Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting Part 1 (held in Public)

Wednesday 7 February 2024
10.00am -12.30pm
Trust Conference Room Warrington/Via MS Teams

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 7 February 2024, 10.00am – 12.30pm
Trust Conference Room, Warrington/Via MS Teams

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/24/02/157	**10:00**	Engagement Story – **My Cancer Journey**	***To Note***	**Presentation**	Karen Mason, Cancer Nurse Transformation Manager
BM/24/02/158	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/24/02/159	**10:17**	Minutes and Action Log of the previous meeting held on **6th December 2024**	***For decision***	***Minutes***	Chair
BM/24/02/160	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/24/02/161	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/24/02/162	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Chair
BM/24/02/163	**10:40**	Board Assurance Framework Annual Review of BAF & Risk Appetite Statement	***For approval***	***Report***	Company Secretary
Strategic aim:					
BM/24/02/164	**10:50**	Care Group Presentation – Quality, Performance & Governance with respect to: • Urgent & Emergency Care • Medicine • Surgery	***For assurance***	***Presentation***	Unplanned Care Group Planned Care Group
BM/24/02/165 **(a)**	**11:30**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
		Quality Dashboard **Including** Assurance Reports Quality and Assurance Committee (QAC) 12.12.23, 09.01.24	***For assurance***	***Report & Presentation***	Chief Nurse & Deputy CEO, Chief Operating Officer, Exec Medical Director Cliff Richards, Committee Chair

(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee (SPC) 20.12.23, 17.01.24	***For assurance***	***Report & Presentation***	Chief People Officer Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard** **Including** Assurance Reports Finance and Sustainability Committee (FSC) 19.12.23, 24.01.24	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
Strategic aim:	 				
BM/24/02/166	**11:40**	Fragile Clinical Services Update	***To note for assurance***	**Paper**	Chief Nurse & Deputy CEO/Executive Medical Director & Chief Operating Officer
BM/24/02/167	**11:10**	CQC Maternity Inspection	***To note for assurance***	***Presentation***	Chief Nurse/ Deputy CEO
BM/24/02/168	**11:50**	**Maternity Update** i. Ockenden ii. Maternity & Neonatal Review	***To note for assurance***	***Report***	Director of Midwifery
Strategic aim:	 				
BM/24/02/169	**12:05**	Freedom to Speak up (FTSU) Development for 2024 onwards	***To note for assurance***	**Paper**	Chief Executive
BM/24/02/170	**12:10**	Communications & Engagement Update – Q3	***To note for assurance***	**Paper**	Director of Communications & Engagement

Strategic aim:	 				
BM/24/02/171	**12:15**	Bi-monthly Strategy Programme Highlight Report	***To note for assurance***	**Paper**	Director of Strategy & Partnerships
BM/24/02/172	**12:20**	Strategy Bi-annual Delivery Report	***To note for assurance***	**Paper**	Director of Strategy & Partnerships

Governance

BM/23/02/173	**12:25**	Update on Approach to Non-Executive Director Champion Roles	***To note***	**Paper**	John Culshaw, Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/24/02/174	Digital Strategy Group Update Report	Finance & Sustainability Committee Date: 24.01.24 Ref: FSC/24/01/203 Outcome: Noted	***To note for assurance***	**Paper**	Executive Medical Director
BM/24/02/175	Infection Prevention and Control Board Assurance Framework Compliance Bi-annually	Quality Assurance Committee Date: 09.01.24 Ref: QAC/24/01/283 Outcome: Noted	***To note for assurance***	***Report***	Chief Nurse & Deputy CEO
BM/24/02/176	Mortality Review - Learning from Deaths Quarterly Report – Q2	Quality Assurance Committee Date: 12.12.23 Ref: QAC/23/12/259 Outcome: Noted	***To note for assurance***	**Paper**	Executive Medical Director
BM/24/02/177	Guardian of Safe Working Quarterly (Q2) Report	Strategic People Committee Date: 20.12.23 Ref: SPC/23/12/177 Outcome: Noted	***To note for assurance***	**Paper**	Executive Medical Director
BM/24/02/178	Trust Senior Management Organograms	n/a	***for Information***	**Paper**	Company Secretary
BM/24/02/179	(FULL) Care Group Presentations – Quality, Performance & Governance with respect to: • Urgent & Emergency Care • Medicine • Surgery	CQC Engagement & Risk Meeting Date: 29.01.24	***for Information***	**Presentation**	Chief Nurse
Closing					
BM/24/02/180	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/24/02/181		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting - 3 April 2024, Education Centre, Halton Hospital					

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My Cancer Journey by Lucy Lavan

Presented by Karen Mason, Cancer Nurse Transformation Manager

Written by Karen Mason, Cancer Nurse Transformation Manager

Susan Dean, Deputy Head of Patient Experience and Inclusion

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Background

My patient journey began with my diagnosis of colorectal cancer in June 2021 and has involved a two and a half year 'rollercoaster ride' taking in a long course of chemo-radiotherapy, some cycles of neo-adjuvant chemotherapy (CAPOX), major surgery (laparoscopic APR with 9 day inpatient stay), 6 months of adjuvant chemotherapy, endless diagnostic tests, along with a couple of gynae interventions and a 13 hour day in AED thrown in for good measure.

I was delighted to be told in December 2023 that 12 months post-op there is no evidence of disease. I remain on a 5 year programme of surveillance under the care of the CRC team at WHH.

My journey, focuses on the WHH elements of my care (my oncology treatment being delivered by Clatterbridge Cancer Centre) and I hope you find it insightful.

I share a timeline of my journey followed by a synopsis of the things that stood out as being fantastic and those that were not quite so good.

My Journey June 2021 to December 2023

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June 2021
- Colonoscopy; biopsy results inconclusive
- Diagnostic scans & sigmoidoscopy; mass likely cancer
- Clinic (MT) – staging (CT3a N1 M0), treatment options, potentially curable, surgery will likely involve permanent stoma
- Plan to try Brazilian protocol to avoid or at least delay surgery; referral to Consultant oncologist at CCC to proceed

July & August 2021
- Radiology planning scan at CCC but required urgent removal of Mirena coil; very swift gynae intervention at WHH ensured planning scan could proceed
- Long course of chemo radiotherapy

September & October 2021
- CAPOX chemotherapy – 4 cycles planned but only two tolerated and stopped when contracted COVID (Oct 2021)
- Severe pain in leg whilst COVID positive*
- Spinal scan (CCC) – no cancer in spine – slipped disc diagnosed and physiotherapy review
- Begin 'Watch and wait ' – 3 monthly cycle of MR scans and sigmoidoscopy; 6 monthly CT scan

November 2021
- Diagnostics suggested 'COMPLETE CLINICAL RESPONSE'!; MR liver indicated that liver spots were benign

January 2022
- Clinic (MT) – advised all good for now but must continue with watch and wait protocol – still a 50:50 chance surgery would be needed
- Chronic pelvic pain thought to be collateral damage from radiotherapy and was the start of a long struggle with pain and fatigue.

Until September 2022
- Continued with 3 monthly cycle of scans and sigmoidoscopy; received unexpected clinic appointment to see MT on 11.10.23

October & November 2022
- PET scan
- Home visit from Community stoma nurse (Bridgewater) in readiness for potential surgery
- Advised that MDT confirmed need for APR procedure with end colostomy to remove the lymph node and the site of the primary tumour
- Operation scheduled for 17.11.22
- Admission to A5, consenting process with MT, pre-op discussion
- Inpatient stay on A5

2023
- January; post operative review and wound check (MT)
- January- June; 6 month course (8 cycles) of oral chemotherapy with reviews and dose adjustments via Consultant Nurse at CCC
- November; first round of annual surveillance scans and colonoscopy
- December 2023; letter from MT advising NO EVIDENCE OF DISEASE! Continue with 5 year surveillance programme

* Further detail in Lucy's story - 13 hours in AED, October 2021

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What mattered to Lucy

What went well and where could WHH improve

Lucy has provided two stories covering her 2½ year journey using WHH Services at both the Warrington and Halton Sites. This insight into such a personal and emotional journey aids our understanding of what went well and where we can look at improvements to support other patients.

Patient Information

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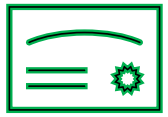
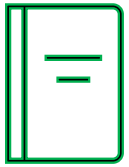
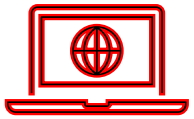


Endoscopy suite safety credentials; promoted prominently, instilling confidence.



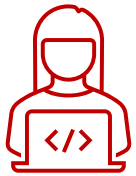
Radiology patient leaflets; very informative.



Website; lack of information:

- CRC specialty and the specialist surgical team; non-existent.
- General surgery and Ward A5; scant.

Endoscopy patient information leaflets; no tailored information for the stoma patient; specific advice needed for bowel prep.



Post Treatment portal- my Medical Record not that user friendly for the patient. Information sought elsewhere.

Communication

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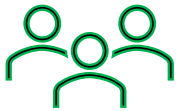
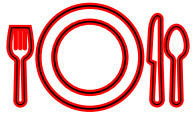


Medical secretaries always very friendly and helpful and conveyed messages promptly.

Incorrect address typed onto letter; received and opened in error by a neighbour.



Not given consistent advice about what could and couldn't be eaten with a stoma.

Accelerated Recovery; assessed by a physiotherapist post-op but wasn't given advice on how to mobilise or minimise hernia risk. Community stoma nurse informed should do immediately and frequently after my surgery.

Diagnostics/Pre-op/Ward

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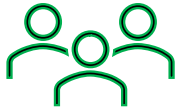
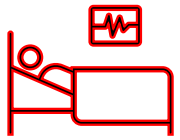
Radiology; Wow what a well-oiled wheel, appointments at the crack of dawn, late in the evening and at weekends and I was never kept waiting.



Staff; Ward, Theatres & Endoscopy Suites (both sites); wonderful and exceptionally kind, caring and conscientious.

Results:

- Endoscopy; the biopsy results from first colonoscopy ‘inconclusive’, procedure repeated at anxious time.
- Histopathology; turnaround of results aligned to timely MDT review; reported later than expected.
- Poor communication; told by anaesthetist had cancer in sacrum, not the case and caused anxiety.



Ward environment;

- Disturbance from other patients’ visitors when want peace, quiet, privacy to rest.
- Pain relief not always timely and there was a reliance on agency staff.

CR Specialist Nurses and Culture

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- Calibre, expertise and experience is outstanding; significantly stood out in comparison to specialist trust.
- Always empathetic and caring, had good advice and tips with excellent knowledge.

- Responded promptly to messages and questions.
- Always had plans for the many ‘curve balls’.
- Always positive and upbeat.

- More than just a number, helping with practical things e.g. prescriptions, admin for pension , holiday insurance.
- Exceptional at delivering good and bad news – when news was good, they were genuinely delighted and when news was bad, there was always a Plan B.

- Visits from the senior medical team were reassuring and much appreciated.
- Always remembered me.

Patient Experience

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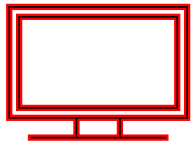

Pay TVs;

- Outdated and not fit for purpose; very poor sound, and visual quality.
- Not good value for money. Important for a lengthy 9-10 day hospital stay when can't get out of bed.

Food:

- Quality and choice was poor and did not cater for patients with bowel conditions, all I could eat from the hospital menu was soup and ice cream.
- Menu not health-promoting and heavily laden with white carbs and sugars; snacks always biscuits, toast/jam.
- Very hard to get sufficient protein and little fresh fruit.
- Relied completely on suitable foods being brought in by my family.

AED:

- Long wait with lack of privacy or dignity.
- Conscious that was COVID positive

Action Plan

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Action	Update
Patient Information	Incorrect address • Apology was issued at time. • Letters printed using information direct from the spine, could not happen now. Stoma information • Leaflet to be developed working with the bowel prep clinic.
Website	WHH website currently being updated: • liaised with communication team as this information is available, but requires updating and more prominent access • Update service page.
Catering	Ensure wards are aware to liaise with the Catering Team and Dieticians to support patients' dietary requirements as available.
Patient TVs	On going project looking into Patient Entertainment with Digital Services and Procurement.
Ward Environment	• Lucy was moved into a cubicle following her feedback at the time. The ward try to accommodate where possible but operationally not always possible. New visiting times introduced in November 2023 has extended hours, which spreads visitors out now so not all arriving at same time. • Inconsistent levels of knowledge about Lucy's condition/operation- can be a symptom of Agency staffing but training to be reviewed.

Action Plan

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Action	Update
Staff and Culture	Share and celebrate the Bowel Cancer UK Gary Logue Award. Recognition to the individuals and teams Lucy has praised.
Results	Turnaround times in histopathology are closely monitored and capacity issues have been raised at the highest level. Improvements have been seen and the department will expedite MDT cases is escalated.
My Medical Record	Comments to be fed back to My Medical Record to facilitate changes to make this more user friendly for the patient.
AED	Working with Clatterbridge and Acute Oncology Team to improve the experience for cancer patients attending the department.

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"My most important message is one of thanks and gratitude. The CRC team have saved my life, I am so thankful to be alive and well and in a great position to embark on my next chapter and embrace my 'new normal'".

Lucy

References

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More stories available about Lucy's Journey and Experiences available on the P Drive/Patient Stories:

- 13 hours in AED, October 2021
- 'The Big One' – My Rollercoaster Cancer Journey

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Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 6 December 2023 Trust Conference Room – Warrington & MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Jane Hurst (JH)	Chief Finance Officer & Freedom to Speak Up Guardian
Dan Moore (DM)	Chief Operating Officer
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Jan O'Driscoll (JO'D)	Partner Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
Dave Thompson (DT)	Associate Non-Executive Director
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
Matt Powls (MP)	Director of Recovery
Ailsa Gaskill-Jones	Director of Midwifery
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Ali Kennah (AK)	Deputy Chief Nurse
Emily Kelso	Corporate Governance & Membership Manager **(minute taking)**
Observing	
John Davis	Member of the public

Agenda Ref	Agenda Item
BM/23/12/133	**Engagement Story – I Just Wanted to be Heard (Maternity)** The Trust Board received the story from a mother whose son was born at the Trust in July 2022. The story detailed their journey through induction of labour to emergency caesarean section and highlighted several areas for improvement and lessons to be learned. The Trust Board heard that the experience had been raised as a formal complaint and had been through the Health Services Safety Investigations Body complaints process.

	AK detailed the recommendations made, and actions from the outputs of the formal complaints process. SMcG thanked the patient for their story highlighting that it was important for the Board to hear stories where issues had been identified - in other words avoid only 'good news' stories - and ensure that action plans were drawn up to improve the quality of care to patients at WHH. KH informed the Board of the culture programme, which was ongoing, AGJ added that this was national piece of work of which the Trust was in phase 3 of and that the improvements in culture since 2022 were evident. The Board discussed the reduction in complaints and concerns raised, AGK noted that there had been one spike around which a deep dive had been presented to QAC. **The Trust Board discussed and noted the Engagement story.**
BM/23/12/134	**Welcome, apologies and declarations of interest.** The Chair welcomed the Trust Board, guests, and observers to the meeting, and noted the apologies received (as detailed above). There were no Declarations of Interest. **The Trust Board noted the welcome, apologies, and declarations.**
BM/23/12/135	**Minutes and action log from the previous meeting held on 4 October 2023.** The minutes of the meeting held on 4 October 2023 were agreed as an accurate record. The Action Log was reviewed, completed actions were noted, there were no outstanding/ongoing actions. **The Trust Board approved the minutes of the meeting held on 4 October 2023 and noted the Action Log.**
BM/23/12/136	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/23/12/137	**Chief Executive's Report** SC introduced the paper, which was taken as read. The following key points were highlighted from the report and board discussions: • JS commented on some of the KPIs that were being adversely impacted by system failures particularly super stranded patients and those with no criteria to reside. The board discussed the lack of PLACE updates within the CMAST report. It was noted that SC was meeting with PLACE leaders and updates would be provided once received. LG added that PLACE updates were included within strategy highlight report, however at present updates were minimal.

	• Continuous Flow – DM confirmed that Continues flow had been rolled out to all medical wards and was in process for surgery. **The Trust Board noted the Chief Executive's Report.**
BM/23/12/138	**Chair's Report** SMcG introduced the report, which was taken as read, though the following key points were highlighted: • Industrial Action – It was noted that conciliation was progressing, and that there had been a number of meetings with ACAS. A further update would be provided in Part 2 of the meeting. **The Trust Board noted the Chair's Report.**
BM/23/12/139	**Board Assurance Framework (BAF)** JC presented the BAF update and highlighted that there had been: • No new risks added; • no changes to the ratings of any of the risks; • no changes to the descriptions of any of the risks; • No risks closed or de-escalated; It was further highlighted that FSC had discussed in detail the scoring of risk 234, and whether it should be increased to a top score of 25 given the current financial position of the Trust, it had been agreed that 20 was appropriate but that further discussions around escalation would continue. SMcG commented on the limitations of BAF scoring given there was only an ability to score in multiples on a 1 – 5 matrix, it was accepted that this was the model adopted across the NHS. **The Trust Board discussed and noted the report**
BM/23/12/140	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance, it was highlighted that the report would be taken as read with key highlights by Executive Leads and any questions on the report content from Non-Executive Directors. It was highlighted that the charts on page 6 showed some good performance, particularly around inpatient falls and harm levels, NICE Compliance, staffing average fill rate, which were consistently passing target and maintaining /improving performance. It was further highlighted that page 5 showed other KPIs that were improving, however there were some KPIs that continued to be a challenge for the Trust notably A&E waiting times. DT queried how the lessons from the Trust's high performance around inpatient falls could be shared with community care settings where performance was a challenge. AK explained that monthly Trust meetings took place to share good practice around falls with community nursing colleagues, it was confirmed that further opportunities around shared learning were being explored.

	JJ queried the consistently failing KPI of Medication Safety - Reconciliation within 24 hours. It was explained that the Quality Assurance Committee had received a Deep Dive on Medication Safety, where it was note that staffing capacity was the main factor impacting performance. A development programme was now in place to drive pharmacy staff retention and the two robots were improving working conditions. It was further noted that there had been no increase in medicine safety incidents as a result of the KPI underperformance. AK further commented around the national shortage of pharmacists including new graduates, which would mean recruitment challenges would likely continue. JD added that the QAC had received assurance that critical meds were being reconciled in critical areas. ***People (Workforce) (MC)*** The following key points were taken from the Workforce section of the report: • Work was taking place to clarify reasons behind workforce growth in reports and in addition including data on raw workforce figures, it was expected that a revised Workforce IPR would be reported into FSC in December. • It was noted that IPR KPI metrics were reviewed and approved each year by the Trust Board. ***Finance & Sustainability (JH)*** JH highlighted the following key points from the finance section of the report: • The financial position had moved away from the controlled total to 21.3m as the likely scenario, it was noted that the Trust was one of only two 2 organisations in Cheshire and Merseyside that had moved away from their controlled total. • The key risks to delivery were discussed these included; CIP delivery, Cost pressures, Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), A&E staffing pressures, Additional capacity open due to the levels of no criteria to reside patients, Cost of Industrial Action, Activity delivered was under plan resulting in loss of income. • The Trust's capital programme was oversubscribed by £1.5m at the beginning of the financial year which reduced to £0.7m in month 5. A further review has been undertaken and an additional scheme can be deferred to 2024/25 (£0.3m) therefore reducing the amount oversubscribed to £0.4m. The Trust Board also noted the committee assurance report from: • Audit Committee **The Trust Board discussed and noted the report**
BM/23/12/141	**Maternity Update** AGJ highlighted the following key points from each of the maternity papers. **i. Ockenden Review Updates** **Key highlights:** • **Ockenden Part 1a**: WHH was 100% compliant.

- **Ockenden 1b**: WHH was 96.58% compliant and is on trajectory to be 100% compliant by 31st March 2024.
- **Ockenden 2**: WHH was 78.08% compliant. Ockenden 2 does not have any national timelines.

AGJ added that following a review of all actions, the Trust had set internal timelines to complete all actions by 31st March 2024.

ii. Maternity Incentive scheme, including Saving Babies Lives Care Bundle (SBLCB)

AGJ explained that the paper provided an update to the Trust Board of the position as of 31 October 2023 and trajectory of the 10 safety actions as recommended by NHSR. The following key points were highlighted from the paper:

- Safety Action 6 - There has been a challenge in extracting data required from the BadgerNet system to accurately define the current position. The position had been reviewed and reassurance was given that the deadline was still achievable.
- MIS Year 5 actions were on track to be compliant by the required timeframes and submission of the completed Board declaration forms to NHS Resolution by 12 noon on Thursday 1 February 2024. LMNS would be reviewing evidence this year, at present the Trust were sitting at amber however following receipt of the paper at today's Board meeting would move into Green.
- It was noted that the final report would be presented to Trust Board at an Extraordinary meeting to take place on the 10th January 2023 (Board Development Day).

iii. Perinatal Mortality Quarter 2 2023-24

AGJ introduced the report which been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. It was noted that the particular report detailed the Trusts Quarter 2 (Q2.) PMRT report for the period covering 01/07/2023 – 30/09/2023. The highlights of the report were:

- During Q2, WHH reported three babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK)
- The WHH stillbirth rate for Q2 2023/24 was 3.32 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.42 per 1000 births. The MBRACE-UK national stillbirth rate for 2022 is 4.1/1000 births. SMcG asked that the Trust Board be provided with details of MBRACE in future papers.
- During Q2, WHH undertook three PMRT review panels. Parental perspective of the care they received had been sought in all cases. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan was monitored at the Women's and Children's Governance Committee.
- Full compliance was reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.

The Trust Board noted the findings of this paper for information.

iv. Maternity & Neonatal Quality Review – September 2023

AGJ introduced the paper which provided an update in relation to maternity and neonatal quality for August and September 2023. The paper provided oversight of key national safety and quality issues in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5, it was noted that the information was reported monthly into the Quality Assurace Committee.

The Board discussed the 15 Step challenge, outputs of which were included as Appendix one. The feedback had been shared with the midwifery leadership team who would implement changes where feasible, it was noted that a proportion of the feedback related to footprint/estates issues for which there would not be short term solutions. AGJ reassured the Trust Board that the service would continue to make improvements to mitigate the issues raised where possible and remain cognisant of the feedback in future planning.

v. Maternity Training Plan 2024

AGJ introduced the paper which provided detail of an updated maternity training plan to reflect the revised standards for training and competency as per the Core Competency Framework version 2 published on 31st May 2023. IT was highlighted that Newborn Life Support was to be included as part of MAMU3 to release capacity within the PROMPT Day for other MDT requirements.

vi. Maternity Self-Assessment Tool Biannual report

AGJ introduced the paper which provided findings following completion of the NHS Maternity self-assessment tool, where services self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements to ensure a safe and effective maternity service. The tool identified 159 criteria to be evidenced of which WHH can evidence for 63.5%. An action plan was to be developed to comply with all criteria, this would be led by the Director of Midwifery with progress reporting into QAC.

vii. Midwifery staffing biannual review Jan-June 2023

AGJ introduced the report explaining that as part of the MIS guidance the Trust Board were now required to receive a standalone midwifery staffing paper biannually. The report provided assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents. The paper detailed the staffing position at as 30th September 2023 and red flag position for the period January-June 2023 alongside other key workforce metrics. The following key points were highlighted from the report and the Board discussion:

- Birthrate Plus - The Maternity funded establishment at the 30th of September 2023 is 126.76 WTE and, therefore compliant with the outcomes of the Birthrate Plus® modelling. AGJ informed the board that Birthrate Plus® was a national tool and did not take into account the continuity of care model.
- The vacancy rate for registered staff as at 30th September 2023 was 13.31%, an improvement of 6.66% from December 2022
- Supernumerary – it was noted that in the period 1st Jan 2023 – 30th June 2023 there are 4 episodes recorded in SAFECARE where the Birth Suite

	Coordinator was NOT supernumerary. This was 1.1% of shifts and occurs rarely. • The Board discussed the WHH Maternity Red Flags particularly the number in Induction of Labour • The Board discussed the changing needs of patients, often with more complexities, increasing rates of caesarean sections and the potential for a complex case midwifery led unit to be considered. **viii. Q1 ATAIN** AGJ introduced the report which provided the Board with details of the Q1 2023/24 ATAIN rate (Avoiding Term Admission into Neonatal Unit) at 6.15%, meaning that for the second consecutive quarter the service had not met the national target. It was further explained that the percentage of avoidable admissions had not risen, therefore the increased term admissions does not appear to reflect a deterioration in the standard of care. All term admissions in Q1 were reviewed and learning from these cases informs the ATAIN action plan. Furthermore, A quality improvement project was underway to put in place a further enhanced transitional care offering, to reduce term admissions and separation of mothers and babies. SMcG reflected on the level of detail in maternity papers being presented to Trust Board. The requirements were mandated nationally and it was understood and recognised that the genesis of the bundle of papers arose from a series of crises. Notwithstanding, there was a risk that the technical detail of reports could become too complex for the Trust Board meetings to truly do justice to the content when set against the backdrop of the many, other issues on Board agendas. It was noted that the papers were presented and discussed in detail at QAC meetings. It was agreed the Governance process would be reassessed in order to provide high level assurance to Trust Board meetings. **The Trust Board noted the updates in relation to Maternity.**
BM/23/12/142	**Moving to Outstanding (M2O) Update Report – Q2** AK introduced the presentation, explaining that purpose of the Moving to Outstanding meetings were to align with the new single assessment framework. The following key points were highlighted from the presentation: • The last CQC Engagement meeting took place on 11 September 2023. Focus of the meeting was ED. No further engagement meetings had taken place, a new liaison officer had been allocated however a first meeting had yet to be arranged. • A well-led review was currently being undertaken lead by Execs and senior leaders across the Trust. • A factual accuracy check was in progress in relation to draft report received following the 14 September formal Maternity CQC Inspection. The Trust had a provided a robust response letter identifying a number of factual

	inaccuracies and had provided evidence to support. A further response from the CQC was anticipated within the coming days. DT sought clarity on those involved in mock CQC inspections, AK confirmed that a number of internal and external stakeholders, including but not limited to; clinical and non-clinical staff (IPC, Estates, Governance) and Governors. **The Trust Board noted the report for assurance.**
BM/23/12/143	**Fragile Clinical Services Update** PF introduced the report which provided the Board with a high-level overview of services currently identified as being Fragile. The following key points were highlighted from the report: • Ear Nose and Throat Surgery had been escalated as a fragile service in November it was noted that this was due to the demand and capacity mismatch – driven predominantly by workforce issues and increased demand. • Gynaecological Surgery - 2 new moderate harms had been identified since previous report to board. • Urology – some improvement had been seen in increased endoscopy cystoscopy capacity by 40/week • Paediatric ophthalmology – New patient waiting list managed by Associate specialist activity – operative and follow up backlogs remained an issue. It was noted that a paper would be presented to Execs around consideration of closing the service, recommending that it was the best option not to close. • Orthopaedics – Fractured Neck of Femur- improvements were being made, however there was more work to be done on the Focused improvement plan to deliver 'prompt surgery'. The Board noted that QAC were monitoring the progress of fragile services and would request further deep dives as deemed appropriate. The Board further discussed the reliance on CMAST to drive improvements in regard to Ear, Nose and Throat Surgery and Gynaecological Surgery. **The Trust Board noted:** • **The current list of Fragile Services and associated high level progress updates.**
BM/23/12/144	**Communications & Engagement Dashboard Quarterly Report Q2** KH introduced the quarterly impact report, highlighting key communications and engagement activity that had taken place in Quarter 2 of 2023/24 (July to September). The report was taken as read with no further questions raised by Board members., **The Trust Board noted the contents of the report.**
BM/23/12/145	**Bi-monthly Strategy Programme Highlight Report** LG introduced the report which provided a progress update on key strategic projects and initiatives that underpin a number of WHH's strategic (QPS)

	priorities. It was noted that this was a revised version of the report, which was aimed at being high level and available in the public domain. The report was taken as read with the following key points were highlighted: **CDC** • Discussions with regional and national CDC programme team were taking place to explore possibility of additional funding. Detailed conversations had taken place in Strategic People Committee meetings around plans to tackle health inequalities, work was ongoing to develop working with the Liverpool City Region. • Phase 2 works were continuing at pace, the project was scheduled to complete in early December. **Living well Hub** • All Major structural works on the building were now complete. • CQC registration was taking longer than planned • Opening would likely be delayed until February 2024 (original plan had been January) **The Trust Board noted the report for information and assurance.**
BM/23/12/146	**Emergency Preparedness Resilience Response** DM introduced the letter from NHS England EPRR Core Standards which detailed the amendments to the assurance process in the wake of lessons identified from recent incidents and a number of public inquiries. DM went on to explain that following the check a challenge process and review of supplementary evidence the Trusts assurance position at 6th November was overall non-compliant, however with zero non-compliant domains. Next steps were explained in detail which included: • A full review of what was required to restore substantial compliance for 24/25 • Work with the Local Health Resilience Partnership to identify areas of collaboration. It was explained that Boards should not interpret the change in rating as being no less prepared, however lessons were being learned around the in change of process, which would take time to fully adopt, it was further explained that the changes had caused significant disquiet across the ICB and Providers. Chief Operating Officers have asked the ICB for an urgent review and response, which has resulted in an agreement that the Regional Lead for EPRR would produce a letter to go to all Boards to explain the process and the rationale for the significant drop in performance. The Board were assured of the governance a reporting of updates on compliance into the Finance & Sustainability Committee. DM reassured the Board of the expectation that the Trust would be fully compliant in time for the EPRR Annual Assurance process 2024/25, and that

	the report would come back to Board in June 2024 to provide assurance on compliance. **The Trust Board noted the update and agreed a further compliance assurance report would be presented to the Trust Board 5 June 2024.**
GOVERNANCE	
BM/23/12/147	**Fit & Proper Persons Policy** JC introduced the report explaining that the first version of the WHH Fit and Proper Persons Policy was approved by the policy review group 26 July 2023. Since then, NHS England had developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). It was explained that the FPPT would be carried out on an individual board member basis, and in the annual submission to the NHS England regional director, the chair would provide the overall summary of the FPPT outcome for the Trust Board. SMcG highlighted the importance of appendix three "allocation of roles when dealing with complaints or concerns", particularly given current matters in other Trusts that had gained media attention, reiterating the importance of a robust framework. **The Trust Board noted the Fit and Proper Person Policy.**
BM/23/12/148	**WHH Membership Strategy 2023-25** JC introduced the report explaining that the WHH Membership Strategy was designed to build on the success of the Trust's Working with People and Communities Strategy 2022-2025 and sough to assist the Trust in progressing as a Foundation Trust that supports its members and actively recruits new members. It was noted that the Membership Strategy had been developed with Governors and approved at the Governor Engagement Group and the Council of Governors at their meeting on the 9th November. **The Trust Board approved the WHH Membership Strategy 2023 – 25.**
BM/23/12/149	**Review of Scheme of Reservation & Delegation and Standing Financial Instructions** JH introduced the report which detailed the proposed minor amendments to the Trust's Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD). It was noted that the amendments had been supported by the Audit Committee. **The Trust Board reviewed and approved the proposed changes to the SORD and SFIs.**
SUPPLEMENTARY PAPERS	
BM/23/12/150	Learning from Experience Summary Report – Q2

BM/23/12/151 **BM/23/12/152** **BM/23/12/153** **BM/23/12/154**	Director of Infection Prevention & Control Quarterly Report Violence Reduction Strategy (bi-annually) Digital Strategy Group Update Report WHH Influenza Vaccination Approach 2023-24
BM/23/12/155	**Review of the Meeting** The Trust Board agreed the meeting had been effective meeting with good discussions and challenge on items.
BM/23/12/156	**Any Other Business** **Meeting ended at 12:30pm**
The Date and Time of the next Trust Board Meeting is Wednesday 7 February 2024 Trust Conference Room, Warrington	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/24/02/159 i	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	7 February 2023

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/12/146	06.12.23	Emergency Preparedness Resilience Response	To provide a progress report on compliance in time for the EPRR Annual Assurance process 2024/25,	DM	June 2024			
BM/23/12/141	06.12.23	Maternity Update Perinatal Mortality Quarter 2 2023-24	Trust Board be provided with details of MBRACE in future papers.	AGJ	April 2024			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/12/141	06.12.23	Maternity Update	Review of Governance and reporting process	AGJ/JC/KSJ	Feb 2024	02.02.2024	Review of Cycle of Business completed	

			for Maternity Papers, to ensure appropriate high level mandated detail was reported into Trust Board in future.					

RAG Key

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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/161**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	7th February 2024			
AUTHOR(S):	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/24/02/161

1. BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 6 December 2023, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 9 - December 2023. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

We continue to focus on length-of-stay and discharge delays. Our total number of super-stranded patients with a length of stay greater than 21 days remains high at 134. The number of patients that do not meet the criteria to reside (NCTR) is also high at 116, although both figures are significantly improved upon the same time last year.

By way of direct comparison, in my January 2023 Briefing, I reported that the total number of super stranded patients with a length of stay greater than 21 days was extremely high at 172, and the number of patients that did not meet the criteria to reside (NCTR) was similarly very high at 142. These figures were over double the national average at the time.

For this year, at the time of writing, 30 January 2024, for Warrington Borough Council residents in hospital, the NCTR number is currently 62 (16.6%, just above the national average of 15%); for Halton Borough Council residents in hospital, it is 26 (26.5%). We continue to work with partners on further improving these figures, as well as working on own processes with regards to length of stay more generally. We also continue to be in receipt of national support to do so, and this has been very helpful and welcome, validating our existing improvement work. This national support, as part of the Tier 1 Urgent & Emergency Care Programme, is also looking at the broader issues of this particular pathway.

We have declared the highest level of NHSE escalation, OPEL 4, three times this year already. Other trusts have been in a similar situation at the same time.

Despite the pressures on our Emergency Department, we continue to prioritise ambulance handovers and deliver well against this vital performance metric. The biggest risk to patients exists when they are unable to access medical assistance when they dial 999. Therefore, we recognise our obligation to off-load ambulances as quickly as possible so that they can attend to those patients who are not risk stratified

in our communities. Undoubtedly, this does create congestion in our relatively small Emergency Department (originally designed for 50 patients) and is of course not the patient or staff experience we would aspire to deliver. However, on balance, we consider that the patient safety aspects can be successfully mitigated by appropriate staffing and processes for escalation.

The Trust continues to undertake an elective recovery programme; the priority this year has been on the elimination of waiting lists longer than 78 and 65 weeks by the end of March 2024. It is probable we will miss such targets and declare a significant number of breaches of both at year-end. Four years on, the impact of the COVID pandemic continues to be felt.

Such breaches, whilst relatively small in number compared to the overall waiting list, at this stage we must consider any as unacceptable. We apologise to those patients waiting such a long time and have plans in place to address this within the coming months. The vagaries of the peaks and troughs of waiting lists mean that we will have the context of a more favourable predicted waiting list position in 2024/25, as the backlog recedes and with fewer new patients joining.

There are currently 44 COVID-19 positive inpatients (14 days or less since their first positive sample). The number of COVID-19 positive inpatients that have tested positive at any time during their admission is 75.

Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees. We also have a weekly Recovery Meeting with Care Group and Corporate Service leads which I chair.

2.2 Senior Leadership Changes

Following a very competitive appointments process which concluded in December 2023, and then the subsequent ratification by our Nomination and Remuneration Committee, I am delighted to report that Ali Kennah has been appointed as our new Chief Nurse. Ali will take up post from 1 April 2024, as we say farewell to Kimberley Salmon-Jamieson who leaves us for Manchester University Foundation Trust on 31 March.

Many colleagues will already know Ali as she has worked at the Trust since 2017, most recently as Associate Chief Nurse and then as Deputy Chief Nurse.

As was the case last autumn between Andrea McGee and Jane Hurst with the Chief Finance Officer portfolio, there will no doubt be a smooth transition between Kimberley and Ali over the coming weeks.

After seven years at WHH, this February Trust Board will be Kimberley's last at WHH. Kimberley's leadership has had a clear positive impact upon this organisation through her diligent, and steadfast, yet kind, approach. Her value set has aligned perfectly to that of us as an acute trust attempting to manage the complexities of our operating environment and the balance of quality, people and sustainability. I wish her well in her future career.

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

The Leadership Board met on 1 December 2023 and received presentations related to previous discussions on digital and workforce alongside recommendations for action by the trusts involved. CEOs will now use the next month or so to engage with their Trust teams on the suggested priorities and identified areas for action reporting back at January Leadership Board with the aim being to secure CMAST agreement for a set of priority activities.

Further items of business related to a review of system financial plans following a requirement for refreshed approaches coming from NHSE instructions to systems on 8 November 2023. The collaborative approach and work of the finance community was noted and commended.

The Leadership Board also received an update on the work being undertaken in relation to current and live Laboratory Information Management System (LIMS) procurement. The stages of the process, requirements for executive and Board engagement, alongside Trust and system decision making, to be underpinned by a system approach to risk and gain share, was set out.

2.4 CMAST Clinical Pathways Programme

As previously reported, I am the chief executive lead and Senior Responsible Owner (SRO) for the CMAST Clinical Pathways Programme. This is just one of the significant workstreams led by this Provider Collaborative, alongside that of Efficiency at Scale and Diagnostics, for example.

The work of the Clinical Pathways Programme is closely aligned to that of Elective Restoration and Recovery, led by Janelle Holmes, Chief Executive of Wirral University Hospitals NHS Foundation Trust. Indeed, we share a monthly Programme Board and a Programme Director. Borne out of the COVID recovery and backlog priorities, specialties have been risk stratified and prioritised and those currently included are Orthopaedics, ENT, Dermatology, Gynaecology, and most recently, Cardiology.

Each specialty has dedicated programme management, a clinical lead as well as an executive medical director sponsor from across the region. Dr Paul Fitzsimmons, Executive Medical Director, is the sponsor for the ENT programme on behalf of the system. This connectivity with the Medical Director community across Cheshire and Merseyside is really important.

We have, for example, now had an Orthopaedics Alliance in place and working together for over one year now, constituting all 7 C&M adult orthopaedics providers. The service review initiated by the Alliance identified some key activities to be pursued:

- Create a ‘one stop shop’ orthopaedic dashboard.
- Create a model that would provide elective ‘cold’ site capacity for trusts without at the designated elective cold sites and ensure continuation of elective orthopaedic surgery year-round.
- Address GIRFT improvement priorities on specific pathways (arthroplasty length of stay, fractured neck of femur length of stay, increase day case

provision). We have, for example, started to see demonstrable improvements in length of stay for hip arthroplasty as a result of the GIRFT work shared across the providers.

I will continue to update on this system-wide work in future WHH Trust Board Reports.

2.5 CQC Maternity Service Inspection

Earlier this month we learnt the news that, following the inspection in the autumn, the CQC continues to rate our maternity services as 'Good'.

This is an excellent result for the whole maternity team and the Trust, against a backdrop of intense scrutiny on maternity services across the country through the national maternity inspection programme. The programme involves an announced inspection of maternity services at each Trust, looking at the safe and well-led key questions, with the aim of providing an up-to-date view of hospital maternity care across the country.

The report, which was published on 17 January 2024, is a very positive account across both the safe and well-led domains, both of which were individually rated 'Good'. This rating is based on the findings from the on-site inspection in September, interviews with key staff and stakeholders, feedback from those who have used the service, plus a multitude of evidence requests and detailed data analysis.

We received no 'must do' actions, with inspectors reporting five 'should do' actions to improve services, which are recommendations related to training, further integration of electronic records and refining our approach to policies and procedures.

Some of the key summary highlights from the report are as below:

Safe:

- Staff understood how to protect women from abuse.
- The service was visibly clean with staff controlling infection risk well.
- Staff assessed risks to women, acted on them and kept good care records.
- Medicines were managed well.
- Safety incidents were recorded, responded to well and lessons learned.

Well-led:

- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Managers monitored the effectiveness of the service and made sure staff were compliant.
- Staff were passionate about the care they provided and were engaged in improving the service further.
- Staff were focused on the needs of women receiving care.
- Staff felt respected, supported and valued by the leadership team, and were clear on roles and accountabilities.
- The service engaged well with women and the community to plan and manage services.

- People could access the service when they needed it and did not have to wait long for treatment.

Inspectors also noted outstanding practice within the service in relation to supporting equality and equity of access to the service. They noted particularly the work with partners to overcome barriers in accessing services, which can be faced by some of the most vulnerable in the communities we serve.

Once the maternity inspection programme is completed across all Trusts providing maternity services, the CQC will publish overall findings to support learning and improvement at a national level.

It is, of course, important that we take on board specific recommendations from the inspectors report to ensure we continue to provide a safe, effective and positive experience of care for all women, birthing people and their families. We will do so with all our usual diligence and attention to detail so that we can be the best that we can be.

I would like to offer a huge personal thank you to all the clinical and support services teams involved in preparing for and supporting this inspection. It is a significant achievement and one of which we should all be extremely proud.

2.6 The NHS Year Ahead

In our 'NHS year', January is also the time we set our plans and ambition out for the next financial year, 2024/25, starting on 1 April. Lots of work starts now, although discussions on planning guidance remain 'live' and subject to change.

We never wait to start planning for next year. It is not expected that the priorities and objectives set out for this current year (2023/24) in the planning guidance and the published recovery plans for urgent and emergency care, and elective and cancer care will fundamentally change.

The key requirements will be for systems (and we sit within the Cheshire & Merseyside system) to maintain the increase in core urgent and emergency care capacity established this year, complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients. The final position and performance expectations will be confirmed.

As I have talked about before, the coming year will require us to continue to focus on recovering our core service delivery and productivity, especially the latter. We will continue to reduce temporary staffing (bank/agency), by making sure we have a substantive workforce that is what we need it to be to do the job that is asked of us.

We are working on the basis that initial planning returns will be expected by the end of February.

2.7 Quality Strategy

Each year the Trust publishes a Quality Account and reviews our quality priorities which are linked to the three domains of quality:

- Patient safety (how we keep our patients free from harm such as falls and pressure ulcers)
- Clinical effectiveness (the standards of care we provide for our patients)
- Patient experience (what the process of receiving care feels like for a patient, their family, and carers)

In this current financial year (2023-24) our quality priorities have focused on key areas:

- Improving the care of deteriorating patients
- Reducing the number of hospital-acquired pressure ulcers
- Improving clinical pathway optimisation through the 'Getting It Right First Time' (GIRFT) programme
- Enhancing quality and safety improvements for patients with mental health needs and/or a learning disability diagnosis ensuring high quality care

We are in the process of reviewing our Quality Strategy and as we start to prepare this along with next year's Quality Account, we have started to gain views on what our key quality priorities should be for the coming year.

We have created a short Quality Strategy and quality priorities consultation survey to seek feedback and help us choose relevant and meaningful priorities for our patients and colleagues, which will be integrated into the new Quality Strategy.

2.8 Digital Strategy

Our vision is that as a 'Digital Trust', WHH will use technology and data to improve the lives of our patients and staff. WHH will also contribute, as partners and system leaders, to the Integrated Care System (ICS) goals to achieve a healthy population that is less reliant on acute healthcare.

To develop our Digital Strategy, we worked with stakeholders representing all service areas in the organisation, including clinicians, nurses, Allied Health Professionals (AHPs), operational management, support functions and patients.

Key priorities identified by our staff and patients will be delivered through a digitally enabled and clinically led approach. Our aim is to drive operational efficiency and clinical excellence by bringing the latest digital tools and industry best practice to WHH.

Digital acts as the enabler for our clinical teams, with technological advancements being driven by teams that understand our patient and service needs, so together we deliver digitally enabled improvements for everyone. We will also connect with our partner organisations and share information with patients to deliver digital integration. To achieve this, several foundations are required and there are some exciting Digital projects underway. We have started the procurement process for a new Electronic

Patient Record (EPR) system which will transform our ways of working, removing duplication, automating workflows, enabling us to make better decisions based on real time data.

The Patient Engagement Portal (PEP) will empower patients, giving them more autonomy over their appointments, medical records, and self-care, enabling them to be digitally connected to their clinical teams. As part of this project, we will be moving all patient and waiting list letters to a digital printing system, delivering cost savings which can be reinvested in care.

In addition, there is also a significant investment in our IT infrastructure, replacing and enhancing devices across the Trust to ensure our systems are reliable, modern, secure, sustainable, and resilient.

We will also be investing in our people, improving digital skills. We will be recruiting Digital Champions and Super Users to support and encourage colleagues, developing the high performing multi-disciplinary digital teams we'll need to deliver these major digital investments.

Our experience in engaging staff during this process demonstrates there is a positive drive within the organisation for digital transformation and embracing change. This transformation will bring its challenges but will ultimately support our ambition of delivering outstanding patient care.

2.9 Patient Engagement Portal

'Dr Doctor' has been appointed to deliver WHH's patient engagement portal (PEP), following a competitive procurement process. 'Dr Doctor' supplies its PEP to more than 50 hospital trusts and manages more than 100 million patient appointments.

Many colleagues and our Experts by Experience supported the procurement process by reviewing submissions and attending the demonstrations; their feedback was invaluable. Access to the PEP will be via the NHS app which plays a role in supporting patients and elective recovery. With over 33 million people signed-up, the NHS App is the digital 'front door' to the NHS.

From this month, patients can see an estimated waiting time for their hospital treatment on the NHS App. We expect this to improve patient experience by better informing patients about their care, and free up NHS resources by alleviating queries usually directed to the trust and local GP practices.

Patients will need access to the NHS app to view their WHH hospital correspondence and request to cancel or rebook when the PEP goes live. This will help reduce the number of phone calls to our admin teams and reduce call waiting times for patients.

In addition, the introduction of the PEP will streamline and improve the way we issue appointment letters, freeing up valuable clinical and administrative time. Prior to the introduction of the PEP, all our patient appointment letters will move to a third-party system that prints letter via an external digital system.

2.10 Community Diagnostics Centre at Halton Health Hub

The Warrington and Halton Diagnostics Centre at Halton Health Hub within Runcorn's Shopping City opened in December 2023. Patients attending for spirometry, phlebotomy and ultrasound appointments have already been attending, with a plan for the new Centre to see 2,000 patients a month before the end of the financial year.

This development has been possible thanks to national funding we have been awarded. The project consists of three phases of development in Halton – the Diagnostics Centre in the Nightingale Building opened in May 2023 and has already provided over 15,000 additional diagnostic tests; this new facility in the Halton Health Hub completes the second phase; and the third and final phase will see a new build extension to create a third Diagnostics Centre in the Captain Sir Tom Moore Building, due to open in 2025.

The CDC scheme has seen us develop a fallow part of the Shopping City unit adjacent to the pre-existing (but still relatively new) Halton Health Hub into a fully functioning CDC offering various diagnostic services to the local population and beyond. It is also an excellent example of reusing existing building stock to provide facilities in the heart of the community. It is also consistent with our wider estates strategy. I pay tribute to Lucy Gardner, Director of Strategy & Partnerships, for her leadership in this regard.

2.11 Healthcare Assistants Rebanding Update

As previously reported, the Trust received a re-banding claim from Unison on behalf of healthcare assistants (HCAs) in May 2023. This re-banding claim asked us to consider the work undertaken by our HCAs, which over time meant that a significant number were working at a higher level than the banding for which they were paid.

We have subsequently considered this very carefully and have worked in partnership with Unison to understand the re-banding claim more fully and reach a resolution. I am pleased to say that a resolution agreement has now been reached in relation to the re-banding and associated back pay.

We are in the process of working towards the implementation of this agreement and will be undertaking briefings for HCAs in order to make sure everyone understands what this means for them.

As is the case with all our colleagues at WHH, we are committed to ensuring fair pay for work undertaken here. We are pleased to have a positive resolution for our healthcare assistants and the Trust that will recognise the work they have undertaken previously in support of delivering care to our patients and community.

2.12 'Share and save' – a Trust-wide efficiency and sharing initiative

A Share and Save initiative has recently commenced to support efficiency savings and better use of clinical items that might otherwise go to waste. The scheme is led by our housekeepers and offers a great way to make savings and ensure that any unwanted items are put to good use and shared with other areas.

Staff are invited to identify any redundant stock from their areas which may be useful to other clinical departments. This surplus stock, of too little value to return, can be effectively donated to another area who can make use of the item on the understanding that they will not be re-charged. Many of these products would otherwise have gone out-of-date or been thrown away, creating unnecessary waste.

It is important to note that surplus stock on the wards is not the result of poor ordering or stock management - it can arise when patients no longer require the items, procedures have changed or simply that a better alternative has become available. Every item is logged on a spreadsheet and associated costs attached by the Procurement Team. Any out-of-date stock is offered to our education teams for use in clinical training and educational use.

Some examples of items shared so far include oral care packs, waste bins, chairs, glove holders, stacker baskets and cannulas. Just over £10,000 worth of waste has been avoided in the first three months of operation. Every little helps.

2.13 Organ Donation

I receive regular communications from NHS Blood and Transplant regarding the outcomes of organ and tissue donation and transplantation activity that goes on within the Trust. This work really matters.

We had one consented donor during the time period between April to September 2023. This patient did proceed to be an actual solid organ donor resulting in two patients receiving a transplant during the time period. Additionally, 6 corneas were received by NHSBT Eye Bank.

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation. In the above time period, we referred 16 patients to NHSBT's Organ Donation Services Team; 10 met the referral criteria and were included in the UK Potential Donor Audit. There was a further one audited patient that was not referred. A Specialist Nurse was present for two organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion. There was one (8%) missed opportunity to follow best practice out of 13 during the time period, compared with 0 (0%) out of 20 in the first six months of 2022/23.

In the North West, 39% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 43% of the population nationally.

England introduced deemed consent in May 2020. In England, between 20 May 2020 and 30 September 2023 there were 1579 occasions when consent was deemed from 2729 occasions where deemed consent applied. In the first six months of 2023/24, 217 people benefited from a solid organ transplant in the North West.

2.14 Continuous Quality Improvement

The Trust Quality Strategy outlines our ambition to build a culture of continuous quality improvement. As part of this we want all staff to have the opportunity, the skills, and the knowledge to question the status quo and make sustainable improvements for our patients, our Trust and each other.

This month, we have launched the 'Five essentials of Continuous Quality Improvement' for WHH. This new approach to CQI provides a framework for improvement work and gives a clear overview of the necessary components to successfully implement sustainable change.

The five essentials of Continuous Quality Improvement should be followed when undertaking any improvement work and the central CQI team have developed the tools to support staff in and QI project work, including a Quick Reference Guide, Digital Toolkit, Certification Criteria (completed QI projects that can evidence the use of the five essentials will be awarded a certificate) as well as a Quality Improvement Standard Operating Procedure (SOP).

