information as recommended by MIS Year 4 recommendations. | | | |
| PREVIOUSLY CONSIDERED BY: | **Committee** | Quality Assurance Committee | | |
| | **Agenda Ref.** | | | |
| | **Date of meeting** | 6th September 2022 | | |
| | **Summary of Outcome** | Noted for information | | |
| FREEDOM OF INFORMATION STATUS (FOIA): | Release Document in Full | | | |
| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None | | | |

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**REPORT TO BOARD OF DIRECTORS**

| SUBJECT | Quarter 1 Perinatal Mortality Review Report | AGENDA REF: | BM/22/09/118 |
|---------|---------------------------------------------|-------------|--------------|

## 1. BACKGROUND/CONTEXT

The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025.

The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) -UK confidential enquiries, reported that 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 4 standards and recommended each maternity service audits all babies born still born and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

Cheshire and Mersey Local Maternity System have introduced a standardised Quarterly Perinatal Board Report Template in January 2022. This quarterly report includes details of all WHH babies/deaths reviewed and action plan implemented.

This report presents WHH Quarter 1 PMRT audit data for 2022/2023 using the new Cheshire and Mersey PMRT reporting template and highlights good practice and lessons learned during the mortality reviews. Q1 covers the reporting period from 01/04/2022 to 30/06/2022.

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

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The Perinatal Review Tool has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland, and Wales.

This paper has extracted the key findings of the report for information and noting.

During Q1 reporting period 4 babies were reported to MBRRACE UK.

**Three Babies were Stillborn:**

One baby born at 25 weeks gestation, one baby born at 26 weeks gestation and one baby born at 27 weeks gestation. The deaths were notified to MBRRACE, and surveillance completed within the specified timescale. One PMRT stillbirth panel meeting has taken place and two are scheduled for September.

**One Baby was Reported as a Neonatal Death:**

One live baby born at 36 weeks gestation was an early neonatal death following and emergency caesarean section for a suspected placental abruption. The baby's death has been notified to MBRRACE-UK. A PMRT review of care is scheduled for September. The infant's death has also been notified to the Child Death Overview Panel (CDOP) and the coroner; no further action was required from the coroner.

Warrington and Halton Teaching Hospital (WHH) have been notified of a neonatal death in a tertiary unit where antenatal care was provided by WHH maternity services. WHH will participate in the PMRT review; this is being arranged by the tertiary provider.

One Compassionate induction for fetal abnormality at 22 weeks gestation was reported to MBRRACE-UK for information only. MBRRACE-UK advise the use of the perinatal mortality review tool is not supported in these cases.

**Key Findings**

**Synopsis of Findings**

One baby was born stillborn at 25 weeks gestation. The mother had duplex kidneys and mental health issues. Sadly, this was the second stillbirth for this woman. The cause of death identified at post mortem there was severe maternal vascular MA perfusion of the placenta, these findings were compared to the previous stillbirth post mortem report and found to be similar. Rapid Incident Review undertaken. No issues with care identified. The PMRT panel meeting has taken place and the report is in progress.

One baby was born stillborn at 26 weeks gestation The mother had several risk factors including cardiac disease, type 2 diabetes and polycystic ovary syndrome, increased risk associated with maternal age over 40 years and a raised BMI. The baby was diagnosed with a cardiac abnormality in the antenatal period. WHH is awaiting the post mortem report for further information. The PMRT panel is scheduled for 2nd September 2022.

One baby was stillborn at 27+6 weeks gestation. The mother attended maternity triage with a history of no fetal movements for a few days. The mother had no obstetric risk factors identified and the

cause of the antenatal stillbirth is unexplained. WHH is awaiting the post mortem result for further information. The PMRT panel is scheduled for 2nd September 2022.

One baby was live born at 36 weeks gestation following antenatal haemorrhage due to placental abruption. The baby was resuscitated and transferred to the neonatal unit but sadly died 4 hours and 8 minutes following birth. The mother had several obstetric risk factors identified including grand multiparity (had birthed more than 5 babies) and smoked cigarettes. Antenatal Carbon Monoxide (CO) reading was 11 parts per million (PPM) (normal reading is below 4 PPM). The infant's death has been routinely notified to the Coroner, Cheshire CDOP and MBRRACE-UK. The date for PMRT review is 2nd September 2022.

**Surveillance Findings:**

- All 3 stillborn babies were of a singleton pregnancy and occurred within the antenatal period

- 1 woman was aged between 20-24
  1 woman was aged between 30-34
  1 woman was aged between 35-39
  1 woman was aged over 40

- All 4 women were identified as white ethnicity.

- 2 women had a healthy BMI between 18.5 - 24.9
  1 woman had a BMI between 25 -29.9
  1 woman had a BMI between 30-34.9. A BMI over 30 is associated with increased risk of complications in pregnancy.

- 2 women were non-smokers and had a carbon monoxide (CO) level below 3 parts per million (PPM)

- 1 woman with a CO reading above 4 PPM had given up smoking in pregnancy.

- 1 woman reported smoking in pregnancy and had a CO reading of 11 PPM (normal reading <4PPM). Compliance with pathways of care in relation to smoking cessation will be considered as part of the PMRT review of this case scheduled for 2nd September 2022 and will be reported at a future Quality Assurance Committee.

**2.2 Q1. WHH Stillbirth Rate:**

- WHH Q1 stillbirth rate for 2022/2023 is 5.23 per 1000 births.

- WHH mean stillbirth rate is 3.06/1000 births which us below the MBRRACE-UK national stillbirth rate which is 3.51/1000 births

- WHH had nil intrapartum stillbirths

- WHH had nil term stillbirths (babies born from 37 weeks gestation)

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

| Metric | Q2 21/22 | Q3 21/22 | Q4 21/22 | Q1 22/23 | 12-month total |
|---|---|---|---|---|---|
| Number of live births | 706 | 687 | 644 | 573 | 2610 |
| Total number of stillbirths >24 weeks | 1 | 3 | 1 | 3 | 8 |
| **Total Stillbirth Rate >24 weeks** | **1.41** | **4.35** | **1.55** | **5.23** | **3.06** |
| **Number of intrapartum still birth rate** | **0** | **0** | **0** | **0** | **0** |
| **Number of stillbirths >37 weeks** | **0** | **1** | **0** | **0** | **0.38** |

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH current annual stillbirth rate between the time from the 1st of July 2021 to 30th June 2022 is 3.06 per 1000 births.

### 2.3 Q1. WHH Neonatal Mortality Rate:

WHH Neonatal mortality rate during Q1 2022/2023 was 1.74 per 1000 live births.

MBRRACE-UK national rate of 1.64/1000 live births.

There was one neonatal death reported in Q1 2022/2023 of a baby at 36 weeks gestation.

A Rapid Incident Review was undertaken following this neonatal death, all care was identified as appropriate. The PMRT panel will meet on 2nd September to review the case.

### 2.4 PMRT Grading of Care

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

The PMRT review concludes with each panel member reporting if, in their professional opinion, the care given up to the point where the baby was confirmed as having died and or care provided following the birth of the baby could have made a difference. One PMRT Stillbirth panel met during quarter one. No care issues were identified which may have or were likely to make a difference to the outcome for the baby.

**Table 2 Q1 PMRT Grading of Stillbirth:**

| PMRT grading | Care provided to the mother up to the point that the baby was confirmed as having died | Care provided to the mother following confirmation of the death of her baby |
|---|---|---|
| **PMRT grade A** No issues with care identified up to the point that the baby was confirmed as having died | | 1 |
| **PMRT grade B** Care issues which would have made no difference to the outcome for the baby | 1 | |
| **PMRT grade C** Care issues which may have made a difference to the outcome for the baby | - | - |
| **PMRT grade D** Care issues which were likely to have made a difference to the outcome for the baby | - | - |
| **Not Graded** | - | - |
| **Total cases** | 1 case | 1 case |

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**Q1 WHH Grading of Care Following Neonatal Death**

There was one PMRT review panel meeting in quarter 1 for a neonatal death which took place in Quarter 4. 2021/2022 audit. This case is a coroner's case therefore the cause of death is awaited.

**Table 3 Q1 PMRT Grading of Neonatal Death:**

| PMRT grading | Care provided to the mother up to the point that the baby was confirmed as having died | Care provided to the mother following confirmation of the death of her baby |
|---|---|---|
| **PMRT grade A** No issues with care identified up to the point that the baby was confirmed as having died | | |
| **PMRT grade B** Care issues which would have made no difference to the outcome for the baby | 1 | 1 |
| **PMRT grade C** Care issues which may have made a difference to the outcome for the baby | - | - |
| **PMRT grade D** Care issues which were likely to have made a difference to the outcome for the baby | - | - |
| **Not Graded** | - | - |
| **Total cases** | 1 case | 1 case |

No care issues were identified which may have or were likely to make a difference to the outcome for the baby. Parental perspective of the care they received were sought in all cases.