In addition to our existing in-house training opportunities (Quality Improvement Foundation Course and Quality Improvement Practitioner Course) we have developed several dedicated bitesize sessions, perfect for anyone curious about quality improvement or those looking to refresh their knowledge and skills.

The five essentials of CQI will underpin all our future training programmes and new training offers are in development as part of a QI capability and capacity building plan. This will support our mission to have one clear and comprehensive quality improvement approach and culture for improvement across the entire organisation.

2.9 Local political leadership engagement

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

2.10 Employee Recognition

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

You Made A Difference Award (October 2023): Joanne Coutts

This award was made to Joanne Coutts from our Cardio-respiratory team for all the work she has done over the last 12 months as part of the development of the Community Diagnostic Centres Programme, specifically the rapid development and mobilisation of a new community spirometry service for Warrington and Halton.

You Made A Difference Award (December 2023): Eleanor Gow

This award was made to Eleanor Gow, Healthcare Assistant from Ward B19 for all the acts of kindness she has deployed for her patients, as well as other staff on the ward. Elle does special parcels and treats for special occasions, going above and beyond on every shift.

The awards for November 2023 and January 2024 are scheduled to be made shortly. The recipients of my own Chief Executive's Award have also been as follows:

Chief Executive's Award (December 2023): The Pre-operative Team

On 14 December 2023, our Pre-operative Team at Halton Hospital successfully resuscitated a patient who collapsed during a pre-operative consultation. Although all staff are trained for and prepared to manage such emergencies, fortunately it is very rare for this to happen in this kind of clinic setting, and they are certainly not doing so on a regular basis. Their approach was very calm, professional, structured and supportive and an excellent demonstration of good teamwork. The patient has now been successfully discharged from hospital.

Chief Executive's Award (January 2024): Emma Painter

This personal award was made for the contribution of Emma Painter, Associate Chief of Nursing for Unplanned Care, in managing a number of very difficult and complex patient/family cases over the last few months. In doing so, Emma demonstrated the utmost conscientiousness and attention to the detail of what matters most to patients and their families, whilst being mindful of the care of staff at the same time.

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

I have also specifically and personally recognised the contribution of the following colleagues:

- Linda Walden, Theatre Manager - Halton Theatres
- Joanne White, Clerical Officer - Endoscopy Waiting List Team
- Dr Ioannis Moukas, Consultant Cardiologist - Medical Care
- Janet Bedford and Team, Paediatric Acute Response Team - Women's & Children's Health
- Dr Kevin Tan, Consultant Anaesthetist & Intensivist - Medical Care
- Dr Adrian Morrison, Consultant Anaesthetist - Digestive Diseases
- Dr Phyu Wai, Consultant Physician - Integrated Medicine & Community
- Denise Adams, Ward Sister - CSTM
- Annabel Power, Specialist Biomedical Scientist - Clinical Support Services

- Dale Brookes, Biomedical Scientist - Clinical Support Services
- Nicola Lightfoot, Biomedical Scientist - Clinical Support Services
- Joseph Furnival, Support Worker - Pathology
- Gillian Banner, Domestic Supervisor - Estates and Facilities
- Hayley Lack, Trusted Care Assessor - Integrated Medicine & Community
- Mr Ansar Farooq, Consultant Breast Surgeon - Digestive Diseases
- Amanda Heaton, Head of HR
- Joanne Jones, Nurse Practitioner - Medical Care
- Dr Chun Wong, Speciality Trainee - Medicine
- Dr Nishita Padmanabhan, Speciality Trainee - Medicine
- Dr Emma Bickerstaff, IMT - Medicine
- Dr Mohammed Mohsen, IMT - Medicine
- Dr Luqman Bin Aizan, Foundation Year 1 Doctor
- Dr Conall Jager, Foundation Year 1 Doctor
- Dr Neil Bailey, Consultant Physician - Urgent & Emergency Care
- Suzanne Johnson, Lead Nurse Colposcopist - Women's & Children's Health
- Stephen Dutton, Staff Nurse - ACCU
- Claire Vere-Hoose, Clinical Nurse Specialist - Palliative Care Team
- Rebecca Broadbent, Medical Staffing Administrator - HR/OD
- Michelle Dutton, Housekeeper - Birth Suite Women's & Children's Health
- Eddie Gordon, Orthotics Service Lead - Clinical Support Services
- Helen Lloyd and Acute Dietetic Team, Clinical Support Services
- Shannon Osbaldeston, Assistant CBU Manager - Women's & Children's Health
- Katherine Eckersley, Sister - Endocsopy Unit
- Hannah Shand, Hospital Independent Domestic Violence Advocate
- Dr Emmanuel Egbase, Specialty Doctor - Maxillofacial Surgery
- Graham Marshall, Microbiology Service Manager – Clinical Support Services

2.11 Signed under Seal

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

- Warrington Town Deal Living Well Hub Collaboration & Contribution Agreement
- Warrington Catering Refurbishment Project
- Warrington MRI Turnkey Works to replace scanner.
- Warrington ED Minors Project
- Warrington Induction of Labour Phase 2 Project

3 MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended in December 2023 and January 2024 since the last Trust Board Meeting.

- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)

- CMAST Clinical Pathways Programme (Various)
- Steven Broomhead, Chief Executive, Warrington Borough Council
- Stephen Young, Chief Executive, Halton Borough Council
- Carl Marsh, ICB Place Director (Warrington)
- Anthony Leo, ICB Place Director (Halton)
- Warrington Wider System Sustainability Group (Monthly)
- Clinical Research Network Northwest Coast Partnership Group Meeting (Quarterly)

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 9 (December 2023)

Appendix 1 - CEO Dashboard Month 9 – December 2023

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	85.10%	
RTT 18 Weeks	92.00%	50.59%	
RTT 65+ Weeks	0	1521	
A&E % patients seen within 4 hours	> 75.00%	61.27%	
A&E % waiting longer than 12 hours	< 2.00%	23.89%	
Cancer 14 Days	93.00%	58.06%	
Breast Symptomatic 14 days	93.00%	17.39%	
Cancer 28 Day Faster Diagnostic Standard	75.00%	75.13%	
Cancer 62 Day Wait	85.00%	73.16%	No SPC
Ambulance Handovers within 60 mins	100%	68.94%	
Discharge Summaries 24 hours	95.00%	89.51%	
Cancelled Operations – 28 days	0	0	
Super Stranded Patients	Trajectory	136	No SPC
Theatre Utilisation	85.00%	84.60%	
Day cases	85.00%	89.97%	

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	
Sepsis Screening Emergency	90.00%	70.00%	
Sepsis Screening Inpatients	90.00%	84.00%	
Sepsis Antibiotics Emergency	90.00%	54.00%	
Sepsis Antibiotics Inpatient	90.00%	88.00%	
Inpatient Falls	20.00% reduction	40	
VTE	95.49%	93.51%	
Pressure Ulcers	10.00% reduction	18	
Medication Reconciliation (24 hrs)	80.00%	45.00%	
Complaints over 6 months	0	0	
Healthcare Infections - MRSA	N/A	0 YTD	
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	32 YTD	
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	65 YTD	
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	17 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	10 YTD	
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	5.09%	No SPC
Maternity 3rd and 4th Degree tears	Less than 1.85%	2.27%	No SPC
Maternity Pregnancy Bookings before 10 weeks	75%	50.60%	
Maternity Pregnancy Bookings before 13 weeks	90%	81.90%	
MUST nutritional assessment completion	85%	51.23%	

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (culm) (£m)	-£1.20	-£2.43	No SPC
Capital Spend (£m)	£16.87	£12.64	
Cash Balance (£m)	£15.52	£6.09	No SPC
Better Practice Payment Code (culm) (£m)	95%	92%	
CIP In Year Delivered (culm) (£m)	£10.74	£10.44	
CIP Forecast (Recurrent) (£m)	£10.74	£4.00	
Agency Ceiling	Less than 3.7%	2.60%	

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.56%	
Retention	85.00%	87.14%	
Core/Mandatory Training	85.00%	90.41%	
PDR Compliance	85.00%	75.46%	

Strategy

Strategy

- **Community Diagnostic Centre:** Phase 2 of the Trust's Community Diagnostic Centre (CDC) Programme went live on the 19th of December. It is delivering Phlebotomy, Ultrasound, Spirometry and Audiology services at the Halton Health Hub, Runcorn Shopping City. Once it is fully operational, the CDC will perform around 1,800 diagnostic tests per month. We welcomed the Minister for Health and Social Care, The Rt Hon Andrew Stephenson CBE MP, to the Halton Health Hub on the 11th of January.

- **Strategy Engagement:** The Strategy Team will be visiting all departments over the next few weeks to disseminate information about the strategy. Contact details for link people within the team who will maintain engagement and be the point of contact for strategy queries will be given.

- **Strategic Priorities 2024/25:** The Strategy Team are also planning to meet with Clinical Business Unit teams in February to discuss strategic priorities for next year. Last year's priorities will be discussed as well as local, regional, and national agendas to develop the strategic plan for 2024/25 and identify support needed to deliver it.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/02/162**			
SUBJECT:	**Chair's Report**			
DATE OF MEETING:	7 February 2024			
AUTHOR(S):	Steve McGuirk, Chair			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	This report highlights activity and strategic issues that, in the opinion of the Chair should be drawn to the attention of the Board but are not necessarily covered elsewhere on the agenda, as well as seeking to represent the point of view of the Council of Governors (COG) at the Board level.
	
	This update draws attention to:
	• **General Trust Update**
	  ○ CQC maternity inspection report publication
	  ○ New Chief Nurse – Ali Kennah
	  ○ Ministerial visit at Halton Hospital
	  ○ Industrial Action
	• **WHH Meetings and Events**
	  ○ Board Development Day
	  ○ Council of Governors Meeting			

	• **System Working & National Updates/Events**
	  ○ CMAST Update
	  ○ Liverpool Provider Joint Committee
	• **Governor Observation Visits**		

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chair's Report	AGENDA REF:	BM/24/02/162

BACKGROUND/CONTEXT

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

MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

Date	Location	Meeting
11.12.2023	Warrington Hospital	Governor Induction Training – New Governors
12.12.2023	Digital	Chair & Chief Executive Network Meeting
12.12.2023	Digital	Northwest System Leaders Call
21.12.2023	Clatterbridge Cancer Centre	Liverpool Provider Joint Committee
13.12.2023 11.01.2024	Digital	Chair's Briefing with Governors
11.01.2024	Halton Hospital	Ministerial Visit, Minister for Health and Secondary Care, The Rt Hon Andrew Stephenson CBE MP,
16.01.2024	The Park Royal Hotel, Stretton	Long Service Event for Staff who reached milestones during COVID-19
16.01.2024	Digital	C&M Health and Care Partnership
17.01.2024	Digital	CMAST Chairs

KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

1. General Update

1.1 Care Quality Commission (CQC) Maternity Services Inspection Report publication

I am delighted to share the news that,the CQC have determined to continue to rate our maternity services as 'Good' in the two domains of being 'well-led' and being safe.

This is an excellent result for the whole maternity team and the Trust, against a backdrop of intense scrutiny on maternity services across the country through the national maternity inspection programme. The programme involves a (short notice) inspection of maternity services at each Trust, looking at the safe and well-led key questions, with the overall aim, of course, being to provide an up-to-date view of hospital maternity care across the country.

The Warrington report, which was published on the 16 January 2024, is a very positive account across both domainsand and is based on the findings from an on-site inspection in September, as well as interviews with key staff and stakeholders, feedback from those who have used the service, plus a multitude of evidence requests and detailed data analysis before and after the inspection itself.

We received no 'must do' actions, with inspectors reporting five 'should do' actions to improve

services, and these recommendations relate to training, further integration of electronic records and refining our approach to policies and procedures.

The report can be read in full on the CQC website,

I wanted to say a huge thank you to all the staff involved in the preparation and the visit itself as well as the follow up. This is a great achievement not least against the backdrop of many services being downgraded.

1.2 New Chief Nurse – Ali Kennah

Following a competitive recruitment process, Ali Kennah has been appointed to the role of Chief Nurse at Warrington and Halton Teaching Hospitals (WHH).

Ali has worked at the Trust since 2017, most recently as Associate Chief Nurse and then Deputy Chief Nurse. She will step into her new role on 1 April 2024, taking over from current Chief Nurse Kimberley Salmon-Jamieson, who is joining Manchester University NHS Foundation Trust as their Executive Group Chief Nurse.

Ali began her career in the NHS 28 years ago, joining after qualifying in 1995 and working her way through the ranks from nurse to matron. Prior to starting at WHH she was Head of Quality at Mersey and West Lancashire Teaching Hospitals NHS Trust (previously St Helens and Knowsley Teaching Hospitals NHS Trust).

1.3 Ministerial visit at Halton Hospital

Minister for Health and Secondary Care, The Rt Hon Andrew Stephenson CBE MP, was welcomed to Halton Hospital on Thursday 11 January to see some of the developments which are supporting our elective recovery efforts. The tour included a visit to the Post Anaesthetic Care Unit in the Captain Sir Tom Moore Building (CSTM), before taking in the new theatre and day case unit, which is currently under construction and being delivered through the Targeted Investment Fund (TIF).

The Minister also travelled to the Halton Health Hub to see the first-hand the services being delivered from within Runcorn Shopping City. These have recently been expanded to incorporate phase two of our Warrington and Halton Diagnostics Centre, which aims to improve access to planned diagnostic tests for our communities.

1.4 Industrial Action

Industrial action for Junior Doctors took place at the Trust:

- From 06.59 on 20 December 2023 – 06.59 on 23 December 2023.
- From 06.59 on 3 January 2024 – 06.59 on 9 January 2024.

The Trust's emergency preparedness plans for both periods of industrial action were led by the Medical Director. This was coupled with the operationally led Multi Agency Discharge Event – 'MADE for Christmas' - focusing on supporting safe discharge for as many patients as possible to ensure that the Trust was a prepared as possible for the impact of the industrial action and Christmas period.

The industrial action did make an impact nationally due to the operational challenges faced by many Acute Trusts in January 2024. WHH did not need to request any derogations during the period of industrial action and managed to mitigate any risks.

2. WHH Meetings and Events

2.1 Board Development Day

Members of the Board took part in a learning and development day on Wednesday 10January 2024. The first item on the agenda was an executive summary of the Urgent and Emergency Care diagnostic findings presented by Andy Lumb of Newton. The presentation provided a comprehensive insight into the system wide improvements required to improve Urgent and emergency Care at WHH, the key aims of the diagnostic were noted (as below)

- A system-wide diagnostic, quantifying the operational opportunities to improve Urgent and Emergency Care (UEC) effectiveness and efficiency across the catchment area of Warrington & Halton.
- Clarity of operational & financial opportunities and outcomes by organisation
- Alignment of key senior leaders around the long-term transformation opportunity
- An outline programme plan to achieve the opportunities identified
- Knowledge sharing across the system including the ICB on the findings and plans.

Work is currently underway with system partners to improve the position. Other agenda items included NHS impact and culture overview, and the Well-led plan.

2.2 Council of Governors Meeting

The next Council of Governors meeting will take place on: 15 February 2023, 4pm to 6pm in the Trust Conference Room, Warrington site.

Papers for Council of Governors meeting are made available to the public prior to meetings on the Trust Website. The meetings are open to members of the public to observe.

3. System Working and National Updates

3.1 CMAST Update

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

3.2 Liverpool Provider Joint Committee

I am now the representative on behalf of the Cheshire and Merseyside provider collaborative on the Liverpool provider joint committee. This committee is seeking to enact the recommendations of the review that was undertaken into the provision of services across Liverpool. My role is to try to ensure that there is integration of thinking between the changes going on around Liverpool providers-and in particular specialist providers that have a relationship to the wider Cheshire and Merseyside geography. I provide feedback to the provider collaborative on anything arising from the joint committee work on a regular basis.

4. Governor Observation Visits

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

- 9th December 2023 – Planned Investigations Unit Halton
- 11 January 2024 – The Hub

RECOMMENDATIONS

The Trust Board is asked to:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/163**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	7th February 2024			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at the relevant Board Committees. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. **I. Since the last meeting:** • No new risks have been added;			

<table>
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Since the last meeting there have been no changes to the ratings of any of the risks; however, it is proposed to reduce the rating of one risk (#115)
Since the last meeting there have been no updates to the descriptions of any of the risks; however, it is proposed to amend the descriptions of two risks.
No risks have been closed or de-escalated;

Risk appetites for each of the risks have been supported by the appropriate monitoring Committees/ Executive Leads and are highlighted in appendix 1

II. During the Financial Year

Two new risks were added during the last financial year
The ratings of four risks have decreased and one increased in the last financial year. It has also been proposed the reduce the rating of one further risk.
There have currently been no amendments to the descriptions of any risks however, it is proposed to amend the descriptions of two risks.
During the last financial year, one risk has been de-escalated

Notable updates to existing risks are also included in the paper.
III. The current Corporate Risk Register is included as appendix 2 for information
IV. The trust-wide Risk Appetite Statement is included for review and approval.
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<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval ✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Board is asked to:

Discuss and approve the changes and updates to the Strategic Risk Register
Note the addition of risk appetites to each risk on the Strategic Risk Register
Note the annual review of the amendments made to the Strategic Risk Register in financial year 2023/24
Note the Corporate Risk Register
Approve the Risk Appetite Statement
Note the next steps
</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">Multiple</td></tr>
<tr><td>Date of meeting</td><td colspan="2">Multiple</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Approved</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/24/02/163

1. BACKGROUND/CONTEXT

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

Risk appetites for each of the risks have been supported by the appropriate monitoring Committees/ Executive Leads and are highlighted in appendix 1

Also included in the paper is a review of the updates that have taken place during the last financial year and

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

The latest Corporate Risk Register is included as Appendix 2

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New Risks

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

2.2 Amendment to Risk Ratings

Since the last meeting there have been no changes to the ratings of any of the risks; however, it is proposed to reduce the rating of one risk **(#115)**

It is proposed to decrease the rating of risk #115 (detailed below) from 20 to 16.

The recommendation to reduce risk is as a result of sustained reduction in registered nurse turnover and overall vacancy.

ID	Risk description	Rating (current)	Rating (proposed)	Executive Lead
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.	20 (5x4)	16 (4x4)	Kimberley Salmon-Jamieson

2.3 Amendments to descriptions

Since the last meeting there have been no updates to the descriptions of any of the risks; however, it is proposed to amend the descriptions of **two** risks.

Risk #224

It is proposed to update the description of **Risk #224** (detailed below) to ensure the risk aligns and links with the current Tier 1 metrics and removes reference to COVID-19

Risk #1215

Current: If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.

Proposed: If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, ~~in part as a consequence of the COVID-19 pandemic~~; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department form time of arrival

Risk #125

It is proposed to update the description of **Risk #125** (detailed below) to better reflect the current position.

Current: If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns

Proposed: If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns

2.4 De-escalation of Risks

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

2.5 Risk Appetite

Risk appetite can be defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take' in pursuit of its strategic objectives. It represents a balance between the potential benefits of innovation and the threats that change can brings.

Risk can generate significant opportunities and therefore should be considered in terms of both opportunities and threats.

- When considering threats, the concept of risk appetite should consider the level of exposure which is considered tolerable and justifiable.

- When considering opportunities, the risk appetite should consider how much the organisation is prepared to actively put at risk in order to obtain the benefits of the opportunity.

Much like risk rating (probability and likelihood), risk appetite should also be dynamic and can change with circumstances.

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

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

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

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

These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix a copy of which is included on page 4 of appendix 1

Table 1

	0 NONE	**1 MINIMAL**	**2 CAUTIOUS**	**3 OPEN**	**4 SEEK**	**5 SIGNIFICANT**
RISK APPETITE LEVEL ➔	Avoidance of risk is a key organisational objective	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust
RISK TYPES ➔	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
FINANCIAL How will we use our resources?						
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders

QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Initial risk appetite for each of the risks have been supported by the appropriate Executive Leads and monitoring Committees and are highlighted below in table 2, and in full in appendix 1

Table 2

Risk ID	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	1	20 (5x4)	8 (2x4)	Cautious
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (4x5)	6 (3x2)	Cautious
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.	1	20 (5x4)	12 (4x3)	Minimal

134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	Open
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	Cautious
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	20 (5x4)	8 (4x2)	Cautious
2001	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (5x4)	6 (2 x 3)	Minimal
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (4x4)	8 (2x4)	Minimal
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	3	16 (4x4)	8 (2x4)	Cautious
1898	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	3	16 (4x4)	4 (1x4)	Seek
125	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	1	15 (3x5)	10 (2 x 5)	Open
145	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (3x4)	8 (4x2)	Open

2.6 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the	<u>Assurances</u> • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. This would constitute phase 3 and onwards of the ED footprint	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	following the building of the Same Day Emergency Care Centre (SDEC) • Update nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor		
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	<u>Assurances</u> • Investment in registered nursing in the Emergency Department • Recruitment Fayre 9th February 2024 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 11.08% in December 2023. • Overall vacancy reduced to 9% in December • Overall CHPPD sustained improvement at national standard of 8.0 • No requirement for staffing incentive scheme YTD • Cost avoidance from agency managed service of £1.5m since April 2022 • Reduction in agency spend of £392K since April 2023. <u>Assurance Gaps</u> • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients • Continued escalation of ward A10 and intermittent escalation of Cardiac Catheter lab	20	Propose to reduce rating to 16
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	<u>Controls</u> • Counter Fraud campaign took place for national anti-fraud week in November 2023 <u>Assurances</u> • C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Any changes to WTE are reviewed at FSC and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. • Participate in the monthly ICS Expenditure Control Group established in October 2023. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation.		
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.67% as at October 2023 and is showing an improving variation. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. Lowest annual absence rate since April 2020. <u>Controls</u> • OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within the last 12 months who have experienced an absence of depression/stress/anxiety, and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required. <u>Assurances</u> • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.5% in October 2023. • Current annual welcome back conversation compliance is 89.8% in October 2023 and remains above target. **Turnover and Attraction** Turnover in October 2023 was below target at 12.53% and is showing an improving variation. Turnover of permanent staff in October 2023 was 11.67% which was below Trust target. <u>Controls</u> • HR are working with pilot areas to review their approach to rostering and the impact on agile/flexible working to support a reduction in turnover. **Temporary Staffing & Agency Spend** Bank and Agency reliance in October 2023 was 16.01% showing a concerning variation. Reasons for the variation can be attributed to industrial action and continuing sickness absence, turnover and additional capacity. Bank reliance continues to increase and is 11.6% in October 2023 as Agency reliance continues to decrease to 4.9% in October 2023. <u>Controls</u> • The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. • The Resourcing Task and Finish group is working with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this will allow the organisation to develop plans to improve the effectiveness of workforce deployment. <u>Gaps</u>		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. Lack of assurance regarding industrial action ending which impacts bank and agency utilisation.		
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	<u>Controls</u> • Trust policies updated in relation to industrial action • Trust approach to industrial action established following implementation of IA task and finish group. • Emergency preparedness meetings underway led by the Medical Director <u>Gaps in Assurances & Controls</u> • JD IA planned for December 2023 and January 2024 concerns regarding operational impact of IA on patient flow, particularly considering the time of year. Emergency preparedness planning underway to mitigate risk.	20	No impact on risk rating
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	<u>Controls</u> • Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • MUSE migration funded <u>Gaps</u> • Using unsupported software SharePoint 2010 for the Hub	16	No impact on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the	<u>Gaps</u>	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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	• Delay in issuing tender due to NHSE FDIB query over technical specifications. • Further assurance required regarding state of readiness for implementation		
1898	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	<u>Assurances</u> • Development of business cases for initial phases of Estates Strategy in progress • Developing scope for work required to create phased new hospital plan for the Warrington site	16	No impact on risk rating
125	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	<u>Controls</u> • Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding • Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk • Complete formal RAAC survey undertaken across whole estate. Small extension building identified as having RAAC present. Remedial action to eradicate ongoing with NHSE. <u>Assurances gaps</u> • Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more,	15	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		with less and the estates maintenance team is currently under resourced		
145	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	<u>Controls</u> • Health & Wellbeing Hub (Living Well Hub) due to open in February 2024 <u>Assurances</u> • Detailed work commenced, supported by external consultants, to help address no criteria to reside & enable admission avoidance. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside	12	No impact on risk rating

3 ANNUAL REVIEW

3 Annual Review of the Strategic Risk Register

Detailed in this section is a review of the updates made to the Strategic Risk Register during the financial year 2023/24 up to an including this meeting (7th February 2024)

3.1 New Risks (2023/24)

During Financial Year 2023/24 **two** new risks have been added and these are detailed below:

Risk #1898

Following discussion at the Audit Committee and Risk Review Group and subsequent approval by the Trust Board in June 2023, **risk #1898** (detailed below) in relation to securing sufficient funding for a new hospital was added at a rating of 12.

ID	Risk description	Rating	Executive Lead
1898	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and	12 (3 x 4)	Lucy Gardner

	recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.		

Risk #2001

Following discussion at the Patient Safety & Clinical Effectiveness Sub-Committee, Quality Assurance Committee and the Risk Review Group, and subsequent approval by the Trust Board in October 2023, it was agreed to add **risk #2001** (detailed below) in relation to services within the Trust that are defined as being fragile, at a rating of 20.

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

ID	Risk description	Rating	Executive Lead
2001	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	20 (5 x 4)	Paul Fitzsimmons

3.2 Amendments to Risk Ratings (2023/24)

During Financial Year 2023/24 the ratings of **five** risks have been updated it and has been proposed to update the rating of one further risk, and these are detailed below:

Approved

Risk #224

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

ID	Risk description	Rating (previous)	Rating (new)	Executive Lead
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	25	20	Daniel Moore

Risk #1215

In light of plans to address the capacity deficit, for example TIF, CDC, mutual aid, GIRFT, validation; it was agreed by the Trust Board in June 2023, to reduce the risk rating from **25 to 20**.

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

Risk #1275

As the number of cases of COVID-19 had reduced and at the time there were no outbreaks, operational impact was reduced, and contact bays were not being closed. It was therefore agreed by the Trust Board in June 2023, to reduce the rating from **16 to 9**

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

Risk #1846

Further to the additional controls that had been but in place, it was agreed by the Trust Board in June 2023, to reduce the rating of the risk from **16 to 12.**

ID	Risk description	Rating (previous)	Rating (new)	Executive Lead
1846	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage	16	12	Kimberley Salmon-Jamieson

Risk #1757

Due to the impact of Industrial Action by Junior Doctors and Consultants and the subsequent potential impact on patient care, it was agreed by the Trust Board in August 2023, to increase the rating of risk #1757 from 16 to 20.

ID	Risk description	Rating (previous)	Rating (new)	Executive Lead
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant	16 (4x4)	20 (5x4)	Michelle Cloney/Paul Fitzsimmons

	workforce gaps which would negatively impact service delivery and patient safety			

Proposed

As detailed in section 2.2, it is proposed to reduce the rating of risk #115 from 20 to 16 as a result of sustained reduction in registered nurse turnover and overall vacancy.

3.3 Amendments to risk titles

During the Financial Year 2023/24, there have been no amendments to the titles/ descriptions of any of the risks; however, as described in section 2.3 of this report, there are proposals to update the titles of two risks: **#224** and **#125**

3.4 De-escalation/ closure of risks

During the Financial Year 2023/24 on risk was de-escalated.

Further to the approval to reduce the rating of **Risk #1275** in relation to the prevention of nosocomial infection in June 2023, as described in section 3.2, it was also agreed de-escalate the risk to the Corporate Risk Register for continued monitoring.

4 CORPORATE RISK REGISTER

4 Corporate Risk Register

The Corporate Risk Register comprises of all risks that could prevent the Trust from carrying out its daily operations.

Risks on the Corporate Risk Register may be escalated or de-escalated to or from the Strategic Risk Register as appropriate. A Corporate Risk Register report is presented to the Risk Review Group monthly. This report contains proposals to amend or close any risks held on the Corporate Risk Register.

The Corporate Risks are also monitored at the appropriate Board Committees

The current Corporate Risk Register is included as Appendix 2

5 RISK APPETITE STATEMENT

5 Risk Appetite Statement

As described in section 2.5. risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

The Trust Board is required to review and approve the risk appetite statement on an annual basis. Detailed below is the current risk appetite statement defined in to five types of risk: Quality, People, Finance & Sustainability, Regulation and Reputation, aligning with the risk matrix described in section 2.5, table 1.

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

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

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

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

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

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

<u>Quality</u>

Providing the best care and treatment we can is our purpose. We will actively avoid risks to the quality of clinical services and will take a cautious and balanced approach. Where innovation may improve quality of care we will however be more open to risk. When making significant decisions about our services, we will assess and record any risks affecting safety, patient experience and clinical effectiveness, and apply the necessary control measures. The impact of changes on quality will be monitored continuously and reported using both quantitative data and qualitative intelligence.

<u>People</u>

We aim to provide a supportive and inclusive culture and working environment, in which both individuals and teams can thrive. We recruit, develop and train current as well as future staff. To achieve our goals in respect of quality services and financial sustainability we will need to take significant decisions about services that will affect our people and may impact their working arrangements. We are therefore open to risk where we can demonstrate longer-

term benefits to patients from our decisions. In arriving at those decisions, we will engage with our staff to shape our proposals, in order to maximise the positive impact on patient care and mitigate any potential adverse impact on staff.

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

The Board is asked to review and approve the Trust's Risk Appetite Statement in its current iteration.

6 NEXT STEPS

Further the developments of the BAF in the previous 12 months, additional work is taking place to align the individual risk target ratings/ risk tolerance with the individual appetites.

The Strategic Risk Register will continue to be reviewed by the Trust Board at each meeting with oversight from the Audit Committee and appropriate Committees of the Board.

7 RECOMMENDATIONS

The Board is asked to:

- Discuss and approve the changes and updates to the Strategic Risk Register
- Note the addition of risk appetites to each risk on the Strategic Risk Register
- Note the annual review of the amendments made to the Strategic Risk Register in financial year 2023/24
- Note the Corporate Risk Register
- Approve the Risk Appetite Statement
- Note the next steps

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Board Assurance Framework

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

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

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

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

Risk Appetite Statement

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

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

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

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

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

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

<u>Quality</u>

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

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

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

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

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

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

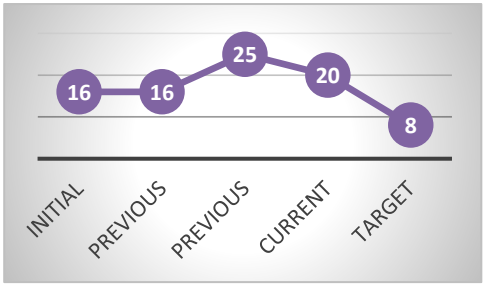
Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

RISK APPETITE LEVEL / RISK TYPES	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.			**Initial:**	16(4x4)
				Current:	20(5x4)
				Target:	8 (2 x 4)
Risk Appetite	**Cautious** – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Controls** • Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day • Discharge Lounge/Patient Flow Team/Silver Command • ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing • Private Ambulance Transport to complement patient providers in and out of hours • FAU/Hub operational operating 5 days per week. • Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. • Increase IMC provided by the system such as the opening of the additional bedded capacity • Increase IMC at home • Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. • Same Day Emergency Care Centre (SDEC) completed July 2022. • Upgrade to Minor's resulting in Oxygen points in all cubicles • Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients • ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. • Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. • Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings • Additional Senior Manager on call support a weekends • Senior Dr at Triage Function • Ward A10 opened as winter escalation capacity funded by the ICB. • Plans being progressed to procure and install a new CT scanner co-located in the main body of the ED department. This will support increases urgent care pathway efficiency in the ED. This is set to be operational in September 2023. • Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients. • Plans to co-locate ED Minors in the SDEC building to enhance patient pathways. The capital project is now agreed and set to be operational in April 23. • Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter • Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E • Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside • Work plan to reduce super stranded and no criteria to reside in 2023/24 is being finalised by the System Sustainability Group				

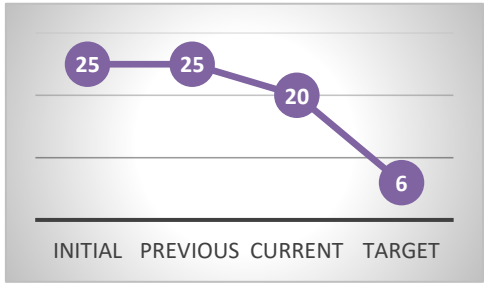
	• Executive led ED Improvement Group established chaired by the Chief Operating Officer with Chief Nurse & Medical Director as co-chairs • Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas to be submitted to the Trust Board in December 2023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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/03/2024 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/03/2024 (ongoing)	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial:**	25 (5x5)
				Current:	20 (4x5)
				Target:	6 (3x2)
Risk Appetite	**Cautious** – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Controls** • Clinical Services Oversight Group (CSOG) established • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23. • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. • Waiting lists are reviewed through the Performance Review Group Weekly • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reservice programme of work. • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward A5 on the Warrington site. • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends. • Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients • Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae by the end of Q4 2022/23. • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • Digital Validation commencing in May 2023 to improve data quality of the Trust waiting lists				

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

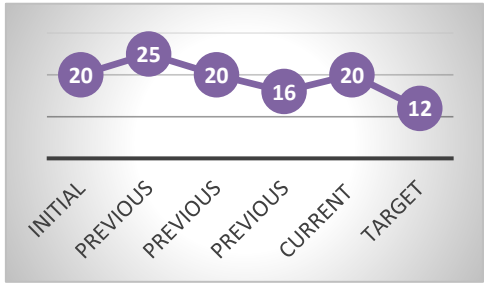
Assurance Details:

Controls

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

Assurances

- Investment in registered nursing in the Emergency Department
- Recruitment Fayre 9th February 2024
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 11.08% in December 2023.
- Overall vacancy reduced to 9% in December
- Overall CHPPD sustained improvement at national standard of 8.0
- No requirement for staffing incentive scheme YTD
- Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.54% in August 2023
- Maternity: Retention rates continuing to follow a positive trajectory. Turnover for all permanent staff has decreased from 29.49% in August 2022 to 14.81% in July 2023 (Reduction of 14.68%) for registered staff this figure has reduced from 30.15% in August 2022 to 16.82% in July 2023 (reduction of 13.33%)
- Maternity: Vacancy rate for registered staff has reduced from a peak of 23.25% in June 2022 to 14.74% at the end of July 2023
- Cost avoidance from agency managed service of £1.5m since April 2022
- Reduction in agency spend of £392K since April 2023. This has been enabled by the introduction of padlock and golden keys systems which can only be removed by the Senior Nursing Team. This controls the cascade of shifts to lower cost and higher cost agencies respectively.
- Reduction in agency hourly rate of £11.12 per hour since April 2022
- Revenue requests for ED have been approved which supports increased staffing establishment to provide corridor care 24/7.



	• International Nurse recruitment: cohort 13, 13 staff have been allocated to clinical areas and are progressing through induction in September 2023. Cohort 14, 11 staff arrive in the UK in September 2023. The Trust does not currently have plans for future cohorts. There will continue to be a focus on pastoral support and retention. • Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead • Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift • Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews • Leaver data is closely monitored and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner • Retention – Internal Transfer process in place for staff • A7, A8 and A9 uplift in healthcare support workers for night shifts has been approved to support the provision of enhanced care • Re-launch of what was the Safe Staffing Group, now the Nurse Staffing and Clinical Outcomes Group to provide a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk	
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients • Continued escalation of ward A10 and intermittent escalation of Cardiac Catheter lab • Partially funded revenue requests • 75% vacancy rate for Band 6 Pharmacists August 2023; 56% Band 7 • Time to post when recruiting new staff • Ensuring safe staffing in response to doctor and healthcare support worker strikes	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment • Position and plans for staff retention. • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Kennah, Ali	31/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	134	**Executive Lead:**	Hurst, Jane	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				

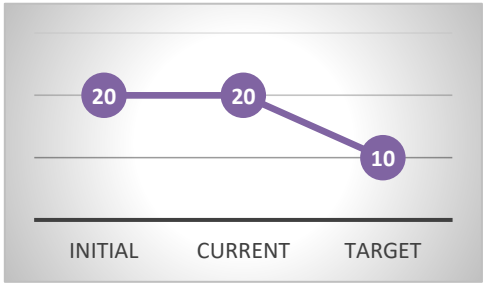
Assurance Details:

Controls

•Core financial policies controls in place across the Trust
•Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning
• Weekly CEO led recovery meeting (inc finance & operations) in place
• Procurement/tender waiver training in place
• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years)
• Latest guidance from MIAA Counter Fraud Team circulated
• Counter Fraud campaign took place for national anti-fraud week in November 2023
• Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced.
• Appointed GIRFT Finance Lead and 5 PAs allocated.
• Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022
• CDC phase 2 application approved for £4.5m capital over three years
• Capital & Revenue Plans for 2023/24 approved by the Trust Board in March 2023 & updated and approved by the Trust Board in May 2023
• Introduced system of escalation where there are risks to CIP delivery
• Reviewed of all aspects of 2023/24 operational plan resulting in an improved finance forecast
• New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified.
• Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee
• Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023
• Tightening controls of non-pay expenditure
• Director of Recovery in place from October 2023 – January 2024 to review CIP, Cost Pressures and Benefit realisations.
• Trust ensuring that activity provided externally does not exceed tariff cost

Assurances

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

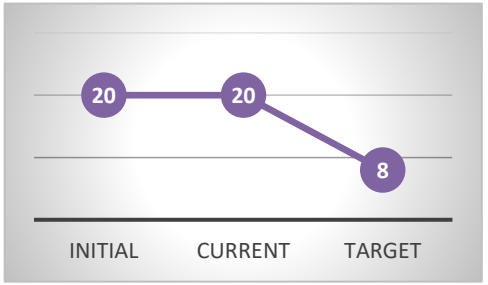


	• Capital is reported monthly to F&SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Any changes to WTE are reviewed at FSC and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. • HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • We have allocated CIP targets under an approved new methodology for 2023/24 • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Participate in the monthly ICS Expenditure Control Group established in October 2023. • Working with the ICS on the forecast position. Letter received confirming additional £4.8m non-recurrent funding, including £1m tier 1 urgent care. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation.	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Risk of unforeseen costs and under delivery of activity and income due to further COVID-19 / Flu surge / Industrial action • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Introduction of protocol for changing forecast outturn with the potential impact of restricting financial freedoms and access to capital. • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Non-recurrent income support for additional capacity presents a risk to the 2023/24 and 2024/25 financial plans • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Not all cost pressures have been funded in plan for 2023/24 • Risk to financial freedoms as the Trust has a deficit plan • Sufficient cash available based on operational plan however, deterioration from plan represents a risk to cash • Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted • New 65 week target will require investment of circa £1m	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Output of review undertaken of CIP, cost pressures and benefits realisation to be monitored via the Committee structure	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane	31.03.2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial:**	20 (4x5)
				Current:	20 (4x5)
				Target:	8 (4x2)
Risk Appetite	**Cautious** – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Control & Assurance Details:	**Sickness Absence** The rolling 12-month sickness absence rate is 5.67% as at October 2023 and is showing an improving variation. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. Lowest annual absence rate since April 2020. **Controls** •New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. •Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers. •Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. •Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management. •People Health and Wellbeing Group. The group have focused on understanding the Trust's absence reasons and reducing the volume of absences recorded as 'unknown'. •Supporting Attendance Month - roadshows, drop-in sessions, comms and events to showcase the Trust's commitment to Supporting Attendance •Focused welcome back conversation recording and internal audit •Following an MIAA Audit, the HR team are working with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. •OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within the last 12 months who have experienced an absence of depression/stress/anxiety, and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required. **Assurance** •The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub. •The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.5% in October 2023. •Pilot took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE •Pro-active health interventions being offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate •Current annual welcome back conversation compliance is 89.8% in October 2023 and remains above target. •Sickness absence, turnover and attraction workstreams have been reviewed inline with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been considered.				

	Turnover and Attraction Turnover in October 2023 was below target at 12.53% and is showing an improving variation. Turnover of permanent staff in October 2023 was 11.67% which was below Trust target. Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving. **Controls** •Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted action. This information is available on the Trust Workforce Information Dashboard. •Rugby League Cares have been supporting WHH since July 2021 •Grief and Menopause cafes •Social media accounts have been created to support recruitment attraction across a number of social media platforms •Financial wellbeing resources have been implmented to support the workforce and retention including Wagestream •A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working. •HR are working with pilot areas to review their approach to rostering and the impact on agile/flexible working to support a reduction in turnover. **Assurances** •The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH. •As a result of analysis of exit interviews, a theme identified was working hours and flexible working. Pharmacy are working towards changes to working hours, which have been raised as a factor by leavers and potential joiners as a barrier. •The responses to Exit Interviews are positive, only 16% of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions. **Temporary Staffing and Agency spend** Bank and Agency reliance in October 2023 was 16.01% showing a concerning variation. Reasons for the variation can be attributed to industrial action and continuing sickness absence, turnover and additional capacity. Bank reliance continues to increase and is 11.6% in October 2023 as Agency reliance continues to decrease to 4.9% in October 2023. **Controls** •The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. •The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies approval o ECF process for bank and agency temporary staffing pay spend approval o Medical Rate Escalations approved by Medical Director • The Resourcing Task and Finish group are developing robust processes to support compliance with national guidelines/standards for using temporary workers. All staff groups/CBUs will be monitored against these standards. Compliance is to be reported within the Medical and Nursing/AHP Workforce Groups and to FSC. A dashboard is being developed that will summarise workforce related intelligence to inform decision making regarding vacancies and temporary staffing. •The Resourcing Task and Finish group is working with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this will allow the organisation to develop plans to improve the effectiveness of workforce deployment.	

	Assurances •Compliance against our processes and rate cards monitored through the Finance and Sustainability Committee •To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace the ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group.	
Assurance Gaps:	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Lack of assurance regarding industrial action ending which impacts bank and agency utilisation.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff	Laura Hilton	31.03.2024	
Embed an agile and flexible working culture within all WHH Teams	Through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2024	
Develop action plan to reduce reliance on temporary staffing	Following the development of a workforce assessment framework for temporary staffing, undertake gap analysis and develop action plan	• The Resourcing Task and Finish group is working with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. • The gap analysis from this will allow the organisation to develop plans to improve the effectiveness of workforce deployment.	Carl Roberts	31.01.2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

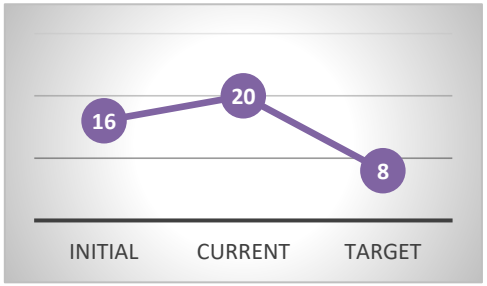
Control & Assurance Details:

Controls

- Trust policies updated in relation to industrial action
- Trust approach to industrial action established following implementation of IA task and finish group.
- Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible.
- Executive led IA Operational Task and Finish group in place for each period of IA with an Executive led check and challenge session to ensure strike rosters support safe staffing.
- IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH.
- Participation in ICB IA Clinical Cell calls where applicable.
- Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA.
- IA Task and Finish group completed organisational preparedness for Industrial Action policies and procedures ratified and FAQ documents created and published and updated regularly.
- Executive Medical Director led check and challenge meetings for periods of Industrial Action to prepare and mitigate risk.
- B2 HCAs industrial action took place 28/09/23 – 29/09/23 – 10 derogations requested, 5 derogations approved.
    - emergency, trauma and maternity theatres
    - x2 theatre cancer fast track lists
- B2 HCSW Industrial Action from 16/10/23 – 21/10/23 – 10 derogations requested, 5 derogations approved.
    - emergency, trauma and maternity theatres
    - x2 theatre cancer fast track lists
- B2 HCSW Industrial Action from 02/11/23 – 08/11/23 – 10 derogations requested 3 derogations approved
    - emergency, trauma and maternity theatres
- Chief Nurse led meetings re: Industrial Action preparedness for periods of B2 HCSW Industrial Action to prepare and mitigate risk.
- B2 HCA IA on hold whilst conversations take place with Acas re collective conciliation.
    - 7am Monday 27 November to 8.00am Saturday 2 December 2023 – stood down
    - 7am Monday 4 December to 8.00am on Saturday 9 December 2023 – stood down
- B2 HCA's out to ballot on Trust offer from 5 December 2023 to 20 December 2023 12:00 – all IA stood down
- Junior Doctor IA planned for:
    - 06.59 20th December – 06.59am 23rd December 2023
    - 06.59 3rd January – 06.59am 9th January 2023
- Emergency preparedness meetings underway led by the Medical Director from 11/12/23

Assurance

- Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.
- Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
- AfC pay agreement implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24
- RCN ballot that closed on the 23/06/23 did not meet the mandate therefore no further planned RCN IA at present time. Society of Radiographers did not meet their mandate at WHH.

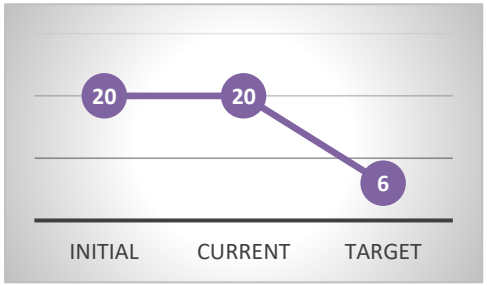


	• Mandate met for Junior Doctors Industrial Action mandate will run until 28/02/2024 • National guidance available for Consultant IA • BMA have published letter 13/07/23 r.e. the process for requesting derogations. • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of Industrial Action • Long term NHS Workforce plan published 30/06/23 to address gaps in workforce. • Trust mitigated the need for derogations to services for Consultant IA held in July 2023 • Recruiting Junior Doctors to WHH bank following legal challenge meaning collaborative bank cannot be utilised during IA. • NHS England letter 03/10/23 to BMA welcoming pause to any further industrial action dates reiterating concerns formally re Christmas Day cover and patient safety concerns. • B2 HCA IA on hold whilst conversations take place with Acas re collective conciliation. • B2 HCA's out to ballot on Trust offer from 5 December 2023 to 20 December 2023 12:00 – all IA stood down. • Government offer made to consultants has been put to ballot by the BMA which closes on 18/12/23. • BMA Consultant and SAS doctor ballot for further industrial action closes 18/12/23.	
Assurance Gaps:	• Lack of clarity from the ICB regarding mutual aid • Lack of MOU from ICB • Lack of clarity from BMA process for requesting derogations • No further updates on national position regarding talks with Trade Unions, specifically the BMA for Junior Doctors • BMA derogations process means unlikely to get derogations signed off for critical services. • High court ruling on 13/07/23 that employers can no longer use agency staff to fill in for striking workers for industrial action from 10/08/23. Also, Collaborative banks cannot be utilised. • Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extra contractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. • The above is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics • Unison ballot met 50% threshold potential period of Industrial Action from 18/09/23 – 03/03/23 • JD IA planned for December 2023 and January 2024 concerns regarding operational impact of IA on patient flow, particularly considering the time of year. Emergency preparedness planning underway to mitigate risk. • Government consultant offer puts meritous LCEA new applications proposal process at risk	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Check and challenge meetings to commence for Junior Doctor Industrial Action	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Fitzsimmons, Paul	31/01/2024	
Check and challenge meetings to commence for Consultant Industrial Action	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Fitzsimmons, Paul	31/01/2024	
Participate in regional ICB Workforce Industrial Action preparedness group	Participate in regional ICB Workforce Industrial Action preparedness group	Attending and participating in regional ICB Workforce Industrial Action preparedness group	Hilton, Laura	31/01/2024	

Board Assurance Framework

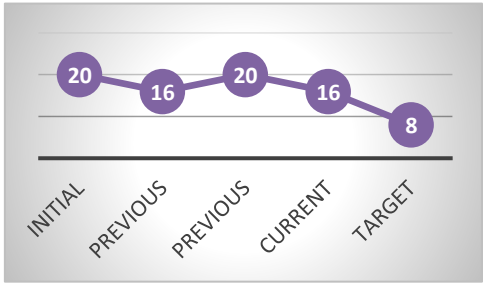
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	2001	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.			**Initial:**	20 (5 x 4)
				Current:	20 (5 x 4)
				Target:	6 (2 x 3)
Risk Appetite	**Minimal – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.**				
Assurance Details:	The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'. Current services included in the Fragile Services Oversight program are: • Gynaecology • Urology • Orthopaedics – Fractured Neck of Femur • Ophthalmology – Paediatric Ophthalmology • ENT Surgery **Controls** • Formal process in place for identification and designation of Fragile Services • Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams • Appropriate prioritisation of Fragile Service Revenue and Capital Requests **Assurances** • Monthly oversight through standardised Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • Escalation to Quality Assurance Committee via PSCESC escalation reports • Bi-monthly Fragile Services report to Trust Board				
Assurance Gaps:	•Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bedbase) •Ongoing industrial action •Increasing demand				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.		**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	8 (2x4)
Risk Appetite	**Minimal** – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Assurance:** • Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active core member C&M Cyber Core Group and the C&M Health and Care Partnership Cyber Security Group. • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • External NHS England approved Cyber Training for the Trust Exec Board • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure				

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

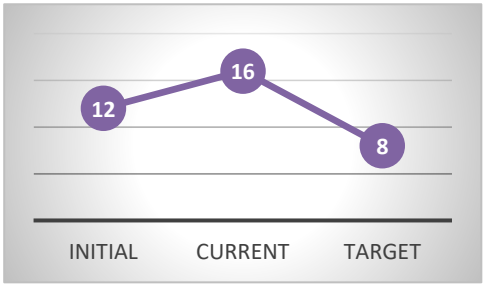
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for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

systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.		IT elements complete. Working with Operations and Digital Analytics to complete work target decommission the server in Q4 WHHNBSSV1 The third-party informed us that due to a software issue the 21st migration date has been postponed. Target date 16th January 2024. NCHVPRISM01 Work scheduled with the third-party. Team leaders of users have been informed of maintenance work. Migration completed and the server to be decommissioned W/C 11/12/23 WHHMUSEV1 Awaiting on funding decision emergency capital prioritisation submitted awaiting CPG support in December 2023 WHHMUSEV2 Awaiting on funding decision emergency capital prioritisation submitted awaiting CPG support in December 2023 WHHDWH1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in January 2024 WHHDWW1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in January 2024 WHHLEV1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in March 2024 WHHCONWRXV1 PO raised works will be scheduled in Q4.			

		WHHCONWRXV2 PO raised works will be scheduled in Q4.			
Upgrade and enable DLP to enable USB read-only. Disabled as its is crashing desktops, needs the ePO agent on the server to be upgraded.	Upgrade and enable DLP	Order has been submitted and is with Procurement. Once order complete the software can be rolled out to the desktops and laptops. No changes can be made over the Christmas holiday period to systems, so will be in January 24 before any installation can happen.	Waterfield, Tracie	31/01/2024	
Seek funding for Cynerio Medical Devices Module	Seek funding for Cynerio Medical Devices Module	Applied for capital funding 24/25 to purchase the Medical Devices module, waiting on outcome.	Deacon, Stephen	29/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 3: We will…Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety			**Initial:**	12 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Assurance:** Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board) • Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch. • Updated OBC following departure from partnership procurement has received Trust Board approval and an ICB letter of support • Trust approval of updated OBC includes extension of Lorenzo contract to enact option to retain to Nov 26 if required due to previous delays in EPR program • NHSE Electronic Patient Record Investment Board (EPRIB) has confirmed approval of the EPR Outline Business Case (OBC) • EPR project group has oversight on state of readyness for deployemnt and associated risks **Controls:** • Business case approved and contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling in OBC includes 5-year Lorenzo costs • ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance. • Senior Programme Manager assigned • Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits				
Assurance Gaps:	**Gaps In Assurance:** • ICS strategic approach to delivering managed convergence through open procurement remains unclear **Gaps In Controls:** • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Phasing of frontline Digitisation Funding with funding availability not matching the timing of forecast expenditure • Deficit in programme year 3 • Delay in issuing tender due to NHSE FDIB query over technical specifications • Further assurance required regarding state of readiness for implementation				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE FDIB leadership fully sighted and remain supportive of procurement approach including Tender format	Ongoing engagement with ICS and NHSE FDIB leadership	Fitzsimmons, Paul	01/04/2024	
Ensure NHSE FDIB query around tender technical specification questions is resolved	Ensure NHSE FDIB query around tender technical specification questions is resolved	Engagement and resolution with NHSE FDIB leadership	Fitzsimmons, Paul	28/01/2024	
Assurance regarding state of readiness for implementation should be provided to DSG and FSC	To ensure that the Trust is ready to implement its new EPR following procurement	Reports from EPR Project Group to DSG and FSC to include risks and assurances regarding state of readiness for deployment	Poulter, Tom	28/01/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Control & Assurance Details

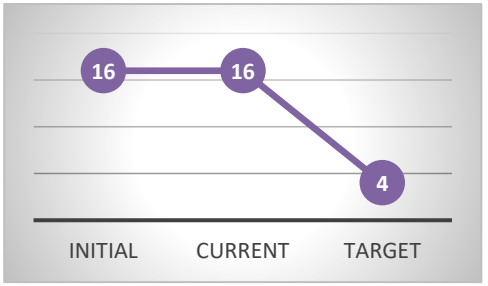
Controls

- Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
- Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have been carried out
- Estates strategy incorporating options and enablers for new hospitals plans complete
- External funding sought to enable estates developments which support delivery of new hospitals plans and estates strategy
- All partners, including MPs, Councils, Education Providers, Place Partners and ICB supportive of our new hospitals plans
- Financial and economic cases for new hospitals being updated and funding options explored

Assurances

DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside ICS to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M.

- Funding secured to deliver:
  - Community Diagnostics Centre,
  - Additional theatre ward and endoscopy capacity at Halton
  - Community Hubs in Runcorn and Warrington
- Development of business cases for initial phases of Estates Strategy in progress
- Developing scope for work required to create phased new hospital plan for the Warrington site



Assurance Gaps:

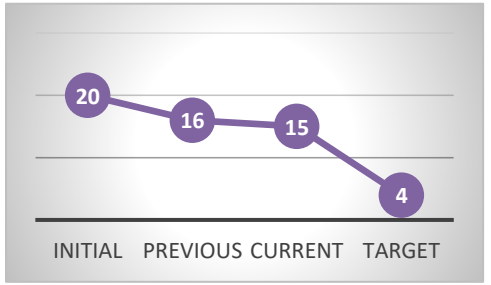
- Confirmation received that the Trust was unsuccessful in securing funding via HIP phase 3. Future rolling programme of funding has been indicated; however, the details are currently unclear.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
New Hospitals Strategy Refresh	Produce updated estates strategy outlining steps required to create new hospital estate for Trust.	Complete and sign off Estates Strategy.	Moore, Dan	10/01/2024	

Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Gardner, Lucy	31/03/2024	

Board Assurance Framework

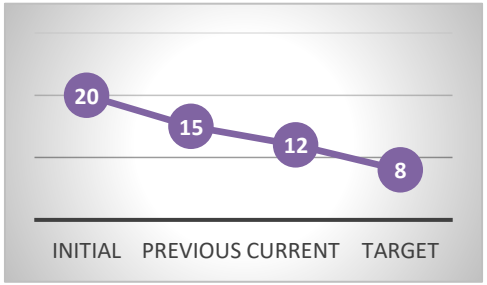
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	125	**Executive Lead:**	Moore, Dan	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns			**Initial:**	20 (5x4)
				Current:	15 (3x5)
				Target:	10 (2 x 5)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Assurance Details:	**Controls:** Annual capital funding is allocated to mandated and statutory estates projects The estates team operate a Planned Maintenance Program (PPM) The estates team operate a reactive maintenance process Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding **Assurance:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group Fire Safety Group – monitors fire safety issues across the trust PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk Complete formal RAAC survey undertaken across whole estate. Small extension building identified as having RAAC present. Remedial action to eradicate ongoing with NHSE.				
Assurance Gaps:	Limited capital funding to address backlog Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more, with less and the estates maintenance team is currently under resourced Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	30/06/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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.			**Initial**	20 (5x4)
				Current	12 (3x4)
				Target	8 (4x2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Description:	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.				
Assurance Details:	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. • Council and Place Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level are refreshed annunallly • Breast Centre of Excellence opened. • Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Revised plans for CDC approved by Trust Board and national diagnostics team. • Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. - Full Business Case for the Health & Wellbeing Hub approved by the Government. • Health & Wellbeing Hub (Living Well Hub) due to open in February 2024 • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside.				

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	30/04/2024	
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Capital bid to be shared with the Executive Team	Lucy Gardner & Dan Moore	30/04/2024	

Appendix 2 - Corporate Risk Register

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
1048	If the Trust does not have the appropriate workforce within Urology then the service will not be able to meet current demand which will increase the backlog, waiting times and potential delays in treatment diagnosis.	20	20	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
1668	If the service does not have a full staffing establishment, then pharmacists will be unable to see patients within 24 hours of their admission and not all areas will have daily visits by pharmacists. Some areas may receive lower input from pharmacists than recommended by national standards. This could cause delays in medicines reconciliation, failure to review patients' prescription and optimise treatment, and delay and/or omission of medicines, including critical medicines.	16	20	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
1749	If ED Nursing Vacancies continue to be above 25%, despite extensive recruitment, then we will not be unable to safely staff the ED Department with sufficient numbers of suitably qualified, skilled and experienced nurses to meet the needs of patients in the Emergency Department. This will impact the ability to comply with regulation 18 (1) in relation to safe staffing numbers.	20	20	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
421	If there is no future investment in hospital ventilation then the built environment may not be fit for purpose in relation to compliance with HTM resulting in possible loss of several clinical services and non compliance with HTM.		16	Quality & Assurance Committee	Health & Safety and Well Being Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
199	If there is no future investment in hospital ventilation then the built environment may not be fit for purpose in relation to compliance with HTM resulting in possible loss of several clinical services and non compliance with HTM.	20	16	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.
1797	If there is not an electronic process to list patients (from ICE to Lorenzo to ORMIS) then there is requirement for administrative staff to enter in patient listing information into the Theatre system (ORMIS) which could cause potential errors in the TCI listing and incorrect surgery.	20	16	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
200	If there continue to be high levels of sickness above the trust target then this will cause staffing shortages resulting in an impact to service delivery, and risk financial targets for temporary staffing / agency spend	12	15	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.
2018	If staff do not have their flu vaccine due to vaccine fatigue, then staff may become ill resulting in unplanned absence and there will be a financial impact if the Trust's CQUIN target is not achieved.	12	12	Strategic People Committee	Operational People Committee	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
423	If lifts are not maintained and replaced at end of lifecycle then there may be preventable occurrences of lifts breaking down resulting in reputational damage, negative financial impact, operational challenges and possible staff and patient safety issues.	12	12	Quality & Assurance Committee	Risk Review Group	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
1051	If there are operational issue which result in non-compliance with Induction Policy and Temporary Staffing Policy, then the Trust will not be compliant with inductions for staff and there will be risks to the safe delivery of services if staff are not correctly inducted to the organisation.	12	12	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
1665	If the Trust does not provide privacy and dignity when transferring the deceased to the mortuary then this will be highlighted on a Regulatory Human Tissue Authority Inspection, which will impact on compliance with regulations.	12	12	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
1741	If the CBU are unable to recruit and retain sufficient staff (qualified and non-qualified) then Maternity services will be unable to operate optimally resulting in increased escalation and divert to alternative units across Cheshire and Merseyside.	15	12	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
1758	If appraisals are not undertaken by Managers, then there could be a negative impact on staff engagement causing a decrease in Staff Survey scores, increased turnover and failure of succession planning	12	12	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
1759	If the organisation fails to effectively manage the use of agency and temporary staffing then this could result in financial overspend on agency / temporary staffing and also impact staff engagement for substantive staff	12	12	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.
1760	If the NHS pay award does not support the increase in cost of living or the real living wage then staff may not be able to afford to come to work or be able to provide for themselves or their families, causing an increase in staff absence and also a negative impact on recruitment and retention	12	12	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.
1764	If workforce turnover does not meet the Trust target of 13% then this will result in increase in agency / temporary staffing costs as well as a negative impact on engagement of substantive staff and thus staff survey results	12	12	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
1867	If the Trust does not achieve the assumed target activity of 104% for 2023/24, then there is a risk that the £10m ERF (including in the operational plan) may be clawed back increasing the Trust financial deficit, posing a significant risk to the Trust financial position. There could also be a reduction in contract income for the activity under PBR.	12	12	Finance & Sustainability Committee	Financial Resources Group (FRG)	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.
1868	If the Trust does not adequately identify the full balance of CIP schemes from a target of 18m. then this poses a significant risk to the Trust achieving its control total of £19.9m deficit.	12	12	Finance & Sustainability Committee	Financial Resources Group (FRG)	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.
1893	If there is a lack of robust Equality, Diversity and Inclusion (EDI) learning and development provisions then there will be a failure to equip our workforce with the EDI knowledge and skills for the organisation to meet its requirements under the Public Sector Equality Duty, Armed Forces Act 2021 and Human Rights Act 1998. Resulting in, a workforce unable to deliver the Trust Workforce EDI Strategy 2022-2025.	12	12	Strategic People Committee	Workforce Sub-Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.

ID	Risk description	Rating (initial)	Rating (current)	Monitoring Committee	Monitoring Sub Committee	Strategic Objective
1503	If the underground pipework and backup manifolds fail then this will affect the supply of piped medical oxygen resulting in the potential loss of service provision to the whole site.	15	10	Quality & Assurance Committee	Health & Safety and Well Being Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.
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.	25	9	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

CQC engagement and risk meeting

Trust Board Summary

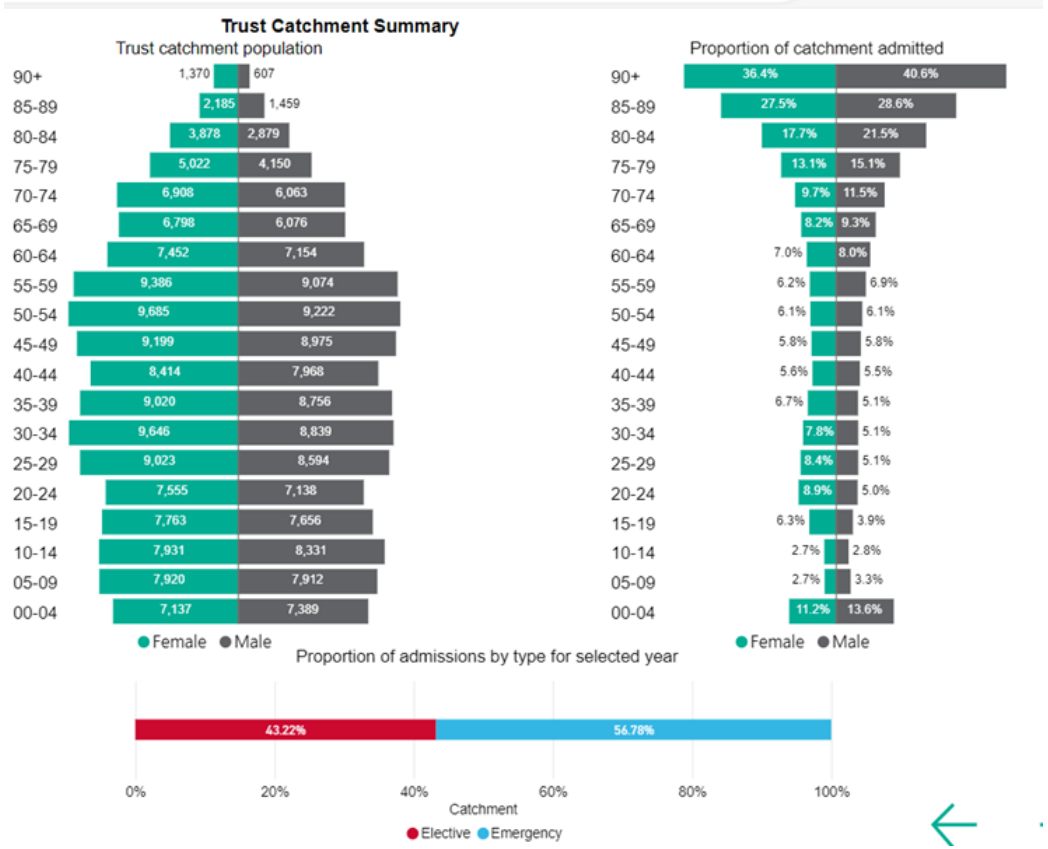
7 February 2024

CQC engagement and risk meeting

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Held on Monday 29 January 2024 at the request of the CQC as part of their new inspection and review methods
- CQC identified three core services and requested additional assurance:
  - Urgent and Emergency Care
  - Medicine
  - Surgery
- Each presented our current position, challenges and plans in place for assurance
- Followed by further information requests received from the CQC

Population demographics and associated challenges



Population of 330,000 - Halton & Warrington

Over 100,000 A&E attendances/year, >270/day

Biggest challenges relate to age & deprivation

Percentage of adults reporting a mental health problem

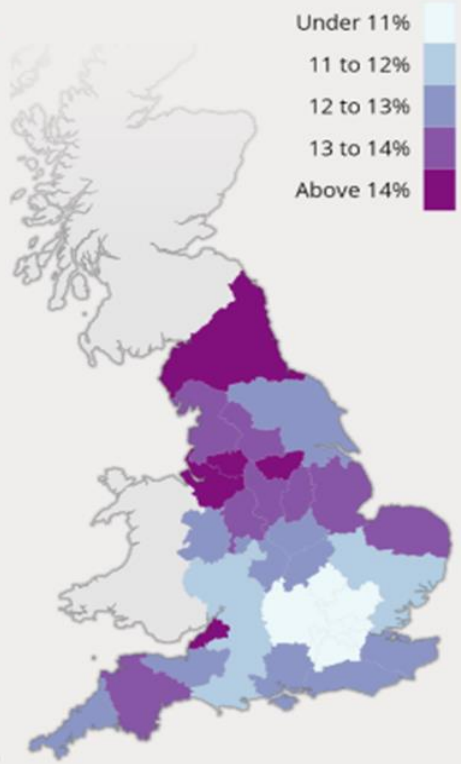
By Integrated Care Board, England, age 18+, GP patient survey, 2022

Highest reported prevalence

North East & North Cumbria	15.6%
South Yorkshire	15.3%
Cheshire & Merseyside	15.3%
Greater Manchester	14.3%
Bristol, N Somerset & S Gloucs	14.1%
Derby & Derbyshire	14.0%
Lancashire & South Cumbria	13.8%
West Yorkshire	13.7%
Nottingham & Nottinghamshire	13.7%
Norfolk and Waveney	13.4%

Lowest reported prevalence

North West London	9.1%
Surrey Heartlands	9.1%
South West London	9.2%
Frimley	9.5%
North East London	9.5%
North Central London	9.8%
Bedfordshire, Luton & MK	10.0%
Hertfordshire & West Essex	10.1%
South East London	10.7%
Bucks, Oxfordshire & Berkshire W	10.9%



Cheshire and Merseyside has one of highest proportions of adults reporting a mental health problem

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Urgent and Emergency Care (UEC)

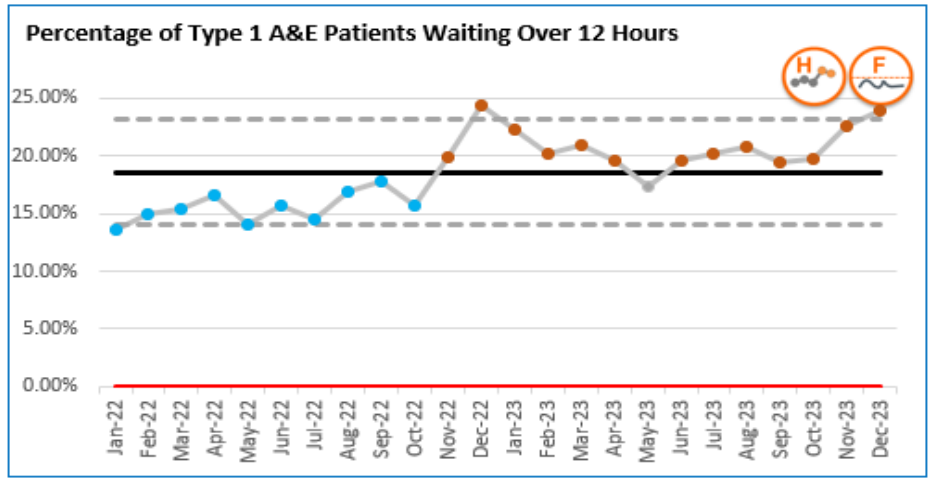
Sharon Kilkenny, Associate Director of Operations
Mark Forrest, Associate Medical Director
Emma Painter, Associate Chief of Nursing

UEC – key challenges and risks

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- 12-hour total time in department
  - Admitted
  - Non admitted
- 17% increase in ambulance attends over the last 12 months, and a 4% increase from November 2023-December 2023
- Provision of care in escalation areas e.g. care on the corridor

Challenge/risk	Actions
Delayed flow = Crowding = Care on corridor	ED escalation tool, escalation at bed meeting, Trust response – Full Capacity Protocol, System Escalation
Deteriorating patients	Escalation to nurse and ED clinician in charge, intentional rounding, reverse cohorting as required
Estate	Floorplan reviews being undertaken with a view to improve capacity and “flow” through department
NEWS2 compliance	NEWS2 focus week planned, auto-population of frequency being developed with system suppliers



UEC – ED improvement schemes

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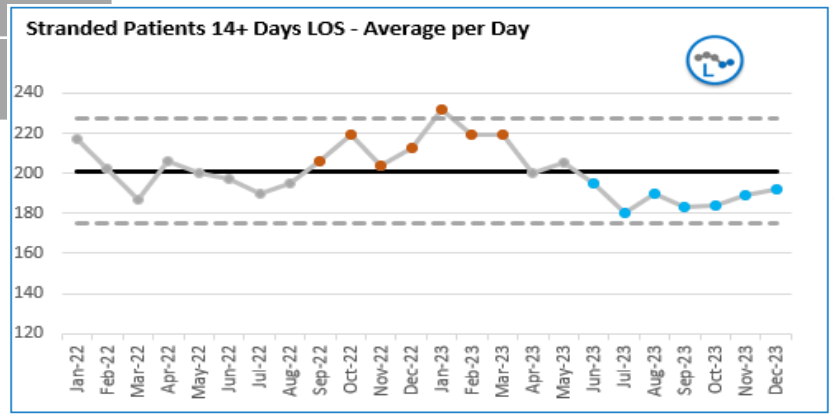
NHS Foundation Trust

No	ED Improvement Project	Plan details	Link to Tier 1 Metric	Delivery of Action	Scheme Performance
1	Continuous Flow	Full role out to all unplanned care wards	Time in ED		
2	Emergency Admissions Unit	Opened Wednesday 8th November	LoS		
3	ED CT Scanner	Co-location of a CT scanner from Aug 23	Time in ED		
4	Collaboration with NWAS	Collaboration to implement direct SDEC access from NWAS	Amb Handover		
5	ED Footprint/Minors	To be completed February 2024 following estates work	Amb Handover		
6	Streaming	Decision to merge SDEC and Ed Ambulatory.	Time in ED		
7	Triage	Implement Manchester Triage process from March	Time in ED		
8	Newton	Findings presented to WHH Board	Amb, TiED, LoS		

- Following the initial 8 schemes agreed with ECIST, 5 have completed and the impact is being monitored via the Trust ED Improvement Group.
- The remaining 3 are set to complete or start in Q4.
- Sustained Improvement in Ambulance and 14 Day LoS

Focus - 12 Hour TiD

	Type 1 A&E Performance (ECDS		Over 12 Hours (ECDS)		% Beds Occupied by Patients 14+ LOS (UEC Daily SitRep)	
Trust Tier Score (Weighted) *based on Type 1 Performance, %> 12h and LOS 14+	Type 1 A&E Performance (ECDS)	Type 1 A&E Performance (ECDS) Tier	% Over 12 Hours (Type 1) (ECDS)	% Over 12 Hours From Time of Arrival (ECDS) Tier	% Beds Occupied by Patients 14+ LOS (UEC Daily SitRep)	% Beds Occupied by Patients 14+ LOS (UEC Daily SitRep) Tier
1.00	45.9%	2	21.5%	1	40.4%	1



UEC – ED improvement next steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Newton, ECIST, GIRFT and internal data review to improve 12-hour time in department

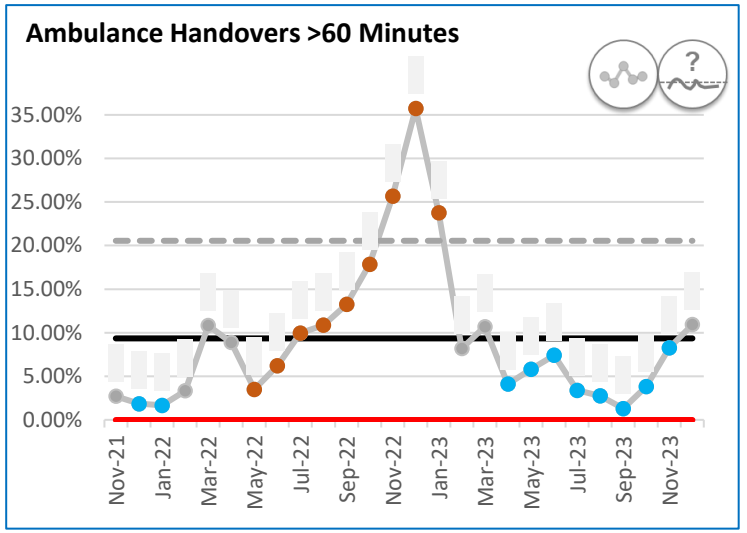
Scheme	Opportunity	Target Impact	Timescale
Increase streaming direct to assessment areas (SDEC/ED ambulatory, FAU)	Support decision makers in **SDEC** to take risk informed decisions around admission, access and refer to community services where appropriate	10% increase in SDEC activity	March 2024
	Support decision makers in **FAU** to take risk informed decisions around admission, access and refer to community services where appropriate	increase utilisation from 7 to 10 admission avoidance patients per day	March 2024
Time to Triage – principles of Manchester Triage	Improve time to initial assessment	Improvement from 22 minutes to 15 minutes	March 2024
Specialty input into ED	Decrease time in ED for patients waiting specialty review	Audit response times against internal professional standards	February 2024
Utilisation of alternatives to ED – UCR	Attendance / admission avoidance into ED	Increase NWAS referrals into UCR by 11 per week	Q1 24/25
Criteria led discharge	Improve flow of medical reviews over the course of the week through Criteria led discharge	Make earlier decisions on discharge to support ED flow	Q1 24/25
Decrease time in ED for non-admitted patients	Support deflection and alternatives to ED to decrease time in department for low acuity patients	Reduction in the number of patients with low acuity waiting > 12 hrs in ED by 80%	Q1 24/25
	Reduce time in ED for paediatric patients	Zero tolerance to paediatric patients > 12 hrs	Q1 24/25

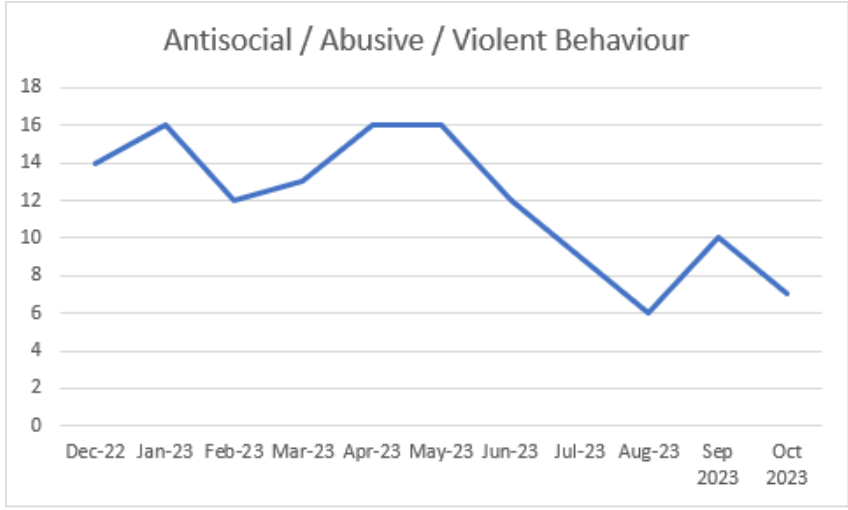
Supported by ECIST Work plan:

UEC – what makes us proud?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Ambulance handovers - sustained performance despite a significant increase in attendances over the last 12 months. Significant improvements in performance winter 23/24 compared to 22/23
- Sustained 4-hour performances despite:
  - No UTC in Warrington resulting in type 3 attendances to main Emergency Department = impacting occupancy
  - Increase in ambulance attendances = increased occupancy
  - Increase in acuity
- Mechanisms that are in place to maintain safety
- Improvements in key workforce metrics
  - Reduced turnover from 27.63% (Jan 23) to 9.93% (Dec 23)
  - Reduced vacancy from 27.95% (Jan 23) to 18.53% (Dec 23)
- Schemes to improve staff safety
- Flexible and responsive to meet the ever-changing needs of our patients
  - CT scanner in ED
  - SDEC
  - Waiting room – refurbishment, waiting room nurse and nutrition/hydration support HCA





Warrington and Halton Teaching Hospitals
NHS Foundation Trust

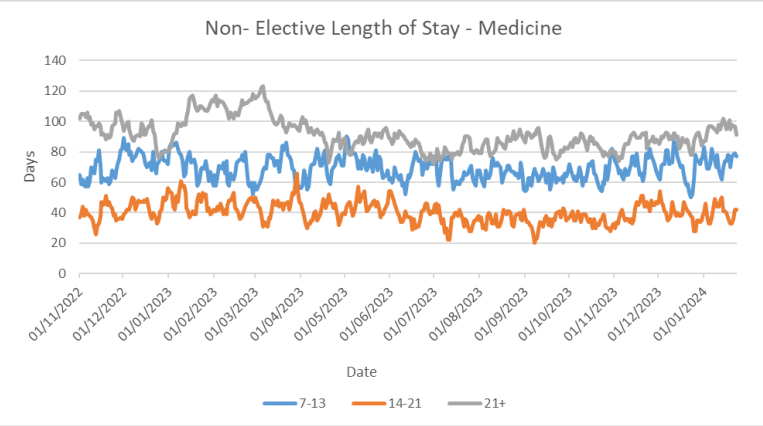
Medicine

Sharon Kilkenny, Associate Director of Operations
Mark Forrest, Associate Medical Director
Emma Painter, Associate Chief of Nursing

Medicine – key challenges and risks

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

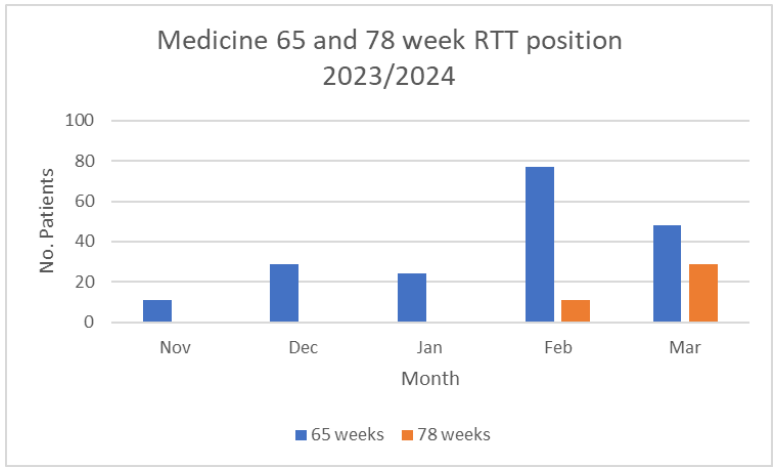
No criteria to reside and length of stay



Reside Status	No Criteria to Reside	
Discharge Route	Current Inpatients	%
Not Recorded	0	0.00%
Pathway 0	9	2.16%
Pathway 1	37	8.89%
Pathway 2	38	9.13%
Pathway 3	35	8.41%
Total	**119**	**28.61%**

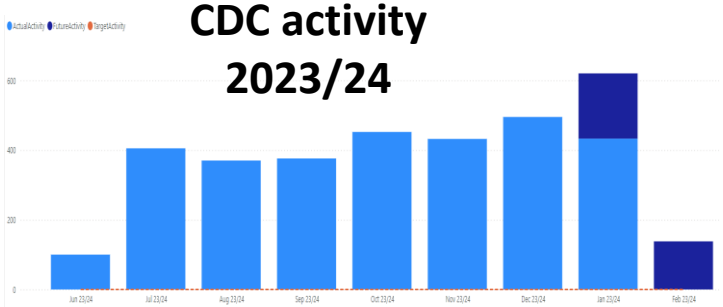
Recovery being achieved through:
- Insourcing/ outsourcing
- Mutual aid
- Increasing CDC capacity (echocardiography, sleep studies and spirometry)

Elective activity



Specialties
- Endocrinology
- Cardiology
- Respiratory
- Respiratory Physiology

CDC activity 2023/24



All data as at 25/01/24

Medicine – improvement goals

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Delayed discharges
- Increased length of stay
- Impact of prolonged hospital admission
- Daily board rounds using SAFER principles on all wards
- Piloting ‘criteria led discharge’

Patients with mental health presentations
- Impact on staff
- Provision of specialist/therapeutic care
- Environmental risks
- Risk assessments
- Training needs analysis and training development

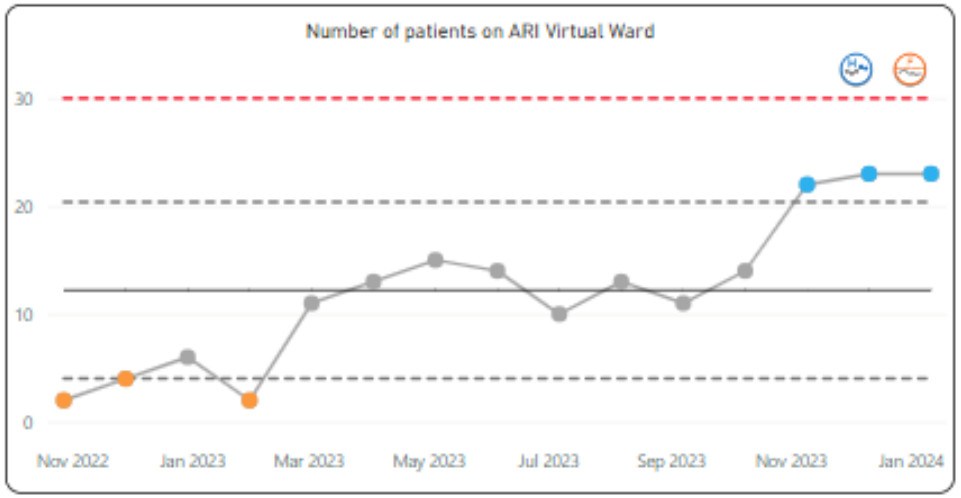
Increased demand on medical take
- Impact on staff

Completion of MUST scores in a timely manner
- Reported to nutrition and hydration steering group
- New dashboard created to support monitoring of compliance in real time
- Quality priority for 2024/25

Medicine – what makes us proud?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Improvements seen in key workforce metrics
- CDC spirometry service
- Enhanced Respiratory Care Unit (B18)
- Virtual wards – frailty and respiratory



Highest occupancy across C&M Integrated Care System in respiratory virtual ward

Medicine – All staff

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Surgery

Neil Gregory, Associate Director of Operations
Natalie Crosby, Associate Chief Nurse
Eshita Hasan, Associate Medical Director

Surgery - key challenges & improvement goals

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

1. **Improvement of fragile service performance within Surgery**
   Reduction of risk to the quality of patient care, patient safety and risk of harm

2. **Elimination of Never Events in Theatre**
   Establishment of Procedural Safety Steering Group and Theatre development work

3. **Elective restoration**
   78ww, 65ww and 52ww by March 2025

4. **GIRFT/ Improvement work**
   Improving service delivery to support elective restoration

5. **Cancer**
   Maintaining low 62-day backlog and good compliance against 28-day Faster Diagnosis Standard

Surgery - what makes us proud?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our workforce, and their commitment to delivering safe, quality care for our patients and their families

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Thank you

Questions and discussion

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/02/165**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	7th February 2024	
AUTHOR(S):	Marie Garnett – Head of Contracts, Performance and Commercial Development Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Kimberley Salmon-Jamieson – Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk	

<table>
<tr><td></td><td>associated with temporary staffing and reliance on agency staff</td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>
The Trust has 81 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance over the last 7 months. Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>9 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality
• Healthcare Acquired Infections (Ecoli)
• VTE Assessment
• Medication Safety Reconciliation within 24 hours
• Sepsis - % screening for all emergency patients
Access and Performance
• Referral to treatment – Open Pathways
• A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge
• Cancer 14 Days
• RTT – Number of patients waiting 65+ weeks
Workforce
• Bank and Agency Reliance

At Month 9 the plan is a £14.2m deficit, however, the actual deficit was £18.5m with the overspend being due in the main to Industrial Action (IA) costs, activity delivered under plan, additional capacity in A&E, specialling and CIP not delivered.
</td></tr>
</table>

PURPOSE: ***(please select as appropriate)***	To note ✓	Approval ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support from NHSE for March 2024 and Q1 of 2024/25 2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 3. Note the KPI amendment as outlined in this paper. 4. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/24/01/195; FSC/24/01/202; FSC/24/01/201	
	Date of meeting	24/01/2024	
	Summary of Outcome	Cash support application supported for approval at Trust Board. Changes to the capital contingency supported and approved. KPI amendment supported for approval at Trust Board.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/24/02/165

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 81 Integrated Performance Dashboard (IPR) indicators have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

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

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

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

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

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

Table 1: KPIs by Assurance and Variation Categories

	Special Variation of a Concerning Nature	Common Cause Variation	Special Variation of an Improving Nature	No SPC/Not Enough Datapoints/NA
Consistently Fails the Target (based on the last 7 months)	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 6. Healthcare Acquired Infections (Ecoli) ***(65 YTD – less than 54 YTD target)*** 10. VTE Assessment ***(93.51% - 95% target)*** 13. Medication Safety - Reconciliation within 24 hours ***(45% - 80% target)*** 23. Sepsis - % screening for all emergency patients ***(70% - 90% target)*** **A&P** 35. Referral to treatment Open Pathways - ***(50.59% - 92% target)*** 37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge ***(23.89% - 2% target)*** 39. Cancer 14 Days ***(58.06% – 93% target)*** 67. RTT - Number of patients waiting 65+ weeks ***(1521 - 0 target)*** **Workforce** 71. Bank and Agency Reliance ***(15.65% - 9% target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) 8. Healthcare Acquired Infections (PA) 24. Sepsis - % screening for all inpatients 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis – 33. MUST nutritional assessment completion **A&P** 36. A&E Wait Times - % patients waiting under 4 hours 47. Ambulance Handovers within 15 minutes 48. Ambulance Handovers within 30 minutes 49. Ambulance Handovers within 60 minutes 50. Discharge Summaries - % sent within 24hrs 51. Discharge Summaries - Number NOT sent in 7 days **Finance** 80. Cost Improvement Programme (recurrent forecast) – In year performance to date	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 21. Friends and Family (ED and UCC) 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis 31a. Maternity Pregnancy Bookings before 10 weeks 31b. Maternity Pregnancy Bookings before 13 weeks **A&P** 34. Diagnostic Waiting Times 6 Weeks 58. Elective Outpatient Activity **Workforce** 68. Supporting Attendance 69. Retention 73. Safeguarding Training 74. PDR **Finance** 77. Capital Programme 78. Better Payment Practice Code	**CONSISTENTLY FAILING TARGET & NO SPC**
Inconsistently Passes/Fails the Target	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **A&P** 40. Breast Symptoms 14 Days 43. Cancer 31 Days Subsequent Surgery	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 7. Healthcare Acquired Infections (Klebsiella) 12. Pressure Ulcers 28. Acute Kidney Injury **A&P** 53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 15. Staffing Care Hours per patient day (CHPPD) **A&P** 41. 28 Day Faster Cancer Diagnosis Standard 59. Patients seen in the Fracture Clinic within 72 hours 65. Theatre Utilisation (measured as productive operating time only) **Workforce** 70. Turnover	**INCONSISTENTLY PASSING TARGET & NO SPC**

	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE	CONSISTENTLY PASSING TARGET & NO SPC
 **Consistently Passes the Target (based on the last 7 months)**		**Quality** 1.Incidents 2. Duty of Candour (serious incidents) 19. Complaints 20. Friends and Family (Inpatients & Day cases) 22. Mixed Sex Accommodation Breaches (Non ITU Only) **A&P** 52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 54. Urgent Operations Cancelled for 2nd Time 66. Day case (measured as an aggregate of total cases)	**Quality** 3.Healthcare Acquired Infections (MRSA) 11. Inpatient Falls & harm levels 14. Staffing - Average Fill Rate 18. NICE Compliance **Workforce** 72.Core/Mandatory Training **Finance** 79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m) 81. Agency Ceiling	
	NO ASSURANCE SPC & DECLINING PERFORMANCE	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**
 **No SPC/Not Enough Datapoints/Not Applicable**		**Quality** 4. Healthcare Acquired Infections (MSSA) 32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 38. Average time in department ED 55. Super Stranded Patients 62. Reduction in Outpatient Follow Ups 64. % Patients discharged to their usual place of residence	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 16. Mortality ratio – HSMR 17. Mortality ratio - SHMI **A&P** 61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	**Quality** 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage 30. Maternity 3rd and 4th Degree tears **A&P** 42. Cancer 31 Days First Treatment (**NEW**) 43. Cancer 62 Days First Treatment (**NEW**) 56. Elective Recovery Activity (Grouped SPCs) 57. Elective Recovery Diagnostic Activity 60. % patients referred to long COVID service not assessed within 15 weeks **Finance** 75. Trust Financial Position (£m) 76. Cash Balance (£m)

Key:

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

Areas exceeding the target and continuously maintaining/improving performance

Areas of a concerning nature due to either:

- **indicators not meeting (failing) their set target**
- **declining nature of the performance**

The proposed changes to the Discharge ready metrics, which form part of the Access and Performance sections of the IPR, are outlined in **Table 2**. Changes are proposed to take place following approval from Trust Board, which will be reflected in the February 2024 Integrated Performance Report (to be reported in April 2024 Trust Board).

Table 2: Updated Access and Performance Indicators

Proposed KPI	Proposed Change	Rationale
82. Discharge Delay Days **Target: NA**	The new Discharge Delay Days KPI will include the following: • **Delay days** - Number of days from Discharge Ready Date to Discharge Date • **Average cost of delay days** - Number of days * £430 These figures will include patients with no criteria to reside at discharge only.	Following a national request, Systems must include Discharge ready metrics to continue the national focus on timely discharge of patients. The inclusion of Discharge Ready patients should be reported by the Trust Board prior to March 2024.

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

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

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

The Trust has agreed a revised control total of £21.2m deficit with Cheshire & Merseyside ICS. This has been increased further due to an allowable increase for the impact of Industrial Action in December and January (£1.6m) resulting in a £22.8m deficit. There are several risks to the achievement of the revised £22.8m deficit. The key risks are as follows:

- CIP delivery.
- Cost pressures – the Trust was unable to fund circa £8m cost pressures and has put in a process to oversee mitigation plans and risk management.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), activity delivered is under plan resulting in loss of income.
- A&E staffing pressures and the additional cost of specialling.
- Additional capacity open due to the levels of no criteria to reside patients.

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

Cash

The cash balance at the end of December is £6.1m. The cash flow forecast has been updated to reflect the revised forecast deficit of £22.8m. Given the current cash position and the likely forecast to the end of 2023/24 it is expected that the Trust will require external support. Therefore, FSC discussed and supported the application for cash support from NHSE. The Trust Board is asked to approve £13.335m cash support for March 2024 and £13.76m for Q1 2024/25. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

CIP

At 31 December 2023, the Trust has delivered a CIP of £10.4m against a target of £10.7m. The full year CIP target is £17.9m of which £16.7m has been identified (93%). The current level of recurrent CIP is £9.8m, further work is required to increase recurrent CIP levels. In order to deliver the revised £22.8m deficit, there is a further £5.3m stretch target that needs to be met. Work is ongoing to identify and deliver further savings.

Capital Programme

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 9		**103**
Proposed changes in month		
Vat Rebate		**31**
Emergency Requests		
Operating Table	- 55	
Rapid Infusion and Fluid Warming Device	- 5	
MUSE	- 42	
Gas Safety Works	- 17	
Subtotal		**- 119**
Requests supported at CPG - 12/01/2024		
ED Minors addendum to create additional capacity	- 67	
Water safety - addendum due to quote following procurement process	- 8	
ENT Stacker & Scope - addendum due to quote following procurement process	- 44	
Sub total		**- 119**
Underspend / slippage to be returned to contingency supported at CPG - 12/01/2024		
Finance Costing System Server - underspend - scheme complete	10	
CT Scanner - underspend - scheme complete	39	
Appleton ventilation upgrade - slippage identified to be deferred to 2024/25	190	
Sub total		**239**
Contingency as at 12/01/2024		**135**

The Trust Board is asked to:

- Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

Financial Forecast

A revised deficit forecast and worse case financial position has been produced (**Table 4**). The revised deficit forecast has been agreed by the ICS at £21.2m plus the impact of the national industrial action that took place in December and January (£1.6m) resulting in a £22.8m deficit. However, there is still a significant risk of £5.3m due to non-delivery of CIP, under delivery of activity and ongoing cost pressures. This is noted as a further stretch target in the table and if this is not delivered the Trust's forecast deficit would increase to £28.1m.