**2.5 Q1. WHH PMRT Panel Attendance**

There have been 2 PMRT panel meetings in Q1 which were attended by multidisciplinary internal and external panel members.

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**Table 4 Q1 WHH PMRT Panel Attendance**

| Number of participants involved in reviews of late fetal losses and stillbirths without resuscitation<br><br>Total number of reviews from 01/04/22 -30/06/2022 = 2 | | |
|---|---|---|
| Role | Total Review Sessions | Reviews with a least one |
| Chair | 2/2 | 2/2 |
| Vice Chair | | |
| Admin/Clerical | | |
| Bereavement Midwife | 2/2 | 2/2 |
| External Rep | 2/2 | 2/2 |
| Management Team | | 1/2 |
| Midwife | 2/2 | 2/2 |
| Neonatal Nurse | | |
| Neonatologist/Paediatrician | 1/2 | 1/2 |
| Obstetrician | 2/2 | 2/2 |
| Other | 2/2 | 2/2 |
| Governance Manager | 2/2 | 2/2 |
| Safety Champion | | |

## 2.6 Maternity Incentive Scheme Year 4 Compliance

**Table 5 PMRT MIS Safety Action 1 Compliance**

| Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? | | |
|---|---|---|
| **Standard Required** | | **Compliant Y/N** |
| a) i | All perinatal deaths eligible to be notified to MBRRACEUK from 1 September 2021 onwards must be and the **surveillance information** where required must be **completed within one month of the death**. | Yes |
| a) ii | A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 **will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust** | Yes |
| b) | At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from **8 August 2021** will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool **within four months of each death and the report published within six months of each death.** | Yes |

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| | | |
|---|---|---|
| c) | For at least 95% of all deaths of babies who died in your Trust from **8 August 2021,** the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. **This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust.** If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. | Yes |
| d) | Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. **The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.** | Yes |

**2.7 Learning and Good Practice**

- The cases have all been notified and surveillance completed within the required timescale
- Bereavement care was graded A at the one PMRT panel meeting, which included feedback from the mother
- One PMRT panel graded antenatal care B, the mother fed back that she felt very well supported with her mental health during and after the pregnancy by the multi-disciplinary team
- Parental involvement was sought in all cases as part of PMRT panel review.

**Datix Action Plan Summary**

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

Two PMRT actions are in progress and on track to be completed by 30th September 2022:

**Table 6 PMRT Action Plan**

| ID | Action | Lead | Start date | Due Date | RAG rating |
|---|---|---|---|---|---|
| 14559 | Review access to bereavement information to women who access care at WHH and who live out of area | Community Manager | 28/07/2022 | 30/09/2022 | |
| 14558 | CO monitoring of smoking status at booking to ensure all women are referred to smoking cessation service | Community Manger | 28/07/2022 | 30/09/2022 | |

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MIAA undertook an external audit of PMRT on the 13th and 14th of June 2022 and were assured by the processes and governance of the PMRT process and pathways at WHH. This has been previously reported in Maternity Update papers presented to QAC.

**2.8 Summary**

➢ WHH Q1 PMRT audit report has been undertaken using the new Cheshire and Mersey PMRT template and recorded four babies to MBRRACE that were born stillborn between 01/042022 and 30/06/2022.

Four babies reported to MBRRACE UK:

- Three Stillbirths at 25 26 and 27-weeks' gestation
- One Neonatal death at 36 weeks following an emergency caesarean section for placental abruption

➢ WHH stillbirth rate for Q1 2022/23 was 5.23 per 1000 births. WHH annual Mean stillbirth rate is 3.06 per 1000 births which is below the MBRRACE-UK national rate 3.51 per 1000 births.

➢ WHH Neonatal mortality rate Q1 2022/2023 was 1.74 per 1000 live births. MBRRACE-UK national rate 1.64/1000 live births.

➢ Two PMRT review panels were held in Q1 and attended by full MDT internal and external membership. PMRT reviews are all graded as either A B C or D as per outcome incurred.

➢ One PMRT stillbirth panel met in Q1 where the care provided to the mother up to the point the baby had died was graded as B and care provided to the mother following confirmation of the death of the baby graded as A.

➢ No care was identified as C (may have changed the outcome) or D (likely to have changed the outcome) for stillbirths occurring in Q1.

➢ One PMRT neonatal panel met in Q1 in relation to a baby reported in Q4. PMRT grading was noted as B and B. No care was identified as C (may have changed the outcome) or D (likely to have changed the outcome) for stillbirths occurring in Q1.

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

➢ PMRT Action Plan is monitored at Women's and Children's Governance Committee and current two actions on track to be completed by 30th September 2022.

## 3. MONITORING/REPORTING ROUTES

The PMRT reports and action plans are monitored at QAC and Women's and Children's Clinical Business Unit.

## 4. RECOMMENDATIONS

The Trust Board is asked to note the findings of this paper as per MIS year 4 recommendations.

**REPORT TO BOARD OF DIRECTORS**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/22/09/119** |
| **SUBJECT:** | **WHH Annual Seasonal Infleunza Vaccine Plan 2022-23** |
| **DATE OF MEETING:** | 28th September 2022 |
| **AUTHOR(S):** | Rebecca Patel, Associate Chief People Officer<br>Caroline Eardley, Head of Occupational Health and Wellbeing |
| **EXECUTIVE DIRECTOR SPONSOR:** | Michelle Cloney, Chief People Officer |
| **LINK TO STRATEGIC OBJECTIVE:**<br>(*Please select as appropriate*) | SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. .    x |
| **LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):**<br><br>(*Please DELETE as appropriate*) | **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain<br>**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. |
| **EXECUTIVE SUMMARY**<br>(*KEY ISSUES*): | This paper provides an overview of the planning, implementation and delivery of the influenza vaccination programme for the workforce at the Trust for 2022-23. The paper covers an overview of the implementation of a Task and Finish group, gives a clear indication of the reporting and governance routes, identifies risks and mitigations, and also identifies the communications and engagement approach that will be deployed for the campaign.<br><br>In addition, the paper provides a baseline self-assessment against the national best practice management of influenza vaccination guidelines. |
| **PURPOSE:** (*please select as appropriate*) | Information    Approval    To note  X  Decision |
| **RECOMMENDATION:** | The Trust Board is asked to note the contents of the report and assurance regarding the programme of delivery for the flu vaccine in 2022/23. |
| **PREVIOUSLY CONSIDERED BY:** | **Committee**    Strategic People Committee |
| | **Agenda Ref.**    **SPC/22/09/95** |
| | **Date of meeting**    21st September 2022 |
| | **Summary of Outcome**    Noted |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:**<br>(*if relevant*) | None |

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**REPORT TO BOARD OF DIRECTORS**

| SUBJECT | WHH Annual Seasonal Influenza Vaccine Plan 2022-23 | AGENDA REF: | BM/22/09/119 |
|---------|---------------------------------------------------|-------------|--------------|

## 1. BACKGROUND/CONTEXT

The organisation's Occupational Health and Wellbeing service leads on the delivery of the annual seasonal Influenza vaccination campaign on behalf of the workforce. In 2021-22, the vaccine was offered to 100% of staff and was administered to 71.6% of patient-facing staff. This year, the campaign will be implemented independently from the COVID-19 vaccination programme however, messaging will be aligned utilising the Winter Well Public Health messaging to support vaccination messaging in the Autumn and Winter period. The programme will be delivered simultaneously by the Occupational Health and Wellbeing clinical team, and Peer Vaccinators working in clinical areas.

Unlike the 2021-22 campaign, the vaccines will be delivered to the organisation in **one** delivery with the anticipated date for the programme to start from the 26th September 2022. This year there is the added potential for co-circulation of influenza, COVID-19 and other respiratory viruses which could add substantially to the pressures of the organisation.

All organisations have an identified CQUIN target for the administration of the Influenza vaccination to patient-facing staff which is set at an ambitious 70-90% for 2022-23. The timeframe of the campaign allocated to vaccinate is anticipated to be from 26th September 2022 until 28th February 2023. The ambition for the organisation is to deliver the majority of the campaign prior to the end of the calendar year.