Table 4: Revised deficit forecast

	Revised deficit forecast	Worse Case
	£m	£m
Plan	(15.7)	(15.7)
CIP	(2.5)	(2.5)
Pressures*	(3.9)	(3.9)
Income*	(3.1)	(3.1)
Band 2 to 3	(1.6)	(1.6)
IA costs not funded*	(2.6)	(2.6)
Pay award gap not funded	(2.0)	(2.0)
Dec & Jan IA (allowable)	(1.6)	(1.6)
Forecast	**(32.9)**	**(32.9)**
ICS Support (Tier 1 £1m, 2% ERF £1.2m and IA £2.6m)*	4.8	4.8
Trust further stretch target	5.3	0.0
Revised forecast	**(22.8)**	**(28.1)**

*Gross revenue impact prior to ICS support

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve cash support from NHSE for March 2024 and Q1 of 2024/25
2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
3. Note the KPI amendment as outlined in this paper.
4. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

		Latest				Previous		Assurance
	QUALITY	Plan/Target	Actual	Period	Variation	Actual	Period	
1	1. Incidents	0	0	Dec-23		9	Nov-23	P
2	2. Duty of Candour (serious incidents)	100.00%	100.00%	Dec-23		100.00%	Nov-23	P
3	3. Healthcare Acquired Infections (MRSA)	0	0	Dec-23	L	0	Nov-23	P
4	4. Healthcare Acquired Infections (MSSA)	No target set	3	Dec-23		2	Nov-23	No SPC
5	5. Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	6	Dec-23		3	Nov-23	F
6	6. Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	9	Dec-23	H	8	Nov-23	F
7	7. Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	0	Dec-23		1	Nov-23	?
8	8. Healthcare Acquired Infections (PA)	Less than 2 - annual	3	Dec-23	H	3	Nov-23	?
9	9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Dec-23	L	1	Nov-23	No SPC
10	10. VTE Assessment	95.00% (quarterly position)	93.51%	Dec-23	L	94.53%	Nov-23	F

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

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11	11. Inpatient Falls & harm levels	20% or more decrease from previous year	40	Dec-23		28	Nov-23	
12	12. Pressure Ulcers	10% reduction	18	Dec-23		9	Nov-23	
13	13. Medication Safety Reconciliation within 24 hours	80.00%	45.00%	Dec-23		59.12%	Nov-23	
14	14. Staffing - Average Fill Rate	90.00%	97.77%	Dec-23		90.43%	Nov-23	
15	15. Staffing - Care Hours Per Patient Day (CHPPD)	7.9	8.01	Dec-23		7.74	Nov-23	
16	16. Mortality ratio - HSMR	No target set	90.04	Dec-23		90.69	Nov-23	No SPC
17	17. Mortality ratio - SHMI	No target set	96.18	Dec-23		97.07	Nov-23	No SPC
18	18. NICE Compliance	90.00%	93.13%	Dec-23		93.32%	Nov-23	
19	19. Complaints	Zero complaints open over 6 months old/in the backlog	0	Dec-23		0	Nov-23	
20	20. Friends and Family (Inpatients & Day cases)	95.00%	97.00%	Dec-23		97.00%	Nov-23	
21	21. Friends and Family (ED and UCC)	87.00%	73.00%	Dec-23		76.00%	Nov-23	

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

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22	22. Mixed Sex Accommodation Breaches (Non ITU Only)	0	0	Dec-23		0	Nov-23	
23	23. Sepsis - % screening for all emergency patients.	90.00%	70.00%	Dec-23		70.00%	Nov-23	
24	24. Sepsis - % screening for all inpatients	90.00%	84.00%	Dec-23		86.00%	Nov-23	
25	25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	54.00%	Dec-23		64.00%	Nov-23	
26	26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90%	88.00%	Dec-23		73.00%	Nov-23	
27	27. Ward Moves between 10:00pm and 06:00am	0	50	Dec-23	No SPC	50	Nov-23	No SPC
28	28. Acute Kidney Injury	Less than previous month	199	Dec-23		222	Nov-23	
29	29. Maternity Postpartum Haemorrhage	3.70%	5.09%	Dec-23	No SPC	5.77%	Nov-23	No SPC
30	30. Maternity 3rd and 4th Degree tears	<1.85%	2.27%	Dec-23	No SPC	1.44%	Nov-23	No SPC
31a	31a. Maternity Pregnancy Bookings before 10 weeks	10-week Target: >75%	51%	Dec-23		55%	Nov-23	
32b	31b. Maternity Pregnancy Bookings before 13 weeks	13-week Target: >90%	82%	Dec-23		86%	Nov-23	

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32	32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	16%	Nov-23		3%	Oct-23	No SPC
33	33. MUST nutritional assessment completion	above > 85%	51.23%	Dec-23		58%	Nov-23	F

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
34	34. Diagnostic Waiting Times 6 Weeks	95.00%	85.10%	Dec-23	H	82.67%	Nov-23	F
35	35. Referral to treatment Open Pathways	92.00%	50.59%	Dec-23	L	51.50%	Nov-23	F
36	36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	61.27%	Dec-23		63%	Nov-23	F
37	37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	23.89%	Dec-23	H	22.6%	Nov-23	F
38	38. Average time in department ED	No Target	426	Dec-23		416	Nov-23	No SPC
39	39. Cancer 14 Days	93%	58.06%	Nov-23	L	60.62%	Oct-23	F
40	40. Breast Symptoms 14 Days	93%	17.39%	Nov-23	L	37.70%	Oct-23	?
41	41. 28 Day Faster Cancer Diagnosis Standard	75%	75.13%	Nov-23	H	78.93%	Oct-23	?
42	42. Cancer 31 Day Wait	96%	98.86%	Nov-23	No SPC	98.86%	Oct-23	No SPC
43	43. Cancer 62 Day Wait	85%	73.16%	Nov-23	No SPC	79.89%	Oct-23	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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47	47. Ambulance Handovers within 15 minutes	65%	31.06%	Dec-23		34.25%	Nov-23	F
48	48. Ambulance Handovers within 30 minutes	95%	55.47%	Dec-23		57.48%	Nov-23	F
49	49. Ambulance Handovers within 60 minutes	100%	68.94%	Dec-23		67.45%	Nov-23	F
50	50. Discharge Summaries - % sent within 24hrs	95%	89.51%	Dec-23		90.40%	Nov-23	F
51	51. Discharge Summaries - Number NOT sent within 7 days	0	12	Dec-23		0	Nov-23	F
52	52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.00%	Dec-23		0.04%	Nov-23	P
53	53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	0	Dec-23		0	Nov-23	?
54	54. Urgent Operations Cancelled for 2nd Time	0	0	Dec-23		0	Nov-23	P
55	55. Super Stranded Patients	Trajectory	136	Dec-23		118	Nov-23	No SPC
56	56. Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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57	57. Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
58	58. Elective Outpatient Activity	0%	76%	Dec-23	H	91%	Nov-23	F
59	59. Patients seen in the Fracture Clinic within 72 hours	95%	100.00%	Dec-23	H	99%	Nov-23	?
60	60. % patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Dec-23	No SPC	0	Nov-23	No SPC
61	61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	No Target set	91%	Oct-23	H	91%	Sep-23	No SPC
62	62. Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	76%	Dec-23		91%	Nov-23	No SPC
64	64. % Patients discharged to their usual place of residence	No Current Threshold	94%	Dec-23		96%	Nov-23	No SPC
65	65. Theatre Utilisation (measured as productive operating time only)	85%	84.60%	Dec-23	H	83%	Nov-23	?
66	66. Day case (measured as an aggregate of total cases)	85%	89.97%	Dec-23		88%	Nov-23	P
67	67. RTT - Number of patients waiting 65+ weeks	0	1521	Dec-23	H	1317	Nov-23	F

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		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
68	68. Supporting Attendance	4.20%	5.56%	Dec-23	L	5.67%	Nov-23	F
69	69. Retention	86.00%	87.14%	Dec-23	H	86.85%	Nov-23	F
70	70. Turnover	Below 13%	12%	Dec-23	L	13%	Nov-23	?
71	71. Bank and Agency Reliance	9% or Below	15.65%	Dec-23	H	15.82%	Nov-23	F
72	72.Core/Mandatory Training	85.00%	90.41%	Dec-23	H	89.82%	Nov-23	P
73	73. Safeguarding Training	Trajectory	84.00%	Dec-23	H	84.10%	Nov-23	F
74	74. PDR	85.00%	75.46%	Dec-23	H	76.36%	Nov-23	F

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
75	75. Trust Financial Position (£m)	-£1.20	-£2.43	Dec-23	No SPC	-0.31	Nov-23	No SPC
76	76. Cash Balance (£m)	£15.52	£6.09	Dec-23	No SPC	9.55	Nov-23	No SPC
77	77. Capital Programme (£m)	£16.87	£12.64	Dec-23	H	£9.41	Nov-23	F
78	78. Better Payment Practice Code	95%	92%	Dec-23	H	90%	Nov-23	F
79	79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£10.74	£10.44	Dec-23	H	8.95	Nov-23	P
80	80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m)	£10.74	£4.00	Dec-23		8.95	Nov-23	F
81	81. Agency Ceiling	Less than 3.7%	2.6%	Dec-23	L	3%	Nov-23	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

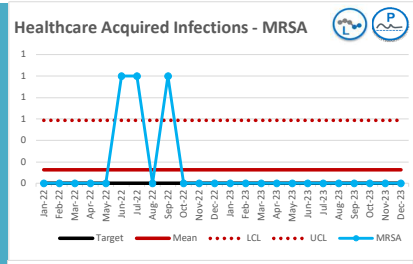
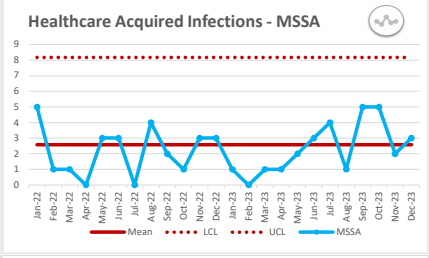
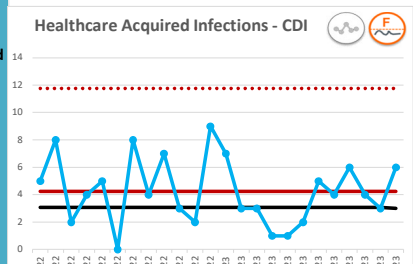
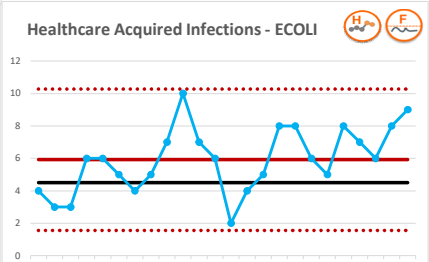
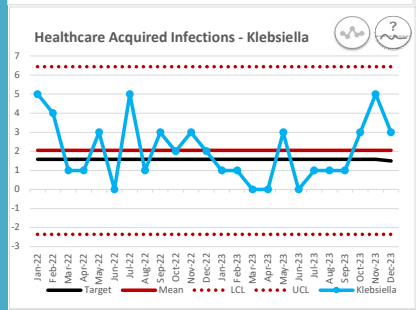
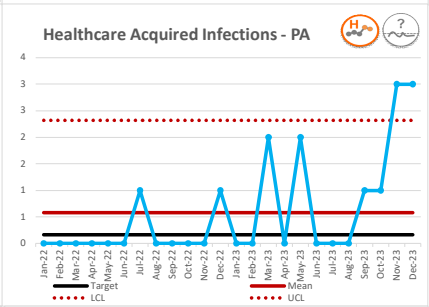
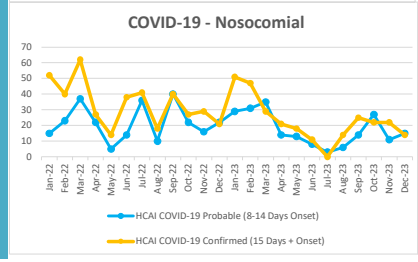
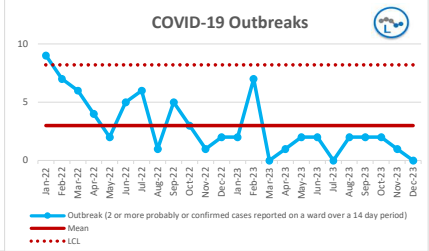
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	Open Incidents - 40 Days Total Incidents Reported Incidents Reported By Month Serious Incidents & Never Events Serious Incidents Actions Breached	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	Incident reporting remains within range with little variance across the Trust. The number of open incidents is within normal control limits. There are 0 overdue 40-day incidents. There was 1 PSII reported - a Never Event. Local anaesthetic administered into incorrect side. There were 0 breached Serious Incident/ PSII actions in December 2023.	**Incident Reporting** A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each CBU is supported by a designated member of the Governance Team to ensure consistency. **Number of incidents within 40 days** Weekly CBU monitoring supports timely escalation to the Associate Director of Governance, thus ensuring the position of zero incidents over 40 days continues to be maintained. **Incident Monitoring** Weekly monitoring continues with appropriate escalation to the CBU leads. PRIRF terminology and methodology now implemented.
There were 0 incidents over 40 days old.				
2. Duty of Candour (serious incidents)	Duty of Candour (DoC) - Moderate Incidents Duty of Candour (DoC) - Serious Incidents	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There is no variance, the Trust remains 100% compliant.	Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.
The Trust achieved 100% for Duty of Candour in month.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO	MRSA cases YTD - annual threshold exceeded by 0		(MRSA) Assurance: The Trust consistently passes the target. (MRSA) Variation: Special Cause Variation of an improving nature.	MRSA: Nil returns for Apr - Dec	MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise patient safety investigation template to align with PSIRF.
4. Healthcare Acquired Infections (MSSA) Target: No set Target	MSSA 26 cases YTD - no threshold set			MSSA: 3 Trust apportioned cases in Dec; 26 cases YTD: different locations and likely sources, some deep seating infections not associated with healthcare	
5. Healthcare Acquired Infections (CDI) Target: Less than 36 -annual	CDI 32 cases YTD - annual threshold exceeded by 0		(CDI) Assurance: The Trust consistently fails the target. (CDI) Variation: Common Cause (Normal) variation.	CDI: 7 Trust apportioned cases in Dec; 33 cases YTD: remain within annual trajectory	CDI: CDI prevention action plan in place. MDT review meetings are aligned to PSIRF, SIGHT mnemonic education will continue.
6. Healthcare Acquired Infections (Ecoli) Target: less than 54 - annual	E. coli 65 cases YTD - annual threshold exceeded by 11 cases		(ECOLI) Assurance: The Trust consistently fails the target. (ECOLI) Variation: Special cause variation of a concerning nature	ECOLI: 9 Trust apportioned cases in Nov; 65 cases YTD: Mainly UTI associated cases, followed by hepatobiliary. FY threshed breached by 11 cases against annual threshold of 54 cases	ECOLI: Klebsiella: Pseudomonas aeruginosa: Audit of hepatobiliary cases has commenced, revise investigation of hospital onset GNBSI cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse led removal, focus support on wards with higher UTI associated cases. The GNBSI Prevention Group has been reconvened and Lead Nurses engaged to drive prevention activity.
7. Healthcare Acquired Infections (Klebsiella) Target: Less than 18 - annual	Klebsiella spp. 17 cases YTD - annual threshold exceeded by 0		(K) Assurance: The Trust inconsistently passes/fails the target. (K) Variation: Common Cause (Normal) variation.	Klebsiella: 3 Trust apportioned cases in Dec; 17 cases YTD: remain within annual trajectory	
8. Healthcare Acquired Infections (PA) Target: Less than 2 - annual	P. aeruginosa 10 cases YTD - annual threshold exceeded by 8 cases		(PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Special cause variation of a concerning nature	Pseudomonas aeruginosa: 3 Trust apportioned cases in Dec; 10 cases YTD. FY threshold breached by 8 cases against threshold of 2 cases.	Covid-19: Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage suspected outbreaks to prevent transmission to additional patients, staff and visitors. The national requirements to report Covid-19 outbreaks remains in place.
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No	0 in month COVID-19 outbreak. Covid-19: 15 day 8-14 cases probable healthcare associated cases YTD 14 day 15+ cases definite healthcare associated YTD		Assurance: N/A - No target. Variation: Special cause variation of an improving nature	Covid-19: nil outbreaks reported in Dec; 12 outbreaks YTD.	
					

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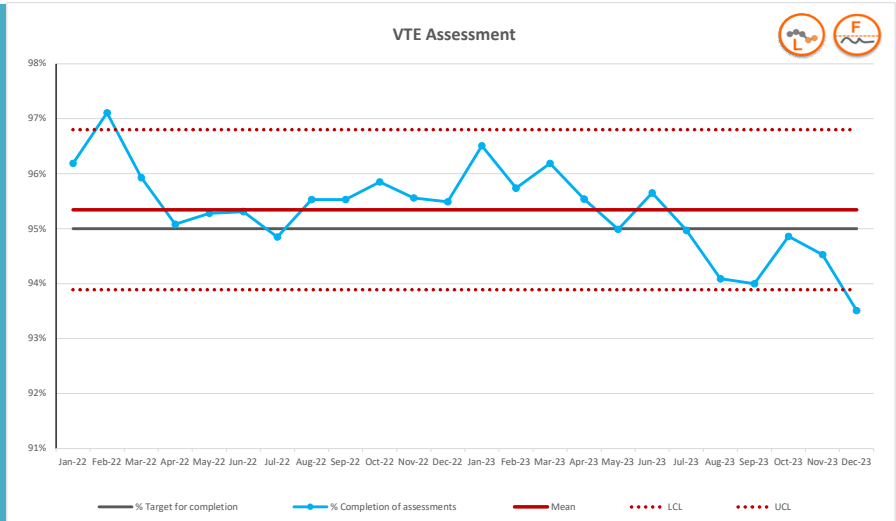
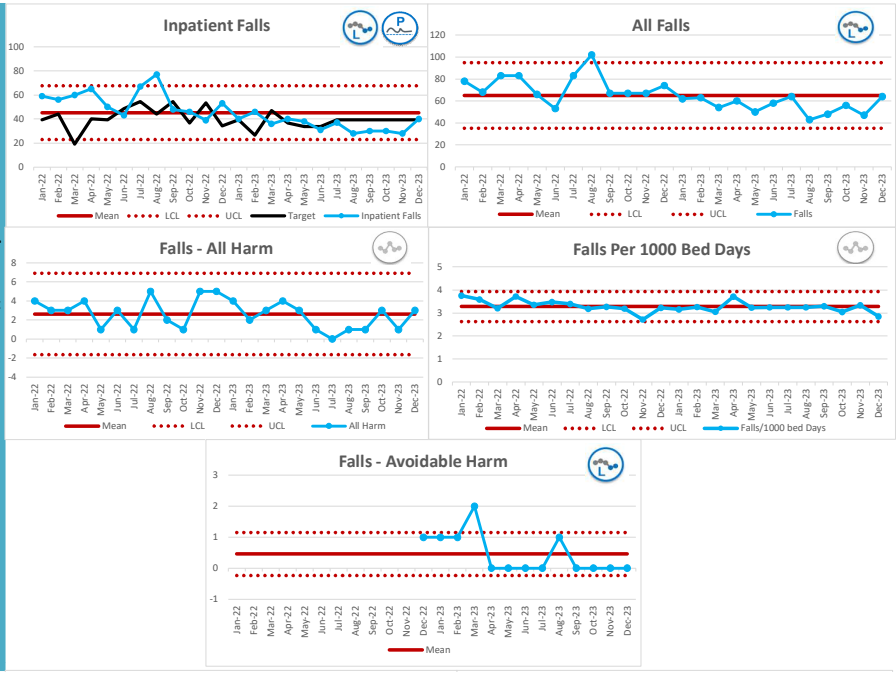
10. VTE Assessment Target: 95% (quarterly position)	The Trust did not achieve the required target at 93.51% for VTE assessments in month.		Assurance: The Trust consistently fails the target. Variation: Special cause variation of a concerning nature	Performance target in November 2023 was below the threshold at 93.51%.	VTE Data sharing Ward productivity dashboard developed in house at WHH now includes VTE risk assessment data at the ward level daily for data sharing purpose and for the ownership of this VTE RA data to improve overall compliance. It has been launched trustwide in Early December 2023. To work in partnership with CBU governance at the ward level to improve overall performance to meet target threshold >95%. Education and training To continue to raise awareness of the need for VTE completion at new August intake induction and with the every changeover of junior doctors 4 months placement. Improvement plan To consider to implement SPC chart for ward level VTE data compliance - to discuss with corporate information team.
11. Inpatient Falls & harm levels Target: 20% or more decrease from 22/23 (610 inpatient	64 total falls were reported in month. 40 of these were inpatient falls. There has been a 7.25% decrease in falls from last year. There has been a 13.98% decrease in inpatient falls from last year. There was 3 fall(s) in month with harm.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Whilst a slight increase has been seen in month in the number of inpatient falls and falls with harm, the overall picture is one of sustained improvement.	Lessons learned and practice shared from the weekly harm free care meeting and via ward safety brief. As part of a quality improvement project a trial of the new bedside eyesight test will commence in January on B12 and a visual aid trial to identify which patients should have bedrails in use on B3 and A6. The newly revised Enhanced Care Policy is available Trustwide. Trust falls alarm video has been recirculated to all ward managers to share with staff.

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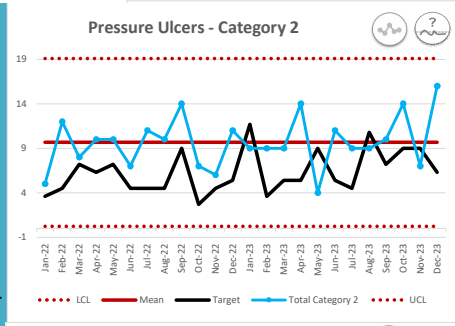
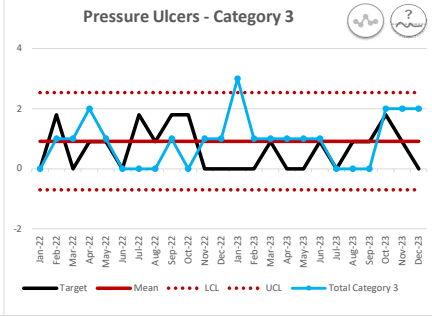
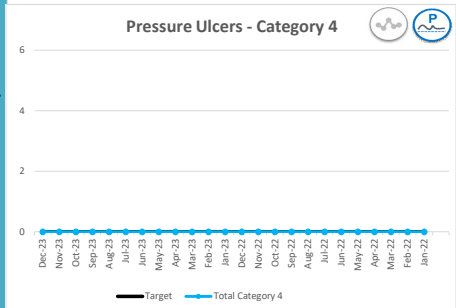
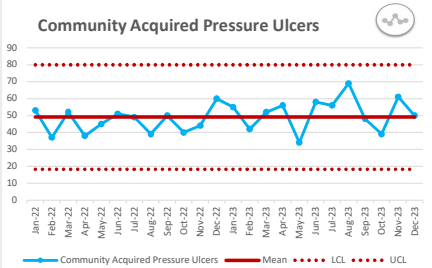
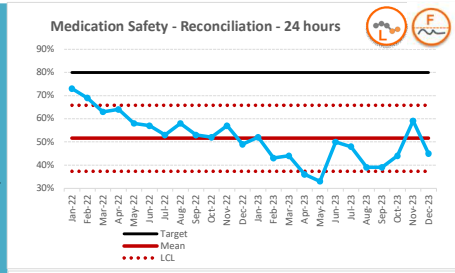
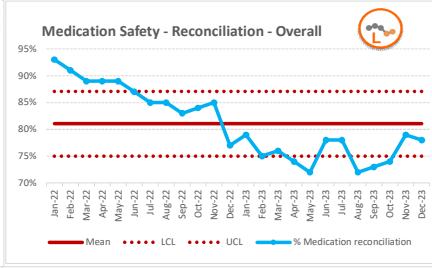
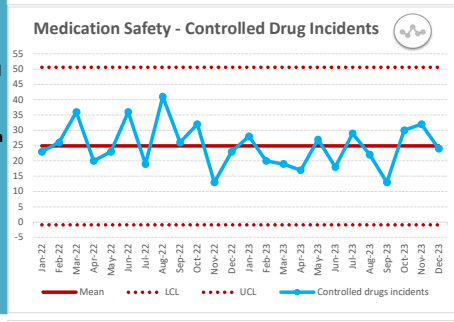
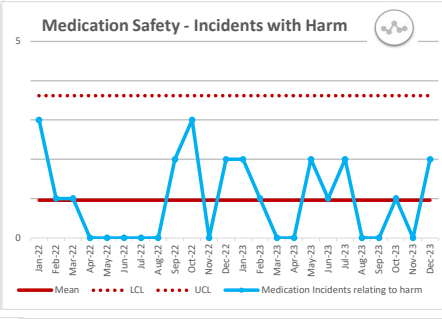
12. Pressure Ulcers **Target: 10% reduction based on 91 in 2021/22** There were 16 hospital acquired category 2 pressure ulcers and 2 Category 3 pressure ulcer in month. There were 50 community aquired pressure ulcers in month.	   	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	Contributory factors to the development of category 2 and 3 pressure ulcers include inconsistent recognition of existing risk factors, long waits in the Emergency Department and assessment of the risk associated with medical devices.	Actions to improve the position include: 1. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses, intervention from lead nurse/matron daily with extra training on ward A9 and A6. 2. A review meeting in relation to the themes identified in the after action reviews has commenced and lessons are shared with ward teams and via Operational Patient Safety Group. 3. Continuous Professional Development (CPD) funded post to support training and supervision of practice on wards. 4. Thematic review will be undertaken using PSIRF methodology to support the remission of actions and identify improvements. 5. Daily practical teaching on ward A9 has demonstrated improvement. 6. Tissue viability training for preceptorship and international nurses. 7. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management.
13. Medication Safety **Reconciliation within 24 hours Target: 80%** Medicines reconciliation was completed within 24 hours of admission for 45% of patients. 78% of patients had MR completed during inpatient stay. There were 24 controlled drug incidents. There was 2 medication harm incident reported in month.	   	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	Medicines Reconciliation: continued failure to achieve target linked to vacancy rate in pharmacy establishment. Improvement in performance observed in November 2023 not maintained in December 2023, however performance in December impacted by increased annual leave and more days with reduced staffing (due to Bank Holidays). Controlled drug incidents: there is no target for this metric. 24 controlled drug incidents were reported in December 2023. The most common type of incident was administration errors (n=8) followed by unaccounted for losses/balance errors (n=5). Incidents causing harm: there is no target for this metric. There were 2 incidents causing harm in December 2023, both including controlled drugs but no themes or links identified.	Medicines Reconciliation: continued recruitment strategy, implementation of ED pharmacy team, use of locum and agency staffing. Work ongoing with W&C to reimplement midwife-led documentation of MR1 for antenatal patients. Medication/controlled drug incidents: all incidents are reviewed by a multiprofessional group and lessons learned are disseminated. Themes are identified and action plans developed through the medicines governance structure.

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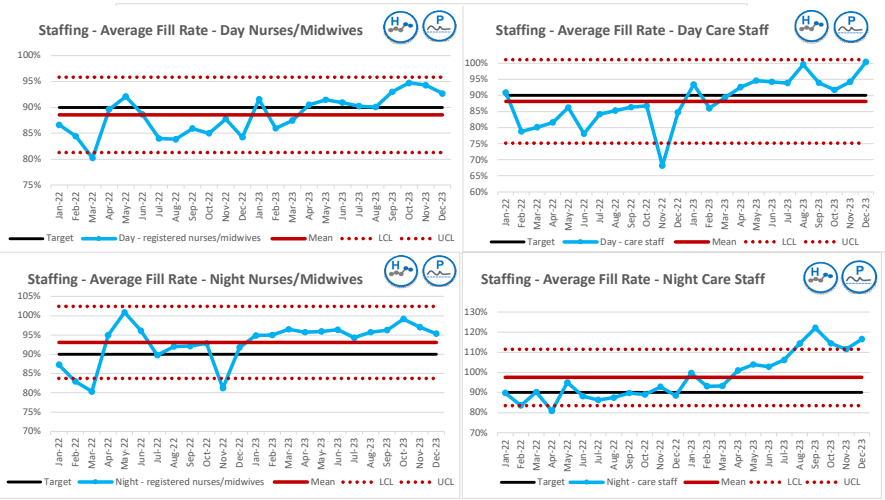
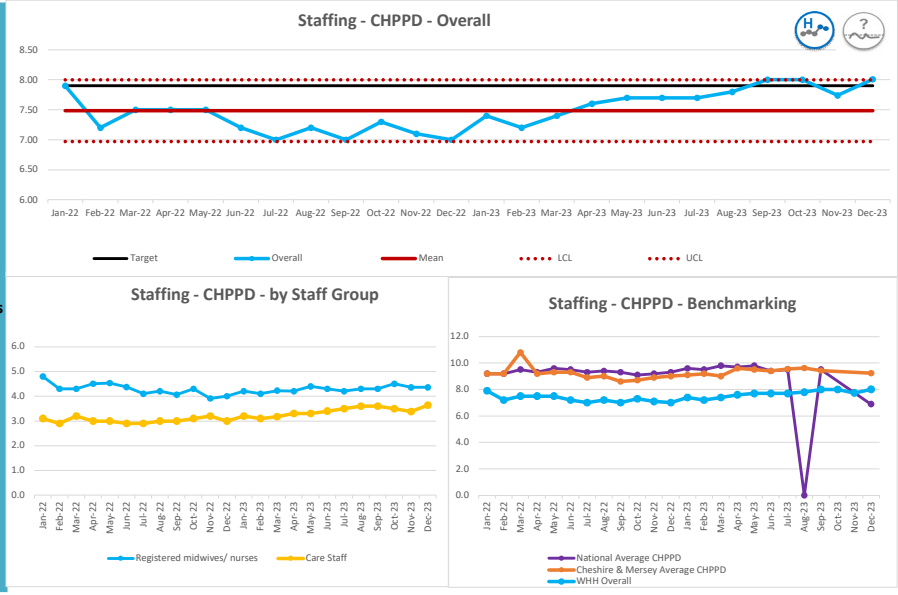
14. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 92.68% Day (Care Staff) 100.42% Night (Nurses/Midwife) 95.33% Night (Care Staff) 116.53%		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	A reduction in staffing fill rates for night shifts is noted and increase in day shift fill. This is due to the increased escalation beds opened and difficulty covering shifts across bank holiday periods.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. RN vacancy is currently 91.95 wte at band 5 with 73.96 wte in the recruitment pipeline. A further 21 students appointed qualifying in July 2024. Trust recruitment event planned for 9th Feb 2024. HCSW vacancy is currently 62.48 wte with 24.86 wte in the recruitment pipeline wte. Interviews scheduled for January 15th.
15. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In month, the average CHPPD were: Nurse/Midwife: 4.4 hours Care Staff: 3.6 hours Overall: 8 hours		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause variation of an improving nature.	The CHPPD December increased to 8.0 overall which is a continued improving trajectory.	Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety and work is ongoing to reduce agency usage, recruit to posts and migrate regular agency workers to NHSP. There are clear processes for escalation to ensure staffing is based upon acuity to ensure patient safety.

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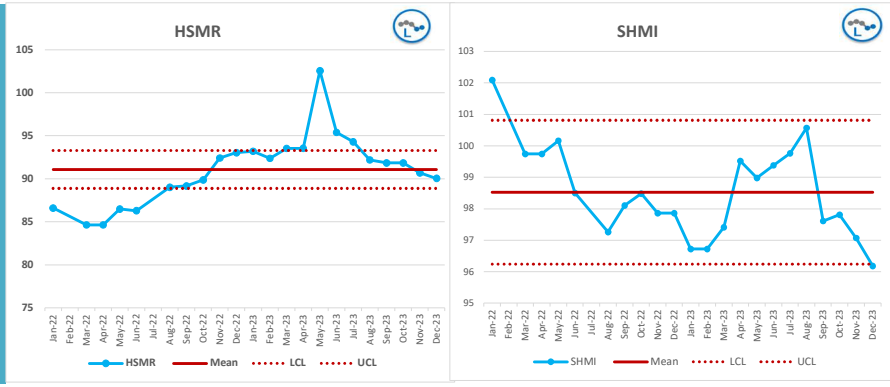
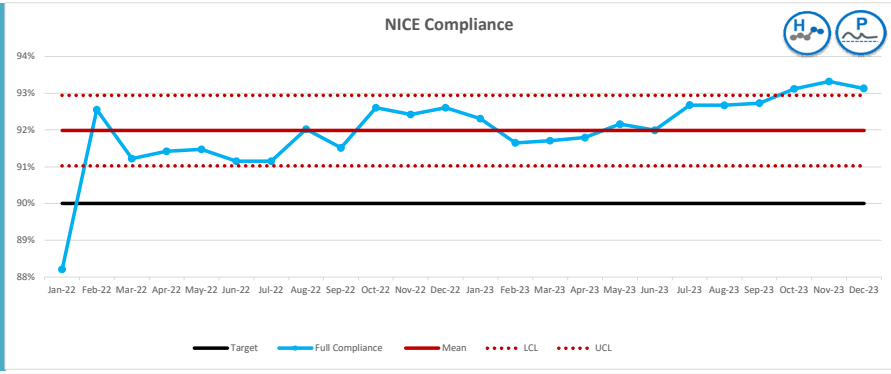
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 90.04. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 96.18.		(HSMR) Assurance: NA - no target Variation: Special Cause Variation of an improving nature. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of an improving nature.	The SHMI relates to 12 months data up to and including June 2023. This result is in band 2 which means this result is as expected using an over-dispersed funnel plot. HSMR (which is based on 12 months data, up to and including August 2023) is a low value outlier based on the 95% Poisson Method. For this report we have had to 'roll back' HSMR analysis and look at the 12 month period up to and including July 2023	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The Clinical effectiveness Coordinator continues to liaise with Safeguarding, ICU and Bereavement to ensure up to date information is recorded. UTI spiked trend has been identified and will be monitored. If trend continues, a focussed review will be undertaken.
18. NICE Compliance Target: 90%	The Trust achieved 93.13% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Performance against the target of 90% continues to be sustained.	The Clinical Effectiveness Manager continues to work closely with the CBUs with focus upon partial compliance and those 'under review' to ensure timeliness of progress and completion.

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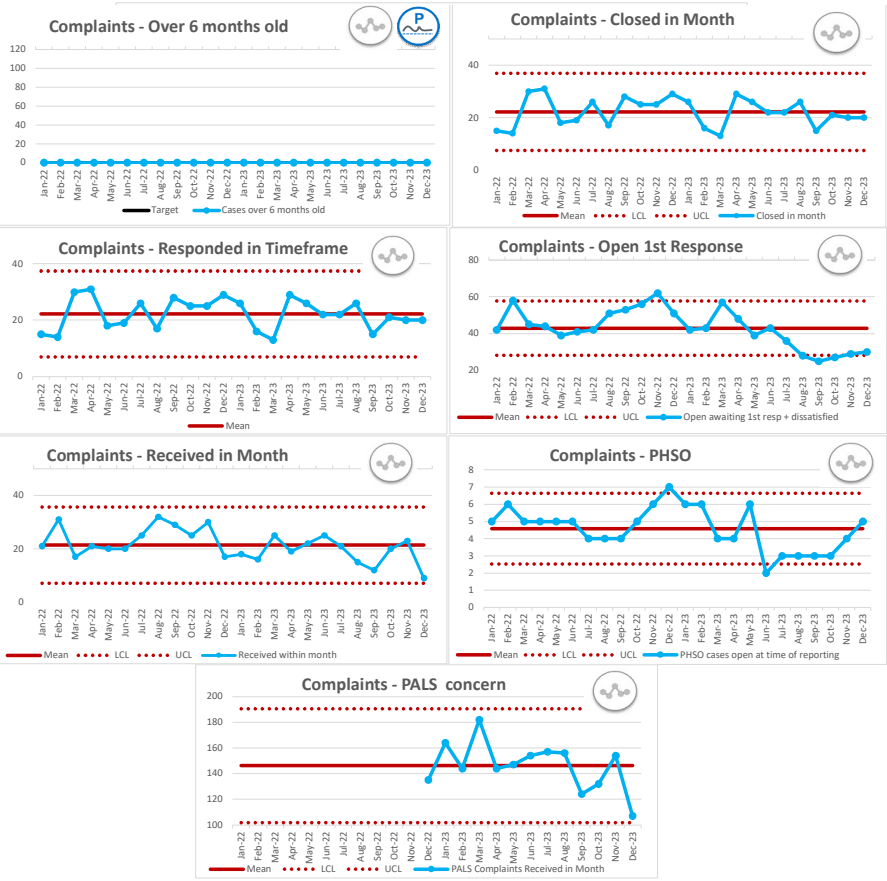
16. Complaints Target: Zero complaints open over 6 months old/in the backlog. **In month, 9 new complaints were received to the Trust which was a decrease of 14 from the previous month. There were 1 dissatisfied complaints received in month, which is an increase from the previous month.**		**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**The Trust continues to sustain performance in the timely completion of complaints. There continues to be no complaints over 6 months old.**	**Positive complaints position of 30 open complaints. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams. All CBUs have a designated complaints case handler to ensure consistency.**

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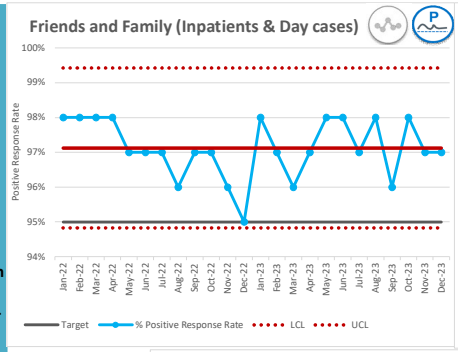
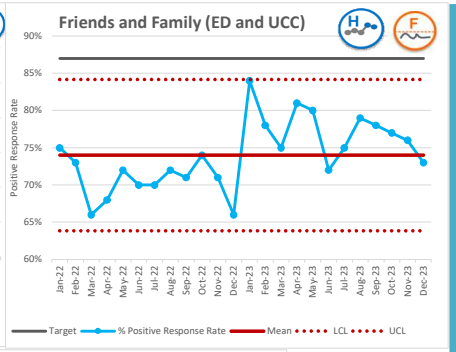
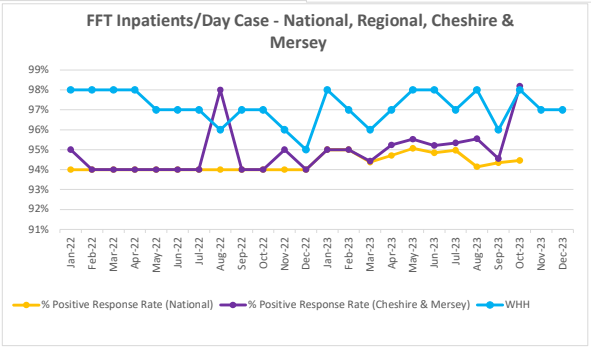
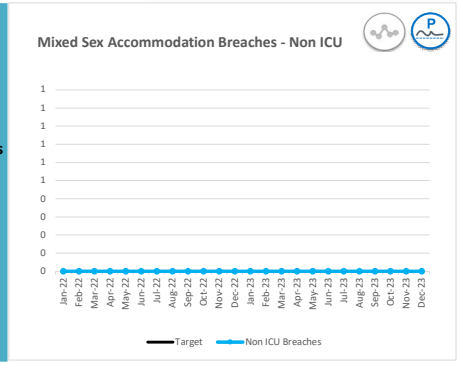
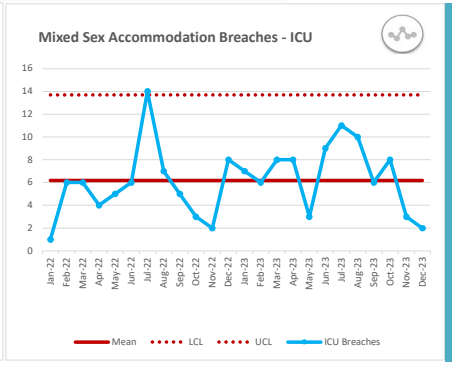
20. Friends and Family (Inpatients & Day cases) Target: 95% 21. Friends and Family (ED and UCC) Target: 87%	The Trust achieved 97% in month for Inpatient & Day case FFT and 73% for ED/UCC FFT. The most recent National average for FFT was 94.46% and for C&M was 98.19%.	  	(IP/DC) Assurance: The Trust consistently passes the target. (IP/DC) Variation: Common Cause (Normal) variation. (ED/UCC) Assurance: The Trust consistently fails the target. (ED/UCC) Variation: Common Cause (Normal) variation.	Inpatient/Day Case - The Trust achieved 97% positive recommendation rate in December 2023. The departmental teams continue to maintain a high positive response rate by monitoring feedback regularly and are currently working on increasing response rates with our Quality Improvement team. ED/UCC - The Trust achieved 73% positive feedback in Friends and Family Test results in December 2023. The focus with Patient Experience & Inclusion Team is to conduct real time surveys with patient with the aim to improve experiences within the ED department for patients/service users/carers. Winter pressures and high attendance levels, with various strikes has impacted the responses.	Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis to look for improvement areas, maintain and share best practice. Patient experience also to visit and audit areas, feeding back via local and trust wide level. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients. ED/UCC - Key themes for improvement in relation to positive recommendation rates continue with communication, waiting times, pain management and the environment. Patient experience also to visit and audit areas, feeding back at a local and trust wide level. Measures taken to improve patient experience within the Emergency Department include but are not limited to: -monitoring of care and comfort rounds - visual communications to be prominent in areas - mapping patient journeys to understand the support required at each touch point.
22. Mixed Sex Accommodation Breaches (Non ITU Only) Target: Zero	There were 0 mixed sex accommodation incidents outside of the ITU in month. There were 2 MSA incidents within the ITU.	 	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There were 2 mixed sex accommodation breach reported in December 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.	Work is underway in the Unplanned Care Group in relation to ongoing patient flow to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each bed meeting. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.

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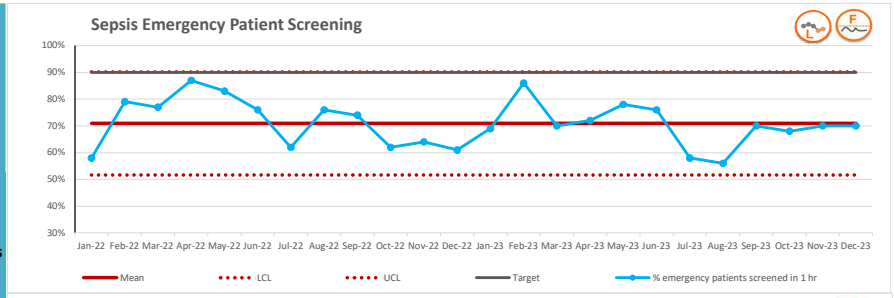
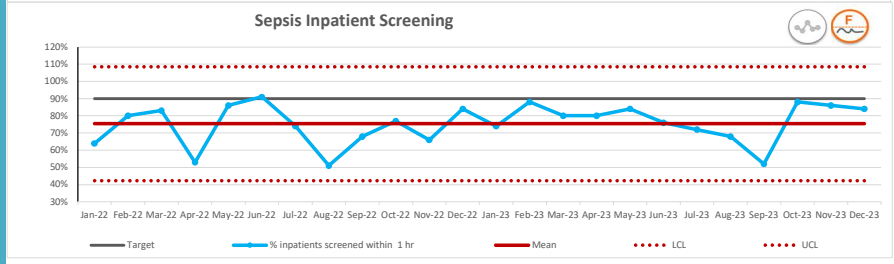
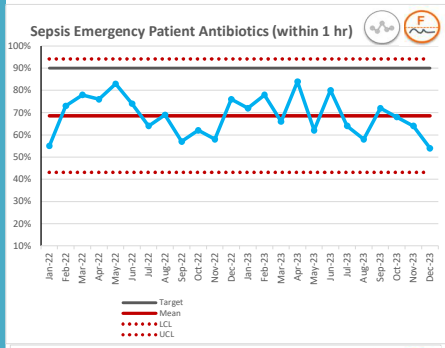
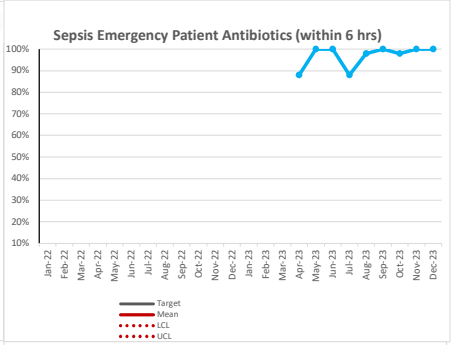
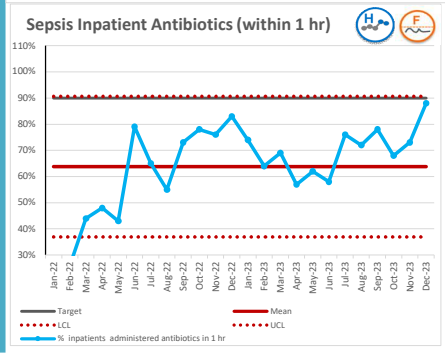
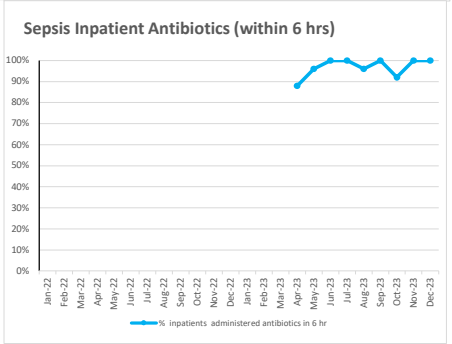
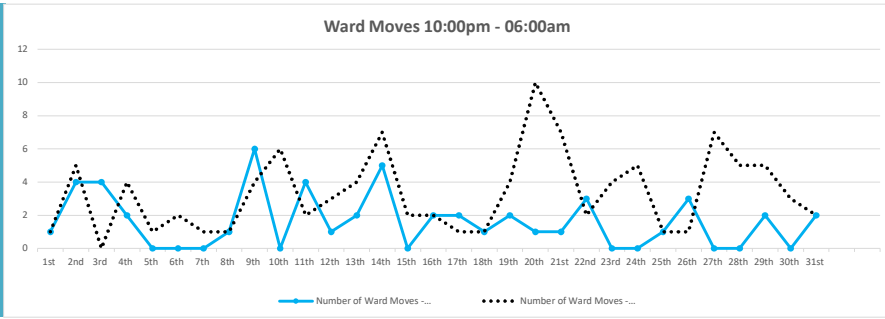
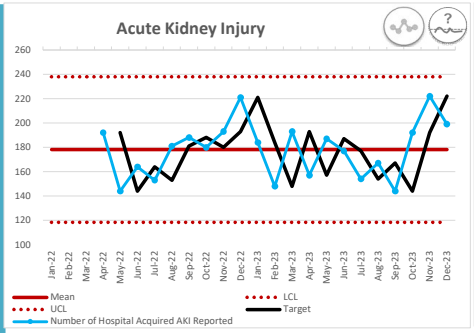
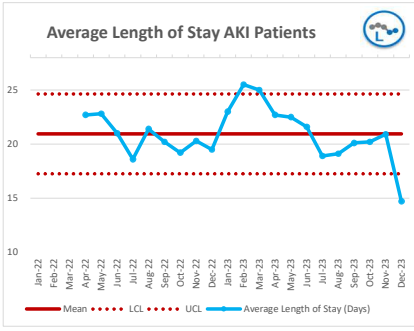
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%** **24. Sepsis - % screening for all inpatients** **Target: 90%**	**The Trust achieved:** **• 70% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** **• 84% screening for all inpatients with suspected sepsis within 1 hour.**	 	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**The contributory factor to not achieving compliance in both in patient and Emergency Department is the completion of blood cultures within the timeframe. Whilst outside timeframe, all ED patients and all but 1 in patient (not screened but given antibiotics in timeframe) received a sepsis screen.**	**Quality Improvement support remains in place to drive improvements across the Trust. There are four workstreams with a focus for improvement: ED, In-patient, Paediatrics and Maternity. Sepsis management remains a focus on Safety Huddles. Training for blood culture competencies is underway in ED with dates available for all Trust staff. Oversight is maintained the Operational Patient Safety Group.**
25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%** **26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis** **Target: 90%**	**The Trust achieved:** **• 54% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 88% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	   	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**All ED and in patients received their antibiotics within a 6 hour timeframe. In patient compliance was most improved at 88%, whist the reason for the reduced compliance in ED is the completion of prescriptions in a timely manner, compounded by the large numbers of patients in the department.**	**The importance of prescribing antibiotics in a timely manner continues to be a focus for improvement. The consideration of the use of PGD'S in ED has been deferred until the end of January awaiting the updated guidance from NICE in relation to timing of antibiotics - due end January 2024. The Patient Safety Improvement Nurses are visible in ED to encourage staff to 'think sepsis' and support any gaps in learning.**

Quality Improvement - Trust Position

Appendix 2

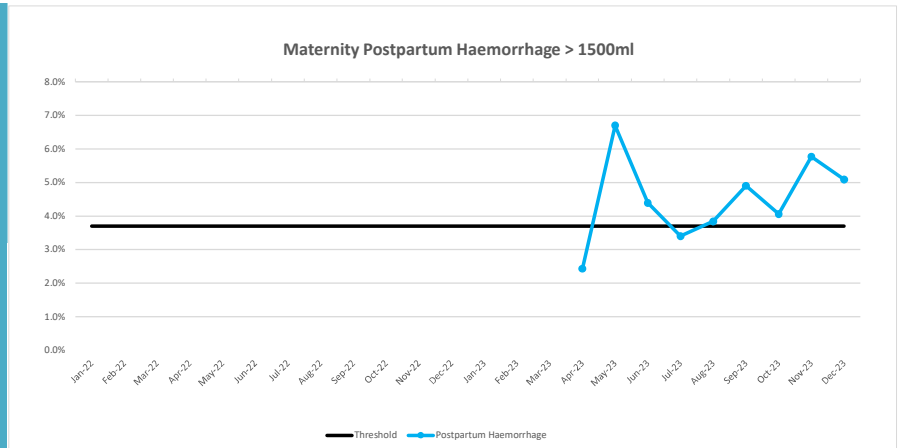
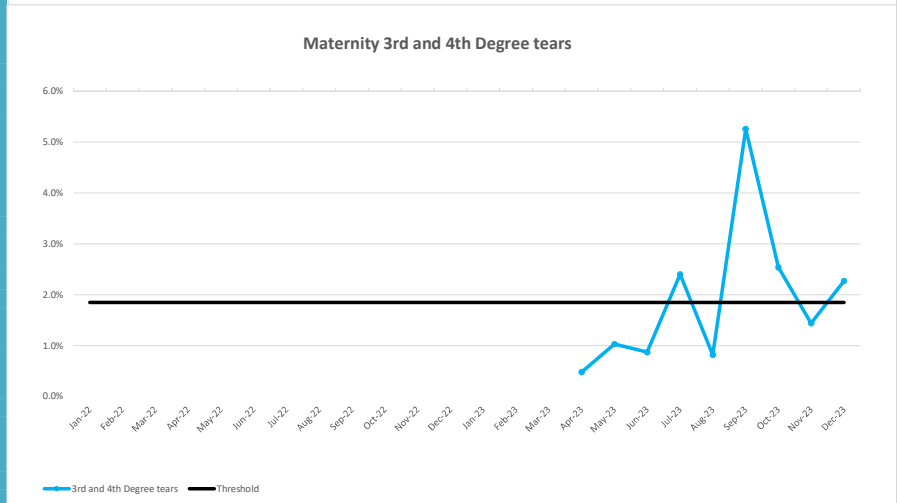
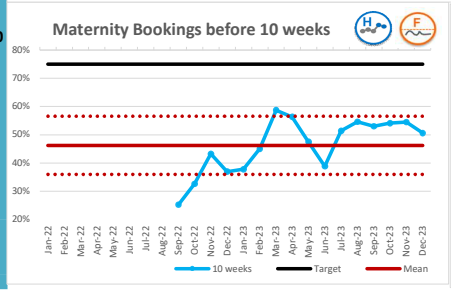
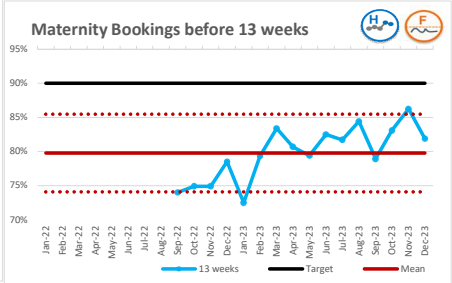
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 50 ward moves between 10pm-6am in month, compared to 103 in 2022.		N/A - Monthly/ Annual Comparison.	The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non essential clinical patient moves.	The Senior Manager on call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who undertake a welfare check.
28. Acute Kidney Injury Target: Less than previous month	There were 199 acute kidney injuries reported in month.	 	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	A positive reduction in LOS for patients with AKI, whilst incidence of AKI has reduced in month.	Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient. Move towards a deteriorating patient bundle or reduce work and improve prevention and management. Staff survey undertaken to understand 'barriers to completion' and suggested E-learning / ward-based teaching package to be developed. Ward based further AKI education as part of the AKI role. Drive to increase the AKI bundle to improve practice and utilise the AKI clinics each week to reduce the 30-day readmission rate.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

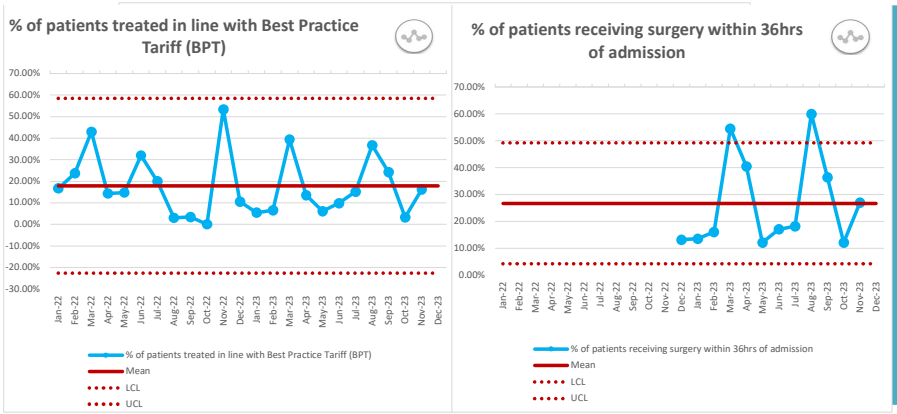
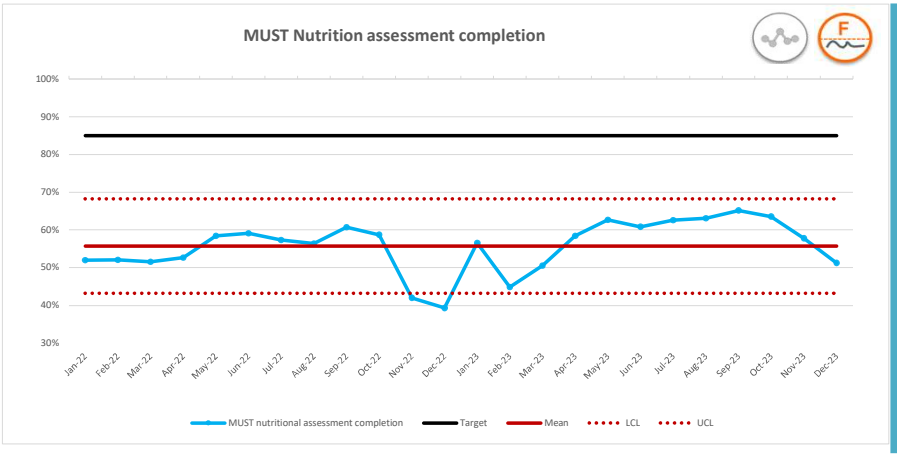
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 5.09% Postpartum Haemorrhages >1500ml in month.**		**N/A - Not enough datapoints.**	**Rates for December are above the benchmark but reduced from November. A full audit of PPH >1500mls March 2023 - September 2023 was reported to Quality Assurance in January 2024 with learning and actions identified.**	**A retrospective audit of PPH is underway. PPH >1500mls will continue to be reviewed on an individual basis via governance processes but will also be subject to additional review through the Intrapartum Incident Review Group which will meet regularly to review patterns and themes from incidents of PPH >1500ml. In addition a PPH QI group has been established. This QI group will lead on the improvements identified as part of the audit.**
30. Maternity 3rd and 4th Degree tears **Threshold: <1.85%**	**There were 2.27% 3rd and 4th Degree tears in month.**		**N/A - Not enough datapoints.**	**Incidence of 3rd & 4th degree tears has increased in December. There were five cases. 3rd & 4th degree tears are reviewed via governance processes and the learning from these reviews is then shared.**	**Incidence of 3rd & 4th degree tears continue to be reviewed via governance processes and the learning from these reviews is then shared. In view of the increased rates these will be reviewed as a cluster to ensure we are capturing any themes and improving practice and shared via Women's Health Governance meeting.**
31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks **10-week Target: >75%** **13-week Target: >90%**	**50.6% bookings before 10 weeks and 81.9% bookings before 13 weeks.**	 	**(10 weeks) Assurance: The Trust consistently fails the target.** **(10 weeks) Variation: Special cause variation of an improving nature.** **(13 weeks) Assurance: The Trust consistently fails the target.** **(13 weeks) Variation: Special cause variation of an improving nature.**	**An action plan is in place to improve timeliness of bookings and there had been general improvement over the last 12 months. For both booking measures performance has continued to improve and is nearing that of local provider best averages (58.9% for bookings <10 weeks and 87.9% for bookings <13 weeks). Work will continue to meet the stretch target to achieve best practice results.**	**An action plan is in place to improve timeliness of bookings and there had been significant improvement following implementation of this particularly in relation to bookings <10 weeks. This work will continue with booking performance monitored on a weekly basis .**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

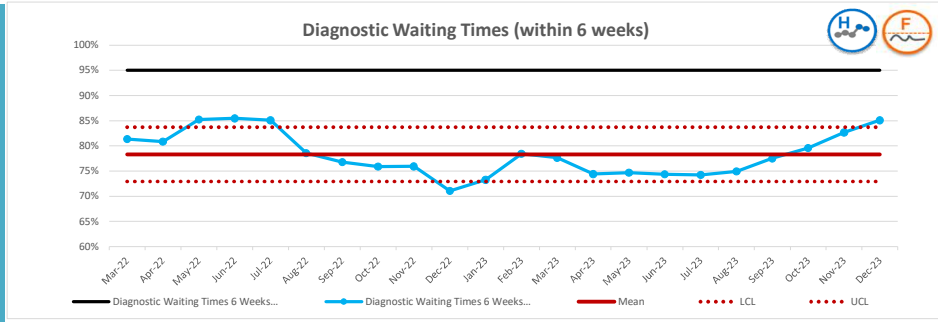
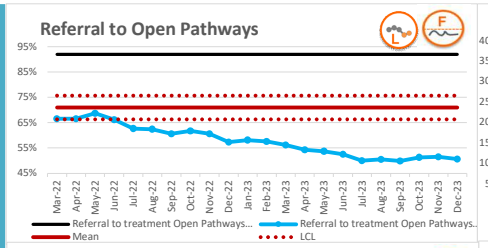
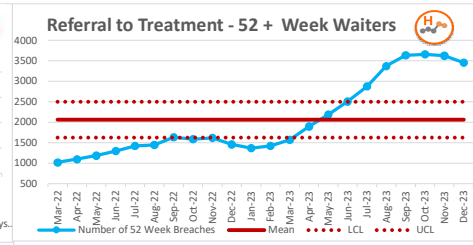
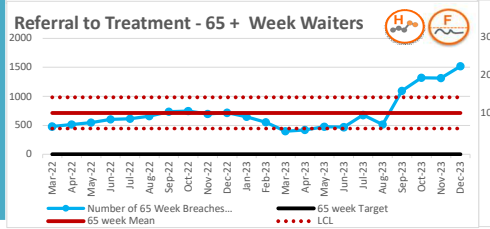
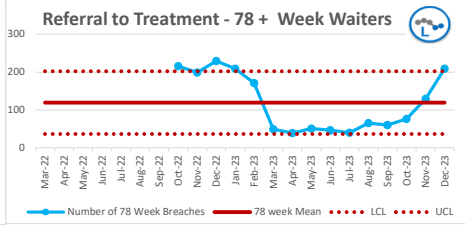
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Fractured Neck of Femur **Target: Best Practice Tariff**	**16.2% of patients were treated in line with Best Practice Tariff (BPT) in Nov-23.**	 	**Variation: Common Cause (Normal) variation.**	**An action plan is in place to improve a sustained compliance with the KPI for 'Prompt Surgery' The reasons for variation are; variation in theatre teams (including anaesthetist), Consultant productivity, fluctuation in demand and most importantly, demand being greater than capacity.** ***Please note, for '% of patients receiving surgery within 36 hours of admission ', data has been refreshed to reflect current data in the National Hip Fracture Database. As a result, figures are different from those previously reported in the IPR. November data is the most current available in the Database.**	**Work continues with regards to improving capacity to aid performance of 'Prompt surgery'. Short term we have been able to request that where possible working through lunch is supported, ad hoc additional lists are scheduled and the improved scheduling of patients the day prior to surgery via eTrauma. Long term, a review of the T&O Consultants job plans has begun, to include an extension to their 'Trauma Consultant on Call' week, from a 5pm to a 6pm finish. This will enable an additional one hour operating -this is already staffed by the anaesthetic and theatres teams.**
33. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 51.23% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**A decline in compliance is noted for December**	**Local QI projects and dashboards are in place. SPC charts for each ward to be added to dashboard to aid data interpretation made available.** **Ward-based interventions are to be re-launched. Collaboration with QI team to analyse audit data and formulate Trust wide Quality improvement project.** **Individual action plans for improved compliance for areas identified, oversight and progress monitoring via Monthly Trust Nutrition Food & Hydration Steering Group**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

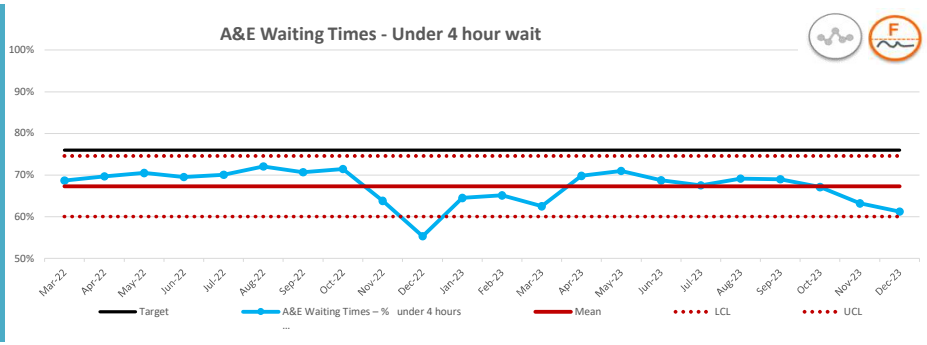
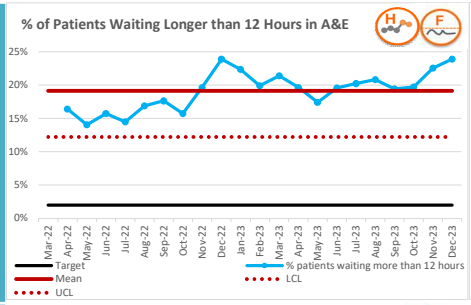
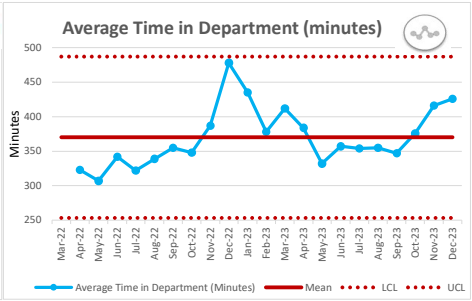
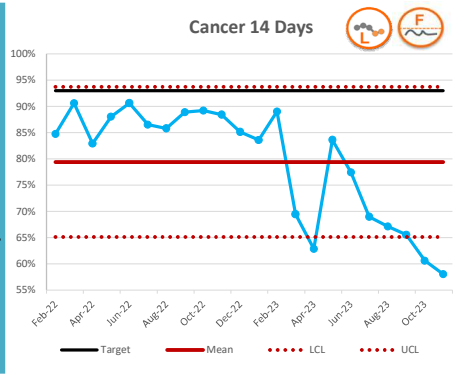
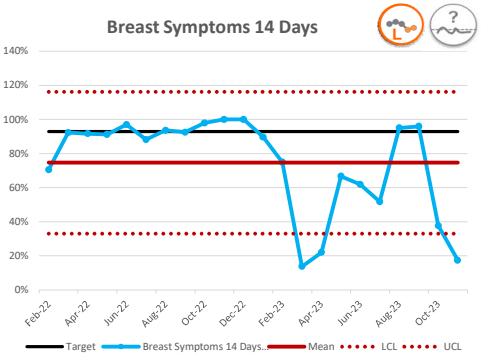
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
34. Diagnostic Waiting Times 6 Weeks Target: 95% **The Trust achieved 85.1% in month.** RR1215 RR1125		**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of an improving nature.**	**The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.**	**A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies, recovery plans are in place for all modalities**
35. Referral to treatment Open Pathways Target: 92% 67. RTT - Number of patients waiting 65+ weeks Target: 0 **The Trust achieved 50.59% in month. There were 3457, 52 week breaches, 209, 78 week breaches and 1521, 65 week breaches.** RR1125 RR1215	   	**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **(65+) Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**RTT performance - 52 week waits have started to improve in line with the trajectory, 78 weeks and 65 remain challenged, mitigation plans through use of insourcing and mutual aid are supporting recovery plans**	**Recovery of the elective programme is taking place with:** **• Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.** **• Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.** **• Restoration and recovery plans for 2023/24 have been drawn up in line with Operational Planning Guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

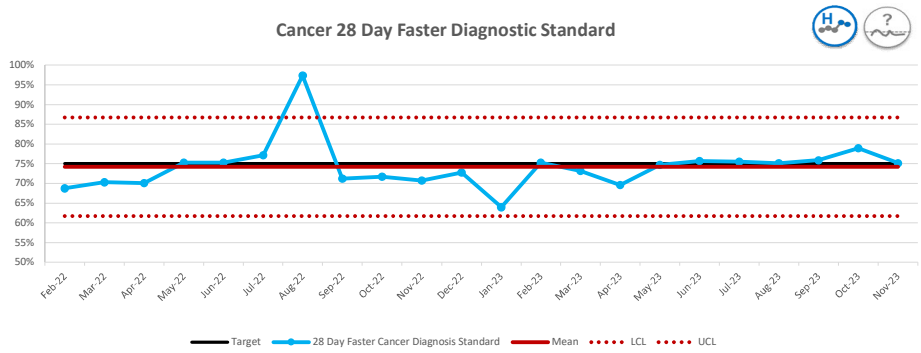
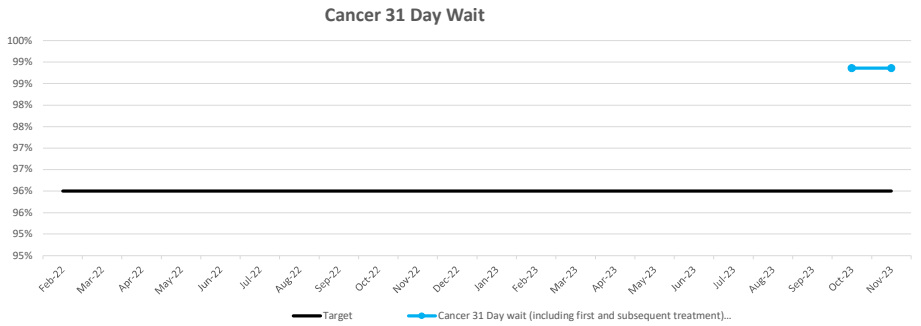
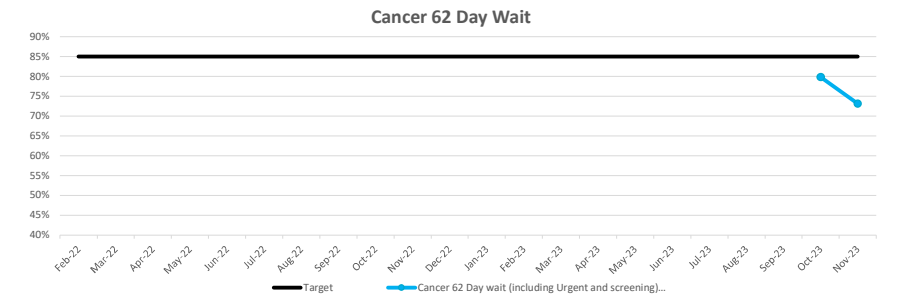
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
36.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 75% CQC **The Trust achieved 61.27% excluding Widnes walk ins in month.** RR224		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy**	**• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** **• System resource investment in order to support Pathway 1 discharges.** **• Additional beds remain open on the Halton site to support bed capacity and flow.**
37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less 38. Average time in department ED No Target **23.89% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 426 minutes.**	 	**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED.**	**The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 23/24 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 23/24 is set up to support improvement.**
39. Cancer 14 Days Target: 93% 40. Breast Symptoms 14 Days Target: 93% SOF CQC **The Trust achieved 58.06% in November 2022 for Cancer 14 days and 17.39% in month for Breast Symptomatic.** RR1125	 	**(C14) Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **(Breast) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation.**	**This metric ceased to exist from the 1st October 2023 with the 28 day Faster Diagnosis standard (FDS) becoming the focus. It is important to note, that in order to achieve the 28 FDS, then there will be a requirement for patients to have their first OPD appointment in 2 weeks or less.**	**The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard.** **Performance against this standard is monitored via the Performance Review Group (PRG).** **Targeted capacity and demand work has been initiated for the Breast service.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

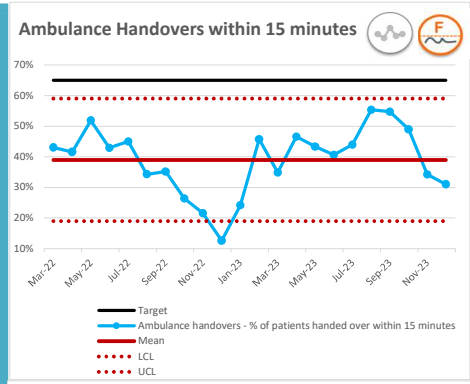
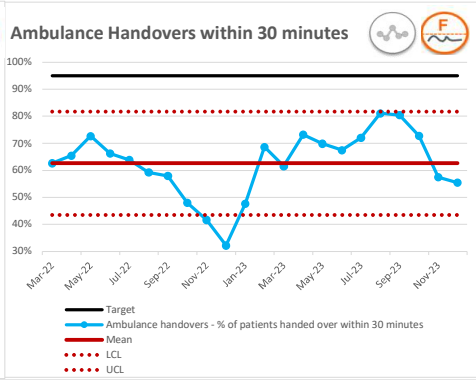
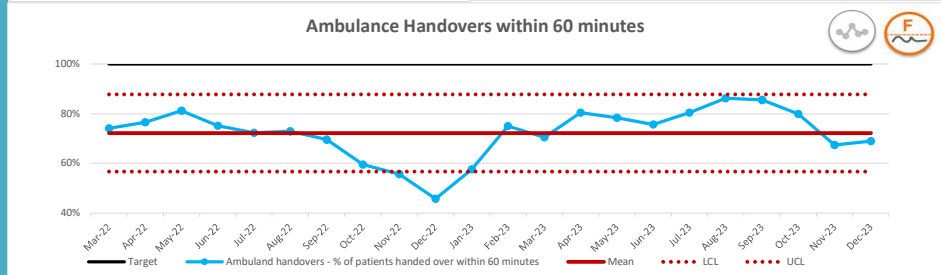
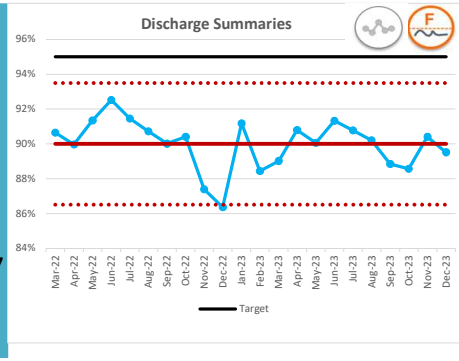
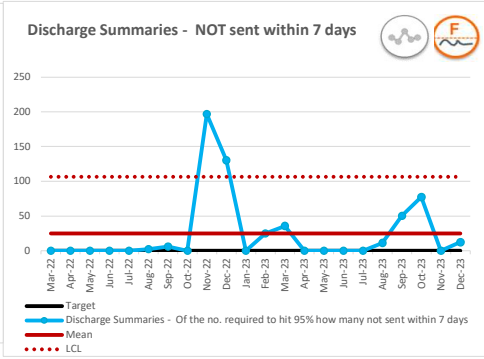
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
41. 28 Day Faster Cancer Diagnosis Standard Target: 75%	SOF The Trust achieved 75.13% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	The Trust is currently meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG)
42. Cancer 31 Day wait Target: 96%	SOF CQC The Trust achieved 98.86% in month for Cancer 31 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	The Trust achieved the 31 day target	
43. Cancer 62 Day wait Target: 85%	SOF CQC The Trust achieved 73.16% in month for Cancer 62 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	From 1st October 2023 62-day screening and 62 day consultant upgrades became combined. Whilst the operational standards remains 85% there is a commitment to reach 70% by March 2024. Early shadow monitoring is at 73.4%.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

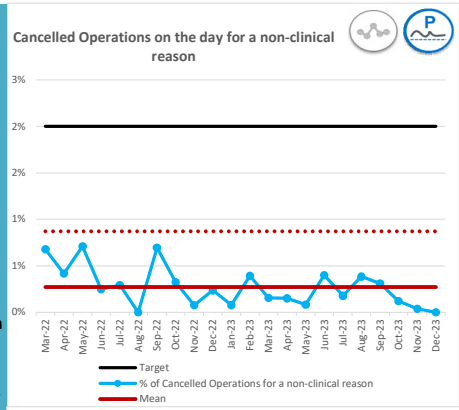
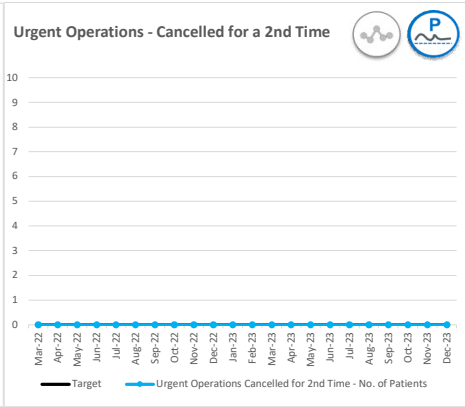
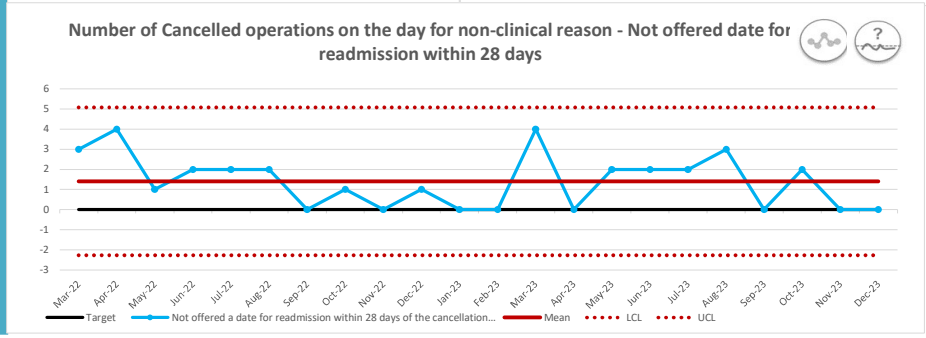
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
47. Ambulance Handovers within 15 minutes Target: 65% 48. Ambulance Handovers within 30 minutes Target: 95% 49. Ambulance Handovers within 60 minutes Target: 100% **In month 31.06% of patients were handed over within 15 minutes, 55.47% were handed over within 30 minutes and 68.94% were handed over within 60 minutes.** SOF	  	**(15) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(29) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(60) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Handover performance has seen a slight dip inline with winter pressures, however it is important to note that this is an improved performance compared to the same period last year**	**The Trust will continue to work in partnership with NWAS to identify and implement improvements.**
50. Discharge Summaries - % sent within 24hrs Target: 95% 51. Discharge Summaries - Number NOT sent within 7 days Target: ZERO **The Trust achieved 89.51% in month for discharge summaries sent within 23 days, against the target of 95%.** **There were 12 discharge summaries in month not sent within 7 days, against the target of 0.**	 	**(24 hrs) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(7 Days) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.** **A deep dive is underway into the increase of discharge summaries not sent within 7 days.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

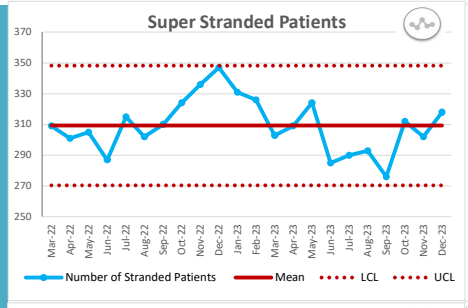
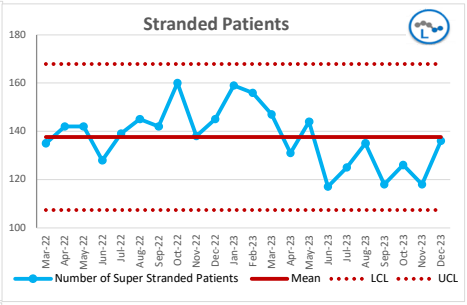
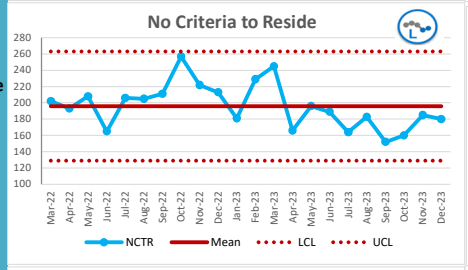
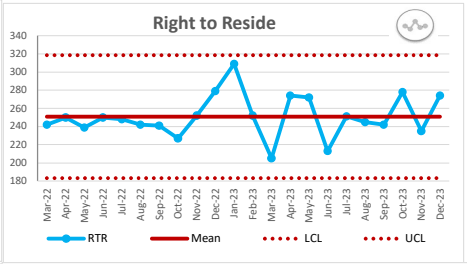
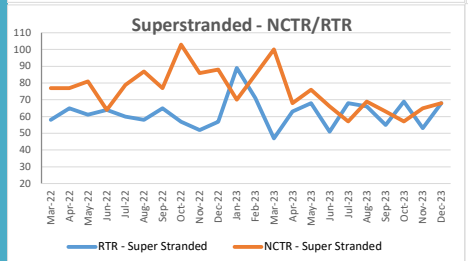
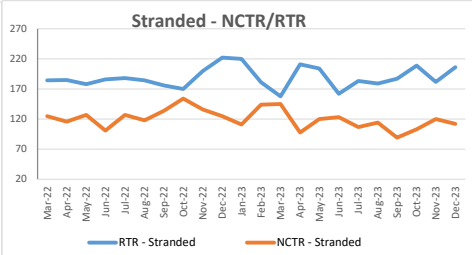
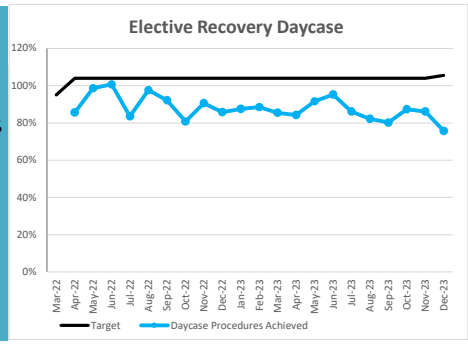
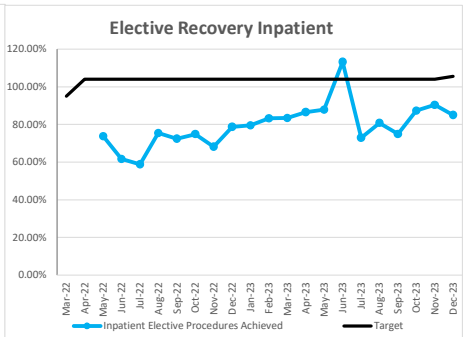
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	Cancelled operations for a non-clinical reason was 0% in month. 0 cancelled operations were not offered a date for readmission within 28 days.		(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via Performance review group.
53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO			(Not offered 28 days) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.		
54. Urgent Operations Cancelled for 2nd Time			(Urgent Ops cancelled 2nd time) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

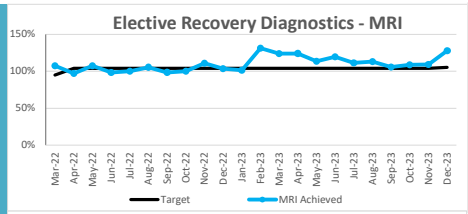
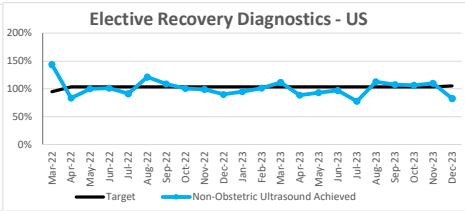
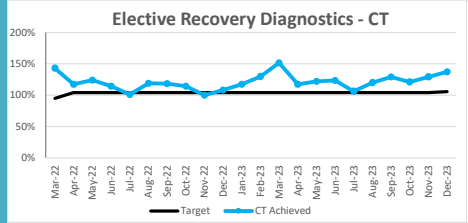
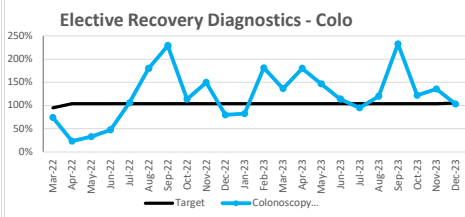
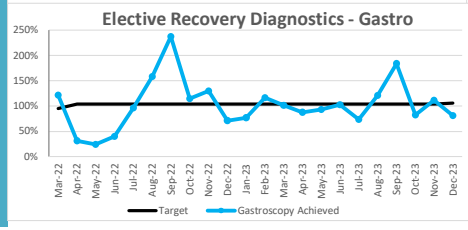
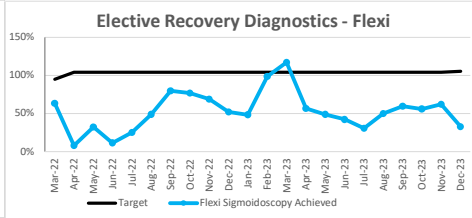
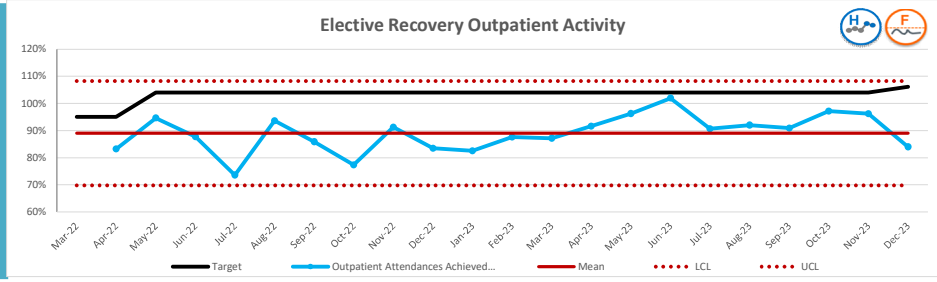
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Super Stranded Patients Target: Trajectory				
There were 318 stranded and 136 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	     	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The number of Super Stranded patients has shown a increase over the winter period, this figure still remains lower than the same time last year	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
56. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included 76% of Daycase Procedures and 85.07% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Elective activity remains challenged, IA did have some impact in December	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

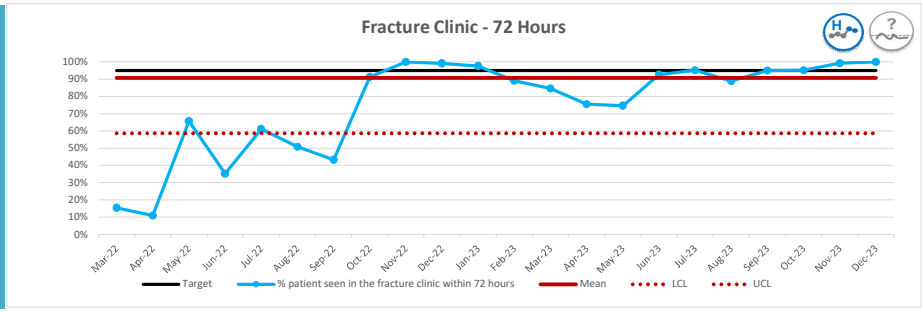
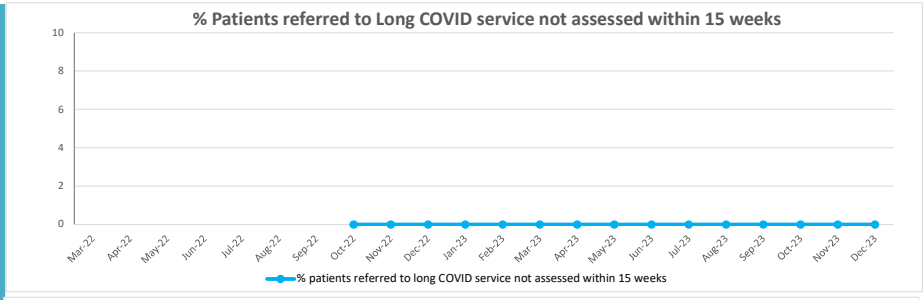
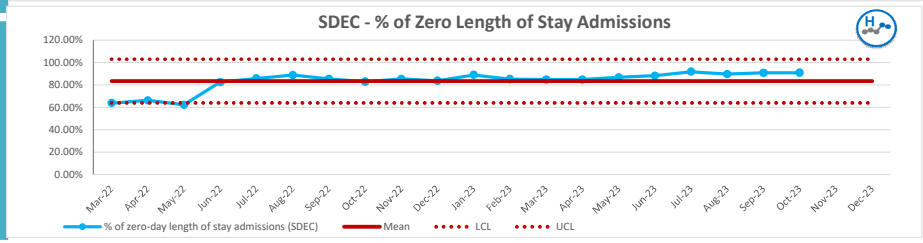
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
57. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 **In month, the Trust achieved the following % of activity against 2019.** **This included:** **127.68% of MRI** **137.04% of CT** **82.84% of Non-Obstetric Ultrasound** **32.59% of Flexi Sigmoidoscopy** **103.2% of Colonoscopy** **81.06% of Gastroscopy** RR1125	     	**N/A - Grouped indicator.**	**Recovery trajectories Radiological specialties and Endoscopy are in line with recovery trajectories.** **Challenges remain in Cardiorespiratory services.**	**The Trust continues to restore clinical services in line with the national operating guidance.** **Additional insourcing support for Echo is being progressed to help reduce waiting times.** **Underperformance in Flexi sig will be explored at the Performance Review Group.**
58. Elective Recovery Outpatient Activity Aggregate Target: 104%	SOF RR1125 **In month, the Trust achieved 84% of Outpatient activity against 2019.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative services such as patient initiated follow. Activity is impacted by Industrial Action.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

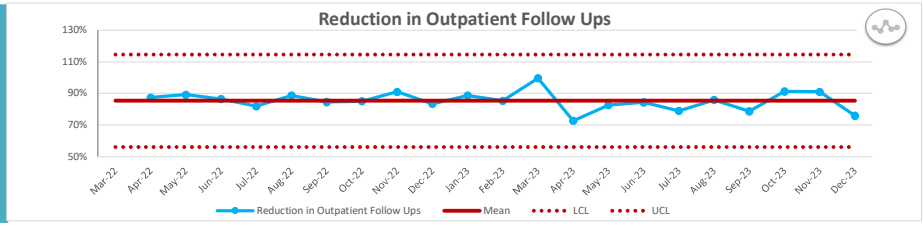
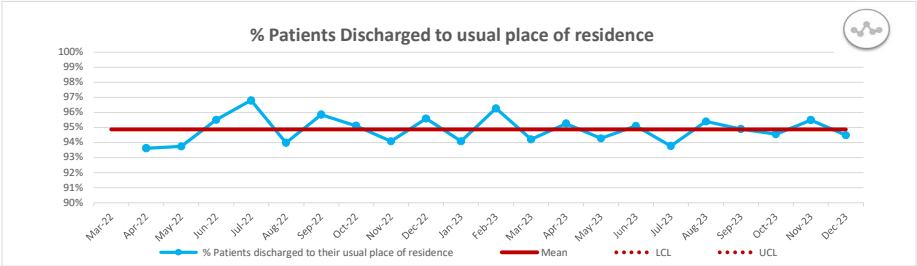
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
59. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In monthly, the fracture clinic saw 100% of patients within 72 hours.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	Issue of non-compliance addressed in-month.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
60. % patients referred to long COVID service not assessed within 15 weeks	This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.		N/A - Not enough datapoints.		
61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	0% of SDEC Emergency Admissions had a zero day length of stay.		Variation: Special Cause Variation of an improving nature.	As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

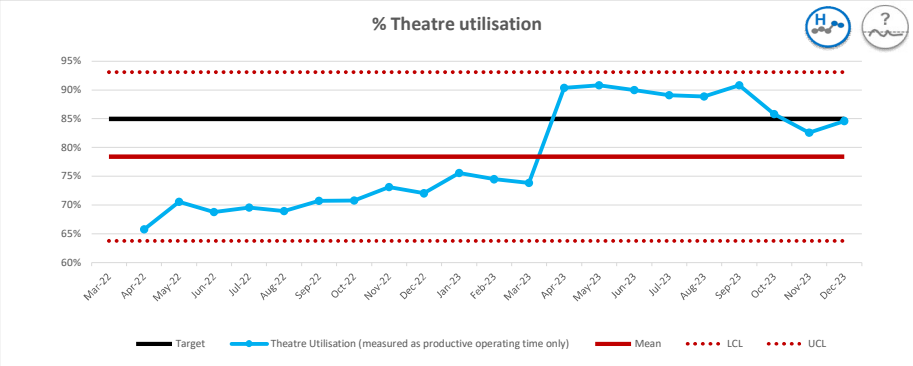
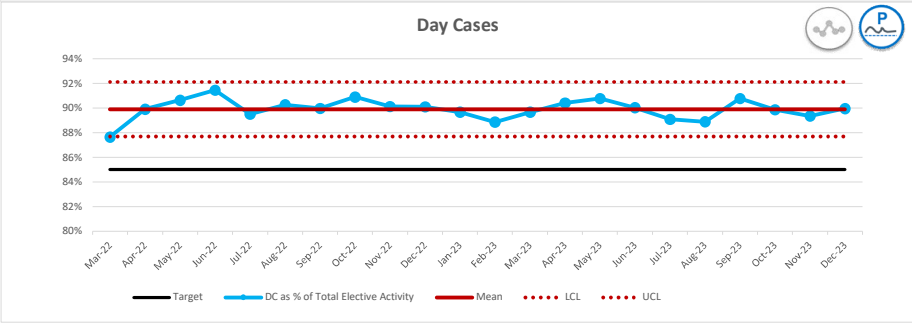
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
62. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 75.9% of 19/20 activity in month.**		**Variation: Common Cause (Normal) variation.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
64. % Patients discharged to their usual place of residence Target: No Current Threshold	**94.48% patients in month were discharged to their usual place of residence.**		**Variation: Common Cause (Normal) variation.**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

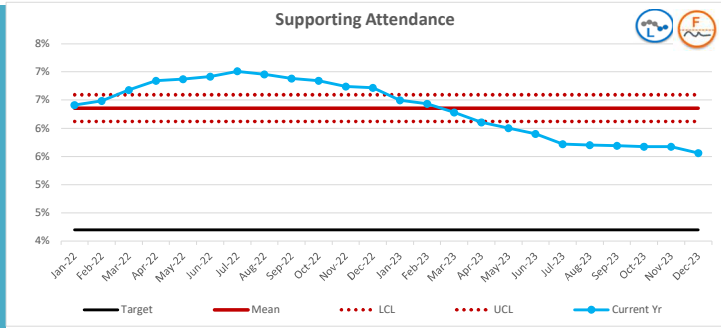
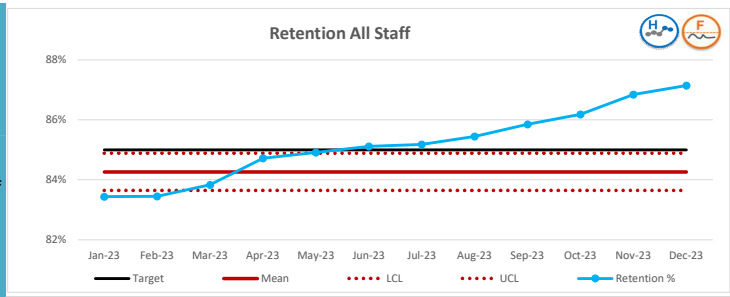
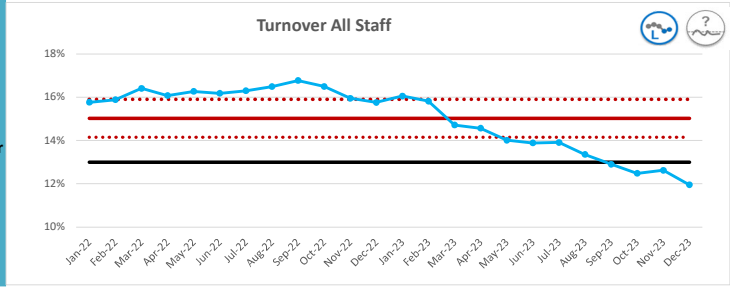
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
65. Theatre Utilisation (measured as productive operating time only) Target: 85%	84.6% Theatre utilisation in month (measured as productive operating time only). There were 89.97% Day cases, of total activity in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	Theatre Utilisation has improved, but has been steadily increasing since Apr 22 with the participation in the regional Theatre improvement programme. The performance is as a result of some utilisation improvement and changes in recording - this is in the process of being validated.	The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data. Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors.
66. Day case (measured as an aggregate of total cases) Target: 85%			Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	Daycase rates have been higher in 2023/24 with majority hitting the target.	The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates. Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

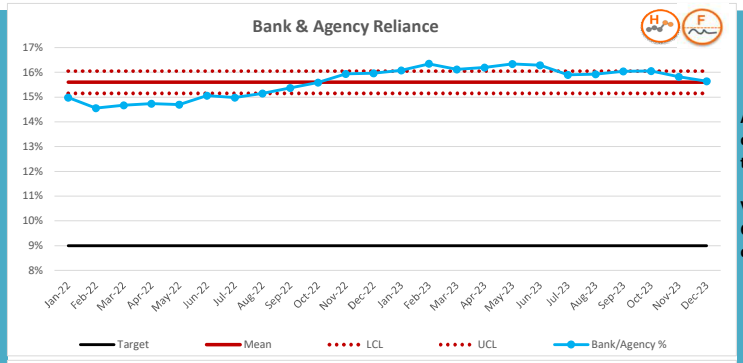
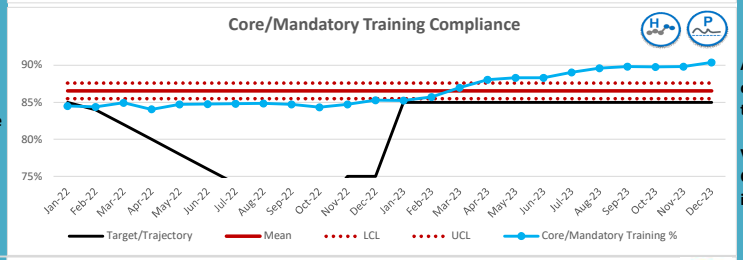
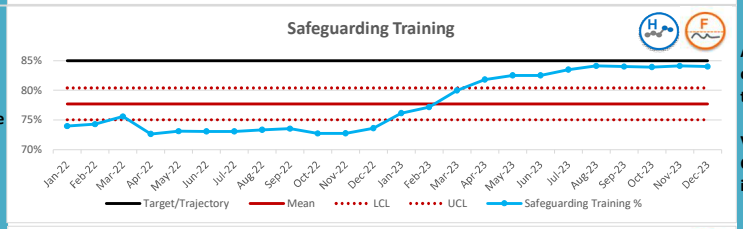
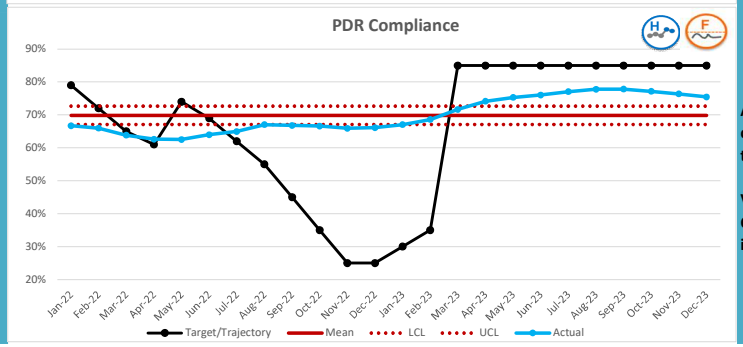
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
S Trust Strategy
RR200 Risk Register

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
68. Supporting Attendance Target: Below 4.2%	UoR SOF S The Trust's annualised sickness rate was 5.56%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence is showing an Improving Variation. The annualised sickness absence percentage in December 2023 was 5.56%, a slight decrease from 5.67% in October 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which are prevalent over winter.	December 2023 annualised absence is the lowest annual absence rate since April 2020. Sickness absence levels remain below 22/23 absence rates. Following the identification of a trend emerging for new starters, particularly those new to the NHS who are being referred to OH within their first year of employment, the People Health and Wellbeing group are reviewing how the Trust supports new starters which will be built into the current review of the induction process. Further work is continuing to understand the scale of the issue and potential interventions.
69. Retention Target: 85%	UoR RR1108 RR1134 The Trust's annualised retention of all staff was 87.14%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Annualised retention is showing an Improving Variation. Retention of all staff in December 2023 was above Trust target at 87.14%, an increase from 86.14% in October 2023. Retention for permanent staff in December 2023 remains above Trust target at 89.43%.	Retirements are reducing compared to the previous 12 months, with relocation the fastest growing reason for people leaving, work/life balance remains the main reason. The People Directorate are working with pilot areas to review their approach to rostering and further supporting leaders to enable flexible working within their areas by launching development sessions and an improved approach to flexible working requests.
70. Turnover Target: Below 13%	S CQC SOF UoR The Trust's annualised turnover of all staff was 11.96%.		Assurance: The Trust inconsistently passes / fails the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in December 2023 was above Trust target at 11.96%, a decrease from 12.53% in August 2023. Turnover of permanent staff in December 2023 was above Trust target at 11.24%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

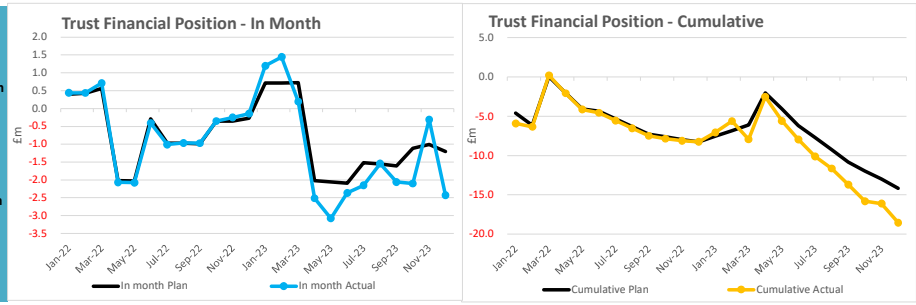
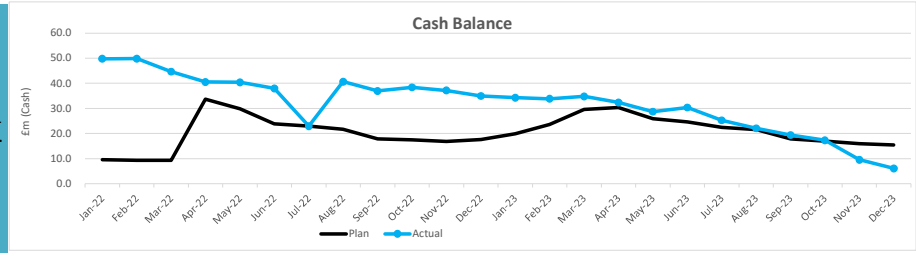
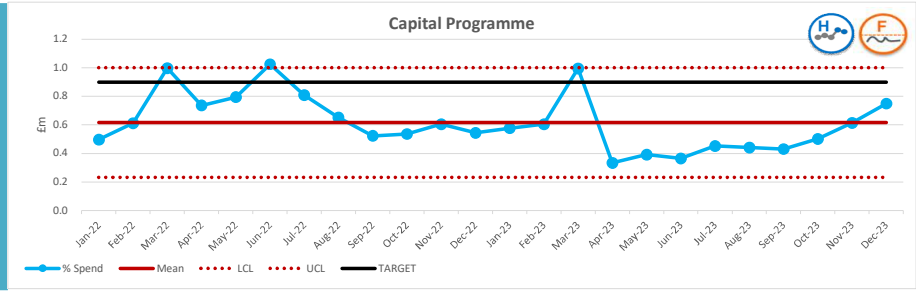
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
S Trust Strategy
RR200 Risk Register

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
71. Bank and Agency Reliance **Target: 9% or Below** UoR Annualised Bank and Agency Reliance was 15.65%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Bank and Agency reliance is showing a Concerning Variation. Bank and Agency reliance in December 2023 was 15.65%, a slight improvement from December 2023 at 16.01%. Bank reliance continues to increase and is 11.8% in December 2023 as Agency reliance continues to decrease to 4.5% in December 2023.	The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. The Resourcing Task and Finish group has benchmarked the Trust against Job Planning and Rostering National Levels of Attainment, and the Workforce Reporting against the nationally expected standards. The gap analysis and recommendations report will allow the organisation to consider plans to improve the effectiveness of workforce deployment.
72.Core/Mandatory Training **Target: 85%** UoR CQC Core/Mandatory training compliance was 90.41% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training (exclusive of Safeguarding) is showing an Improving Variation. In December 2023, CSTF Mandatory Training compliance was 90.41%, excluding Safeguarding Training (Children's and Adults); Safeguarding (Children's and Adults) compliance was 84%.	Compliance continues to be supported by the continual review of training and accessibility at the Mandatory and Role Specific Training Panel and the offer of face to face training. Care Groups report compliance at Operational People Committee with actions required to ensure targets are met. The HRBP team are identifying hotspot areas and supporting the CBUs in writing out to staff congratulating those 100% compliant, informing those with 85% compliance and asking them to achieve 100% compliance, and those with less than 85% compliance have been written to and asked to complete their outstanding mandatory training.
73. Safeguarding Training **Target: Trajectory** Safeguarding Training compliance was 84% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.		
74. PDR **Target: 85%** S CQC Annualised PDR compliance was 75.46%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In December 2023, Appraisal compliance was 75.46%, an increase from 74.93% in August 2023. Currently Appraisal rates are below the trajectories but higher than 2022.	A new electronic appraisal has been launched with associated guidance, dedicated extranet pages and training which was as a result of a workforce feedback regarding streamlining the process. It also includes EDI objectives and a wellbeing section. A review of hotspot areas is underway to inform a targeted approach to support improving compliance and ensuring our workforce are supported in their development by having annual appraisals.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

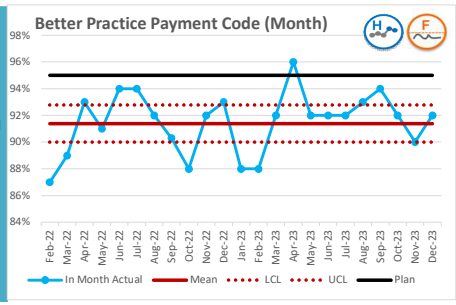
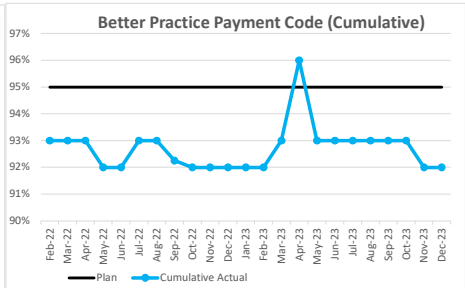
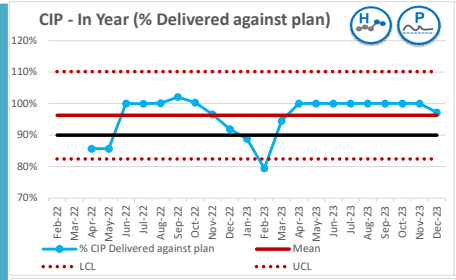
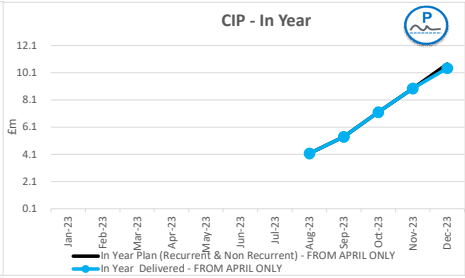
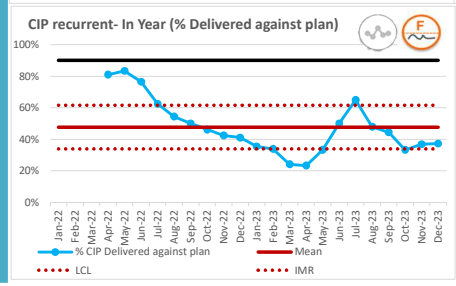
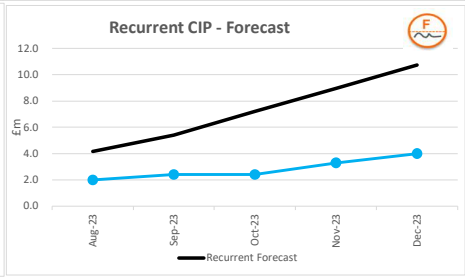
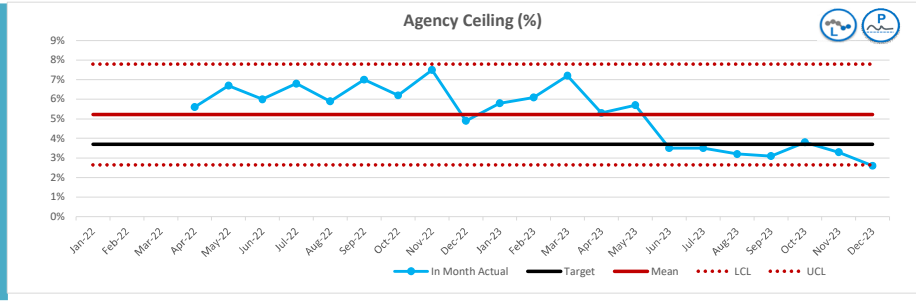
Key:
- SOF System Oversight Framework
- UoR Use of Resources Assessment
- RR116 Risk Register
- CQC Care Quality Commission
- Trust Strategy

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
75. Trust Financial Position **Target: Plan**	The Trust has recorded a deficit position of £18.5m at 31 December 2023 against a deficit plan of £14.2m. The position includes funding for Industrial Action costs and lost activity between April and October of £4.5m.		The main drivers for the deficit being worse than plan are further unfunded Industrial Action (IA) costs in December, activity delivered under plan, the cost of additional capacity in A&E and specialling as well as undelivered CIP.	Following work with the ICS, the Trust is now forecasting a £22.8m deficit, which is £7.1m worse than plan. However there are significant risks to achieving this forecast.
76. Cash Balance **Target: On or better than plan**	UoR The cash balance as at 31 December 2023 is £6.1m. RR134		The current cash balance is £6.1m which is £9.4m worse than the cash plan. In the main this relates to the ongoing impact of the deficit position, including additional payroll costs due to Industrial Action.	Given the current cash position and the likely forecast to the end of 2023/24 it is expected that the Trust will require external support.
77. Capital Programme **Target: On plan 90%-100%**	UoR Capital expenditure at the end of month 9 is £12.6m against a plan of £16.9m.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Annual Trust capital plan of £28.3m is £0.4m oversubscribed against £27.9m of capital funding. The monthly profile of the Trust plan has been updated to be more reflective of the expected position. With the updated profile, £14.2m was expected to be spent by 31 December 2023 giving a variance of £1.6m.	The underspend year to date is mainly due to the timing of externally funded schemes. In particular, the plan for CDC is £4.9m which was profiled in 12ths whilst waiting for a detailed plan from cost advisors. There was also a subsequent delay due to an additional funding request. The majority of CDC expenditure is now expected in months 10 to 12.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

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

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
78. Better Payment Practice Code **Target: Cumulative performance 95%**	The Better Payment Practice Code (BPPC) performance based on volume for NHS is 77% and non-NHS is 92%. The Better Payment Practice Code performance based on value for NHS is 83% and non-NHS is 92%. In November, the national average for BPPC by value was 91.5%, and the Cheshire & Merseyside average was 93.7%.	 	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Cumulative performance is 92% which is below the national target of 95%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.
79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**	The month 9 CIP plan is £10.7m and £10.4m has been delivered.	 	Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	93% of savings have been identified for 2023/24 which is £16.7m of the £17.9m target. As well as the £1.2m remaining to be identified an additional stretch target of £5.3m needs to be achieved to meet the revised deficit plan. Plans are underway to identify schemes to deliver the revised plan.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT programme with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust.
80. Cost Improvement Programme (recurrent forecast) – In year performance to date **Target: Recurrent Forecast is more than 90% of annual target**	£4m CIP has been delivered recurrently against the target of £10.4m.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	The Trust is working to identify additional recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust. Of the £16.7m identified, £9.8m is recurrent.	The Trust is in the process of identifying additional recurrent CIP schemes for 2023/24. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.
81. Agency Ceiling **Target: Agency spend should not exceed 3.7% of total pay (ICS target)**	The Trust Agency spend in month is 2.6% against a target of 3.7%		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	For the months of June to December 2023 the monthly percentage has been below 3.7% with the exception of October which was 3.8%. This is due to moving agency staff onto the bank, a reduction in vacancies and tightened controls.	The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: - Agency controls best practice - Rostering compliance - Rate card compliance - Establishment Control compliance (or an alternative approach) - Unplanned absences - Recruitment activity

Appendix 3 – Trust IPR Indicator Overview

	Indicator	Detail
	Quality	
1.	**Incidents**	• Number of incidents reported in month. • Number of incidents open over 20 days and 40 days. • Number of serious incidents reported in month. • Number of serious incidents where actions have breached the timescale. • Number of never events reported in month.
2.	**Duty of Candour**	• Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where the Trust contacts the patient or their family to advise of the incident; this has to be done within 10 working days.
3. **4.** **5.** **6.** **7.**	**Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)**	• Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. • MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin. • Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. • Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. • Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis. • Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.
9.	**Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks**	• Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. • Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
10.	**VTE Assessment**	• Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month, however this indicator is reported quarterly.
11.	**Inpatient Falls & Harm Levels**	• Total number of falls which have occurred in month. • Falls per 1000 bed days in month. • Total number of inpatient falls which have occurred in month. • Levels of harm reported as a result of a fall in month. • Level of avoidable harm which has occurred in month.
12.	**Pressure Ulcers**	• Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).
13.	**Medication Safety**	Overview of the current position in relation to medication, to include: • Medication reconciliation within 24 hours. • Medication reconciliation throughout the inpatient stay. • Number of controlled drugs incidents. • Number medication incidents resulting in harm.