The organisation are also required to send monthly reporting externally to the UK Health Security Agency via ImmForm and CQUIN. Data will be made publicly available approximately six weeks after each quarter in order to provide benchmarking information. In addition to external reporting, internal reporting will be delivered by the Chief People Officer through Executive meetings on a weekly basis.

## 2. KEY ELEMENTS

### 2.1 Task and Finish Group

In order to support the vaccination campaign, a collaborative internal stakeholders Task and Finish group has been established to provide oversight on the planning and implementation of the programme.

The team have also undertaken a baseline assessment against the Flu Programme Best Practice Management Checklist [1] which is available in **Appendix one** and formed the basis for the organisational approach for 2022-23.
Regular meetings have been diarised and will continue to be utilised throughout the campaign to highlight any concerns in a timely way and to enable any recommendations of change to be taken at pace. Membership of the group is multidisciplinary and illustrated in **Appendix two**.

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[1]     www.gov.uk/government/publications/national-flu-immunisation-programme-plan/appendix-h-healthcare-worker-flu-vaccination-best-practice-management-checklist

The Task and Finish Group have also contributed to the action plan taking into consideration any national campaigns such as the Winter Well campaign and ensuring that key messages are accessible and shared across the organisation.

## 2.2 Governance and Reporting (include 2.9 and 2.7)

There is a national requirement to report on participation rates for the programme, which will be reported externally via ImmForm and CQUIN utilising the NiVs system to UKSHA.

From an internal reporting perspective, data will be input into ESR and will be reported through executive governance routes via the Chief People Officer, including Executive meetings and via Operational or Strategic People Committee as appropriate.

## 2.3 Vaccination Eligibility and Delivery Timescales

Eligibility for the Influenza vaccine will follow national guidance which is initially prioritised for frontline Health Care Workers and non-clinical staff who have contact with patients. This definition will be taken from the Green Book Chapter 12 and there may be some local internal variation from this in order to capture individuals who may be working in patient areas or tending to equipment in patient-facing areas. The plan for 2022-23 is to comply with the national planning paper[2] which was circulated by the Government in July 2022 and focuses on targeting patient-facing staff with a 100% offer to all staff.

The timescales for the 2022-23 campaign are aligned to the delivery of the vaccines and it is anticipated that the scheduled delivery dates are week commencing 26th September 2022.

## 2.4 Clinic Location(s)

Learning from previous campaigns, the utilisation of Peer Vaccinators is critical to success in clinical areas and can provide an out of hours option as well for individuals on night shift and weekend working.

The Occupational Health and Wellbeing team will be visible across both sites on the corridors and in areas that do not have a nominated peer vaccinator. Sites include:
- Main hospital reception area – Warrington
- Occupational Health department – Warrington
- George Lloyd Restaurant – Halton
- Education Centre – Halton

The location of the roaming and static clinics will be communicated via informal and formal communication channels across the organisation, throughout the campaign (September 2022 to February 2023).

## 2.6 Identification of Vaccinators (Including Training)

The recruitment drive for Peer Vaccinators commenced in June 2022 and the organisation has 25 Peer Vaccinators with another 5 being sourced to support the campaign. The Peer Vaccinators will be using a Patient Group Direction and will be registered staff who are legally entitled to operate under this.

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[2] www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2022-to-2023-letter

Before administrating the vaccine, the individuals will have undertaken the required training and will have been authorised to vaccinate staff. Practitioners must be aware of any changes to best practice recommendations or changes to the recommendations for the preparation lists, including advice and guidance from the UK Health Security Agency and adverse drug reaction (ADR) bulletins which will be checked and delivered by the Occupational Health and Wellbeing team prior to any vaccination taking place.

### 2.7 Communications and Engagement approach

Both informal and formal communication mechanisms and channels will be fully utilised to deploy the campaign as articulated in **Table one** and a robust communications plan linked to Winter Well messaging is currently being finalised in partnership with the Communications team. The communications approach will include a weekly update across the Trust of success stories, venues, availability, priority group, appointment information and participation rates.

**Table One:** Communication Channels

| Formal Communication Channels | Informal Communication Channels |
|---|---|
| <ul><li>Trust-wide communication</li><li>Safety Brief</li><li>Team Brief</li><li>Extranet pages / announcements</li><li>The Week</li></ul> | <ul><li>People Champions Networks</li><li>Staff Networks</li><li>People Directorate Roadshow (physical and virtual events)</li><li>Staff Engagement noticeboards</li><li>WHH People Twitter and Facebook channels</li><li>Staff side colleagues</li></ul> |

From an engagement perspective, existing stakeholder relationships will be maximised including the engagement of People Champions and Staff Network members to support key messaging across the organisation aligned to the Winter Well campaign.

### 2.8 Overview of Risks

For the 2022-23 campaign, it is recognised that there may be vaccine hesitancy due to the fatigue of the pandemic and any associated vaccination programme. In addition, with a return to normal and lack of social distancing measures for the first time in over 2 years, there is likely to be a possibility of increased co-circulation of Influenza, COVID-19 and other respiratory illnesses which may have an impact on service capacity and service delivery across the organisation.

Some of the key risks and mitigations to the programme are outlined in **Table two**.

**Table Two:** Influenza Campaign Risks and Mitigations

| Risk | Mitigation |
|---|---|

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| | |
|---|---|
| 1. Staff may refuse the vaccination due to personal behaviours and belief in over-vaccination, which has an impact on achievement of the CQUIN target which has financial incentive attached . | Communications campaign will include Public Health messaging focusing on behaviour change. The utilisation of internal advocates will also be deployed to support decision making. |
| 2. Internal reporting via ESR is reliant upon staff capacity which may be impacted by sickness absence rates. | Administrative functions in the People Directorate to be able to cross-cover and scale up to support inputting as required to support the Occupational Health and Wellbeing team. |
| 3. Delayed delivery of the vaccine from the supplier or a shortage will delay the administration of the vaccine and therefore shorten the delivery timescales, impacting on the ability to administer the CQUIN. | Delivery plan developed to mitigate against delays, which includes the provision of increased activity within the first 2 weeks of the campaign. |

**2.9 Next Steps**

The Occupational Health and Wellbeing Team will continue to implement the 2022-23 Influenza campaign on behalf of the organisation utilising the learning from previous campaigns and bespoke communications and engagement approaches as appropriate across the organisation.

## 3.   RECOMMENDATIONS

Trust Board are asked to note the contents of the report and assurance regarding the programme of delivery for the flu vaccine in 2022/23.

## 4.   APPENDIX ONE: Baseline Assessment – Best Practice Management Checklist

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| 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 |

| | | Overview | Evidence | Trust Self-Assessment | Timescales |
|---|---|---|---|---|---|
| **Committed Leadership** | | A1: Board record commitment to achieving the ambition of vaccination all frontline healthcare workers (both clinical and non-clinical staff who have contact with patients) | The WHH Board does support the campaign year on year. Acknowledgement of national documentation to encourage all frontline patient-facing staff to be vaccinated embedded into communications plans as required.<br>As representatives of the Board, the Executive team will receive regular assurance reports on vaccine updates throughout the programme. | | June 2022 |
| | | A2: Trust has ordered and provided a quadrivalent (QiV) influenza vaccine for healthcare workers | The Trust has ordered in total 3,400 vaccines split as follows:<br>• 2430 Influenzas cell – cultural / quad inactivated egg-free QIVc (supplied by Seqirus)<br>• 970 Influenzas recombinant quad inactivated egg-free QIVr 65+ (Sanofi)<br><br>This is based on a headcount of 4387 split as follows (which may fluctuate as this was at a point in time):<br><br>In the 2021-22 Influenza campaign, the organisation ordered 2750 vaccines. The 3,400 ordered for the first phase of this year enables the organisation to deliver the following, with an option for further delivery dates throughout the campaign: | Awaiting delivery of vaccines. There have been no communications to indicate that these will be delayed. | Q1 2022/23 |

Table embedded in A2 evidence:

| Category | No. |
|---|---|
| Patient-Facing | 2828 |
| Non-patient Facing | 1559 |

| Category | % | Total |
|---|---|---|
| | 100% | 2828 |

6

| | | | | | |
|---|---|---|---|---|---|
| **Patient-facing** | 90% | 2545 | | | |
| | 70% | 1979 | | | |
| **Non patient-facing** | 100% | 1559 | | | |
| | 90% | 1403 | | | |
| | 70% | 1091 | | | |
| **Combined** | 100% | 4587 | | | |
| | 90% | 4128 | | | |
| | 80% | 3669 | | | |
| | 70% | 3210 | | | |

What this means is that the organisation is able to deliver at least 70% across both patient facing and non-patient facing staff groups in the first phase of the campaign.