14.	**Staffing Average Fill Levels**	• Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
15.	**Care Hours Per Patient Day (CHPPD)**	• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
16.	**HSMR Mortality Ratio**	• Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
17.	**SHMI Mortality Ratio**	• Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
18.	**NICE Compliance**	• The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. This indicator monitors Trust compliance against NICE guidance.
19.	**Complaints**	Overall review of the current complaints position including; • Number of complaints received in month. • Number of dissatisfied complaints in month. • Total number of open complaints in month. • Total number of cases over 6 months old in month. • Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month. • Number of complaints responded to within timeframe in month. • Number of PALS complaints received and closed in month.
20.	**Friends and Family Test (Inpatient & Day Cases)**	• Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
21.	**Friends and Family (ED and UCC)**	• Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
22.	**Mixed Sex Accommodation Breaches (Non-ITU)**	• Number of MSA Breaches in month (outside of ITU).
23. **24.** **25.** **26.**	**Sepsis**	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.
27.	**Ward Moves Between 10pm and 6am**	• Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
28.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.

29.	**Postpartum Haemorrhage >1500ml**	• To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. • PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the North West Coast Maternity Dashboard.
30.	**3rd and 4th Degree tears**	• To monitor rates of 3rd & 4th degree tears against North West Coast Regional Dashboard. • WHH are not currently an outlier for 3rd & 4th degree when compared to the North West Coast Maternity Dashboard, but 3rd and 4th degree tears are a significant outcome with the potential for long term impact of women's health and wellbeing.
31.	**Maternity bookings**	• To monitor pregnancy bookings met within the 10 and 13 week target. • Timeliness of pregnancy booking is a key performance indicator. • WHH is currently an outlier for bookings before 10 weeks when compared to the North West Coast Maternity Dashboard. • WHH is also currently an outlier for bookings before 13 weeks gestation when compared to the North West Coast Maternity Dashboard
32.	**Fractured Neck of Femur**	• The % of patients treated in line with Best Practice Tariff (BPT). • The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)). • Shorter time to theatres significantly reduces risk of mortality and improves pain.
33.	***MUST nutritional assessment completion***	• To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE) • In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity
	Access & Performance	
34.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.
35. **67.**	**RTT Open Pathways and 52 & 65 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
36.	**Four hour A&E Target and ICS Trajectory**	• All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.
37.	**A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.**	• % of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.
38.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
39.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
40.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

41.	**Cancer – 28 Day Faster Diagnostic Standard**	• All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.
42.	**Cancer 31 Day wait**	• All patients to receive treatment for cancer within 31 days of decision to treat.
43.	**Cancer 62 Day wait**	• All patients to receive treatment for cancer within 62 days of decision to treat.
47.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
48.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
49.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
50.	**Discharge Summaries – Sent within 24 hours**	• The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
51.	**Discharge Summaries – Not sent within 7 days**	• If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
52.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
53.	**Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days**	• All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
54.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.
55.	**Super Stranded Patients**	• Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
56.	**Elective Recovery Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
57.	**Elective Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
58.	**Elective Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
59.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
60.	**% Outpatient referred to long covid service within 15 weeks**	•
61.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).
62.	**Reduction in Outpatient Follow Ups**	• % reduction of Outpatient follow ups compared to 19/20 activity.
63.	**COVID-19 Recovery Cancer First Treatment**	• % of people who received their first treatment for cancer compared to the equivalent month in 19/20.
64.	**% Patients discharged to their usual place of residence**	• % of patients who were discharged to their usual place of residence.

65.	**Theatre Utilisation (measured as productive operating time only)**	• Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. • Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.
66.	**Day case (measured as an aggregate of total cases)**	
	Workforce	
68.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
69.	**Retention**	Staff retention rate % over the last 12 months.
70.	**Turnover**	A review of the turnover % over the last 12 months.
71.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
72.	**Core/Mandatory Training**	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
73.	**Safeguarding Training**	A summary of safeguarding training compliance.
74.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
75.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
76.	**Cash Balance**	The cash balance at month end compared to plan.
77.	**Capital Programme**	Capital expenditure compared to plan.
78.	**Better Payment Practice Code**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
79.	**Cost Improvement Programme – Plans in Progress in Year**	Cost savings schemes in-year compared to plan.
80.	**Cost Improvement Programme – Recurrent**	Cost savings schemes recurrent compared to plan.
81.	**'Agency Ceiling'**	At ICS level, agency spend should not exceed 3.7% of total pay. The Trust ceiling is still to be confirmed.

Appendix 4 - Statistical Process Control

1.0 What is SPC?

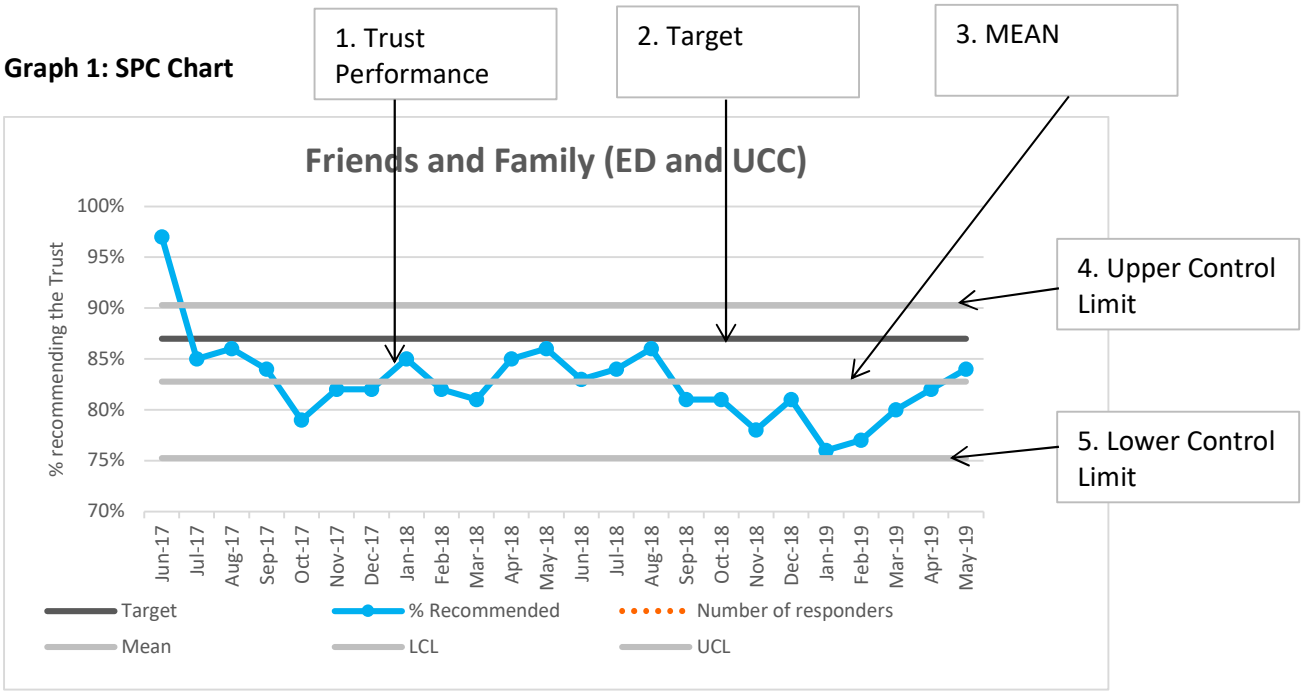
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

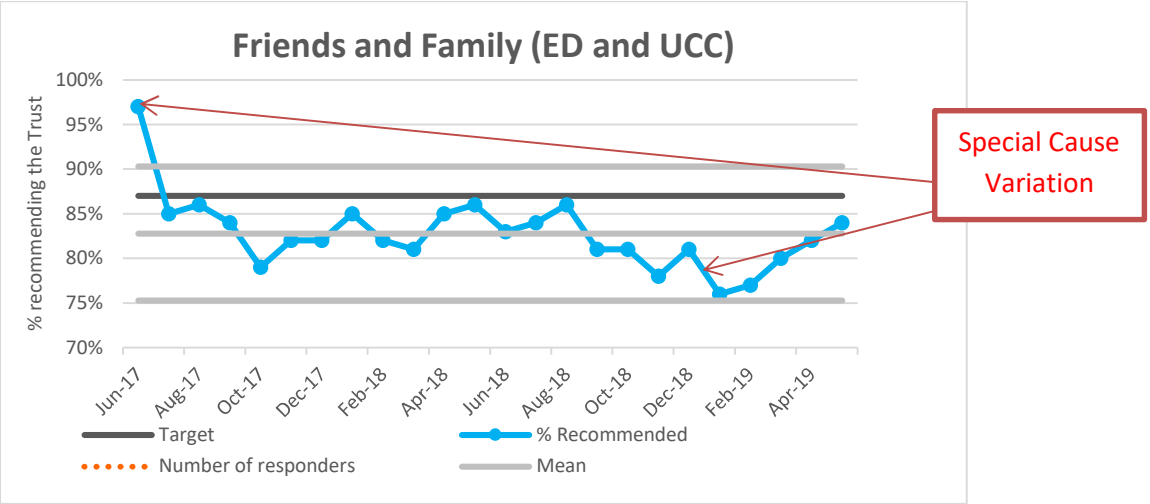


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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

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

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

Income Statement as at 31st December 2023

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**308,681**	**25,853**	**25,940**	**87**	**231,018**	**229,869**	**-1,149**
Non NHS Clinical Income							
Private Patients	8	1	0	0	6	9	3
Non NHS Overseas Patients	60	5	0	-5	45	75	30
Other non protected	728	61	75	14	546	427	-119
Sub total	**796**	**66**	**75**	**9**	**597**	**511**	**-86**
Other Operating Income							
Training & Education	9,093	758	823	65	6,820	8,059	1,239
Donations and Grants	2,095	0	277	277	2,095	1,861	-234
Miscellaneous Income	14,620	1,217	2,012	795	10,954	17,277	6,323
Sub total	**25,808**	**1,975**	**3,112**	**1,137**	**19,869**	**27,197**	**7,328**
Total Operating Income	**335,285**	**27,894**	**29,128**	**1,234**	**251,483**	**257,576**	**6,093**
Operating Expenses							
Employee Benefit Expenses	-248,897	-20,737	-21,885	-1,149	-188,056	-195,382	-7,326
Drugs	-20,191	-1,673	-2,110	-437	-15,229	-15,675	-447
Clinical Supplies and Services	-22,298	-1,825	-2,135	-310	-17,024	-18,741	-1,717
Non Clinical Supplies	-38,398	-3,221	-3,642	-421	-29,100	-31,432	-2,332
Depreciation and Amortisation	-14,278	-1,205	-1,146	59	-10,602	-10,202	400
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-344,062**	**-28,661**	**-30,919**	**-2,258**	**-260,011**	**-271,433**	**-11,421**
Operating Surplus / (Deficit)	**-8,777**	**-766**	**-1,791**	**-1,024**	**-8,528**	**-13,856**	**-5,328**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	16	16	0	61	61
Interest Income	518	9	83	74	494	1,113	619
Interest Expenses	-191	-16	-30	-14	-144	-101	43
PDC Dividends	-5,679	-473	-473	0	-4,257	-4,257	0
Total Non Operating Income and Expenses	**-5,352**	**-480**	**-403**	**77**	**-3,907**	**-3,184**	**723**
Surplus / (Deficit) - as per Accounts	**-14,129**	**-1,246**	**-2,194**	**-947**	**-12,435**	**-17,040**	**-4,605**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,095	0	-277	-277	-2,095	-1,861	234
Add Depreciation on Donated & Granted Assets	475	40	40	1	356	360	3
Total Adjustments to Financial Performance	**-1,620**	**40**	**-237**	**-276**	**-1,739**	**-1,501**	**237**
Adjusted Surplus / (Deficit) as per NHSI Return	**-15,748**	**-1,207**	**-2,430**	**-1,224**	**-14,174**	**-18,542**	**-4,368**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/02/165a (i)	MEETING	Trust Board	DATE OF MEETING	7 February 2024

Date of Meeting	12 December 2023
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Jayne Downey
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/12/252	**Maternity Incentive Scheme Year 5**	The Committee received a report which related to the assurance role of Local Maternity & Neonatal System (LMNS) for the Maternity Incentive Scheme. The Committee were assured that LMNS had reviewed the evidence to date and were satisfied with the Trusts position for the majority of the actions. WHH had been graded as amber, which would move to green following presentation of maternity papers to Trust Board.	The Committee received **a high-level assurance,** noting the Year 5 actions were on track to be completed by 31 March 2024.	Board Development 12.01.2024
QAC/23/12/253	**Patient Story – Recognising my Support Needs**	The Patient Story was presented which related to admission of a patient with multiple learning difficulties, following their journey from through both ED and SDEC, including personal reflections from the patient and their family. The committee were presented with the lesson learned and the actions developed. The committee took assurance that learning would be taken through the	The Committee discussed the patient story and received **moderate assurance** due to the current training compliance; however, the Committee received reassurance that learning on a wider scale would be implemented.	

		nursing and midwifery forum to drive improvements Trust wide.		
QAC/23/12/254	**Hot Topic - Tracheostomies**	The Committee received a Hot Topic relating to a cluster of displaced Tracheostomies incidents in ICU. The committee took assurance that each incident had been robustly investigated, and an action plan developed which included retraining staff on competencies. The committee were assured that Duty of Candour conversations with patients and relatives had taken place.	The Committee discussed the update received **moderate assurance** noting the action plan in place to ensure that lessons had been learnt from this.	
QAC/23/01/255	**Deep Dive – ENT Fragile Services**	A Deep Dive was presented in relation to the ENT fragile service, providing background to the issues experienced in the service particularly around outpatient backlogs, and the difficulties in reducing. Further discussion took place around capital investment. The Committee were heard that a business case was being developed in respect of new equipment.	The Committee considered the update and received **moderate assurance** noting the development of a capital request for new equipment to support the reduction in the backlog	Trust Board 07.02.2024

The Committee also received the following items:

QAC/23/12/256 - Board Assurance Framework & Risk Register
QAC/23/12/257 - Patient Safety & Clinical Effectiveness Sub-Committee Exception Report
QAC/23/12/258 - Quality IPR Metric
QAC/23/12/259 - Learning from Deaths Q2 Update
QAC/23/12/260 - Quality Priorities Q2 Update
QAC/23/12/261 - Quality Strategy Update
QAC/23/12/262 - Maternity Update
QAC/23/12/263 - Palliative & End of Life Care Bi-Annual Report
QAC/23/12/264 - Paediatric Audioloy Report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/02/165a (ii)	MEETING	Trust Board	DATE OF MEETING	7 February 2024

Date of Meeting	9 January 2024
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/24/01/273	**Hot Topic – ED Incident Profile & Long Waits**	The Committee received a presentation providing insight to Emergency Department Harm Profile and Long Waits. The Committee discussed tracking and deterioration of patients with pressure ulcers, challenging patient behaviours, and harm data. The committee took assurance from the remediation work taking place led by the ED Improvement Group; it was noted that, the positive impact of the work was not yet reflected in the data, hence it was agreed an update would be presented in March.	The Committee received **a moderate level assurance** and noted the next steps.	**An update to be presented to the Committee in March.**
QAC/24/01/274	**Deep Dive – Never Events Thematic Review**	A Deep Dive was presented in relation to Never Events and the thematic review which had been undertaken in January 2021. Although it was noted there had been no lasting harm, it would prove difficult to quantify the psychological effects on patients. This would be part of the next steps and training would be rolled out as required. Some of the work would also be undertaken as part of PSIRF.	The Committee discussed the update and received **moderate assurance** noting the next steps in respect of the development of the culture programme and actions to embed the recommendations of the review	**Ongoing as part of the IPR**

		Updates in relation to this work would be included as part of the IPR report going forward.		
QAC/24/01/277	**Patient Safety & Clinical Effectiveness Sub-Committee Exception Report**	Of the items escalated to the Committee in the Patient Safety & Clinical Effectiveness Sub-Committee Exception report; of particular note was that Legionella was detected in some of the water outlets in Daresbury wing. Most outlets had shown low counts of Legionella apart from a shower. The Committee were advised the instances had been reported appropriately that testing and decontamination work was in place	The Committee noted the update and actions in place and received **moderate assurance**	**Patient Safety & Clinical Effectiveness Committee - ongoing**
QAC/24/01/276	**Harm Review Process**	The Committee received a report which provided a summary of the key points in relation to the Harm Review Process. It was noted currently there were 3700 patients overdue a review, and AI software was being considered as a solution to support management of the backlog, which the Committee supported.	The Committee received **substantial assurance** after discussion, and supported AI as a solution to support the Harm Review Process.	
QAC/24/01/278	**Theatres Safety Day and External Review Report**	The Committee received a report detailing findings of a Theatres Safety Day and External review of procedural safety. The report followed escalation to the Patient Safety & Clinical Effectiveness Sub-Committee in relation to positive audits of theatre safety standards contrasting with the occurrence of never events. It was agreed that a cultural programme would be launched in April 2024 to support the recommendations of the report	The Committee discussed and noted the update and actions in place and received **moderate assurance**	**QAC July 2024**
QAC/24/01/281	**Maternity Update – Maternity Incentive Scheme**	The Committee received the report and noted assurance role that the Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) have assurance role in relation to the Maternity Incentive Scheme (MIS). The LMNS have reviewed WHH MIS evidence to date and are satisfied with the position against the MIS standards.	The Committee noted the update and received **substantial assurance** ahead of submission to the Trust Board for approval.	**Board Development 12.01.2024**

QAC/24/01/282	**PPH Follow Up Audit**	The committee received a follow up presentation with details of the Audit undertaken to review all Post partum haemorrhages (PPH) over 1500mls during an 8-month period between March and October 2023. The Audit looked at, Prevention, Recognition, Management and Aftercare. The Committee received assurance that the Trust was not an outlier for PPH. The Committee sought assurance on issues relating to culture, it was explained that culture was a focus area for driving improvements Trust wide and work was being undertaken to address.	The Committee took **moderate assurance** around the outcomes of the Audit and the actions developed. It was agreed that update against the action plan would be presented in 6 months' time.	**July QAC Meeting**

The Committee also received the following items;

QAC/24/01/275 - Board Assurance Framework & Risk Register
QAC/24/01/279 - Liberty Protection Service
QAC/24/01/280 - Arbury Court update
QAC/24/01/281 - Maternity Update including; Ockenden, Maternity Neonatal Quality Review incl Saving Babies Live Care Bundle (SBLCB)
QAC/24/01/283 - Infection Prevention and Control Bi-Annual BAF
QAC/24/01/284 - GNSBI Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/02/165b (i)	Meeting	Trust Board	Date Of Meeting	7th February 2024

Date of Meeting	20th December 2023
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/ Mandate to Receiving Body	Follow Up / Review Date
SPC/23/11/172	**Hot Topic: Band 2 and Band 3 HCA Implementation of Skill Mix Review and Retrospective Rebanding.**	The Committee received a detailed presentation regarding HCA retrospective rebanding, enabling recognition for work undertaken in the past, and an update of the skill mix review implemented from 9th October 2023. A robust discussion took place which included developing staff and partnership relationships, ensuring staff did not feel isolated, and ensuring when reviewing competencies that staff would be supported by the organisation. It was noted that there was a lack of leadership from the ICS and lessons to be learnt. There is currently a national review of nursing profiles which the Trust must be aware of.	The Committee discussed the presentation and received **moderate assurance** due to the current stage of the process and the requirement of full implementation at which point, full assurance should be sought regarding implementation.	**SPC Monthly CPO Report**
SPC/23/12/173	**Deep Dive: Update on Action Against Bullying**	The Committee received a detailed presentation regarding action taken to address bullying and harassment following the results of the 2022 Staff Survey.	The Committee discussed the presentation and received **moderate**	**SPC March 2024**

		It provided an overview of the actions taken by the Trust to address areas of concern with a variety of offers in place. It was noted that triangulation takes place where there are disparities and efforts are made to tackle specific issues. Further assurance regarding the impact of interventions will be provided once the 2023 Staff Survey results are received.	**assurance**. The Committee were assured in relation to the Trust's approach, with the impact of interventions to be measured once the 2023 Staff Survey results received.	
SPC/23/12/176	**Chief People Officer Report**	The Committee received and discussed a paper summarising a number of key people related topics. The Committee discussed Local Clinical Excellence Awards (LCEAs) and the Consultant pay offer from the Government which proposes to cease new LCEAs, retaining those awarded prior to 2018. The Committee received assurance regarding the management of current industrial action.	The Committee received **substantial assurance** on the topics noting the management of the current industrial action and propose cessation of LCEAs.	**SPC December 2023**
SPC/23/12/177	**Guardian of Safe Working Q2 Update**	The Committee received and discussed the report covering July – September 2023. The Committee noted the number of exception reports has decreased significantly for this quarter which is in line with trends from previous years.	The Committee received **substantial assurance** on the organisation having mechanisms in place to support Safe Working for Doctors.	**SPC February 2024**
SPC/23/12/178	**Workforce Equality, Diversity and Inclusion Strategy Bi-Annual Update**	The Committee received the detailed report which provided an overview of the actions implemented to support the achievement of the strategy. It was noted the significant work that has been undertaken to develop a Workforce EDI dashboard which is leading best practice nationally.	The Committee received **substantial assurance** on the work to achieve the strategy.	**SPC 2024 to be scheduled**

		The Committee continue to be assured on the work to achieve the strategy.		

The Committee also received the following items:

Matters to Discuss and Note Assurance
SPC/23/12/171 – Staff Story – Journey to Becoming a Consultant

Matters for Approval
SPC/23/12/174 – Board Assurance Framework and Corporate Risk Register
SPC/23/12/175 – NHSE Self-Assessment Report for Education and Training

Matters to Note for Assurance
SPC/23/12/179 – Safe Staffing Report
SPC/23/12/180 – Midwifery Safe Staffing – October 2023 Update

Sub-Committee Minutes/Notes
SPC/23/12/181 – Workforce Review Group (7th December 2023)
SPC/23/12/182 – Workforce Equality, Diversity and Inclusion Sub-Committee (13th November 2023)

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Trust Board: Committee Assurance Report

Agenda Reference	BM/24/02/165b (ii)	Meeting	Trust Board	Date Of Meeting	7th February 2024

Date of Meeting	17th January 2024
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/ Mandate to Receiving Body	Follow Up / Review Date
SPC/24/01/190	**WHH People Strategy Bi-Annual Update**	The Committee received a detailed report which provided an overview of the actions implemented to support the achievement of the strategy. The Committee acknowledged the positive impact of these actions on the People IPR data. The Committee discussed whether we are sufficiently triangulating between Sub-Board Committees on the issue of staffing levels, given both financial and quality implications.	The Committee discussed the report and received **substantial assurance**. It was agreed to raise with the Chair whether further discussion is needed on how we triangulate information and data on staffing levels between SPC, FSC and QAC.	**SPC 2024 to be scheduled**
SPC/24/01/192	**Chief People Officer Report**	The Committee received and discussed a paper summarising a number of key people related topics. The Committee discussed the limited impact of 'Draw Down' for Pensions since its launch in October 2023. It was noted that applications will continue to be monitored and any risks reported accordingly.	The Committee received **substantial assurance** on the topics noting the assurance of monitoring of draw down for Pensions.	**SPC January 2024**

SPC/24/01/193	**Workforce Integrated Performance Report**	The Committee received the report of the Workforce IPR including the new Workforce EDI data. The Committee noted the continuing improvement of the IPR metrics. The Committee discussed that whilst overall the People IPR data is performing well, when disaggregated by department or staff group, there are areas with low compliance which require specific targeted support to achieve the required targets.	The Committee discussed the presentation and received **moderate assurance**. The Committee were assured in relation to the Trust's approach, noting that performance at department / staff group level in areas is below target.	**SPC March 2024**
SPC/24/01/194	**Safe Staffing Report**	The Committee received the detailed report which provided an overview of Safe Staffing for November 2023. The Committee discussed the positive performance of safe staffing and generally improving IPR. However, it was noted that there was not a reduction in red flags for safe staffing as might be expected and therefore it was agreed to review the consistency of application of red flags.	The Committee received **substantial assurance,** noting the red flags for review.	**SPC January 2024**

The Committee also received the following items:

Matters to Note for Assurance
SPC/24/01/191 – Workforce Brief on National, Regional, ICB or Local Workforce Issues

Sub-Committee Minutes/Notes
SPC/24/01/195 – Workforce Review Group (4th January 2024)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/02/165c (i)	MEETING	Trust Board	DATE OF MEETING	7 February 2024

Date of Meeting	19 December 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/12/171	**BAF & Risk Update**	The Committee received the report noting:- • No new risks and no amendments to the rating of risks • New risk appetite has been applied to each of the risks and will be monitored at FSC going forward, all risk appetites will also be discussed further at Trust Board	The Committee **noted** and discussed the report receiving **substantial** assurance	**FSC January 2024 and Trust Board February 2024**
FSC/23/12/172	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance small decrease on last month to 63.19% • Slight deterioration in ambulance handovers however continuing to see good performance compared to local partners • Remain in Urgent Care Tier 1 however there has been improvements in three of the four indicators that drive this. Challenge still within the 12 hour time in department metric and interventions are in place. Expected that the tiering will be re-run in Q4 • RTT performance – 51.5% which is still behind trajectory due to Industrial Action although has plateaued. • Slight increase in 78 week wait which was expected in November and December. This is expected to reduce in January in line with trajectory	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC January 2024**

		• The diagnostic performance is 82.67% which links to the recovery plan for elective surgery. Sleep activity is starting to increase and Echo capacity is expected to increase in December, both areas are on an improvement trajectory • Cancer 62 day referral performance has improved due to combining under the new metric to 79.89%		
FSC/23/12/173	**Pay Assurance Report**	The Committee received the report noting:- • Reporting on increases in WTEs linked to revenue requests approved since March 2023 including the reasons for approval. These have been approved in order to keep the Trust safe. • Workforce metrics received from Cheshire and Merseyside, data is two months behind and expected to be received each month. Broadly in line with the rest of providers in C&M in terms of WTEs, headcount, vacancies, sickness absence and agency spend.	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC January 2024**
FSC/23/12/174	**Recovery Plan**	The Committee received the report noting:- • High risk schemes in relation to GIRFT, positive operational delivery however no cash releasing savings • 19 additional schemes identified and RAG rated (3 green – expected to deliver in 2023/24, 7 amber – may deliver in 2023/24, 9 red – won't deliver until 2024/25) equates to a likely saving of £290k in 2023/24 • Delivery of the CIP plan is required as well as acceleration of additional CIP and GIRFT schemes in order to deliver the revised forecast for 2023/24 • A reduction of cost pressures is required in order to deliver the revised forecast for 2023/24 however there was acknowledgement that significant areas of staff spend are not able to be turned off • There is risk to delivery of the revised forecast of £21.2m, however this has been clearly communicated to the ICS • Newton work around Urgent and Emergency Care has been well received and is adding credence to the issues that have been highlighted by the Trust previously around flow out of the hospital with an independent view across all parts of the System	The Committee **noted** and discussed the report, receiving **limited** assurance	**FSC January 2024**
FSC/23/12/179	**Finance Report**	The Committee received a report noting:- • The month 8 ytd position is off plan by £3.1m with a deficit of £16.1m	The Committee **noted** the paper	**FSC January 2024**

		• Cash has reduced from £17.3m to £9.5m in month due to large capital payments and the timing of invoices being paid compared to debt being collected later • Activity target is not being achieved, the forecast activity now needs to deliver in order to meet the revised forecast deficit • Reduction in agency spend (3.9% ytd) with 5 out of the last 6 months below the 3.7% target • Revenue requests supported by the Executive Team are highlighted in the report • Risks highlighted around Activity, cost pressures, CIP achievement and no provision for potential backpay for Band 2 to 3 • The likely scenario forecast has been RAG rated around expected delivery	receiving **limited** assurance.	
FSC/23/12/180	**Revenue Requests A10 Beds**	The Committee received a revenue request noting:- • £0.5m was ringfenced in the 2023/24 Plan to open beds on A10 for Winter • It had been planned to open a small number of beds on B4 in December, however more beds were required and therefore A10 was opened instead • It is planned that B4 will close at the end of February 2024 (rather than March 2024) as a mitigation	The Committee **supported** the revenue requests for approval at Trust Board.	**Trust Board February 2024**
FSC/23/12/181	**Capital Position**	The Committee received a presentation noting:- • YTD spend is £9.4m, underspent against plan mainly due to timing • Movements in capital contingency approved, now stands at £103k • IFRS16 position presented following review of the year to date position. Movements supported by CPG were approved	The Committee **noted** the presentation and **approved** the changes to the capital contingency and IFRS 16	**FSC January 2024**

Items for noting

FSC/23/12/175	Monthly CIP Report & GIRFT
FSC/23/12/176	Cost Pressures M8 2023/24
FSC/23/12/177	Benefits Realisation Q2
FSC/23/12/178	Costing Update Q2
FSC/23/12/181	Schemes over £500k
FSC/23/12/182	Digital Strategy Group Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/02/165c (ii)	MEETING	Trust Board	DATE OF MEETING	7 February 2024

Date of Meeting	24 January 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/24/01/189	**Hot Topic – Operational Plan**	The Committee received the report noting:- • Guidance expected 31 January, although this may potentially be delayed • Trusts expected to treat all patients >52 weeks by March 2025 • Trusts expected to not have patients waiting > 6 weeks for a diagnostic test • Triangulation between finance, activity and workforce expected to have more focus • No growth in costs above inflation expected • No growth in WTE expected • ERF target expected to be in line with 2023/24 • CIP requirement expected to be in line with 2023/24 • ICS expectation is improvement from current year and in line with the recovery plan	The Committee **noted** and discussed the report receiving **limited** assurance	**FSC February 2024**
FSC/24/01/190	**Deep Dive – Update on Elective Recovery**	The Committee received the report noting:- • Approval of additional elective recovery expenditure to deliver additional activity is mitigating underperformance on activity in other areas (TIF activity delayed until April 2024) • Contribution of £0.2m from activity delivered to date due to costs being lower than income generated	The Committee **noted** and discussed the report receiving **moderate** assurance	

FSC/24/01/192	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance decrease on last month to 61.27% although this is an improvement compared to December 2022 • Improvement in ambulance handovers compared to local partners and last Winter • Challenge remains in the 12 hour in department metric, interventions are in place. • Ambulance arrivals have increased over the last 8 months and this is being investigated further to feed back next month • NCTR and super stranded numbers have improved compared to last winter • RTT performance – 50.63% which is behind trajectory • Growth in the size of the waiting list has started to stabilise, reduction in 52 week waits which will prevent them reaching 65 and 78 week waits. • The diagnostic performance for patients waiting over 6 weeks has decreased to 14.9%, continued improvement • Sleep and Echo activity are both areas are on an improvement trajectory • Cancer 62 day referral performance has achieved 73.16% against 85% standard, benchmarking just above the average of Providers in C&M • Achieved the combined 28 day cancer metric, 75.12% against 75% standard	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC February 2024**
FSC/24/01/193	**Financial Recovery – What Next?**	The Committee received the report noting:- • Planned £15.7m deficit moved to a £21.2m adjusted deficit supported by the ICS • An allowable adjustment of £1.6m for the impact of Industrial Action in December and January increases the deficit plan to £22.8m • A stretch target of £5.3m is required to be delivered to meet the revised plan, there is a risk a delivery of this which would increase the deficit • The financial forecast in month 9 due to the delay in delivery of TIF mitigations for this can therefore not be used to support the £5.3m gap • Overview of 2024/25 CIP plan presented with the Newton work as an enabler • CIP overview at month 9, shortfall of £0.3m delivery against a plan of £10.7m • Further £0.7m identified in month, total of £16.7m leaving a gap of £1.2m • £1.2m expected to be covered by £0.5m CDC and further balance sheet review • £5.3m stretch remains the risk to the financial position, £0.4m identified to date with work ongoing to identify further savings	The Committee **noted** and discussed the report, receiving **limited** assurance	**FSC February 2024**

		• Theatre utilisation is below the 90% target, an improvement in late starts is noted • Virtual wards usage is improving • Working with Care Groups to further define the 2024/25 GIRFT projects and to understand the improvement required to reach the baseline of activity before any cash releasing efficiencies can be realised		
FSC/24/01/194	**Pay Assurance Report**	The Committee received the report noting:- • Review of increase in WTE, increases due to approved internal and external business cases partly offset by CIP reductions • B2 – B3, working through a review of competencies, estimated to be around 60 applications per month	The Committee **noted** the report, receiving **substantial** assurance	**FSC February 2024**
FSC/24/01/195	**Cash Borrowing Principles & Processes**	The Committee received the report noting:- • Cash support is expected to be required from March 2024 onwards due to the increased deficit position of the Trust • Revenue and capital cash now considered separately in order to assess the level of drawdown required • ICS supports the application for cash and review how they can support the Trust • Approval required at Trust Board to submit application	The Committee discussed the report and **supported** the application for approval at Trust Board	**Trust Board February 2024**
FSC/24/01/198	**Finance Report**	The Committee received a report noting:- • The month 9 ytd position is off the original plan by £4.4m with a deficit of £18.5m • Main drivers of the deficit are cost pressures in A&E and specialling, activity underperformance, cost of IA and CIP not delivered • Activity target is not being achieved, with the main reason for this being delayed TIF activity due to the delay on the build. The forecast activity needs to deliver in order to meet the revised forecast deficit • Agency spend 3.7% ytd with 6 of the last 7 months below the 3.7% target • Revenue request supported by the Executive Team highlighted in the report • Risks highlighted around activity, unfunded cost pressures, CIP delivery and no provision for backpay for Band 2 to 3	The Committee **noted** the paper receiving **limited** assurance.	**FSC February 2024**
FSC/24/01/199	**Pathology LIMS Business Case**	The Committee received a report noting:- • The full business case is expected to be received from C&M on 26 January 2024 and will be presented to Trust Board on 7 February 2024	The Committee **noted** the paper receiving **limited** assurance with	**Virtual FSC meeting prior to**

		• Finances not yet final, currently £1.8m contribution over 10 years however reliant on cash releasing benefits for which additional details have been requested • A number of risks highlighted including the Trust's current system having additional functionality. This has been included in the business case contingency however if the contingency is not sufficient for all risks this could become a risk to the Trust • Virtual FSC meeting required following receipt of the business case prior to onward support to Trust Board	virtual FSC support to be received prior to going to Trust Board.	**Trust Board February 2024**
FSC/24/01/200	**Revenue Request Local Clinical Excellence Award**	The Committee received a revenue request noting:- • The Trust is required to operate a round of Local Clinical Excellence Awards annually • Non-recurrent funding requested for £948,934 which was ringfenced as part of the 2023/24 plan	The Committee **supported** the revenue request for approval at Trust Board.	**Trust Board February 2024**
FSC/24/01/201	**Amendment to IPR to include Discharge Delay**	The Committee received a report noting:- • Support for the inclusion of a nationally mandated 'Delay Days from Discharge Ready' indicator in the IPR	The Committee **supported** the change for approval at Trust Board.	**Trust Board February 2024**
FSC/24/01/202	**Capital Position and Schemes >£500k**	The Committee received a presentation noting:- • YTD spend is £12.6m, underspend against plan mainly due to timing • Movements in capital contingency approved, now stands at £135k • Oversubscription remains at £418k, net of contingency this stands at £283k • 2024/25 capital plan is currently showing an oversubscribed position, work continues to finalise the plan • Approved the bringing forward of 2024/25 schemes to achieve the year end 2023/24 capital spend • Ultrasound scheme paused as total cost exceeded the funding available and no availability in the 2024/25 capital programme to fund the shortfall • Warrington Town Deal, forecast overspend of £197k reduced by £50k due to VAT reclaim, continuing to look at other options to reduce the overspend	The Committee **noted** the presentation and **approved** the changes to the capital contingency and request for 2024/25 items to be brought forward if required	**FSC February 2024**

FSC/24/01/203	**Digital Strategy Group Update**	The Committee received a presentation noting:- • EPCMS – The procurement process was paused due to questions raised as part of the bidder's clarification process, expected to restart at the end of January. This has caused a delay in the planned timetable, the aim is to recover the timetable in other areas to mitigate the risks of the delay	The Committee **noted** the report, receiving **moderate** assurance	**FSC February 2024**

Items for noting

FSC/24/01/191 Board Assurance Report and Risk Register
FSC/24/01/196 Cost Pressures M9 2023/24
FSC/24/02/197 CDC Activity Plan

Assurance Key:

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/166**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	7 February 2024	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper aims to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: • Urology • Gynaecological surgery • Orthopaedics – Fractured Neck of Femur • ENT • Paediatric Ophthalmology		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	Trust board is asked to: - Note the current list of Fragile Services, associated clinical risk and high-level progress updates - Note that no services have been stepped up into, or down from Fragile Services Oversight since the last report - Receive further Fragile Service Oversight reports		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/24/02/166

1. BACKGROUND/CONTEXT

Following recognition of a need for a systematic oversight mechanism for Fragile Services the oversight of these services via PSCESC has been trialled from March 2023. Following iterative development, a formal process for oversight of Fragile Services has been incorporated into the PSCESC Agenda reporting to QAC since July 2023.

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

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

2. SER VICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

None

3. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- 5 in year incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged. No new harm identified since previous report to board.
- Transperineal Biopsy and Surveillance cystoscopy position improved (>50% reduction from peak).
- P2 backlog increased in month
- Significant volume of high risk patients confirmed by AI list validation
- Ongoing risk of harm remains given P2/Stone and surveillance cystoscopy backlogs
- Service exceeding clinical activity targets (>105% of 19/20 activity)
- Completed Actions
    - Revenue requests approved for additional medical staff
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved
    - 3 Middle Grade doctors recruited
    - Advert out for replacement consultant
- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site
    - PCNL Stone patients transferred to Chester
- Ongoing improvement plan actions:
    - Mutual aid request to C&M Hub and WWL
    - 1 locum consultant post out to advert
    - Plan to reintroduce PCNL at Warrington site with new IR Radiologist
    - Development of plan for specialist nurse delivered cystoscopy

Gynaecological Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues with some initial diagnostic equipment pressures (hysteroscopes – now resolved)
- 6 incidents of moderate harm identified in year due to delays which have been subject to appropriate investigation and Duty of Candour has been discharged. 3 relate to a delay in diagnosis with no further ongoing harm. No new moderate harms identified since previous report to board.
- AI validation work has identified 30 waiting list patients with critical urgency scores – all have undergone harm reviews with no harm identified, 2 patients have had their surgery expedited.
- Service has recovered its Cancer 2WW position – no breaches since December - monitored daily as position remains volatile.
- Completed Actions
    - Full complement of hysteroscopes now purchased and in service.
    - Gynaecological surgery capacity supported by approved elective c-section revenue request.
    - Full consultant job plan review completed informed by demand and capacity exercise.
    - 2 consultants recruited (2 replacements) – start dates Feb – March 2024. 1 new post remains vacant following withdrawal of a candidate.
    - 30 complex cohort patients to transfer to LWH through mutual aid
- Current mitigations
    - Insourcing and WLI as appropriate/available
    - Waiting list validation process underway utilising AI risk stratification and a repeat harm review on all P2 waiters
    - AI aided Harm Review process in place
    - Daily 2WW performance tracker in place
- Ongoing improvement plan actions:
    - Further new Consultant post to advert
    - Triage/Advice and Guidance workstream
    - Pathway development with assigned consultant model

Orthopaedics – Fractured Neck of Femur

- Demand and capacity mismatch – driven predominantly by increased demand, increased pressures on bed base and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery remains remaining significant challenge
- Current mitigations:
    - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
    - Additional orthogertiatrican and orthogeriatric fellow in post
    - Additional ad hoc fractured neck of femur list utilising bank locum consultant
- Ongoing improvement plan actions:
    - Focused improvement plan to deliver ‘prompt surgery’
    - Agreement of ringfencing process to allow direct admission to specialist ward

Ear Nose and Throat Surgery

Designated as a Fragile Service – PSCESC November 2023

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Significant medical staffing challenges
- 'Routine' New patient waiting list has grown very significantly, 'urgent' numbers remain high and static
- Emergent growth in 2 week wait cancer demand
- ENT currently has the Trust's largest backlog

- No harm reported to date
- Recent P2 harm review exercise undertaken

  Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
  - NHS Locum recruited and commences 21st February
  - Additional ENT stacker and scope in procurement process
- Current mitigations
  - Outsourcing sessions funded
- Ongoing improvement plan actions:
  - GIRFT Further, Faster baseline assessment and action plan outstanding
  - Capital bid for further scope and stacker equipment in 24/25
  - Triage and clinical waiting list validation exercise underway

Ophthalmology - Paediatric Ophthalmology

- Demand and capacity mismatch – driven predominantly by workforce issues
- Significant consultant workforce issues – Associate Specialist in post
- Locum consultant recruited to commence Feb 2024
- New patient waiting list managed by Associate specialist activity – operative and follow up backlogs remain an issue
- No harm identified to date
- Current mitigations:
  - Monthly review of all high risk and 17 week plus patients
  - Regular interim orthoptic/optometry review if potential risk to sight
  - Re-prioritisation as clinically indicated by patient level risk
  - Agreement with Specialist Trust to support a number of undated patients on operative waiting list
  - Agreement with specialist Trust to accept paediatric emergencies and any patients deemed at risk of sight loss requiring surgery
  - Additional activity from external consultant as available
- Ongoing improvement plan actions:
  - Recruitment – further new consultant post out to advert
  - Further negotiation with Specialist Trust underway regarding mutual aid for listed and dated non urgent patients – unlikely to provide additional capacity.
  - Capital request in development for Retinal Screening Camera to increase capacity for Retinopathy of Prematurity screening – 24/25 capital round

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

None

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high level progress updates
- Note that no services have been stepped up into, or down from Fragile Services Oversight since the last report
- Receive further Fragile Services Oversight reports

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Maternity CQC Update

Kimberley Salmon- Jamieson, Chief Nurse, Deputy Chief Executive
Layla Alani, Director of Governance, Deputy Chief Nurse, January 2024

Maternity

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- CQC Maternity Inspection was undertaken on 14th September 2023
- Factual accuracy concluded and final report published on 17th January 2024
- 0 Must Do's identified
- 5 Should Do's identified as follows, action plan is in place and will be monitored by the Quality Assurance Committee:
    I. The service should continue to improve training compliance rates for all staff in all relevant areas
    II. The service should ensure all policies and procedures are in place and reflect current evidence-based best practice and are fit for purpose
    III. The service should ensure that electronic patient records are integrated as far as is possible to avoid the risk of missed information.
    IV. The service should continue to develop, communicate, and embed the transitional care provision
    V. The service should ensure that all staff complete regular simulation training/Skills and Drills training, such as regular pool evacuation and abduction drills

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/02/168i</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Maternity Update – Ockenden Report</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">7 February 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Ailsa Gaskill-Jones, Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:</td><td colspan="4">SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</td><td colspan="5">All</td></tr>
<tr><td rowspan="8">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">✓</td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">✓</td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">✓</td></tr>
<tr><td colspan="5">The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates. This paper provides the Trust Board with oversight with regards to Ockenden recommendations.

In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b</td></tr>
</table>

	following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 30th November 2023 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 96.58% compliant and is on trajectory to be 100% compliant by 31st March 2024. • **Ockenden 2**: WHH is 83.56% compliant. Ockenden 2 does not have any national timelines. Following a review of all actions, WHH has set internal timelines to complete all actions by 31st March 2024.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to receive and discuss this report as per Ockenden recommendations.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/24/01/11i	
	Date of meeting	9 January 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/24/02/168 i

1. BACKGROUND/CONTEXT

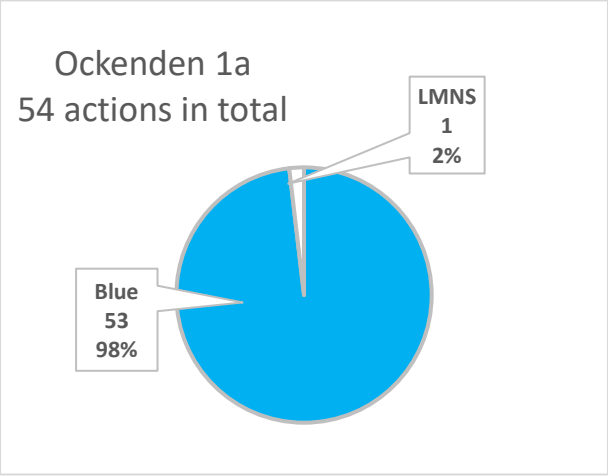
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report

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

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

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

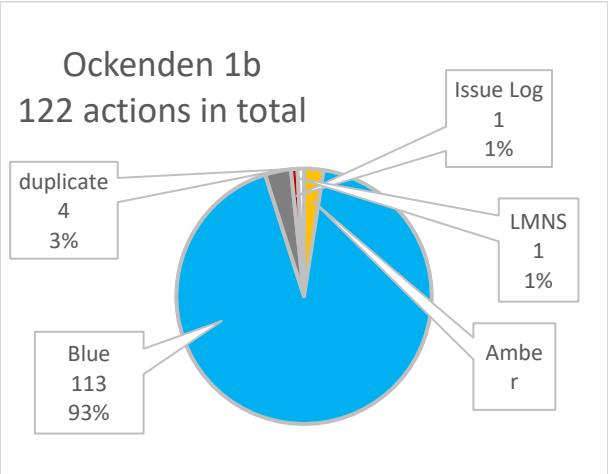
No change from previous month.

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

2.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



4 Outstanding Actions:

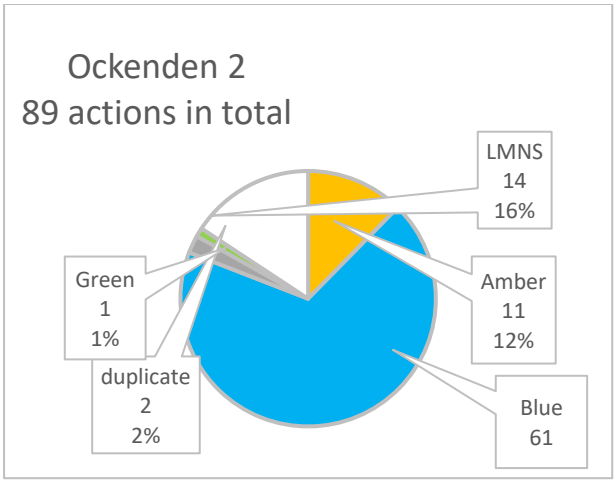
3 Amber Actions and 1 Action transferred to a BadgerNet Specific Issue Log.

Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is currently 6.58% compliant at 30 November 2023. All actions due to be completed by 31 March 2024.

2.1.4 WHH Compliance with Ockenden 2 Report

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

Chart 3: WHH Ockenden 2 Compliance



12 Outstanding Actions:

11 Amber (previously 14)
1 Green

1 action transferred to a BadgerNet Specific Issue Log now closed.

All actions due to be completed by 31 March 2024.

Excluding the 14 LMNS and 2 duplicate actions, Ockenden 2 action plan is 83.56% compliant at 30 November 2023 (previously 75.34% compliant at 31 October 2023). All actions due to be completed by 31 March 2024.

a. WHH Risks for Escalation

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

- The Lead Obstetrician in Fetal Surveillance role is included in a new Consultant post. An appointment was made following interviews undertaken on 5 December 2023. Fulfilment of this recommendation will be achieved following commencement in post of the newly appointed Consultant, expected to be March/April 2024.
- Within the Ockenden report additional supernumerary clinical skills facilitators are recommended. Having reviewed the current provision it has been agreed, following recruitment into the Retention Midwife post which has commenced and utilising other experienced colleagues in a supernumerary capacity, this recommendation will be met.

b. Ockenden Summary

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

- Ockenden 1a Action Plan is 100% compliant.
- Ockenden 1b Action Plan is 96.58% compliant.
- Ockenden 2 Action Plan is 83.56% compliant.

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

2. MONITORING/REPORTING ROUTES

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

3. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 9th January 2024..

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/168 ii**			
SUBJECT:	Monthly Maternity & Neonatal Quality Update			
DATE OF MEETING:	7th February 2024			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update in relation to maternity and neonatal quality for November and December 2023. The paper provides oversight of key national safety and quality issues in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 (Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal			

safety and quality issues). This information is reported monthly to Quality Assurance Committee.

In particular:

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

This paper will also provide an overview of emerging regional/local issues as appropriate. including:

- Maternity Triage
- Compliance with PDRs

In October and November 2023 there were two moderate harm events across the maternity and neonatal service. There were no major or catastrophic harm events

At the end of November 2023 compliance for mandatory training across maternity and child health colleagues was 86.68% for Trust mandatory training above the Trust target of 85%.

Compliance for role specific mandatory training was 84.55% and mandatory safeguarding training was 83.82%, both slightly below the Trust target. Action plans remain in place to achieve and maintain compliance in these areas:Workforce measures related to retention and vacancy rate remain much improved.

Service user feedback and staff feedback has been collated. The service has received feedback via PALs from a family with regard to their care following the diagnosis of tongue tie in their baby. The family also raised concerns in relation to their experience on the maternity ward.

The service has received individual feedback regarding care experience, this is included in appendix two. Feedback has also been received from the parents of AD, the woman who experienced a major obstetric haemorrhage of 15 litres. This is shared for information in appendix three.

Maternity Safety Champion Walkarounds took place on 14th November 2023 with a focus on Community, Antenatal Services and Birth Suite and on 12th December 2023 with a with focus on the maternity ward and neonatal unit. Feedback

	from staff was both constructive and positive with no issues to escalate to Trust Board. Maternitiy Triage performance continues to meet KPI standards. In November 2023 94% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance), an increase of 1% from October and improvement of 4% since August. 98% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Six complaints were received in the CBU in October and November 2023. Two of these complaints related to care within the maternity and neonatal services. These complaints has both been fully investigated and a response provided to the families. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/23/12/262v QAC/24/01/11ii	
	Date of meeting	12th December 2023 9th January 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF:	BM/24/02/168 ii

1. BACKGROUND/CONTEXT

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

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

2. HARM INCIDENTS

There were 126 events reported across the CBU in October 2023.

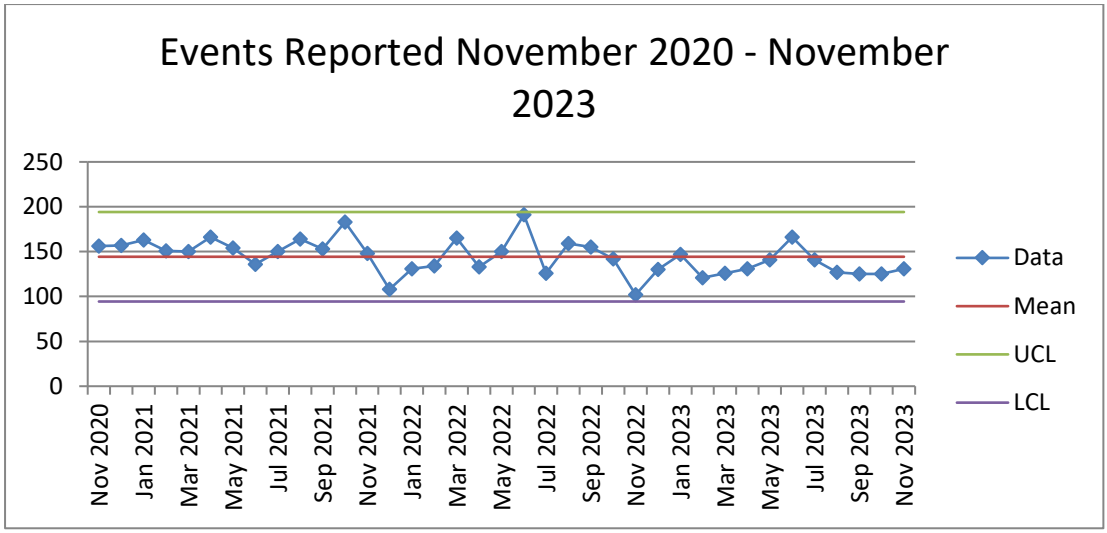
Below shows a breakdown of patient safety events reported and investigations declared in October 2023:

Severity	Sept 2023	Oct 2023
1 – No Harm	99	98
2 – Low Harm	30	29
3 – Moderate Harm	0	2
4 – Severe Harm	0	0
5 – Fatal	0	0

There were two moderate harm events across the CBU in October, one of which was care within the maternity service and related to a neonatal death following antepartum haemorrhage at 33+2 weeks gestation. This case is being reviewed via a joint PMRT process led by Liverpool Women's Hospital as this is where the baby died. The final report will be shared with the WHH maternity team and through the WHH Patient Safety Oversight meeting.

There were no severe harm or fatal events in October 2023.

There were 131 patient safety events reported across the CBU in November 2023.



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

Severity	Oct 2023	Nov 2023
1 – No Harm	98	104
2 – Low Harm	29	26
3 – Moderate Harm	2	1
4 – Severe Harm	0	0
5 – Fatal	0	0

There was one moderate harm events across the CBU, this event was in the maternity service and relates to a major obstetric haemorrhage of 15 litres. An Initial Safety review and MDT review have both been completed. The formal investigation of the event is ongoing.

There were no severe harm or fatal events in November 2023.

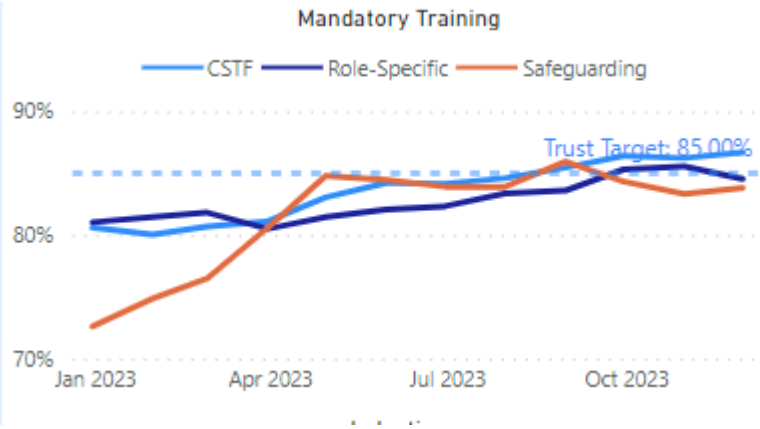
Included in appendix one for information and oversight is a report of Maternity & Newborn Safety Investigations (MNSI) (previously Healthcare Safety Investigation Branch - HSIB) reports during period 06.12.2022 – 30.11.2023.

3. WORKFORCE METRICS

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

At the end of November 2023 compliance for mandatory training across maternity and child health colleagues is 86.68% for Trust mandatory training above the Trust target of 85%.

Compliance for role specific mandatory training is 84.55% and mandatory safeguarding training is 83.82%, both slightly below the Trust target. The graph on page 6 shows the current position with regard to mandatory training as at 30/11/2023, action plans remain in place to achieve and maintain compliance in these areas:



Compliance with PDR completion is an ongoing piece of work. Rates in November (excluding long term absence) for maternity staff is 81.29% and 81.25% for child health colleagues. The overall rate for maternity and neonatal services is 81.27%. This remains below the Trust target of 85%. A revised action plan for improvement has been commenced

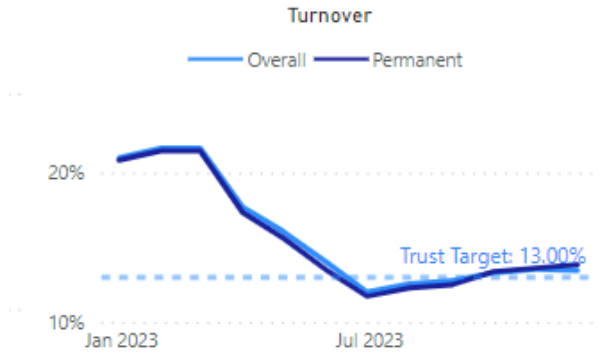
Compliance with PROMPT (multidisciplinary team skills drill training) remains good. WHH are meeting the Maternity Incentive Scheme Year 5 target of 90% compliance overall for PROMPT with an overall rate of 95.8%. When analysed by staff group, compliance for Obstetric Anaesthetic consultants , Midwives and Maternity Support Workers is above 95%. However for Obstetric Consultants and other Obstetric Doctors compliance is averaging 84.21%. Medical compliance has been impacted by industrial actions. All medical colleagues affected have been provided with new dates for PROMPT.

Compliance for MAMU2 at end of November 2023:

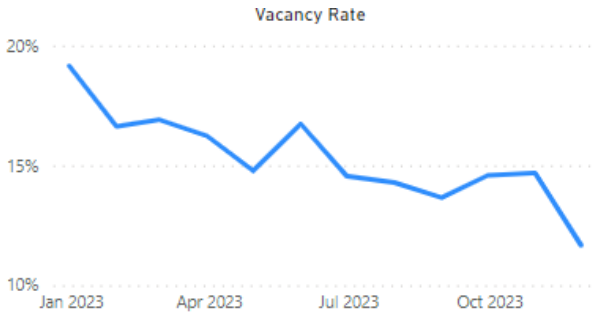
Staff Group	Fetal Surveillance training	Fetal Surveillance competencies
Midwives	84%	52%
Medical staff	71%	50%
Agency staff	84%	68%

The end of November position for MAMU2 fetal surveillance training is meeting the trajectory to achieve the compliance required to meet Maternity Incentive Scheme Year 5 for midwives and agency staff. However, compliance amongst medical colleagues is not yet achieving the required trajectory. Non-compliance is being managed on an individual basis with the support of the CBU leadership team. Compliance with fetal surveillance competencies have reduced. A robust action plan remains in place to improve compliance with competencies, All non-compliant colleagues have been advised competencies must be completed by the end of January 2024, this is being monitored weekly. A further update will be provided to February Quality Assurance Committee.

Turnover for maternity and child health staff has shown a slight decrease from 13.55% in October 2023 to 13.49% in November 2023. This is slightly above the Trust target for turnover of 13% and as a result will be closely monitored.



The vacancy rate for maternity and child health staff has reduced from a peak of 17.23%% in September 2022 to 8.94% in November 2023. This is illustrated in the graph below:



Of particular note is the reduction in midwifery vacancies. In January 2023 the vacancy rate for registered midwives was 19.97%. At the end of November 2023 this rate was 7.68%, an improvement of 12.29%. This vacancy rate excludes those in the recruitment pipeline. There are 6.52fte registered midwifery staff with start dates scheduled for December, January and February 2024, the actual vacancy rate is therefore 0.8%.

4. SERVICE USER FEEDBACK

The service has received feedback via PALs from a family with regard to their care following the diagnosis of tongue tie in their baby. The family have also raised concerns in relation to their experience on the maternity ward, this included:

- Facilities for fathers who wish to remain with their family overnight (including availability of refreshment and sleeping facilities
- Efficiency of discharge processes

Following discussion with the family it has been agreed feedback with regard to facilities for fathers will be fed into the ward environment QI project as well as into the Trust Nutrition and Hydration working group. The concerns raised in relation to the management of the tongue tie diagnosis and issues around discharge have been further explored by the Deputy Director of

Midwifery and a subsequent meeting to discuss these matters has been held with the family. The family have confirmed they are satisfied with the response and plan.

The service has received individual feedback regarding care experience, this is attached in appendices two and three and includes feedback from the parents of AD, the woman who experienced a major obstetric haemorrhage of 15 litres.

5. STAFF FEEDBACK

A Maternity Safety Champion Walkaround took place on 14th November 2023 with a focus on Community, Antenatal Services and Birth Suite. Feedback from staff was both constructive and positive.

Antenatal Services staff discussed with the walkaround team the challenges faced in sharing information with other providers and potential solutions to resolve this. This will be a key piece of work for the new Antenatal Services Manager who commences in early December.

There was good engagement with staff from the Community service and Birth Suite. Some issues were highlighted with regard to availability of equipment within the community service and this has been fed back to the wider maternity leadership team.

Birth Suite colleagues highlighted a concern with regard to the location of the Butterfly Bereavement Suite. This area is located next door to an elderly care ward and patients can often be heard shouting, particularly at night, which impacted on the experience of families experiencing pregnancy loss. The team acknowledged this is an estates issues and not easily solved. It was agreed this would be noted and shared as part of any future discussions re the maternity and wider Trust estate.

A further Maternity Safety Champion Walkaround took place on 12th December 2023 with a with focus on the maternity ward and neonatal unit. Feedback from staff was both constructive and positive.

The safety champions also reviewed the existing induction of labour provision and the plans for the of induction of labour activity to relocate. The estates work to support this is underway and has been well received by the maternity team.

6. MATERNITY TRIAGE

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

Current performance

- In November 2023 519 maternity triage attendances were recorded in the BadgerNet patient record system.
- 22.9% of attendees were seen immediately on arrival, an improvement of 4.1% from October.
- The longest wait for initial review was 75 minutes. This was the result of an attendee arriving at Maternity Triage and staff not noting her arrival. This is a rare occurrence

and is the first time this has occurred since Maternity Triage relocated to the ground floor space. Learning will be shared with the Maternity Triage team.

- 94% of attenders were seen within 15 minutes of arrival (best practice guidance), an increase of 1% from October and improvement of 4% since August
- 98%% of attenders were seen within less than 30 minutes of arrival (NICE guidance).
- 1.1% of attendees (6 women) were categorised as red on arrival. All were seen within 15 minutes for initial assessment and received immediate ongoing care. Two were immediately transferred to Birth Suite for 1:1 care, three were stepped down to orange/yellow, one was transferred immediately to bereavement pathway.

Activity in place to support a safe service

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. However, following reallocation of existing midwifery resource including utilising the Specialist Midwife cohort to support clinical activity in triage this has reduced to £380,000. There is the potential the cost could be reduced further if other options are implemented in relation to Maternity Support Worker cover within the Nest/Triage footprint. Options are being explored by the midwifery leadership team. Once the additional ask has been finalised, this will be progressed in collaboration with the commercial development team as a cost pressure for 2024/25.
- To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as timely commencement of induction of labour pathways..

Next Steps (January – June 2024)

- Maternity triage task and finish group in place.
- Audit of timeliness of medical review is being completed for the period Jan-March 2024 to support further improvement in quality of care provision.
- Shift leader for triage to be identified from next roster to support oversight and effective escalation processes
- Implementation of new staffing model
- Telephone triage to be moved from the clinical triage area, this will be dependent on the new staffing model being implemented.
- Telephone system to be upgraded

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

7. COMPLAINTS

Six complaints were received in the CBU in October and November 2023. Two of these complaints related to care within the maternity and neonatal services. One complainant raised concerns in relation to the care she has received from consultants during her pregnancy and reported not feeling listened to by medical colleagues. The second complainant and partner felt that there was a lack of support throughout their pregnancy and raised concerns in relation to treatment in ED, maternity triage, and a lack of consistency

with midwives. Both complaints have been fully investigated and written responses provided to the families concerned.

Following an increase in maternity complaints in 2022/2023 a complaints deep dive was completed and learning shared to September QAC. As part of this, it was agreed a further regular quarterly deep dive of complaints would take place with effect from Q2 2023/24. Maternity data from Q2 has been collated. In total five complaints were received in the period. No themes were identified. In light of the small number of complaints received in the quarter and to ensure ongoing oversight of the maternity complaints position, the Q3 deep dive will include all complaints for Q2 and Q3.

8. CULTURAL LEADERSHIP PROGRAMME

The WHH maternity and neonatal team are fully engaged with the NHSE Perinatal Cultural Leadership Programme. This is a quadrumvirate (Quad) led programme, WHH is represented by the CBU Clinical Director, CBU Manager, Lead Nurse for Paediatrics and Gynaecology and the Director of Midwifery.

Phase One of the programme has comprised a number of face to face sessions exploring leadership methodology and how these can be implemented within teams and services alongside developing a broader understanding of the Quadrumvirate leadership model. This phase completed at the end of November.

Phase Two of the programme is the implementation of a SCORE cultural survey across the maternity and neonatal teams and provides an opportunity to understand more about team culture and engage in conversations about how this can be enhanced.

The survey closed at the end of November and results are being collated. Once this process is completed there will be a series of cultural conversations (Phase 3) with the maternity and neonatal teams as well as sessions with the Quad to develop actions moving forward.

As part of the development of a robust Quad leadership model the Quad will also meet quarterly with the non-executive Board Safety Champion (BSC). The purpose of the meeting will be to ensure that the BSC is providing support to the Quad in the work to better understand and craft local cultures, and sharing insights and good practice to participate and mobilise improvement . Evidence of the meetings will be provided to Quality Assurance Committee and to Trust Board and any support required of the Board will be identified and implemented.

The Quad met with the BSC on 23rd November. Various matters were discussed, no areas for escalation were identified..

9. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

10. MONITORING/REPORTING ROUTES

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

11. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committees on 12th December 2023 and 9th January 2024.

12. RECOMMENDATIONS

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

Appendix One - Maternity & Newborn Safety Investigations (MNSI) (previously Healthcare Safety Investigation Branch - HSIB) Reports during period 06.12.2022 – 30.11.2023

Author	Lisa Davies, Integrated Governance Quality Lead
Report Title	Maternity & Newborn Safety Investigations (MNSI) (previously Healthcare Safety Investigation Branch - HSIB) Reports during period 06.12.2022 – 30.11.2023
Purpose	Overview of all MNSI cases in Maternity Services for Chief Nurse oversight
Date	30 November 2023

Overview and Background

Chief Nurse to be provided with an overview of all MNSI referrals in Maternity Services during period 6 December 2022 to 30 November 2023.

Background, Key Issues and Risks

All cases that have met or are thought to meet the MNSI reporting criteria (See Appendix 1) have been reported to MNSI. Provisional notifications to MNSI always occur for transparency and to ensure that MNSI have oversight. The Integrated Governance Quality Lead submits this information through the MNSI secure central reporting online system (HIMS).

MNSI will proceed to a full investigation if family consent is obtained and maintained. There are currently no exceptions to report in terms of MNSI referrals from WHH.

To note - all cases of term babies who receive therapeutic cooling are provisionally reported to MNSI, although due to changes in the MNSI investigation criteria made during Covid-19 these cases may only proceed to full investigation if there are abnormalities on the babies' brain on MRI, there are concerns from the family or there are issues identified on the Trust initial safety review that MNSI would like to investigate further. MNSI may therefore reject cases due to the following:

- No family consent or consent withdrawn.
- MRI brain normal following therapeutic cooling
- Does not meet MNSI criteria (As per appendix 1)

In terms of the MNSI criteria, it may not always be clear immediately whether this has been fully met, or this may emerge through further investigation, hence a provisional notification will always be submitted via HIMS for transparency and triage of cases.

Examples of circumstances where the criteria may not be clear are:

- A term baby has been therapeutically cooled, however MRI brain outstanding (MRI brain is normally conducted >72 hours once the baby has been re-warmed, and dependent upon babies' condition may only occur some weeks after the event).

- The mother has attended with contractions and further clarification needed surrounding if she perceived herself to be in labour.

The MNSI team hold quarterly review meetings with Women's and Children's Clinical Business Unit and provide regular updates during investigations. Details of all cases to date can be found on the embedded report below which was received from Samantha Ladd, who is the trust link and North (West) Team Leader from MNSI:

20230526_Maternity Investigations Upda

All cases referred to MNSI undergo an internal initial safety review opened within Trust and this is presented at the patient safety summit meeting as soon as possible following the event. Any initial learning identified at the initial safety review is recorded and actioned through the Trust incident reporting system, Datix.

Three cases from WHH within the specified period have proceeded to full MNSI investigation. Two are currently still active, and details of the three cases are included below:

Table of WHH MNSI Referrals Accepted for Full Investigation 6th December 2022 – 7th December 2023				
Date of MNSI opening investigation and MNSI Reference Number	**Summary of Incident**	**MNSI Criteria Met**	**WHH Initial Safety Review**	**Status**
04.01.2023 MI-019689	Ruptured uterus	Potential severe brain injury – therapeutic cooling	 Initial Review MI-019689.pdf	Report received and case closed  20230516_MI-01968 9-Final Report.pdf
05.06.2023 MI-027840	Pathological CTG – Delay to delivery	Potential severe brain injury – therapeutic cooling	 Initial Review MI-027840.pdf	In progress. Draft received & awaiting final report.
23.06.2023 MI-028203	Pathological CTG	Family concerns with care	 Initial Review MI-028203.pdf	In progress. Awaiting draft & final report.

Finalised MNSI reports can take up to six months.

Cases referred to MNSI may also meet the criteria for a Perinatal Mortality Review Tool (PMRT) review (See Appendix 2). As per MNSI process – PMRT review will only occur once the Trust is in receipt of the finalised MNSI report.

There have been a further three cases from WHH that have been provisionally reported to MNSI within the last 12 months but have not proceeded to full investigation/have been rejected by MNSI.

The WHH MNSI **rejected** cases for the past 12 months are detailed below:

Table of WHH MNSI Rejected Cases Past 12 Months				
Case Date and Referral Reference Number	**Summary of Incident/Reason for referral**	**Reason Rejected**	**Comments**	**Initial Review**
03.02.2023 MI-021735	Potential severe brain injury – therapeutic cooling	No Trust or family concerns	Low risk Pool birth Shoulder Dystocia	Initial Review MI-021735.pdf
17.04.2023 MI-025532	Early Neonatal Death	Lack of family consent	Neonatal collapse Coroner case PMRT on hold as agreed with MBRRACE	Initial Review MI-025532.pdf
23.08.2023 MI-032197	Potential severe brain injury	No Trust or family concerns	Reduced fetal movements overnight. Bradycardia on admission	Initial Review MI-032197.pdf

Recommendations and next steps

Integrated Governance Quality Lead for Women's and Children's CBU to continue to share MNSI updates and quarterly review meetings through Patient Safety Oversight Meeting to ensure Chief Nurse and board oversight is maintained.

Integrated Governance Quality Lead for Women's and Children's CBU along with the Director of Midwifery to undertake a Cluster Review of completed case for the period 1 January 2023 to 31 December 2023 for identification of themes and richer learning opportunities as advised to Quality Assurance Committee at their meeting on 8th August 2023.

MNSI (HSIB) Reporting Criteria

Our maternity programme investigates cases of:

- early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England.
- maternal death in England.

Babies

Babies who meet our criteria to be referred to us by NHS trusts for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes:

- intrapartum stillbirth
- early neonatal death
- potential severe brain injury.

We do not investigate cases where health issues or congenital conditions (something that is present before or at birth) have led to the outcome for the baby.

The definition of labour used by HSIB includes:

- Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation.
- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).
- When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.

This means that for us to investigate a maternity incident under the HSIB criteria, the mother must have been in term labour as defined by these conditions.

We do not investigate neonatal cases where the mother has not gone into labour. For example, when a caesarean section was performed before the mother had started having contractions or ruptured her membranes.

Intrapartum stillbirth

Where the baby was thought to be alive at the start of labour and was born with no signs of life.

Early neonatal death

When the baby died within the first week of life (0-6 days) of any cause.

Potential severe brain injury

Potential severe brain injury diagnosed in the first seven days of life, when the baby:

Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.

Was therapeutically cooled (active cooling only). This is where the baby’s body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.

Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

We no longer routinely investigate cases involving therapeutically cooled babies where there is no apparent ongoing neurological injury following cooling therapy. This would usually mean a brain MRI showing no hypoxic damage (a type of brain injury that occurs when there is a disruption in supply of oxygen to the brain) and the baby demonstrating no ongoing neurological signs or symptoms. However, this remains as one of our criteria. NHS trusts should continue to refer cases to us. We’ll decide which investigations proceed based on an individual baby’s clinical outcome, after discussion with the family and the NHS trust.

Maternal deaths

We investigate direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

We may investigate some maternal deaths which do not entirely fit within these two categories.

We do not investigate cases where suicide is the cause of death.

Direct deaths

Direct deaths include those resulting from obstetric complications of the pregnant state (pregnancy, labour and after the birth), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.

Indirect deaths

Indirect deaths include those from previous existing disease or disease that developed during pregnancy, and which was not the result of direct obstetric causes but was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

PMRT Reporting Criteria

The PMRT has been designed to support the review of the following perinatal deaths:

Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;

All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;

All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;

Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

Termination of pregnancy at any gestation;

Babies who die in the community 28 days after birth or later who have not received neonatal care;

Babies with brain injury who survive.

Appendix two - Service User Feedback

KD – email feedback received

I would just like to email to provide feedback on the maternity services at Warrington hospital.

For a bit of background, in 2022 I suffered with three miscarriages. On the third miscarriage, Sandra Millington (Early Pregnancy) was kind, supportive and was just what I needed at the time. She recommended, that if we fell pregnant again, ask for progesterone pessaries to support the early stages of the pregnancy.

When I fell pregnant for the fourth time, I took Sandra's advice and asked for progesterone pessaries. After confirming the heartbeat at 6 weeks, I was prescribed the pessaries, and had scans every two weeks until the twelve-week scan. Sandra throughout this time was amazing. As she sees many families and couples through her role, I can guarantee that she will forget me and my boyfriend; but I know I will never forget her. She got me through the early stages of my pregnancy (due to many anxieties) and this is something I will remain grateful for always.

My assigned midwife, Cate Fitzpatrick, was attentive, caring, thoughtful, & reassuring. No question or concern was never too onerous for her and she always took the time to listen & guide me through. She is truly an exceptional midwife.

Lauren Davenport & Joanne Harvey were my midwives within The Nest. My birth & my aftercare was amazing, by the two midwives. I couldn't have asked for a better birth experience, and it was due to the support I had in the room during and after.

Sometimes people aren't recognised and appreciated for the support they provide during an anxious and difficult time; but all these ladies provided something really special to me during my pregnancy in each of their roles. Each of them made my experience positive, when I was dealing with internal anxieties and worries; I will be forever grateful to all of them.

Appendix three- Service User Feedback

AD – email feedback received

Hi Simon,

I understand that you sent a message to all your staff on 4th December outlining and congratulating your staff in the life saving treatment given to our daughter, Adele.

My wife Donna and I are still coming to terms with what Adele went through and we are massively grateful to all the staff who worked on Adele during the two operations and with the outstanding care given after that in ICU leading to her leaving recovery.

After we were called in, the wonderful surgical team were great in coming to see us and her husband Ian, and giving detailed, honest assessments of how things were going in theatre. But even when the assessments were grim, they managed to keep us hopeful that Adele might survive. Many of your staff stayed well beyond their normal working hours as they were invested in seeing her survive.

We cannot thank the whole team enough for their skills, their dedication and refusal to give in. On top of this was their kindness and care which was a great comfort to us all. This continued through her thirteen days of excellent care in ICU. Whilst there, she had many visits from all the nurses, midwives, theatre staff and all the surgeons and involved; some very lovely and emotional “reunions”.

Some more of her experiences are coming back to her including the lovely Dr Rita Arya gently telling her that she was having to remove her womb to save her life. (Rita was one of the main people giving us regular informative, caring updates).

Adele remembers saying to one of the Doctor’s are she was being taken back to theatre “I’m dying, aren’t I?” to which he replied, “Not on my watch Adele”. How fantastic is that! I am sorry, but we can’t help sobbing each time we think of that!

As you know, the NHS gets a lot of bad press because of waiting lists and long waits in A&E, all caused by a lack of resources making it unable to meet the ever-increasing need/demand. However, what we have experienced is the NHS at its very best, is beyond doubt, the best in the world.

We should also not forget that your staff also delivered to her a beautiful healthy baby - Jasmine Faye. She is a blessing and joins her other lovely four sisters and husband Ian into her family.

We are unable to contact each and every one of the Staff involved in saving her life and giving her the best, kindest treatment that anyone could ever wish for. We would be eternally grateful if you please thank them on our behalf – thank you all for really caring.

With love and thanks

Steve & Donna Birch

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/169**	
SUBJECT:	**Freedom to Speak Up – Developments for 2024 onwards**	
DATE OF MEETING:		
AUTHOR(S):	Jane Hurst, Chief Finance Officer	
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.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation, and financial position.	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

	Further Information:		
EXECUTIVE SUMMARY ***(KEY ISSUES):***			
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** **x**	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the developments in the delivery of the Freedom to Speak Up service.		
PREVIOUSLY CONSIDERED BY:	**Committee**		
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome	noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Freedom to Speak Up – Developments for 2024 onwards	AGENDA REF:	BM/24/02/169

1. BACKGROUND/CONTEXT

This paper outlines the developments in the Freedom to Speak Up (FTSU) service across the Trust.

2. KEY ELEMENTS

The current Freedom to Speak Up Guardian (FTSUG), Jane Hurst, has been in post since the inception of the role in May 2017. After six years in post, and following recent promotion to the substantive post as Chief Finance Officer, Jane is stepping down as FTSUG.

There has been a recent review of the FTSU structure alongside other recommendations made nationally and regionally.

It was proposed that the Trust required more specific capacity resource for the development of the FTSU role and service.

The current postholder has no specific ring-fenced dedicated time for FTSU, backfill within substantive job-plan being arranged with other members of the senior finance team

Following an expressions of interest process late in 2022, the Trust interviewed four senior members of staff interested in undertaking up to three days per week as FTSU Guardian, supporting the network of 30 FTSU champions embedded within teams across the Trust

The successful candidate, Deborah Carter (Interim Patient Safety Project Director) has been appointed as the new FTSUG and is due to start on the 1 February 2024.

In addition, Alison Jordan (Associate Director of Information) will provide additional support with 1 day a week as Deputy FTSU Guardian. Furthermore, administrative support, and a point of contact, for the Guardian, Deputy Guardian and the FTSU champions will be provided by the Corporate Governance Team. **Appendix 1** gives further information on what Deborah and Alison will bring to the FTSU team.

The current Executive lead for FTSU is Kimberley Salmon-Jamieson (Chief Nurse & Deputy Chief Executive). Kimberley is due to leave the Trust on 31 March 2024; It is therefore also proposed that the Executive Lead for FTSU will be passed to the current Guardian, Jane Hurst; this natural transition will support the transition of the new Guardian and give continuity and organisational memory.

The Non-Executive Director Lead is Julie Jarman remains unchanged. This interface and oversight of FTSU activity will be further strengthened and our policies and procedures will be reviewed in line with national recommendations.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

There will be increased focus on engaging, supporting and developing the FTSU Champions, ward and department walk arounds to increase awareness, including harder to reach areas and increased attendance at staff meetings, training and inductions.

The new Guardian will review the FTSU policy, strategy and annual plans, as above.

The new Guardian will consider items of concern from the review of the national toolkit in recent Trust Board sessions including staff training, reducing barriers to speaking up and evaluating the impact and increase the understanding what detriment looks like. See Appendix 2 for toolkit review.

The Guardian and Executive lead will ensure FTSU is part of the Trust culture framework.

4. MONITORING/REPORTING ROUTES

The Guardian will continue to report to the Strategic People Committee and the Trust Board twice a year with a greater focus on staff stories, lessons learnt and outcomes. They will ensure the Board is sighted on areas of concern and actions being taken.

5. RECOMMENDATIONS

The Trust Board is asked to note the developments in the delivery of the Freedom to Speak Up service.

Appendix 1

Biography for FTSU Guardian - Deborah Carter RN, MA

Deborah commenced working in the NHS at 16 years of age as a nurse cadet and worked in a number of settings before becoming a midwife. She has been fortunate to work in a number of large health systems across the NHS in a broad range of roles. She has experience working in operational, corporate and strategic roles in Nursing & Midwifery, Quality and Governance and Operational roles, and has also supported national work programmes and worked for the Nursing and Midwifery Council supporting Fitness to Practice. Passionate about both patient and staff experience within the NHS, and particularly she is keen to improve patient safety and the development of a psychologically safe workplace for staff.

Having retired from the NHS in 2020 whilst working as Chief Nurse and having led the Covid Preparedness and Response as the Delivery Director across North Wales; Deborah has been supporting Warrington and Halton Foundation Trust for the past 3 years in a number of roles and most recently with the work to implement the National Patient Safety Strategy.

Deborah has explained that she is really looking forward to supporting the organisation in the role as Freedom to Speak Up Guardian is looking forward to meeting as many staff as possible when she commences in the role on the 1st February 2024.

Biography for FTSU Deputy Guardian - Alison Jordan RMN PGCERT

Alison commenced working in the NHS aged 17 as a volunteer and then commenced her Mental Health Nurse training. She has worked in a variety of Mental Health (MH) settings ranging from acute MH, Learning Disabilities and High Secure Forensic Mental Health. After 20 years in clinical roles Alison was enticed into the world of Digital firstly operationalising an electronic rostering system. She was then invited to join a Digital Shared service and began to gain experience of working with Acute General NHS Trusts. She was a business Change Manager and then moved into Programme Management and latterly an Account Manager.

Alison then returned to education and qualified in Commercial Building Surveying that took her into an Estates Director role.

She returned to Digital in 2018 as Chief Nurse Information Officer at WHH. And then took a secondment opportunity for 2 years to programme direct a Shared Records programme for the whole of the North West Coast of England. Returned to Warrington in 2021 into her current role.
In all the roles she has held during her varied NHS career she is always keen to get involved with initiatives that increase patient safety and support a healthy and well cared for workforce, including being a qualified workplace Mediator, Investigator and Mental health responder. Alison is now looking forward to support Deborah as deputy FTSU Guardian.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up.

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide.

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up.

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I have led a review of our speaking-up arrangements at least every two years	3
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	4
Enter summarised commentary to support your score. Exec Lead and CEO are up to date on FTSU issues reading articles etc. Meetings with FTSUG take place as required with quarterly meetings to catch up more formally. Both have an open door policy and FTSUG is comfortable approaching both with issues.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Trust should consider ringfenced time for FTSUG.	
2 Review and share the findings of the Bewick Review	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I am confident that the board displays behaviours that help, rather than hinder, speaking up	4
I effectively monitor progress in board-level engagement with the speaking-up agenda	3
I challenge the board to develop and improve its speaking-up arrangements	4
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	4
I am involved in overseeing investigations that relate to the board	n/a
I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

I have read national guidance, understand the importance and attend a NED FTSU seminar from NHSE.
We have a culture of open discussion, scrutiny and challenge at Board. We are open to challenge ourselves and as a Board understand the importance of FTSU. For example, we have a Board development session planned.
I think I could do more – I monitor progress and have discussed with the Chair but there are many priorities so the attention to FTSU needs to be proportionate – but I do try to ensure a focus on our organisational culture at Board. We take a bi-annual report on FTSU at Strategical People Committee (SPC) as a Board level committee and the reports are then also sent through to Board.
We are having the development session and I raise the importance of FTSU when appropriate to Board discussions. I regularly champion the need for staff and service user feedback (not the same thing but enables a helpful culture)
FTSUG replacement will be recruited through an open application process.
Not sure if the FTSUG has enough ringfenced time – but you have done such a great job that it's hard to know. I think the plan for your replacement is for FTSU to be a core element of their job and more significant amount of tie will be ringfenced.
Overseeing an investigation hasn't arise but would expect to be involved.
I provide support with regular meetings with FTSUG and did ward visits in FTSU month – it's not a huge amount and I would like to get to Champions meetings regularly.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Prioritise the recruitment of your replacement and provide ringfenced time.
2 The Board development sessions are important to ensure the whole Board is focused on the importance of FTSU. 3 As NED lead on FTSU I think it would be really helpful for me to get to a few of the Champion's meetings, and I need to maintain my knowledge around recent developments by attending seminars etc. 4 Continue with the current good practice around FTSU Champions, the month of action and maintaining visibility and regular communications to staff.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture.

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	4
We regularly and clearly articulate our vision for speaking up	4
We can evidence how we demonstrate that we welcome speaking up	4
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	2
We regular discuss speaking-up matters in detail	4

Enter summarised evidence to support your score.

Regular discussion at Strategic People Committee and Board
Annual update to all staff during National FTSU month.
Annual plan to Board and refresh of strategy.
Staff are thanked when they speak up.
Presentation to staff discusses Detriment and the support if this happened.
Keeping in touch with the individual, HRBP link to service, where possible we don't even mention FTSU but draw from staff survey, HR intelligence and exit interviews.
Regular catch up with CEO and Exec for FTSU and NED. Board and Committee paper and discussion
The Trust has ensured that key Employee Relations Policies reference the FTSU process they are available to all Trust staff on the extranet (intranet)

Weekly meetings take place with Senior Leaders in the People Directorate to ensure that any issues are escalated accordingly, and resolutions worked through with individuals via the FTSUG, line managers, senior leaders and members of the HR Business Partnering Team. The Trusts internal staff side colleagues link with the FTSG and the Deputy Staff Side Chair is also a FTSU Champion
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)
1 The Trust should encourage staff / managers to do the FTSU training which highlights role modelling behaviour that encourage speaking up.
2 Develop and communicate a process for what to do if you have suffered detriment

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	3
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3
We support our guardian(s) to make effective links with our staff networks	5
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	4

Enter summarised evidence to support your score.

- Kindness civility and respect campaign that will be further strengthened with organisational culture work in partnership with PSIRF.
- Staff survey prioritisation focus groups for Care Groups to respond to staff feedback.
- Standing agenda items on Freedom to Speak Up as part of people governance processes for Operational People Committee, Joint Negotiating Consultative Committee, Workforce EDI Sub-Committee
- Representation of Freedom to Speak Up Guardian on task and finish groups affecting staff such as staff facilities.
- Messaging on Freedom to Speak Up and speak up culture embedded into corporate induction for all new starters to the organisation.
- Freedom to Speak Up information also included on Local Induction Checklist for all new starters.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Delivering the WHH culture work for 2023-24 which embeds and makes reference to Freedom to Speak Up
2 Deliver Just and Learning culture as part of People Strategy objectives for 2023-24

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
We have reviewed the ringfenced time our Guardian has in light of any significant events	4
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	4
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	4
Enter summarised evidence to support your score. Chairman, CEO, NED and FTSUG met January 2023 and discussed ringfenced time. FTSUG guardian is supported by her line manager if she needs to take time on FTSU issue and she has strong team in her main job to pick up / support when required. The discussion highlighted that the role of FTSU is to sign post and support to the Trust policy and support available and therefore the Trust adopts light touch. FTSUG guardian is supported by HR and OD teams when issues are raised, and they do the investigations and apply the Trust policies available. Where issues are patient or staff safety, they are handed to senior nurse team to investigate as appropriate. The discussion concluded that the current structure is sufficient for the Trust. Budget is made available for basics needed for FTSU such as materials for FTSU month – pens / sporks/ posters etc.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 The Trust is reviewing the FTSU ringfenced time.	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so.

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	4

Enter summarised evidence to support your score.

The revised policy went to September 2022 Strategic People Committee and Trust Board.

FTSUG attends inductions for rotational doctors and preceptorship. FTSU has a presence at all staff inductions with information at the marketplace and a champion present.

FTSU is on the first page of the Trust internal website, posters in staff rooms, ward visits in October as part of national FTSU month, ad-hoc visits over the last 12 months have included Pathology and Maternity and stalls in the hospital during October and at the start of the year event in May, slide in Trust Team brief and GMWHH newsletter.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Continue to consider increasing awareness of FTSU suggestion from champions include posters, desktop links, more walk around, Grand Round and Hot topics

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

Significant publicity in October FTSU month but time is an issue for other times of the year.
Attend preceptorship induction, rotational doctors induction and international nurses
Posters in staff area
We have an annual plan.
FTSU Champions wearing FTSU lanyard.
Ward visits
Hot Topic, desk top advert, Team brief, staff induction, front page of intranet
Ad-hoc attendance at Team Meetings to highlight the role of the FTSG and FTSU

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Include a positive story in team brief or GMWHH
2. We could do a Trust wide questionnaire to measure do people know who we are? On National FTSU month when we ask people in the corridor do you know what FTSU is circa 70% say yes which is higher than when we started. At induction it varies I would say 50% know what it is even if they are Y4 or Y5
3. GMWHH in October with different view points of FTSU

Principle 4: When someone speaks up, thank them, listen and follow up.

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	1
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	1

Enter summarised evidence to support your score.

We have not mandated the FTSU training.
FTSU is on corporate induction and included in ward accreditation, and junior doctor induction, preceptorship and international nurses, not sure if it is in all local team based induction.
We don't measure impact of training as it is not mandated.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Trust should consider mandating the FTSU Training and monitor impact
2 Monitor the staff survey results linked to speak up

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	2
All managers and senior leaders have received training on Freedom to Speak Up	1
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3

Enter summarised evidence to support your score.

FTSUG or HRBP discuss FTSU issues with management as they occur, HRBP support managers in actions required including OD training, facilitated conversation and mediation as appropriate.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Trust to consider mandating FTSU training for all staff.

2 Trust to look at understanding and measuring the wider speak up culture of the organisation.

Through:-

1 Delivering the WHH culture work for 2023-24 which embeds and makes reference to Freedom to Speak Up

2 Deliver Just and Learning culture as part of People Strategy objectives for 2023-24

Principle 5: Use speaking up as an opportunity to learn and improve.

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	4
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

FTSUG works closely with HR and weekly meeting are used to share intelligence from across the Trust. Highlighting possible issues and where support is needed.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3) – N/A

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	4
We use this information to add to our Freedom to Speak Up improvement plan	4
We share the good practice we have generated both internally and externally to enable others to learn	4

Enter summarised evidence to support your score.

FTSUG attends Regional FTSU meeting where best practice is discussed.
This toolkit has generated discussion from champions to Board Members we have assessed gaps and measures to close them.
FTSUG recently spoke at a nation finance conference about FTSU and ED&I – feedback included others would develop some of our ideas in their Trusts.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3) - N/A

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements.

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. There was an internal advert, and 3 members of staff were interviewed. FTSUG has completed training and attends the regional meetings.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	4
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	4
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

Annual plan for FTSUG is worked through and reviewed wit Exec lead and Champions – not formal appraisal.
FTSUG feels supported by Exec lead for FTSU and CEO and own line manager. Also assess and support from other Executives when issues relate to their areas.
Guardian checks in regular with HR and understands the support available if required.
FTSUG has several Champions some of which have been in post as Champions for over 5 years and would be able to cover unexpected leave due to their seniority and experience.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	3/4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
We are assured that confidentiality is maintained effectively	4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	4
We are confident that if people speak up within the teams or directorates, we are responsible for, they will have a consistently positive experience	3/4

Enter summarised evidence to support your score.

FTSUG logs information on the disclosure and HR make own notes to follow up with Teams. – Check If HR keeps a log?
HRBP link to managers to resolve issues.
HRBP maintain confidentially and FTSUG only given names if necessary to take action.
FTSUG meets weekly with HR to progress cases.
We encourage managers to listen to all staff.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 HR keep a log once they passed to HR process

Delivering the WHH culture work for 2023-24 which embeds and makes reference to Freedom to Speak Up and Deliver Just and Learning culture as part of People Strategy objectives for 2023-24 will support staff positive experience of speaking up

Principle 7: Identify and tackle barriers to speaking up.

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	3
We know who isn't speaking up and why	2
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	2

Enter summarised evidence to support your score.

We understand the barrier and encourage Champions from across the Trust to make FTSU more accessible. We notice an increase in Oct / Nov and this would indicate visibility is a key thing for FTSU.
Meet 6 weekly with Champions, each volunteer to be a champion has a 121 meeting with the guardian before commencing.
Aware that visibility of FTSUG increases contacts – impact of October national awareness month.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Reviewing the findings of the Bewick Review
2. Continue to raise awareness and be more visible
3. New Guardian – increase ringfenced time and more department visits
4. Champions to discuss potential barriers first suggestion is physical comments boxes in areas where staff don't tend to access email – domestics & catering.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	1
We monitor whether workers feel they have suffered detriment after they have spoken up	3
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	4
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	n/a

Enter summarised evidence to support your score.

Feedback on detriment is limited, we ask for feedback on support they got from FTSU and if they feel they suffered detriment but often no response.
If someone felt, they had suffered detriment this would be managed with HR and within the Trust process / policies.
No specific cases of detriment from speaking up through FTSU have been identified.
We have reviewed cases in another Trust to consider could that happen here.
FTSUG contacts to check in with people who have raised issue a couple of weeks after where appropriate / possible.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Questionnaire asking if they have ever spoken up and felt they were listened to or worse suffered detriment as a result of speaking up – include in People Directorate Culture work
2 Raise awareness with managers that detriment will not be tolerated

Principle 8: Continually improve our speaking up culture.

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	4
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	4
We routinely evaluate the Freedom to Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
Our improvement plan is up to date and on track	3
Enter summarised evidence to support your score. Strategy is reviewed every 1- 2 years it includes an action plan and is shared with the SPC and Trust Board The Plan is reviewed by the FTSUG, Champions and Executive lead. The plan is shared with Champions for ideas and suggestions.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Evaluation of strategy to be added to the Board paper annually.	
2 Improvement plan to be updated and appended to Board paper annually.	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	4
Enter summarised evidence to support your score. Staff survey gives an indication of how confident people are to speak up and the current increase in numbers is an indication staff feel they can speak up. Our Champion meetings discuss what has gone well with cases or awareness campaigns – informal review. Currently evaluating are FTSU arrangements.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
We have we evaluated the content of our guardian report against the suggestions in the guide	3
Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3

Enter summarised evidence to support your score.

Report goes to SPC Committee and Trust Board twice a year along with Quarterly meetings with CEO, Chairman, NED and Exec lead.
When the report was originally set up it followed current guidance.
We know that speaking up has resulted in learning and improvement by working across the Trust with People Directorate and managers. Often these are cultural issue and take time to improve.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Content of FTSUG report to be evaluated against suggested guide.

2 Consider how we capture assurance that speaking up results in learning and improvement as part of the just and learning culture.

Stage 2: Summarise your high-level development actions for the next 6 – 24 months.

Development areas to address in the next 6–24 months	Target date	Action owner
1 Trust to review mandating FTSU training for all staff – helping managers understand the valuable learning.	December 2023	Exec Lead
2 Look to measure the speak up culture is improving – SPC is looking at this with short surveys not FTSU but wider speak up culture.	March 2024	FTSUG
3 Further review of ringfenced time for FTSU guardian	December 2023	Exec Lead
4 Understand what detriment looks like	March 2024	FTSUG
5 Look to capture speak up that goes directly to Execs.	December 2023	FTSUG
6 Further work on identifying barriers to speak up	March 2024	FTSUG
7 Consider who isn't speaking up and how they can be reached.	December 2023	FTSUG
8 Work on reducing barriers and measure the effectiveness of these actions.	June 2024	FTSUG
9. Reviewing the findings of the Bewick Review	June 2024	FTSUG
10. Consider the role of FTSU in the Cultural Work and Just and Learning Culture	June 2024	CPO
11. Recruitment of new FTSU	December 2023	CEO
12. Produce a development plan for the new FTSUG	March 2024	Exec Lead

Stage 3: Summary of areas of strength to share and promote.

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Continue to recruit more champions - Aim for a FTSU Champion in every area	Ongoing	FTSUG
2 Ensure FTSU remain prominent in everyday ward business – poster, ward accreditation, Governor walk rounds, Champion	Ongoing	FTSUG
3 Maintain visibility of Exec, NED, FTSUG and Champions	Ongoing	FTSUG
4 Maintain visibility with the Board through development sessions and reports	Ongoing	FTSUG
5 Maintain regular meeting between FTSUG and Board members	Ongoing	FTSUG
6 FTSUG maintain network links and attend regional meetings	Ongoing	FTSUG
7 Maintain a presence at inductions	Ongoing	FTSUG
8 Engage in the National FTSU Month	October 2023	FTSUG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/170**			
SUBJECT:	**Communications and Engagement Update – Q3 2023-24**			
DATE OF MEETING:	7 February 2024			
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report updates on communications and engagement activity during quarter 3 of 2023-24. It incorporates the quarterly reporting on the Working with People and Communities Strategy and elements of the previous Communications Dashboard into one report. The report consists of: • Communications and Engagement Team updates • Overview of Q3 activity • Updates on Experts by Experience involvement • Key campaigns and highlights from Q3 • Working with People and Communities Strategy Q3 update • Details of the current plan of engagement events which the Trust is organising or attending during 2024			

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the quarter.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Governor Engagement Group	
	Agenda Ref.	GEG/24/02/53	
	Date of meeting	1 February 2024	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and engagement update

Quarter 3 2023-24 (October to December)

Trust Board

7 February 2024

Our role within WHH

The Communications and Engagement Team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including – content development for trust's corporate social media channels and updates to the website
- Identity and branding
- Design work
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information
- Freedom of Information (FOI) requests

During the Q3 period (October to December 2023) the Communications and Engagement Team…

- processed and allocated **103** separate communications 'Job Request' forms for design, film, photography and communications campaign support
- issued **19** media releases/statements
- handled **20** enquiries from local, regional and national print and broadcast media
- processed **212** emails through the enquiries inbox
- received **179** Freedom of Information (FOI) requests
- processed and issued **142** FOI request responses

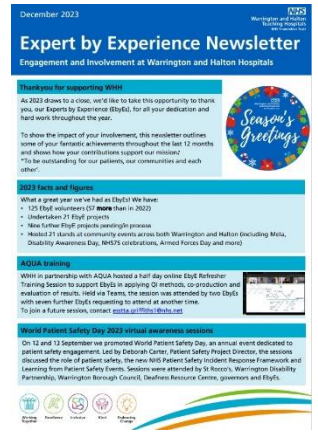
Team updates

- Appointment of Eve Allman as Senior Communications and Engagement Specialist (starting 19 February 2024). Eve joins us from the NHS North West Leadership Academy, where she is in post as Marketing and Engagement Manager. Eve has previously worked at Manchester University NHS Foundation Trust on the large-scale roll out of their new electronic patient record.