The quantity ordered also enables a partial refund to the organisation as well if unused.

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**A3: Board receives an evaluation of the influenza programme 2021-22 including data, successes, challenges, and lessons learned**

Executive briefing paper provided in Q4 2021-22, and headlines are illustrated below:

<u>Data</u>
71% administration of Influenza vaccination for frontline healthcare workers across both sites.

<u>Successes</u>
Achieved "herd immunity" (70%) providing the best protection for staff, patients, and wider community.

<u>Challenges</u>
The campaign was run during an intense period of the COVID-19 pandemic and increased operational pressures. Due to these pressures, there were fewer Peer Vaccinators which had an impact on frontline healthcare professionals engaging in the campaign. In addition, Occupational Health and Wellbeing teams were also supporting the organisational response to the COVID-19 pandemic.

Due to PHE guidance at the time regarding social distancing, taking the

Q4 2021/22

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| | | | |
|---|---|---|---|
| | campaign to staff in clinical areas was complex due to COVID-19 restrictions.<br><br>Although there was an opportunity to vaccinate staff in the COVID Vaccination Hub, there was limited capacity due to the volume of activity within the Hub.<br><br><u>Lessons Learned</u><br><br>The early implementation of a centrally accessible clinic would support a successful vaccination programme. The easing of restrictions and transition to "living with COVID-19" will further support deployment and targeted effort into clinical areas and supporting Peer Vaccinators.<br><br>Peer Vaccinators are a vital resource and tool to ne improve participation rates in the campaign. | | |
| A4: Agree on Board Champion for Influenza campaign | As the Occupational Health and Wellbeing department are within the People Directorate, it is recommended that the Board Champion for the campaign is the organisation's Chief People Officer | | Q1 2022/23 |
| A5: All Board Members receive Influenza vaccination and publicise this | The Board will be offered the Influenza vaccine as soon as practically possible and publicity photographs will be offered with the consent of the individual in order to support the organisational campaign. | Due to awaiting commencement of campaign | September / October 2022/23 |
| A6: Influenza team formed with representatives from all Directorates, staff groups and trade union representatives | A Task and Finish group for both Peer Vaccinators and key stakeholders has been developed to plan, implement and deliver the Influenza vaccine. | | June 2022 |
| A7: Influenza team to meet regularly from September 2022 | The Occupational Health and Wellbeing Team will lead the Influenza vaccination programme. Both Task and Finish Groups will continue to meet during the campaign regularly to adapt approach | | June 2022 |

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| Communications Plan | | | | |
|---|---|---|---|---|
| | | and communications in response to workforce feedback and need. | 🟧 | |
| | B1: The rationale for the Influenza vaccination programme and facts to be published – sponsored by senior clinical leaders and trade unions | The Task and Finish group will discuss communication approaches and updates in partnership with the communications team and aligned to clinical guidance and information from UKSHA. | 🟧 | July 2022 |
| | B2: Drop-in clinics and mobile vaccination schedule to be published electronically on social media, and on paper | The Influenza administration in clinical areas will be supported by Peer Vaccinators with a targeted approach by the Occupational Health and Wellbeing team as required. In addition, the team will be visible across both sites offering mobile and pop-up clinics to support the campaign.<br><br>Opportunities to be vaccinated will be published via mixed media and informal and formal communication mechanisms as per the communications plan. | 🟧 | Ongoing for duration of campaign (September 2022 – March 2023) |
| | B3: Board and senior managers having their vaccinations to be publicised | Photographs capturing senior management and the Board participating in the vaccination programme will be publicised within the Trust by the communications team and with consent from the individual. | 🟪 | September / October 2022 |
| | B4: Influenza vaccination programme and access to vaccination on induction programmes | The Occupational Health and Wellbeing Team are scheduled to attend induction and capture all new starters for the duration of the campaign. | 🟪 | Ongoing for duration of campaign (September 2022 – March 2023) |
| | B5: Programme to be publicised on screensavers, posters and social media | The communications plan to support the 2022-23 campaign includes the use of desktop screensavers which have already been deployed to garner interest in the campaign and a tool to recruit Peer Vaccinators. In addition a raft of resources will be made available and deployed via formal and informal mechanisms for the duration of the campaign and updated in response to | 🟧 | Ongoing for duration of campaign (September 2022 – March 2023) |

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| | | | | |
|---|---|---|---|---|
| | | workforce need and Winter Well messaging. | 🟧 | |
| | B6: Weekly feedback on percentage uptake for Directorates, teams and professional groups | Weekly figures will be provided from the data submitted into ESR for use by the Chief People Officer to provide oversight and assurance with executive colleagues and for communications to promote participation rates. | 🟪 | Ongoing for duration of campaign (September 2022 – March 2023) |
| Flexible Accessibility | C1: Peer Vaccinator, ideally at least one in each clinical area to be identified, trained, release to vaccinate and empowered | Peer Vaccinators have been recruited onto the campaign from June 2022 and from the majority of areas. All have been trained and ready to support the 2022-23 campaign. For areas without a Peer Vaccinator the Occupational Health and Wellbeing team are encouraging volunteers with the support of the senior nursing team and will deploy resources to support those areas as necessary throughout the campaign. | 🟩 | July 2022 |
| | C2: Schedule for easy access drop-in clinics as agreed | The influenza campaign will be delivered in visible and accessible areas across both sites. This will be publicised utilising informal and formal mechanisms. | 🟧 | Ongoing for duration of campaign (September 2022 – March 2023) |
| | C3: Schedule for 24 hour mobile vaccinations to be agreed | Early morning clinics have been scheduled to enable night staff easy access to the vaccination. In addition, a Peer Vaccinator will be available to support peers on alternate shifts, including night and weekend shifts which will be advertised on a weekly basis. | 🟧 | Ongoing for duration of campaign (September 2022 – March 2023) |
| Incentives | D1: Board to agree on incentives and how to publicise this | The Occupational Health and Wellbeing team have developed a bid for the Charitable Funds Committee which is due to meet in September for a decision. | 🟧 | 31st August 2022 |
| | D2: Success to be celebrated weekly | The communications plan identifies the areas that will be celebrated as part of success stories to support participation rates. This will also include key messages on social media utilising the WHH People channels. | 🟧 | Ongoing for duration of campaign (September 2022 – March 2023) |

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**REPORT TO TRUST BOARD**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/22/09/120** | |
| **SUBJECT:** | **Bi-monthly Strategy Programme Highlight Report** | |
| **DATE OF MEETING:** | 28 September 2022 | |
| **AUTHOR(S):** | Stephen Bennett, Head of Strategy & Partnerships | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Lucy Gardner, Director of Strategy & Partnerships | |
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>*(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):**<br><br>*(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<br><br>X | Approval | To note | Decision |
|---|---|---|---|---|

| | | | |
|---|---|---|---|
| **RECOMMENDATION:** | The Trust Board is asked to note the report for information | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Choose an item. | |
| | **Agenda Ref.** | | |
| | **Date of meeting** | | |
| | **Summary of Outcome** | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Whole FOIA Exemption | | |
| **FOIA EXEMPTIONS APPLIED:** *(if relevant)* | Section 43 – prejudice to commercial interests | | |

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# Strategy Programme
# Highlight Report – June/July 2022

| Page | Project | SRO | Strategy Lead | Status |
|------|---------|-----|---------------|--------|
| | | | | |
| 5 | Living Well Hub in Warrington | LG | SB/CL | 🟩 |
| 6 | Runcorn Town Deal | LG | CM | 🟩 |
| 7 | Runcorn Shopping City | LG | CM | 🟥 |
| 8 | New Hospitals Programme | LG | KJ/RO'D | 🟩 |
| 9 | Community Diagnostic Centre | LG | SB | 🟩 |
| 10 | WHH Green Plan | IW | VR | 🟩 |
| 11 | Warrington Wider Estates Review | LG | RO'D | 🟩 |
| 12 | Halton Blocks | LG | CM/RO'D | 🟧 |
| 13 | Breast Service Reconfiguration – Phase 2 | LG | CL | 🟩 |
| 14 | C&M Pathology Network | LG | KJ/VR | 🟥 |
| 15 | Health & Care System Reconfiguration | LG | KJ/SB/CM | 🟩 |
| 16 | Health & Social Care Academy | WVRC | SB/CL | 🟩 |
| 17 | Anchor Programme Development | LG | KJ | 🟩 |
| 18 | Development of Overall Trust Strategy | LG | KJ/SB | 🟩 |

| Key code | |
|----------|--|
| 🟩 | On track |
| 🟧 | In progress but slippage that is recoverable and does not impact completion date |
| 🟥 | Not started and start date has passed, or in progress and end date has passed |

## Pipeline of Strategic Opportunities

| 19 | 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.

| Key Stakeholder Engagement in Period | Job Title, Organisation | Topic/Nature of Engagement |
|---|---|---|
| Lisa Sculpher | Strategic Estates, NHSEI | Warrington Wider Estates Review, New Hospitals Programme & staff facilities – health and wellbeing framework development |
| Cheshire & Warrington Local Enterprise Partnership | Board | New Hospitals Programme |
| Andy Carter | MP | New Hospitals Programme |
| Andrea Ashbury | Programme Director, System P | System P and potential to use data to inform service redesign and tackle health inequalities |
| Lauren Sadler | Transformation and Change Lead – Warrington Together Partnership | Warrington Wider Estates |
| Warrington System Finance Directors | Warrington Together Finance, Investment & Resources Committee | Living Well Hub and need to support investment in prevention agenda across Warrington |
| Amanda Amesbury | Director of Children's Services, WBC | Involvement of Warrington Children's Services in Living Well Hub |
| Eleanor Blackburn | Head of Inclusive Growth and Partnerships, WBC | Potential use of UK Shared Prosperity Fund to support Living Well agenda |
| Tom Butterworth | CIPHA Programme Manager | Potential to use data from CIPHA system to inform service redesign and tackle health inequalities |
| Martin Griffiths | CAPITA | Halton Blocks |
| Nicki Goodwin | Senior Programme Manager, One Halton | One Halton Programme, Shopping City Clinical Hub |
| Anthony Leo | Place Director, One Halton | Place development |
| Hannah Flemming | Regeneration Development Manager, Riverside Housing Ass. | Halton Lea Regeneration / Levelling Up Opportunity |
| Ifeoma Onyia | Director of Public Health, Halton | Health and wellbeing strategy |
| Thara Raj | Director of Public Health, Warrington | Population health |
| Samantha Yates | Director of Nursing, Bridgewater | Runcorn Town Deal Health and Education Hub |
| Andy Davies | CEO Warrington and Halton CCGs | ICS development |
| John Watkins | Investment manager Shopping City | Shopping City future plans |

| Key Stakeholder Engagement in Period | Job Title, Organisation | Topic/Nature of Engagement |
| --- | --- | --- |
| Ian Triplow | CDC Programme Director Cheshire & Merseyside | Presented business case for Fast-Track CDC to regional programme board |
| Liz Bishop | CEO Clatterbridge Cancer Centre and SRO for CDC Programme in Cheshire & Merseyside | |
| Ruth Austin-Vincent | Cheshire & Merseyside Neuro-Diversity Alliance | Living Well Hub and inclusion of services for neuro diverse people |
| Mike Watson | CEO Active Cheshire | C&M Obesity plan and involvement of Active Cheshire in Warrington Living Well programme and the Living Well Hub |
| Carl Marsh | Place Director, Warrington | Place delivery plan and governance |
| Stephen Young | CEO, Halton Borough Council | All Halton programmes |
| Wesley Rourke | Operations Director, Halton Borough Council | Regular catch up with senior HBC representatives |
| Linda Buckley | MD Provider Collaborative, Cheshire & Merseyside | Regular catch up with Provider Collaborative leadership |
| Su Foster | Strategic Estates Lead (Cheshire & Merseyside) | Feedback on proposed lease arrangements for the Living Well Hub |
| Neil Hutchinson, Mark Lloyd | Owen Ellis Architects/NHSPS | Further review latest stage 3 designs for the Living Well Hub |
| Marie-Ann Hunter | PCN Strategic Manager for Central East, East and South Warrington PCNs | Opportunities to collaborate with local PCNs and how to engage GPs in development of projects across Warrington |
| Alex Pitman | Green Project Director, Alder Hey | Discussion to share approaches to developing organisations as 'Anchor Institutions' |
| Dave Sweeney | Director of Partnerships, C&M ICS | Attended launch of Great, Green & Good Forum to talk about ICS Green Plan. |
| Hitesh Patel | CEO, Halton Citizens Advice | Runcorn Shopping City |
| David Wilson | GP, Runcorn | Halton developments |

# Living Well Hub in Warrington

Anchor Institution

Social Value | Green Agenda | Health Inequalities

## 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

- Lease negotiations have progressed sufficiently and will be progressed further on completion of stage 4 designs
- Stage 3 designs have been completed. Stage 4 designs are now in progress.
- Initial conversations have commenced with Warrington Borough Council around planning permission and vehicle access to the Hub.
- Options paper approved by WHH Board recommending that the Trust should hold the head lease on the property identified as the preferred location for the Hub.
- Further work and discussions aimed at ensuring the hub is aligned with Warrington Together system-wide programmes of work including the Living Well programme, single front door and the Clear programme.
- Presentation to Warrington Together Finance, Investment and Resources Committee around the importance of investing in the prevention agenda and projects like the 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 |
|---|---|---|---|
| Design team working up to stage 4 | Jul- 22 | | Although initially delayed by appointment of NHSPS as a partner this remains on schedule |
| Tender for build contractor | Aug 22 | | Post stage 4 completion |
| Seek planning permission | Sep-22 | | Post stage 4 completion |
| Hub operational | May-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 the Contact Centre 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

## 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

- Initial draft received for Heads of Terms of lease. Currently under internal review.

- Final business case received following feedback from all partners.

- Business case progressing through individual organisations governance. The case has been approved by the Trust, the College, Merseycare and the Council to date.

- Press release drafted with input from the Trust, Halton Borough Council and Riverside College

## 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 |
|---|---|---|---|
| Completion of local sign-off for business case from partner organisations, including Bridgewater, Mersey Care and One Halton | Aug 22 | | |
| Business case submission DLUHC | Aug-22 | | |
| Expected funding announcement | Nov 22 | | |

| Risk description | Impact | Risk score | Mitigations | Mitigated risk score |
|---|---|---|---|---|
| Failure to: secure funding Caused by: Government rejecting business case Resulting in: failure of project | Failure of project, no health and education hub | 9 | Strong governance, oversight and local engagement, sound project management and lessons learned from similar programmes | 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 |

# Runcorn Shopping City

## Project Overview

The Runcorn Shopping City 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

- Refurbishment on-going. Current completion date September 22.

- Project Group stepped up to weekly to enable increased levels of operational delivery planning ahead of planned service start in October. Remit includes detailed operational plans and assurance around CQC requirements

- Local schools produced ideas around design of graphics for the Hub.

- Shop unit hoarding now dressed, featuring advertisements for upcoming services and logos for all partners.

- Reports currently in production detailing issues with Capital cost overrun.

## Financial Implications/ Budget Update

Total Programme Budget: £844.5k, funded via:

Internal Trust Capital Programme: £494.5k
Donated income: £350k (via LCR Town Centre Commission)

Current forecast cost: £966k

Actions being taken to identify sources of additional funding and reduce costs.

| Upcoming Key Milestones | Date | Status | Comments |
|---|---|---|---|
| Construction Programme Complete | May-22 | 🟥 | Construction programme currently due to complete in September 22 |
| Service Delivery Commencement | May-22 | 🟥 | Delivery due to begin October 22 following delays to construction programme |

| Risk description | Impact | Risk score | Mitigations | Mitigated risk score |
|---|---|---|---|---|
| Failure to: complete the programme to time and / or budget Caused by: programme overruns / unforeseen issues requiring spend | Resulting in: added complexity, delayed delivery, risk to project | 15 | All variations reviewed in detail to identify any cost reductions achievable. Additional capital funding currently being sought through Trust and external partner organisations | 12 |
| Failure to: secure long term | Resulting in: reconfigured | 12 | Revenue case agreed | 12 |

# New Hospitals Programme

**NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust**

## Project Overview

Development of new WHH hospital estate and infrastructure.

Within Warrington, this is the development of a new hospital for Warrington, either on the current site or elsewhere in the town.

Within Halton this is the redevelopment of the Halton Hospital site, including extending CSTM to incorporate all existing services and additional services, whilst releasing land to support Health and Wellbeing Campus vision.

## Progress since last report

- Capital costs for the programme have been revised by Turner and Townsend and are being used to inform financial modelling.
- Building sizes for Warrington and Halton Hospitals have been reviewed and adjusted to account for the increased requirements arising from Health Building Notes. The revised m2 uplifts for both hospital sites will inform costings.
- The Trusts financial baseline has been agreed and this has enabled progress to be made on the financial model for new hospital options.
- A Logo and strapline for the programme have been agreed and comms material is in production.
- A new hospitals update was presented at the Cheshire and Warrington Local Enterprise Partnership and members have agreed to input into site selection for the new Warrington Hospital.
- New Hospitals Strategy session held with Trust Executive Team to provide oversight of changes since the original SOCs were produced and to validate planning assumptions.

## 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. | Sep-22 | 🟩 | |
| Selection of preferred site for new Warrington Hospital | Sep-22 | 🟩 | Plan in place and ready to be progressed following completion of financial model |

| 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

## 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 Trust has submitted two business cases to the regional/national programme team.  The first is to develop a Fast-Track CDC within the next 12 months based within the existing Nightingale building on the Halton site.  The second is for a full new build CDC as an extension to the CSTM building on the Halton site.

## Progress since last report

- 2 separate but linked business cases have been produced and subsequently approved by WHH Trust Board.

- The cases were presented to the regional CDC programme board in June 2022 and were well received.

- The case for the Fast-Track CDC has subsequently been sent to the national team for review/approval and decision. Initial list of questions/queries was received and subsequently responded to. This has led to an agreed re-profiling of elements of the project (and costs).  A decision on the case has been requested by the end of July 2022.

- The second case for the full new build CDC will be submitted to the national team in July with a decision requested by the end of August 2022.

- Interviews for the Senior Project Lead to oversee delivery scheduled to take place in early August.

## Financial Implications/ Budget Update

Fast-Track CDC (phase 1) - £11.5m capital
Full New Build CDC (phase 2) - £14.9m capital

| Upcoming Key Milestones | Date | Status | Comments |
|---|---|---|---|
| Project Lead to commence in post | Oct-22 | | |
| Complete design work for Fast-Track CDC | Nov-22 | | |
| Decision from regional/national team on Full CDC | Aug-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 tariff | 6 |

# WHH Green Plan

Anchor Institution

Social Value | Green Agenda | Health inequalities

NHS
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

- First meeting of the Great, Green & Good Forum took place 4th July, attended by action leads and colleagues with an interest in the Green Agenda. Dave Sweeney, Director of Partnerships at C&M ICS, delivered opening remarks reiterating the importance of the programme of work and the links to social value and health inequalities. The Forum will take place bi-monthly, with the next on 5th September.

- Green plan is being designed for sharing and publication on the Trust's website.

- There are a number of funding opportunities coming online, including round 3b of the Public Sector Decarbonisation scheme. The guidance for the scheme has been released and is being interrogated in order to develop a bid to be submitted in September.

## 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 design and publish Green Plan | August 2022 | | |
| Submit bid for Healthier Futures Action fund | August 2022 | | |
| Submit bid for Public Sector Decarbonisation Scheme 3b | Sep 22 | | |
| Submissions open for Anchor Hackathon | Sep 22 | | Hackathon to take place October 2022 |

| 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 found | 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 recurrent roles to provide Sustainability | 9 |

# Warrington Wider Estates Review

Anchor Institution

Social Value | Green Agenda | Health inequalities

## 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

- Stakeholder engagement is now complete with 22 partners involved across the Borough.
- Estates Asset Map produced. Training has been provided by Turner and Townsend on how to navigate and update the Asset Map.
- Asset Map has been shared with Partners along with identified opportunities.
- Asset Map and opportunities socialised with co-chairs of Warrington Together Partnership Board and ready to be shared with the full Board in September 22 (Deferred from July-22 meeting).
- Work is underway with Place partners to agree an online digital solution to enable real-time updating of the asset map by partners.
- Discussions progressing with Place partners aimed at ensuring the asset map is governed appropriately and embedded as a key tool to support shared decision making and maximise efficiencies.

## 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 ongoing governance arrangements for the asset map | Oct-22 | | |
| 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

## 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 to the Trust 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.

## 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 |
|---|---|---|---|
| Sign off Appraisal Paper, including costed options and detailed delivery plan | June-22 | 🟧 | Delayed to August due to Annual Leave and Covid |
| Report to execs outlining report recommendations and next steps | Aug-22 | 🟩 | |

| 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 | 10 |

# Breast Service Reconfiguration – Phase 2

**NHS**
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

- The public consultation completed on the 20th June
- The consultation made use of various methods of communication and engagement:
  - Website and social media campaigns
  - Stakeholder briefings
  - Press coverage
  - Experts by experience panel
  - GP and PCN communication
- The consultation was delivered in a range of formats including:
  - face to face engagement
  - paper surveys
  - online surveys
  - MS teams Live event
  - verbal scribe

- 163 responses were collected

- The results of the consultation are currently being circulated via Warrington, Halton and St Helen's local authority meetings, Warrington and Halton CCG and Specialised Commissioning routes

- IT requirements assessed and an audit of current available hardware within the Trust made.

## 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 |
|---|---|---|---|
| Public consultation completed and results circulated to relevant Commissioning and Local Authority Committees | Sep-22 | | Public consultation period commenced in June following local elections. |
| Project completed and allocated capital for this financial year spent. | Jan-23 | | Likely to be January now due to increased refurbishment works 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 commenced work to accelerate production of a Cheshire & Merseyside FBC. The initial phase of work will be completion of a readiness assessment to progress to FBC. This is due September 2022 and will be used to inform the timescale for production of the FBC.
- A localised procurement approach for histopathology has been agreed with the network. Work is underway to determine the financial viability of aligning the contract term with the network's suggestion. Before a contract is awarded full consideration will be given by WHH executive team to the longer-term vision for harmonisation and the financial implications for the new contract.
- A review of governance arrangements has been completed and WHH representation aligned across workstreams.
- The Networks Microbiology Clinical Workstream Lead has stood down and Expressions of Interests are being sought from clinicians across the Network who would be willing to take on the role.

## 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 |
| 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. | 10 |

# Health & Care System Reconfiguration

## Project Overview

System reforms mean a transition to Integrated Care Systems (ICS) from 1st July 2022, comprising an Integrated Care Board (ICB) to discharge NHS functions and duties and an Integrated Care Partnership (ICP) comprised of health and care partners across the ICS, both will work collaboratively to:
- improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access,
- enhance productivity and value for money and help the NHS support broader social and economic development

During this transition, WHH is working with system leaders to ensure organisational prioritises and interests are understood at region and place level and relationships developed to support attainment of organisational objectives.

## Progress since last report

- Integrated Care Systems were formally constituted on 1st July 22 with the Cheshire & Merseyside Integrated Care Board formally commencing its duties from this date.
- Place Based Boards – One Halton and Warrington Together Partnership Board were also constituted on 1st July 2022.
- While the legal structures underpinning system reforms have been established, a significant amount of work remains to ensure the benefits are leveraged. Work continues to ensure Trust representation across region and place and to ensure appropriate influence.
- At Place, work has commenced to refresh the existing health and wellbeing strategies which will then be translated into Place Delivery Plans.
- Place Directors for both Warrington and Halton have commenced in post.
- Views have been sought and provided on the devolvement of specialised commissioning to ICS and providers.
- Fragile services prioritised for action by medical and strategy director networks in CMAST, joint session arranged to agree plan and action. Solution for dermatology accelerated.

## Financial Implications/ Budget Update

The ICS will be the regional commissioning body through which finances will flow. Relationships may influence the status of WHH at region and any financial benefits or risks derived by will be captured and quantified.

| Upcoming Key Milestones | Date | Status | Comments |
|---|---|---|---|
| Revised health and wellbeing strategies completed | TBC | | |
| Place delivery plans developed | TBC | | |
| ICS Joint Working Agreement and Committees in Common proposal to be reviewed and feedback provided | Aug 22 | 🟩 | |
| Update session on Place arrangements with Place Directors at Board | Sep 22 | 🟩 | |
| Joint medical and strategy directors CMAST session on fragile services | Sep 22 | 🟩 | |

| Risk description | Impact | Risk score | Mitigations | Mitigated risk score |
|---|---|---|---|---|
| If WHH does not appropriately influence at place and regional level there is a risk that priorities will not be supported or delivered and that future funding and service delivery could be negatively impacted. | Potential negative impact on service delivery. Potential reduced funding allocated. | 10 | Ensure appropriate representation and influence. Demonstrate delivery. | 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

- Joint oversight committee meetings with the Health and Wellbeing hub are ongoing to ensure synergy across both projects. The college Principal attends these meeting.

- HSCA focus steering group meetings are ongoing with direct input into shaping the curriculum to meet the Trust's needs by the Trust's Head of Education and Wellbeing.

- Site visit was conducted to share learning of the Town Deal projects and the Health and Social Care Academy and to develop an understanding of the continued development of the curriculum.

- As a result of this project, closer links have now been developed with WVRC which are resulting in ongoing mutually beneficial opportunities.

| Upcoming Key Milestones | Date | Status | Comments |
|---|---|---|---|
| Implementation of new Health and Social Care Curriculum | Sep 22 | | |
| Commence delivery of courses within Health and Social Care academy | Sep 22 | | |
| Official opening of the Health and Social Care Academy | Oct-22 | | |

| Risk description | Impact | Risk score | Mitigations | Mitigated risk score |
|---|---|---|---|---|

No risks identified at this stage.

# Anchor Programme Development

Anchor Institution
Social Value | Green Agenda | Health Inequalities

## 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

- An Anchor Programme Update was given to Trust Board in July 22, which provided a summary of progress since November 2021 and progress against additional priorities agreed at Trust Board in January 2022.
- 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.
- In July 2022, **The Great, Good and Green Forum** was launched. The Forum's purpose is to promote awareness and widespread adoption of the Trust's ambitions as an anchor institution, facilitate open discussion and idea sharing on initiatives.
- Consideration has been given to how the overarching impact of the programme is measured and discussions with Place colleagues are advancing to move towards a collective Place focus.
- The programme has been reviewed against the Cheshire & Merseyside Anchor Institute Charter and Principles which was released in July 22 and the Trust is already making progress against each of the identified priorities.

| Upcoming Key Milestones | Date | Status | Comments |
|---|---|---|---|
| **Incorporating Anchor into Strategy refresh** Embedding our anchor ambitions will be further cemented by including them as core features of the Trust wide 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

## 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 |
|---|---|---|---|---|
| • Guidance for developing an enabling strategy has been refreshed and uploaded to the intranet, alongside links to all existing enabling strategies.<br>• Workshops delivered with CBU teams to understand key strategic objectives for clinical specialty teams and specialty responses to key organisational strategic priorities.<br>• Plan developed and supported at Trust Board in July 22 for how the refresh of the overall Trust strategy will be approached. | Complete CBU Clinical Strategy discussions | Aug-22 | | |
| | Commence work to refresh overall organisational strategy (2023 onwards) | Aug-22 | | |
| | Refreshed 5 year strategy 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 |
| Runcorn Shopping City – 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). Currently discussing with partners and looking at potential service and funding options. | 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 (see slide 6), use of GP ARRS roles, Use of Runcorn UTC. | 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 | Working with Halton Borough Council to look at options for the use of the latest round of capital investment as part of the Government's Levelling Up agenda. | 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 | 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. | Kelly Jones |
| Respiratory One Stop Shop | Explore potential to establish a one stop shop to confirm diagnosis of COPD/review those with suspected COPD/review medications and ensure they're optimised and suitable for current condition. This was piloted previously in Widnes | Rachel O'Dwyer |

| Proposal Name | Brief Description | Strategy Team Contact |
|---|---|---|
| Digital Health Partnership Award Funding | Money is available for partnership projects that incorporate collaborative approaches to the development and delivery of digital projects. Discussions about whether an application can be aligned to an existing planned project that could be expedited with additional funding | 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 Directory of Services | Steve Bennett |
| Discharge Integration Forerunner Programme | There was an opportunity for each ICB to submit an expression of interest for a 'Discharge Integration Frontrunner' programme. Cheshire & Merseyside put forward  Cheshire East and West but were willing to fund another two pilots. This was explored and following discussion with Local Authorities a decision made not to submit an expression. | Kelly Jones |
| 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 |

**REPORT TO TRUST BOARD**

| AGENDA REFERENCE: | **BM/22/09/121** | | |
|---|---|---|---|
| **SUBJECT:** | **Audit Committee Chairs Annual Report 2021-22** | | |
| **DATE OF MEETING:** | 28th September 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. | | 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*) | **All** | | |
| **EXECUTIVE SUMMARY** (*KEY ISSUES*): | This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls. The overall Head of Internal Audit opinion for the period 1st April 2021 to 31st March 2022 provides **Substantial Assurance**. This provides assurance that there is good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. | | |
| **PURPOSE:** (*please select as appropriate*) | Information | Approval **X** | To note | Decision |
| **RECOMMENDATION:** | The Board reviews the document, ensures it meets its purpose and ratifies the Committee Chair's Annual Report. | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Audit Committee | |
| | **Agenda Ref.** | AC/22/08/71 | |
| | **Date of meeting** | 18th August 2022 | |
| | **Summary of Outcome** | Supported | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | |
| **FOIA EXEMPTIONS APPLIED:** (*if relevant*) | None | | |

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**The Committee**

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and, where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2021-31 March 2022.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda and are in support of the achievement of the Trust's objectives.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. I have been the Chair of the Committee since 1st November 2021 taking over from Ian Jones who retired in September 2021.

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee has been met by Ian Jones as the Chair of the Committee and Terry Atherton, Non-Executive Director and Deputy Chair of the Trust.

| Member | Attendance (Actual v Max) |
|---|---|
| Michael O'Connor. Non-Executive Director | 3/3 |
| Julie Jarman, Non-Executive Director | 1/1 |
| Ian Jones, Non-Executive Director & Chair | 2/2 |
| Margaret Bamforth, Non-Executive Director | 4/4 |
| Terry Atherton, Non-Executive Director | 3/4 |
| Anita Wainwright, Non-Executive Director | 3/3 |
| Cliff Richards, Non-Executive Director | 4/4 |

Regular attendees at the Committee Meetings were the Trust's external auditors Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency (MIAA - Internal Audit and Counter-Fraud Services), the Chief Finance Officer & Deputy Chief Executive, the Director of Integrated Governance and Quality and the Trust Secretary.

**Terms of Reference**

The Committee's Terms of Reference were reviewed and agreed in 2020 to ensure they continue to remain fit-for-purpose and will be reviewed again in August 2022.

**Frequency of Meetings & Summary of Activity**

The Committee met five times during the year. A summary of the activity covered at these meetings follows:

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**High Assurance** was provided in the following: Key Financial Controls

**Substantial Assurance** was provided in the following: Patient Level Information & Costing System (PLICS), Data Quality, Waiting List Management, Patient Discharge and Data Security & Protection Toolkit (DSPT) submission (assessment against self-assessment)

**Moderate Assuranc**e was provided in the following:  CPR Decision Making

**Limited Assurance** was provided in the following: Waiting List Initiatives, Data Security & Protection Toolkit (DSPT) submission (assessment against National Guardian Standards)

There were no areas reported as providing no assurance.

**Governance & Risk Management**

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes.  It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and the Quality Assurance Committee on a monthly basis.  In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Substantial Assurance** rating from the Head of Internal Audit (HOIA)

**Internal Audit Activities**

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.   The assurance level for each audit completed during the year are listed below:

An efficient and effective Assurance Framework is a fundamental component of good governance, providing a tool for Boards to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success.

The Assurance Framework Review concluded that the organisation's Assurance Framework is structured to meet the NHS requirements, all elements rated Green.

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| Opinion | |
|---|---|
| **Structure** | The organisation's AF is structured to meet the NHS requirements. |
| **Engagement** | The AF is visibly used by the organisation. |
| **Quality & Alignment** | The AF clearly reflects the risks discussed by the Board. |

It was also confirmed that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

The Internal Audit reports include detailed recommendations to improve systems and address weaknesses identified. Based on these recommendations, actions are agreed with Line Management and the Audit Committee tracks the implementation of the agreed actions to ensure implementation within an appropriate timeframe.

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

**External Audit**

Grant Thornton commenced its initial 3-year term as Auditors to the Trust in January 2017. The company then commenced a two year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contains the option to extend for one year in the third and fourth years.

During the year the Auditors reported on the 2021-22 Financial Statements. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

**Anti-Fraud Activity**

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the AFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

**Issues Carried Forward**

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

With respect to the Internal Audit plan for 2022-23, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the 2022-23 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2021-22, alongside the Audit Committee, fout main Board assurance committees were in place: (1) Quality Assurance Committee, (2) Finance & Sustainability Committee, (3) Strategic People Committee and (4) Clinical Recovery Oversight Committee. All of these Committees were Chaired by Non-Executive Directors and each Committee included at least two Non-Executive Directors. This structure gave strong visibility and focus at Non-Executive level on the key issues facing the Trust. The NEDs meet several times a year to assess a wide range of Trust issues including the appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

**Summary**

In year, the Committee has considered a wide range of issues in relation to financial statements, operations and compliance and has sought to gain assurance on each element by working closely with Internal Audit, the other Board Committees and key individuals across the Trust.

Throughout the reporting period, the Chair of the Committee reported in writing on the nature and outcomes of its work to the Board of Directors highlighting any area that should be brought to its attention through a Chair's Committee Assurance Report.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in November 2022

The Committee will also assess its own performance during the year and will report to the Board of Directors in November 2022.

The Audit Committee acknowledges the significant amount of work carried out by the Quality Assurance Committee in continuing to refresh and embed the Trust's governance and risk management systems.

I would also like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during a year which again proved to be unusually challenging. The pandemic continued to create significant unexpected pressures, and all concerned adapted to the situation in a highly professional manner to ensure that effective risk management and good governance were maintained throughout.

**Mike O'Connor**

**Chair of Audit Committee**
**August 2022**

**REPORT TO TRUST BOARD**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/22//09/122** |
| **SUBJECT:** | **Finance & Sustainability Committee Terms of Reference** |
| **DATE OF MEETING:** | 28th September 2022 |
| **AUTHOR(S):** | John Culshaw, Trust Secretary |
| **EXECUTIVE DIRECTOR SPONSOR:** | Simon Constable, Chief Executive |
| **LINK TO STRATEGIC OBJECTIVE:**<br><br>*(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):**<br><br>*(Please DELETE as appropriate)* | **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken.<br>**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.<br>**#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 | | | |
| **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 on an annual basis.<br><br>Proposed changes to the Finance & Sustainability Committee ToR include amendments to the Duties & Responsibilities and Reporting Groups sections<br><br>Proposed amendments to the ToR are detailed by the track changes and included in the Revision Tracker | | | |
| **PURPOSE:** *(please select as appropriate)* | Information | Approval<br>**X** | To note | Decision |
| **RECOMMENDATION:** | The Trust Board is asked to review and approve the ToR for the Finance & Sustainability Committee | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Finance + Sustainability Committee | | |
| | **Agenda Ref.** | FSC/21/09/161 | | |
| | **Date of meeting** | 21st September 2022 | | |
| | **Summary of Outcome** | Supported | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |

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| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None |
|---|---|

# FINANCE & SUSTAINABILITY COMMITTEE
## TERMS OF REFERENCE

### 1. PURPOSE
The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

### 2. AUTHORITY
The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

### 3. REPORTING ARRANGEMENTS
The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

### 4. DUTIES & RESPONSIBILITIES
The Committee's responsibilities fall broadly into the following two areas:

**Finance and performance**
- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the Monitor Provider License (under the auspices of NHS Improvement).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).
- To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored

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appropriately.
- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- To review the performance indicators relevant to the remit of the Committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the ~~Key Issues~~Committee Assurance Report.
- To monitor compliance with NHSE~~I~~ requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee

**Strategy, planning and development**
- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

## 5.  MEMBERSHIP
The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee.  Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication).  Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the member's Trust email account.

## 6.  CORE ATTENDEES
The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:
- Chief Finance Officer & Deputy CEO
- Chief Nurse & Deputy CEO
- Chief Operating Officer

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- Executive Medical Director
- Chief People Officer
- Deputy Chief Finance Officer
- Director of Strategy & Partnerships
- Trust Secretary

Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

## 7. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive  Directors cannot attend a meeting of the Committee, one of the Non-Executives Directors not  normally members of the Committee may attend in substitution and be counted in the quorum.

## 8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

## 9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting;
- separate reports to support the working of the Committee or addressing areas of concern these Reporting  Groups may have;
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- Finance and Resources Group
- Digital ~~Board~~Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group

## 10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting.  No papers will be tabled at the meeting without prior approval of the Chair.  The Committee will be supported by the Secretary to the Trust Board.

## 11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its   achievements. These terms of reference will be reviewed at least annually by the Committee.

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**TERMS OF REFERENCE REVISION TRACKER**

| Name of Committee: | Finance and Sustainability Committee |
|---|---|
| **Version:** | **V8 DRAFT** |
| **Implementation Date:** | September 2021 |
| **Review Date:** | September 2022 |
| **Approved by:** | Finance & Sustainability Committee |
| **Approval Date:** | FSC 22 September 2021, Trust Board 24 November 2021 |

| REVISIONS | | | |
|---|---|---|---|
| **Date** | **Section** | **Reason on Change** | **Approved** |
| **22 March 2017** | **3 – Reporting arrangements** | - There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum. | |
| **22nd March 2017** | **4. Duties and Responsibilities** | - To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement | |
| **22 March 2017** | **6 - Attendance** | - Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy.<br>- Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance | |
| **22 March 2017** | **9. Reporting Groups** | Two groups removed:<br>- The Business Planning sub Committee (strategic).<br>- Strategic & Annual Planning Steering Group.<br>One Group added:<br>- Pay Spend and Review Committee minutes to reporting groups. | |
| **22 March 2017** | **10 Administrative Arrangements** | - Due to change in administrative support to the Committee<br>- Agreement with the Chair and Director of Finance to amend the timescale for circulating papers | |
| **18 October 2017** | **4. Duties and responsibilities**<br><br>**6. Core attendees**<br><br>**9. Reporting Groups** | - Delete items relating to Estates and IM&T<br><br>- Delete Director of IM&T | |

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| | | Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records | |
|---|---|---|---|
| 22 November 2017 | Section 4 Duties and Responsibilities | - To monitor compliance with NHSI requirements relating to pay policies<br>- To review and monitor the Trust's overall pay bill<br>- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee | |
| | Section 9 Reporting Groups | To include: reports on premium pay spend | |
| 21 March 2018 | Core Attendees | Addition of Medical Director | Trust Board 29.5.2019 |
| 19 September 2018 | Core Attendees | Remove Director of Transformation | Trust Board 29.5.2019 |
| 20 March 2019 | Section 6: Core Attendees | Remove Medical Director<br>Add Head of Corporate Affairs | Trust Board 29.5.2019 |
| 20 March 2019 | Section 9: Reporting | Add Financial Resources Group<br>Remove Out Patient Turnaround<br>Remove ICIC | Trust Board 29.5.2019 |
| 18 March 2020 | Section 6: Core Attendees | ADD Medical Director<br>Amend Title of Head of Corporate Affairs to read Trust Secretary<br>Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development<br>ADD Director of Strategy (when required) | FSC 18.03.2020 Trust Board 25.03.2020 |
| 18 March 2020 | Section 9: Reporting | Remove Urgent & Emergency Care Improvement Committee | FSC 18.03.2020 Trust Board 25.03.2020 |
| 23 September 2020 | Section 4 Duties and Responsibilities | Addition of reports from Digital Services | FSC 23.09.2020 Trust Board 25.11.2020 |
| 23 September 2020 | Section 6: Core Attendees | Amend the titles of three Directors<br>Add Chief Information Officer | FSC 23.09.2020 Trust Board 25.11.2020 |
| 23 September 2020 | Section 9: Reporting | Add Digital Board | FSC 23.09.2020 Trust Board 25.11.2020 |
| 22 September 2021 | Section 6: Core Attendees | Amend title of Deputy Director of Finance & Commercial Development and<br>Delete post of Chief Information Officer | FSC 22.09.2020 Trust Board 24.11.2020 |
| | Section 9: Reporting | **Add Medical Staffing Review Group and Strategy & Sustainability Review Group** | |
| 21st September 2022 | Section 4: Duties & Responsibilities | Updated reference to Committee Assurance Report and amended NHSI to NHSE following NHS Improvement becoming part | |

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| | | of NHS England in July 2022 | |
|---|---|---|---|
| **21st September 2022** | **Section 9: Reporting Groups** | Addition of GIRFT/Clinical productivity Group<br>Amend title of Digital Board to Digital Management Group | |

| TERMS OF REFERENCE OBSOLETE | | |
|---|---|---|
| **Date** | **Reason** | **Approved by:** |
| **20 March 2020** | **V5 to be replaced by V6** | FSC 18.03.2020 |
| **23 September 2020** | **V6 to be replaced by V7** | FSC 23.09.2020 |
| **22 September 2020** | **V7 to be replaced by V8** | FSC 22.09.2021 |

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