- The Freedom of Information function will move from the Communications and Engagement Team to the Corporate Governance Team from 1 April 2024. It is expected that this will involve the transfer of one team member (subject to necessary HR processes taking place).

Q3 achievements overview

- Supported the Annual Members' Meeting in October 2023
- Ongoing communications to minimise the impact of industrial action
- Supported co-ordination and undertaking of three Equality Delivery System (EDS) Public Engagement Events
- Continuing brand re-fresh roll out of materials to reflect new brand and style guidelines within existing team workload
- Produced communications and materials to support the Care Quality Commission (CQC) inspection of maternity services
- Launched Engagement and Involvement Newsletters
- Supported the Stay Well this Winter campaign
- Launched a communications campaign to publicise the benefits of the Acute Respiratory Infection (ARI) Virtual Ward
- Launched a communications campaign to support Mouth Cancer Awareness Month and a free mouth cancer screening event
- Co-ordinated and hosted a De-mystifying Research online session in partnership with the Research Development and Innovation Team



Media

The media releases/proactive external announcements issued during Q3 included:

Bowel Cancer UK announced Louise Foley and Clara Dennis, WHH Colorectal Clinical Nurse Specialists, as winners of the prestigious Gary Logue Colorectal Nurse Cancer Awards
Read the release.

‘Your Future Your Way’ was awarded a Royal College of Nursing (RCN) North West Award for Outstanding Contribution to Equality, Diversity, and Inclusion
Read the release.

Ali Kennah has been appointed as Chief Nurse at WHH. Having worked at the Trust since 2017, Ali will step into her new role on 1 April 2024.
Read the release.

Engagement, involvement and insight

During Q3 (Oct to Dec 2023) we recruited **5** Experts by Experience (EbyEs)

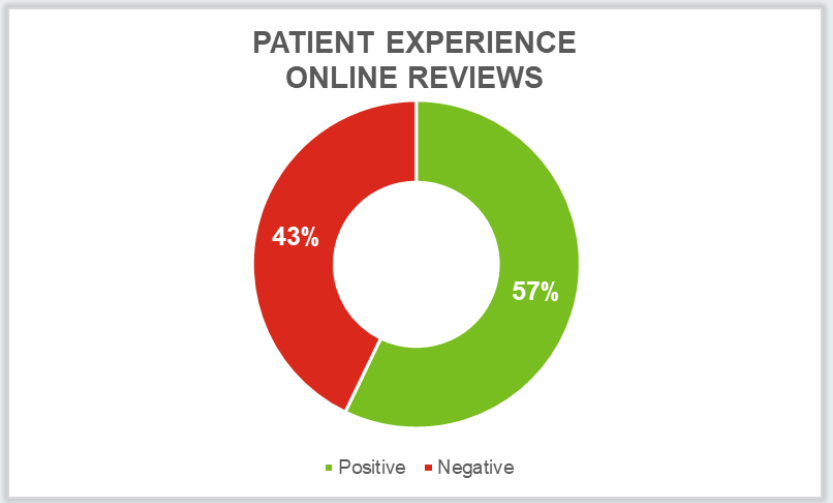
We received requests for engagement support for the following projects:

- Patient Engagement Portal next steps development
- Five Essentials of Quality Improvement infographic feedback
- Pediatric sepsis care experiences
- Patient experience feedback
- Redevelopment of Warrington, Halton, St Helens and Knowsley Breast Screening website
- Redevelopment of Trust website

WHH Innovation survey

In November, EbyEs were offered an opportunity to inform the wording, questions and formatting of the Trust's Innovation survey.

Three EbyEs helped inform the survey's text, accessibility and content, which was updated and shared publicly in January 2024.



A total of 44 online reviews from patients rating their WHH experience were published in Q3

Sources of data:

- NHS Choices
- Google reviews
- I want great care

Experts by Experience (EbyE) projects

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Name	Overview	No of EbyEs	Outcomes
Patient Engagement Portal (PEP) Stage 2	Request for EbyEs to join strategic groups (Enterprise architecture/service model, Communications plan, Project Board)	3	• 3 EbyEs recruited (1 per group) • Further meetings to be held per topic
5 Essentials of Quality Improvement (QI) infographic	Request for EbyE feedback on infographic to be used trust-wide via digital and printed resources, to raise awareness/create a culture of QI	N/A	• Feedback anonymised
Paediatric Sepsis care	Request to EbyEs to share Trust experiences of Sepsis and Sepsis care of children aged 0-16yrs	1	• 1 EbyE recruited • Feedback shared with project lead • EbyE to support Trust compliance of sepsis management, in line with current National Institute for Health and Care Excellence (NICE) guidance
Redevelopment of WHH website	Request for EbyE feedback to informed redevelopment of WHH website	16	• 16 EbyE survey responses • Feedback shared with project lead • 9 EbyEs recruited to join Task and Finish group

EbyE projects (continued)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Name	Overview	No of EbyEs	Outcomes
Mental health (MH) care experiences	Request for patient stories to support project and development of MH training package with real life events features	1	• 1 EbyE recruited • Feedback shared with project lead • EbyE to be invited to share feedback with project team and to develop MH training
Hospital care experiences	Request for EbyE to enhance existing bank of care stories, to enable learning and celebrate examples of good practice	6	• 6 EbyEs recruited • EbyE feedback typed up and share with Patient Experience Team • EbyEs to be offered opportunity to join digital patient story bank
Breast screening website redevelopment	Request for EbyE involvement within Warrington, Halton, St Helens and Knowsley Breast Screening website	7	• 7 EbyE survey responses • Feedback shared • 5 EbyEs recruited to join Task and Finish group

NHSE campaigns shared with EbyEs: 2
(Child Health Vaccination Invites, Learning from People about Things That Go Wrong)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key campaigns / highlights from Q3

Maternity explainer animations project

Overview
Communications worked with maternity services to create six animated videos to support families during pregnancy, labour and beyond. The team is working with supplier Squideo and animations will also be available in five alternative languages plus British Sign Language (BSL) format to support accessible communication. From the start of the project Experts by Experience (EbyE) and the Maternity Voices Partnership were asked for input and suggestions.

EbyE involvement included:
- Eight EbyEs recruited
- Initial stage of engagement - virtual EbyE feedback on scripts
- Second stage of engagement - virtual EbyE feedback on animation visuals
- Third stage of engagement – animated videos (in English) shared with EbyEs before translations completed

Benefits
- EbyE involvement ensures the information meets the needs of people choosing to use our maternity services
- English subtitles plus different formats enhance accessibility of information (translations/BSL)
- Animations will improve patient safety and awareness of the pregnancy journey, especially among people who may face communication barriers

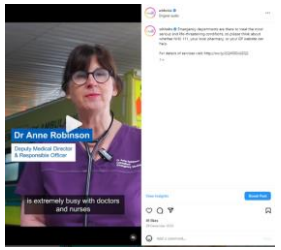
"The videos all look great. I think everything is clear and easy to understand. The visuals have enough detail to illustrate what is being said but aren't too overcrowded or distracting"

Jennifer - WHH Expert by Experience

‘Help us to help you stay well this Winter’ campaign

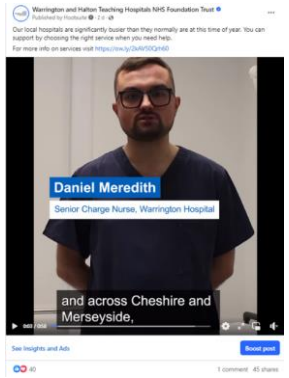
We have been working with partners across NHS Cheshire and Merseyside to deliver this and other health campaigns to support the NHS and patients during the pressured winter period.

National and regionally developed resources have been shared, in print and online including accessible formats, and WHH resources have been produced to complement these.



Specific WHH outputs include:

- Updating information on the Help us help you website page to better inform communities about urgent and emergency care services available to them.
- Videos from Executive Medical Director and Deputy Medical Director plus Emergency Department (ED) staff, sharing ‘help us help you’ messages on social media.
- Stay well this winter editorial published in the ‘Options guide to care and independent living’ which is distributed in hospitals and care settings.



Outcomes:

The video we produced based on a Cheshire and Merseyside Winter Comms Cell script, featuring two WHH ED staff, and posted on Trust socials on 16 January made 3.3K impressions across Facebook and Instagram, received 93 reactions and was shared 45 times. This content made 579 impressions on Twitter and received 32 interactions.

Video messages from the Executive Medical Director and Deputy Medical Director were also shared between the Christmas and New Year periods and ahead of the junior doctor industrial action campaign,

The updated ‘Help us help you’ web page received 210 page views in the first two months of the campaign and continues to be promoted via social media.

Living Well Hub update

Final preparations are being undertaken ahead of the official opening for the new Living Well Hub at Warrington town centre in March 2024, supported by increased internal and external communications.

Recent external coverage has included:

- A ‘first look’ behind the scenes feature
- A Warrington Guardian column with Lucy Gardner, Director of Strategy and Partnerships and
- An updated media release

Work over the coming weeks will include video interviews with Emma Whaley, Hub Manager, and service leads, as well as an updated digital marketing toolkit for stakeholders, and engagement with partner providers to ensure the messaging across Place is fully aligned.

Significant communications support will be required in promoting the proposed timetable to encourage Warrington residents and those most in need of support to use the services on offer.

Read more in the recent press release.

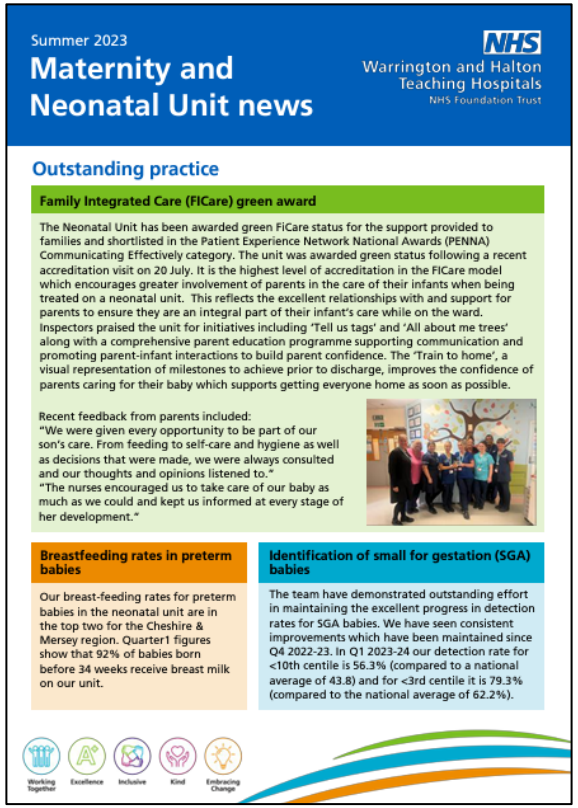
Care Quality Commission maternity inspection

The team contributed to the support and preparation for the CQC inspection of maternity services. This included:

- preparation of a Maternity and Neonatal Unit newsletter to showcase examples of best and outstanding practice
- internal updates to keep staff updated from the announcement of the inspection through to the initial feedback stage
- Promoting the opportunity for people who have used WHH maternity services to provide feedback to the CQC through social media and posters

The inspectors' final report was published on 17 January 2024 when the following communications were issued:

- Good morning WHH message to all staff
- Media statements released under embargo to accompany the CQC media release
- Stakeholder bulletin
- Website updates and social media posts



Summer 2023

Maternity and Neonatal Unit news

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Outstanding practice

Family Integrated Care (FICare) green award

The Neonatal Unit has been awarded green FiCare status for the support provided to families and shortlisted in the Patient Experience Network National Awards (PENNA) Communicating Effectively category. The unit was awarded green status following a recent accreditation visit on 20 July. It is the highest level of accreditation in the FICare model which encourages greater involvement of parents in the care of their infants when being treated on a neonatal unit. This reflects the excellent relationships with and support for parents to ensure they are an integral part of their infant's care while on the ward. Inspectors praised the unit for initiatives including 'Tell us tags' and 'All about me trees' along with a comprehensive parent education programme supporting communication and promoting parent-infant interactions to build parent confidence. The 'Train to home', a visual representation of milestones to achieve prior to discharge, improves the confidence of parents caring for their baby which supports getting everyone home as soon as possible.

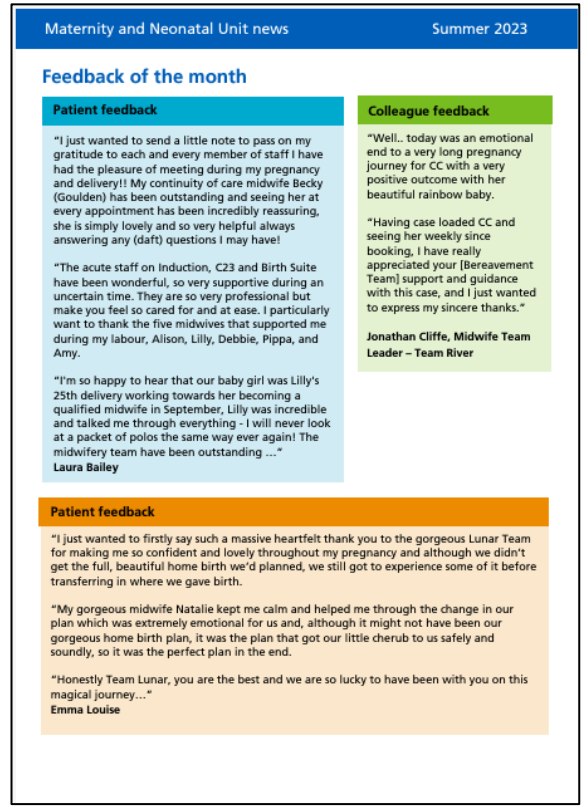
Recent feedback from parents included:
"We were given every opportunity to be part of our son's care. From feeding to self-care and hygiene as well as decisions that were made, we were always consulted and our thoughts and opinions listened to."
"The nurses encouraged us to take care of our baby as much as we could and kept us informed at every stage of her development."

Breastfeeding rates in preterm babies

Our breast-feeding rates for preterm babies in the neonatal unit are in the top two for the Cheshire & Mersey region. Quarter1 figures show that 92% of babies born before 34 weeks receive breast milk on our unit.

Identification of small for gestation (SGA) babies

The team have demonstrated outstanding effort in maintaining the excellent progress in detection rates for SGA babies. We have seen consistent improvements which have been maintained since Q4 2022-23. In Q1 2023-24 our detection rate for <10th centile is 56.3% (compared to a national average of 43.8) and for <3rd centile it is 79.3% (compared to the national average of 62.2%).



Maternity and Neonatal Unit news Summer 2023

Feedback of the month

Patient feedback

"I just wanted to send a little note to pass on my gratitude to each and every member of staff I have had the pleasure of meeting during my pregnancy and delivery!! My continuity of care midwife Becky (Goulden) has been outstanding and seeing her at every appointment has been incredibly reassuring, she is simply lovely and so very helpful always answering any (daft) questions I may have!

"The acute staff on Induction, C23 and Birth Suite have been wonderful, so very supportive during an uncertain time. They are so very professional but make you feel so cared for and at ease. I particularly want to thank the five midwives that supported me during my labour, Alison, Lilly, Debbie, Pippa, and Amy.

"I'm so happy to hear that our baby girl was Lilly's 25th delivery working towards her becoming a qualified midwife in September, Lilly was incredible and talked me through everything - I will never look at a packet of polos the same way ever again! The midwifery team have been outstanding ..."
Laura Bailey

Colleague feedback

"Well.. today was an emotional end to a very long pregnancy journey for CC with a very positive outcome with her beautiful rainbow baby.

"Having case loaded CC and seeing her weekly since booking, I have really appreciated your [Bereavement Team] support and guidance with this case, and I just wanted to express my sincere thanks."

Jonathan Cliffe, Midwife Team Leader – Team River

Patient feedback

"I just wanted to firstly say such a massive heartfelt thank you to the gorgeous Lunar Team for making me so confident and lovely throughout my pregnancy and although we didn't get the full, beautiful home birth we'd planned, we still got to experience some of it before transferring in where we gave birth.

"My gorgeous midwife Natalie kept me calm and helped me through the change in our plan which was extremely emotional for us and, although it might not have been our gorgeous home birth plan, it was the plan that got our little cherub to us safely and soundly, so it was the perfect plan in the end.

"Honestly Team Lunar, you are the best and we are so lucky to have been with you on this magical journey..."
Emma Louise

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy
Q3 update

Pillar 1: Co-production in Service Change/ Development

Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 57 Experts by Experience recruited during 23/24 (5 in Q3) • 125 Experts by Experience total (cumulatively to date) • EbyE newsletter shared as Moving to Outstanding feature December 2023 • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs from the outset of projects (#StartwithPeople) • Hosted 8 stands at community events to promote EbyE recruitment	• By Quarter 4 2023/24
2. Support EbyE recruitment and retention	• 33 EbyE Projects delivered in 23/24 (plus 3 extended projects – Maternity Explainer content, Sepsis improvement and PEP) • 8 further EbyE projects pending (NHSE Criteria Led Discharge, Hospital Entertainment System, Paediatric Virtual Wards, Respiratory Therapies, Dementia Delirium Steering Group, Smoke free Steering Group, Quality Strategy workshop, Quality Improvement training) • 47 EbyEs participating in Q3 projects	• Ongoing
3. Enhance our programme for involvement	• Annual involvement timetable for Awareness Days and Events informs engagement plan – dependent on team availability (see slides 20 and 21) • Discussions with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement or advocacy representation	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• Demystifying Research session online workshop with stakeholders and EbyEs held 11/12/2023 • Inclusion of EbyE engagement from beginning of significant projects e.g. Breast Screening services website redevelopment, WHH website redevelopment, Research, Development and Innovation Team innovation priorities development	• By Quarter 4 2023/24
5. Ensure representation to support Place-Based integrated care delivery	• Governor representation on Warrington and Halton People's Voice forums • Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy/equality groups	• Ongoing

Pillar 2: Accessible Information Standard (AIS)

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient Letters	• A new Patient Engagement Portal (PEP) is being developed and accessibility functionality will be enhanced. The supplier has now been appointed following a procurement exercise and the system is due to be rolled out by the end of March 2024. Experts by Experience involved in PEP procurement exercise and implementation stages. • Work has commenced on a tendering exercise for a new Electronic Patient Record (EPR) system to succeed the current system, Lorenzo. Functionality to support accessible information and communication needs will be key to this development.	• 2024-25
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• All updated content being compared against accessible content checklist to ensure it is up to date and accessible. • A new website (and intranet) have been commissioned. Communications and Engagement Team working with NHS Informatics Merseyside on both projects and accessibility and ease of navigation for patients/communities will be a key priority. Engagement with Experts by Experience will inform site structure and the content of the new website. To be launched mid 2024 onwards.	• Ongoing
3. Accessible content creation	• Working with maternity on a series of six animations to provide information to women and families during pregnancy. Will be subtitled and in five languages most commonly requested by users of the service, plus British Sign Language.	• Ongoing
5. Patient Information	• Production of Patient Information Policy is being updated to reflect increasing use of subtitled videos to support patients as part of the clinical pathway in addition to leaflets. • Awaiting completion of digital system changes to launch Communications Passport – see update on EPR above.	• Ongoing
7. Signage/Wayfinding	• Delivered via First Impressions programme.	• Ongoing

Pillar 3: Reducing Health Inequalities

Using WHH engagement and understanding health inequalities to geographical areas of Warrington North, Warrington South, Widnes and Runcorn

1. Strengthen WHH engagement programme	• Work with collective WHH teams (Patient Experience and Inclusion, Workforce EDI, Membership and Governance, Children/Young People, Dementia, Staff Health and Wellbeing team, charity, volunteers, chaplaincy, catering/estates, ward/service reps) to set/link events calendars and activities for 2023/24 • Quarterly WHH Events Meetings, co-hosted by Engagement and Involvement/Patient Experience, to discuss and agree 2023/24 plans together (held 17/05/2023, 31/08/2023, 06/12/2023). Next meeting due March 24.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. speaking with visitors about the constituencies they represent, showcasing their roles, sharing info, collecting details of visitors interested in becoming a WHH Foundation Trust Member. Events undertaken were: ✓ Annual Members Meeting 2023 ✓ WHH Quality Café ✓ MS Society awareness event ✓ WHH Carers Cafes ✓ EDS Engagement events (Warrington, Halton and online) ✓ Applied Research Collaboration quarterly event (ARCFest) North West Coast	• Ongoing
3. Support Place Based activity and other key local events	• Governor representation at Warrington Together People and Communities Forum and One Halton People and Communities Forum • Warrington Living Well Hub - developed as part of the borough-wide Living Well programme, formal opening (due March 2024) • Community Diagnostic Centre Phase 2 official opening (due February 2024)	• Ongoing

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key health improvement and economic wellbeing initiatives. • Support Wellbeing Enterprises to promote the Active Travel project, being delivered from WHH's Halton Health Hub. • Included Apprenticeship Team in Trust and community engagement events (i.e. Armed Forces Day, Disability Awareness Day). • Team sharing of '350 Careers, One NHS, Your Future' booklet and online link to information.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer in order to enhance the aspirations and life chances of local people. • Level of engagement with social media and websites. • Promoting Nurse Recruitment event in February 2024 at The Village Hotel, Warrington.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Cherry Tree Courtyard hub – providing internal communications support for this project and working with People Directorate to ensure this facility is available to support patient/community engagement where appropriate. • Work with charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at Patient Experience Sub Committee (PESC) and Patient Equality, Diversity and Inclusion Sub-Committee (PEDISC). • Charity stakeholder and staff newsletters created and shared monthly.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2024

Date	Event	Time	Venue	Event purpose
1 Feb 24	Still Me Dementia Network Event	2pm to 4pm	The Gateway, Sankey Street, Warrington, WA1 1SR	Quarterly open event led by Warrington Speakup, to strengthen the voices of people living with dementia and showcase support for carers in Warrington. Confirm attendance by calling 01925 246 888 or emailing lisa@advocacyhub.org.uk
8 Feb 24	WHH Shared Learning Forum	9.45am to 12.30pm	Postgraduate Centre, Warrington Hospital, Warrington, WA5 1QG	Trust-led event for partners, individuals, and staff to learn about quality improvement through sharing experiences, ideas, and feedback for current and future initiatives.
9 Feb 24	Hong Kong Nationals Info Event	Midday to 4pm	The Gateway, Sankey Street, Warrington, WA1 1SR	Partnership event led by Warrington Wellbeing, sharing info and support available to Hong Kong nationals living in the town.
10 Feb 24	WHH Team Lunar – Homebirth Team 1st Birthday Celebration	10am to 4pm	Thelwall Parish Hall, Warrington, WA4 2SX	Trust-led event for discharged patients/families, those currently under WHH maternity services, or those who want to hear more about homebirth.
March 24	Living Well Hub Launch	TBC	Living Well Hub, 26-30 Horsemarket St, Warrington, WA1 1XL	Official partnership opening of the Living Well Hub, which will focus on prevention, early intervention, and self-care for residents to maintain their independence.

Upcoming engagement events: 2024

Date	Event	Time	Venue	Event purpose
20 May 24	WHH International Clinical Trials Day	10am to 2pm	Atrium Warrington Hospital and George Lloyd Restaurant, Halton Hospital	Trust-led, annual event promoting the accomplishments of clinical research professionals in public health/medicine and their efforts in clinical trials.
8 June 24	Warrington Pride	TBC	Town centre, Warrington	Annual partnership event celebrating the LGBTQ+ community in the town.
29 June 24	Armed Forces Day	9am to 6pm	Crossfield's Rugby Club, Great Sankey, Warrington, WA5 1XU	Annual partnership event comprised of Armed Forces Rugby League games, military vehicle displays, stands and activities.
14 July 24	Disability Awareness Day	10am to 4pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual partnership family fun day, led by Warrington Disability Partnership, to promote services and celebrate pan-disability.
Sept 24	Warrington Mela	TBC	Queen's Garden, Palmyra Square, Warrington, WA1 1JN	Annual partnership event supporting cultural diversity and community inclusion within Warrington.
2 Oct 24	Annual Members' Meeting	3.30pm to 5pm	Post Grad Centre Warrington	Trust-led annual membership event, bringing together Foundation Trust Members, Governors, Directors and the Chair.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/02/171</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Bi-monthly Strategy Highlight Report</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">7 February 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Megan Wainwright, Strategy Project and Team Support Officer</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Lucy Gardner, Director of Strategy & Partnerships</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

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

(Please DELETE as appropriate)</td><td colspan="5">#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.</td></tr>
<tr><td rowspan="7">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">✓</td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td>✓</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td colspan="2">N/A</td></tr>
<tr><td></td><td>✓</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="5">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">The following Strategy Highlight Report provides a progress update on key strategic projects and initiatives that underpin a number of WHH's strategic (QPS) priorities.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td colspan="2">Approval</td><td>To note
✓</td><td colspan="2">Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="5">The Trust Board is asked to note the report for information.</td></tr>
</table>

PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

Strategy Update
November - December 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key Messages

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Phase 2 of the Trust's Community Diagnostic Centre (CDC) Programme went live on the 19th of December. It is delivering Phlebotomy, Ultrasound, Spirometry and Audiology services at the Halton Health Hub, Runcorn Shopping City. Once it is fully operational, the CDC will perform around 1,800 diagnostic tests per month. We welcomed the Minister for Health and Social Care, The Rt Hon Andrew Stephenson CBE MP, to the Halton Health Hub on the 11th of January.

- The strategy team will be visiting all departments over the next few weeks to disseminate information about the strategy. Contact details for link people within the team who will maintain engagement and be the point of contact for strategy queries will be given.

- We are also planning to meet with Clinical Business Unit teams in February to discuss strategic priorities for next year. Last year's priorities will be discussed as well as local, regional and national agendas to develop the strategic plan for 2024/25 and identify support needed to deliver it.

Stakeholder Engagement Overview

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Martin Wood	Senior Advisor (Town Deal Programme), Dept. for Levelling Up, Housing and Communities	Site Visit to Living Well Hub
Matthew Wall	Director, Morris & Spottiswood	Final contract discussions re: Living Well Hub build programme
Deb Monfared	Service Lead – Warrington & Halton, Macmillan Cancer Support	Development of Macmillan Strategy and closer links with acute Trust
Amanda Ridge	Associate Director – Transformation and Partnerships - Warrington, NHS Cheshire & Merseyside	Future resourcing of Warrington Together infrastructure and programme support. Place-based transformation, including same day emergency care
Ian Triplow	CDC Programme Director Cheshire & Merseyside	Community Diagnostic Centre – capital funding for programme
Lauren Sadler	Transformation and Change Lead – Warrington Together Partnership	Warrington Place programme development
Jamie Foster	Partner, Hill Dickinsons	Collaboration and Contribution Agreement for Living Well Hub
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme across Warrington and Community-Led Support programme board
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB	Development of Women's Health offer in Living Well Hub
Melanie McLaughlin	Head of Adult Services – Warrington, Bridgewater	Inclusion of targeted community services within Living Well Hub
Alison Cullen	CEO, Warrington Voluntary Action	Development of Living Well programme in Warrington and development of Warrington VCSE compact
Catherine McLennan	Programme Director - Women's Health and Maternity Programme Cheshire & Merseyside ICB	Development of Women's Health offer in Living Well Hub
Cathy Morgan	Director of Prevention and the Public Health System, Office for Health Improvement and Disparities, Department of Health and Social Care	DHSC virtual round table discussion re: prevention and the national major conditions strategy
Laurence Pullan	Head of Communications, Warrington Borough Council	Development of communications plan for Living Well Hub
Stephen Young	CEO, Halton Borough Council	Runcorn Town Deal

Stakeholder Engagement Overview

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Linda Buckley	MD CMAST Provider Collaborative, Cheshire & Merseyside	Provider Collaborative leadership
Wesley Rourke	Operational Director, Economy, Enterprise and Property	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Wayne Longshaw	Integration Director, Mersey and West Lancs (MWL)	Service collaboration opportunities
Steve Park	Growth Director, Warrington Borough Council	Local plan, new hospitals, Estates planning
Ifeoma Onyia	Director Public Health, Halton	Service provision, Widnes
Rick Howell	Strategic Lead Commissioning, WBC	Contribution and Collaboration agreement for Living Well Hub
Tracey Cole	Diagnostic Programme Director C&M	CDC, pathology collaboration
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M clinical strategy
Dani Jones and Alfie Bass	Director of Strategy and Medical Director, Alder Hey	Paediatric surgical hub
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy, Living Well Hub
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
David Cooper	Finance, Place, Warrington	Strategic estates planning, Warrington
Nick Armstrong	Estates, Cheshire and Merseyside ICB	Strategic estates planning, Warrington
John Smith and Mark Swift	Liverpool City Region CA CEO, Wellbeing Enterprises	Active travel hub in Halton Health Hub
David Mills	Deputy Medical Director, Bridgewater	Living Well Hub, Runcorn Health and Education hub
Leigh Thompson, Tim McPhee	Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan
Zoe Fearon	Director Children's services, Halton Borough Council	Runcorn Health and education Hub, One Halton delivery plan

Living Well Hub in Warrington

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Project overview

WHH is leading a major project to develop a system-wide Health and Wellbeing Hub in Warrington Town Centre. The project forms part of the Town Deal programme, which covers 7 different infrastructure projects across Warrington, funded as part of the Government's levelling up agenda. The Health & Wellbeing Hub (to be known as the Living Well hub) is designed to target and address health inequalities in Warrington by providing a range of services focussed on prevention and early intervention in a town centre location with proximity to the areas of the town with the highest levels of deprivation. The Hub will be a space where providers from across mental and physical health, social care and the third sector can come together to deliver integrated services, support and learn from one another for the collective benefit of the local population.

Progress since last report

- Practical completion of the build works is scheduled for 15th January 2024.
- Interior furnishings are scheduled for delivery and fitting in the week commencing 15th January 2024.
- Confirmation received from all four core partners (Warrington Borough Council, Bridgewater, Merseycare and WHH) around approval of Collaboration and Contribution Agreement to underpin the ongoing revenue costs of the project. Trust solicitors are now leading on the collation of the final signed copy of the agreement.
- The new General Manager for the Hub is set to commence in post on 8th January and the recruitment of two part-time Assistant Manager posts is now underway with interviews scheduled for 9th January 2024.
- Work to finalise the initial operating model for the Hub is almost complete. Planned services include those focussed on Families and Children, Pre-Frailty/Falls/Dementia, Women's Health, Care Leavers and Healthy Lifestyles. A broad range of partners from community health, primary care, secondary care, mental health and voluntary sector organisations have now committed to delivery of services in the Hub.

Latest Images/Links/ Further information

What is the new Living Well Hub that is coming to Warrington? | Warrington Guardian

What does this mean for WHH?

Delivery of WHH services, including midwifery, cardiac rehab and physio from a convenient and accessible town centre location. Working alongside key partners including Bridgewater, Mersey Care, Warrington Borough Council and the Voluntary, Charity and Social Enterprise organisations to support the prevention agenda.

Quality	People	Sustainability
Patient Safety	**Looking after our people** ✓	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Upcoming Key Milestones

Milestone	Date
Completion and signing of Collaboration and Contribution agreement between 4 core partners	Jan 24
CQC registration of facility	Jan/Feb 24
Build work completed	Jan 24
Opening of Hub to public	Feb 24

Contact details

Caroline Lane - Strategic Project Manager
caroline.lane10@nhs.net

Runcorn Town Deal

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

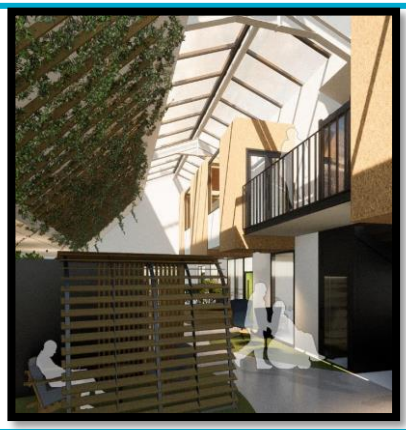
Project overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long term conditions from a central location in Runcorn.
The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

Progress since last report

- RIBA stage 4 designs produced by project architects, Cassidy & Ashton. This has been shared with all partners for consultation on room layouts etc. to ensure that the spaces work for their intended purposes and comply with Health and Safety, Clinical Requirements and operational effectiveness.
- Preferred governance arrangements for delivery of capital element of programme agreed by Strategic Oversight Group
- Planning Application submitted
- Principles around risk and gain share discussed at Strategic Oversight Group

Latest Images/Links/ Further information




Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

What does this mean for WHH?

Delivery of WHH services, including maternity, respiratory and phlebotomy, from a convenient and accessible town centre location.
Opportunity to work with local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies.
Opportunities to further integrate services with other providers across health, care and wellbeing.

Quality	People	Sustainability
Patient Safety	**Looking after our people** ✓	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Upcoming Key Milestones

Milestone	Date
RIBA Stage 4 designs approved	Apr 24
Procurement process for lead contractor commencement	Jun 24
Lead contractor procured	Oct 24
Opening	Autumn 25

Community Diagnostic Centre

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

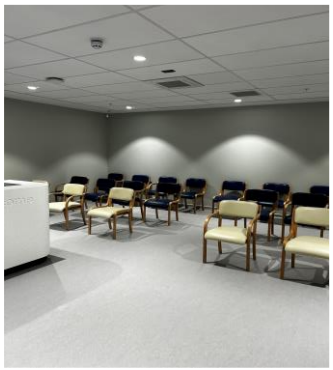
Project overview

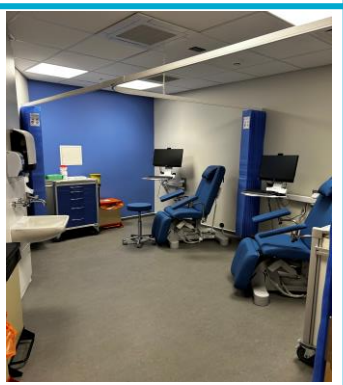
As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.
The final approved CDC Programme covers three phases:
Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton.
Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City.
Phase 3 will see the development of a small new build extension to the CSTM building on the Halton site to accommodate CT and MRI services.

Progress since last report

- The **Phase 2** works at Halton Health Hub, Runcorn Shopping City completed in early December 2023. The first patients to receive a diagnostic test at the new facility were seen on 18th December.
- Minor final works remain outstanding on phase 2 including the installation of new glass doors on the front of the unit. All final works should be completed by the end of February 2024.
- Final stages of the design process for **Phase 3** (New Build CDC) are now complete and we await formal planning permission for the development and a final contract price for the works.
- Over 15,000 additional diagnostic tests have been undertaken in the CDC development within the Nightingale building (phase 1) since it's completion in May 2023.

Latest Images/Links/ Further information





What does this mean for WHH?

Additional capacity to undertake diagnostics for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.
New estate at Halton General Hospital, which supports new hospitals plans and estates strategy.

Quality	People	Sustainability
Patient Safety	Looking after our people	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	Working responsibly
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Planning Permission for New Build Received	Jan 24
Final contract for New Build phase agreed	Mar 24
Services within new build CDC to commence	Mar 25

Contact details

Lefteris Zabatis - Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New Hospitals and strategic estates planning

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Project overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital for Warrington, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending CSTM to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

Progress since last report

- A refresh is underway of the Trust's Estates Strategy, which will incorporate a refreshed new hospitals plan. This includes an outline of expected key milestones across the next 5 year period.
- New hospitals strategic oversight group meeting to discuss revised plans and strategy with relevant stakeholders, including with Place Directors, and representatives from Warrington Borough Council and Halton Borough Council to support development of revised new hospitals plans and confirm strategic estates priorities.

Latest Images/Links/ Further information

Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

What does this mean for WHH?

Delivery of Trust services from modern, accessible and safe environments.
Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations.

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people** ✓	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Estates Strategy to be finalised and approved.	Feb 24
High level business cases to be developed for agreed strategic estates priorities.	Feb 24

Other Trust strategic updates

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Digital Projects

Warrington Together
A business case has been drafted setting out the proposal that Warrington goes first as part of regional ICS plans for shared care records, consolidating existing records already in use and onboarding other places, utilising the Graphnet solution.

Patient Engagement Portal (PEP)
Procurement is finished and a preferred supplier has been identified. Readiness assessment sessions will be taking place with senior colleagues in preparation. The PEP will launch in March 2024.

Business Planning

A round of collaborative business planning meetings with Clinical Business Units will begin shortly and complete by the end of March 2023. The aim of the meetings will be to discuss activity, finance, quality, and clinical priorities.

The Strategy Team will present previous clinical priorities, highlight relevant Trust and National guidance, and discuss clinical priorities for next year. The meetings will also provide an opportunity to consider plans to reduce health inequalities and future needs. Information will be circulated in advance of the meetings to enable focused discussion and development of business plans for 2024/25.

Place based strategic updates

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington

- The Trust has received feedback on the bids submitted to Warrington's Transformation Fund. The bid to support the development of a Living Well virtual hub has been viewed favourably. The panel have requested that funding is secured to cover the recurring revenue costs of the system before any funding to cover the initial development and implementation can be formally agreed.
- Facilitated workshop held with all members of Warrington Together Partnership Board (WTPB) to discuss future relationship and interaction between WTPB and the Warrington Health and Wellbeing Board in terms of responsibility and accountabililty for delivery against agreed place-based strategic priorities.
- Further work has been completed on the refreshed "Warrington Compact". The compact is a document compiled by all core partners at place, which sets out the commitment to working closely and supporting the voluntary, charity, faith and social enterprise (VCFSE) sector.

Halton

- The five priority workstreams that make up One Halton have been developing their individual delivery plans for 2024/25. These workstreams are:
  - Starting Well
  - Living Well
  - Ageing Well
  - Wider Determinants
  - Integrated neighbourhood teams
- There is a workshop for all partners in January 2024 where these delivery plans, and the logic models supporting them, will be scrutinised by senior leaders from organisations across the borough with the aim of producing an overall One Halton work plan for 2024-25.

Cheshire and Merseyside strategic updates

Warrington and Halton Teaching Hospitals NHS Foundation Trust

C&M pathology

- The full business case for the Laboratory Information Management System (LIMS) has been received for comment. The recommendation on the preferred supplier is expected by end of Feb 2024.
- A timeline has been set out for the collaboration of pathology services across Cheshire and Merseyside, with phased implementation planned to commence in Dec 2025. Work on core principles of the collaboration are underway with a refreshed Outline Business Case due in Sep 2024.

C&M endoscopy

- Construction works continuing for the daycase unit and theatre 5 at CSTM. Working closely with estates and contractors around mechanical, electrical and plumbing (MEP)
- Construction works have commenced in Nightingale Building for the additional Endoscopy rooms and decontamination unit
- Operational teams working through plans around the delivery of activity whilst construction works are taking place
- Initial drawings submitted for ward B2 refurbishment

Development of Women's Health Hubs

- A small amount of funding is available regionally to help C&M make progress towards the development of Women's Health Hubs. This forms part of the national strategic vision for women's health services aligned to the recent national strategy. The offer for Warrington will be developed on a Monday afternoon each week as part of the Living Well Hub in the town centre and discussions are ongoing around the potential to access some of the regional funding to support.

Cheshire and Merseyside strategic updates

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Health Inequalities

Significant work has been undertaken within Warrington and Halton Teaching Hospitals NHS Foundation Trust to tackle inequalities in health outcomes, patient experience, and access. This includes development of the Living Well Hub in Warrington town centre, the Runcorn Health and Education Hub Halton and the Halton Health Hub in Shopping City, Runcorn. Many other programmes of work continue to address this issue and have previously been reported to the Trust Board.

In recognition of increased health inequity following the Covid 19 pandemic, NHS England's planning guidance for 2023/24 sets out five priority areas to address the challenge:

1. Restoring NHS services inclusively
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes
5. Strengthening leadership and accountability

A process is being developed in collaboration with the strategy team and Workforce EDI to ensure robust and transparent reporting against these priorities which will provide assurance to the relevant Trust Committees and Board.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/172**			
SUBJECT:	**Strategy Bi-annual Delivery Report**			
DATE OF MEETING:	Wednesday 7th February 2024			
AUTHOR(S):	Carl Mackie, Halton Healthy New Town and Strategy Manager			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation, and financial position.			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In May 2023 Trust Board ratified governance and reporting arrangements for the updated Trust Strategy 2023-25. It was agreed that reporting against the delivery of the Strategy would be standardised, including a bi-annual update of progress against the priorities within each of the strategic aims (Q, P, S) to the appropriate Board committee.			

	There are a total of 62 strategic priorities within the refreshed 2023-25 Trust Strategy. These are broken down and monitored as below: There are 23 strategic priorities against the 4 objectives within the Quality aim of the Trust strategy. These are reported twice yearly through Quality Assurance Committee. H1 KPIs were reported on 12th December 2023. There are 24 strategic priorities against the 4 objectives within the People aim of the Trust strategy. These are reported twice yearly through Strategic People Committee. H1 KPIs were reported to SPC on 20th September 2023. There are 15 strategic priorities against the 4 objectives within the Sustainability aim of the Trust strategy. These are reported twice yearly through Finance and Sustainability Committee. H1 KPIs were reported to FSC on 29th November 2023. As of this report, the Trust is on target to meet 37 priorities, 21 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 3 are behind expectations with limited or no mitigations. 1 priority is not yet rated.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims..		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee Strategic People Committee Finance and Sustainability Committee	
	Agenda Ref.		
	Date of meeting	Various	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests		

REPORT TO TRUST BOARD

SUBJECT	Strategy Bi-annual Delivery Report	AGENDA REF:	BM/24/02/172

1. BACKGROUND/CONTEXT

In March 2023, Trust Board approved a refresh of the Trust Strategy, which included a set of 12 strategic objectives underpinned by high level priorities. A summary of the refreshed Strategy is below.

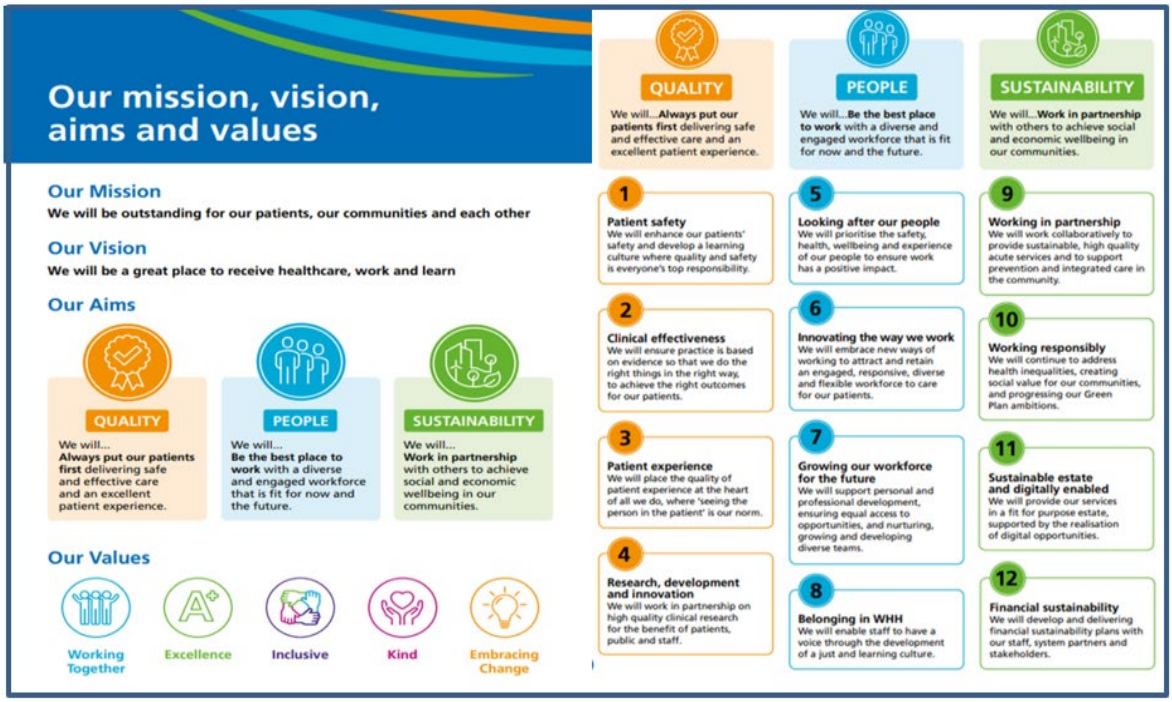


Figure 1: Summary of Trust Strategy 2023-25

In May 2023, Trust Board ratified the governance and reporting arrangements for the updated Trust strategy. This included the alignment of reporting across all aims of the strategy, and the approval of KPIs and / or Measures of Success aligned to each strategic priority.

As part of the alignment of reporting it was agreed that progress on the delivery of the strategy would be reported twice yearly, with the measures of success/KPIs relating specifically to Quality aims being monitored via Quality Assurance Committee, People aims being monitored via Strategic People Committee, and Sustainability aims being monitored via Finance and Sustainability Committee.

The refreshed Objectives, related Measures of Success / KPIs and associated baselines are described within the relevant appendix for each aim.

2. KEY ELEMENTS

The updated position for H1 2023/24 can be found in the table below. There have been some minor updates to some measures of success.

The H1 KPIs against the Strategic Priorities for the Quality aims were reported on 12th December 2023.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
1. Patient Safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	1.1 We will reduce avoidable harm and patient deterioration with a focus on Covid-19 elective recovery.	Delivery of 104% of pre-pandemic activity by the end of 2022/23.	85.07%	96.90%	104%		**Metric Change: Target updated to reflect activity requirement.** Inpatient activity remains challenged although October showed the highest figures since March 2023 Radiological specialties and Endoscopy are in line with recovery trajectories. Challenges remain in Cardiorespiratory services. The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative services such as patient initiated follow. Activity is impacted by Industrial Action.
		Potential Harm review panel will continue to undertake reviews where harm is suspected following a delay to treatment – feeding into wider governance processes					
	1.2 We will implement actions to deliver new standards required as a result of national reviews in Maternity care/provision, ensuring learning is acted upon.	Progress against action plans - Ockenden 1b:	94.91%	96.58%	100% compliant by 31 March 2024		**Metric Change: Target date of compliance updated as per agreement at QAC** WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 30th September 2023 is: • Ockenden Part 1a: WHH is 100% compliant.
		- Ockenden 2:	68.53%	78.08%	100% compliant by 31 March 2024		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
		Change in practice as a result of learning being acted upon, evidenced through monthly tracking of improvements and impact of actions with triumvirate.					• Ockenden 1b: WHH is 96.58% compliant and is on trajectory to be 100% compliant by 31st March 2024. • Ockenden 2: WHH is 78.08% compliant. Ockenden 2 does not have any national timelines. Following a review of all actions, WHH has set internal timelines to complete all actions by 31st March 2024.
	1.3 We will enhance timely patient recovery through therapy led initiatives, including work around deconditioning and rehabilitation.	Reduction in the number of patients who develop pressure ulcers.	10		0		In line with the SSKIN model of pressure ulcer prevention, from November 2023, on wards A9, A6 and B14 a therapy led initiative commenced to identify 5 patients on each ward who would benefit from engaging in regular activities in order prevent de-conditioning whilst on the ward. The activity therapy plan for each patient will be included in e-outcomes. On a monthly basis, the reporting of pressure ulcers will be monitored to measure its success. Other Therapy Led initiatives planned in remaining financial year: • From December 2023 at Prevention of De-conditioning Occupational Therapist will be in post within the acute medical therapies team. • The SSKIN model of pressure ulcer prevention to be included in therapy training. • Patient exercise sheets in development.
		Patients participating in active movement and cognitive stimulation on the wards.					
		Annual reduction in the number of inpatient falls & harm levels. Based on 590 falls in 2021/22	46	204	20% annual reduction (472)		
	1.4 We will improve recognition and response to	Clinical deterioration is recognised and escalated in accordance with NEWS2 parameters, evidenced by	56%	As of Q2, 60% compliance with CQUIN	CQUIN compliance target:		NEWS2: Compliance with CQUIN baseline above upper threshold. Improvement noted in screening in

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
	deteriorating patients.	recording of and response to NEWS2 score for unplanned critical care admissions (CQUIN)			Min 10% Max 30%		inpatient areas. The contributory factor to not achieving compliance in both inpatient and Emergency Department is the completion of blood cultures within the timeframe. Quality Improvement support is in place to drive improvements across the Trust. There are four workstreams with a focus for improvement: ED, In-patient, Paediatrics and Maternity. Sepsis management remains a focus on Safety Huddles. Blood gas analysis and training for obtaining blood cultures within the Emergency Department and in patients is under review within the CBU's to ensure to ensure timely completion. Short sepsis teaching sessions are underway on the wards facilitated by the Patient Safety Nurses. No harm is recorded for patients following review of health care records.
		20% improvement in response to patients who trigger a clinical review on NEWS2.	63%	63.0%	75.6% correct escalation for NEWS 5-6		
		Time to medical review and coordination of treatment	19%		33% of patients seen within 60 minutes		
		Sepsis - % screening for all emergency within 1 hour	72%	52%	90%		
		Sepsis - % screening for all inpatients within 1 hour	80%	52%	90%		
		Sepsis - % patients within an emergency setting receive antibiotics administered within 1hour of diagnosis	84%	72%	90%		
		Sepsis - % patients within an inpatient setting receive antibiotics administered within 1hour of diagnosis	88%	88%	90%		
	1.5 We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)	Reduction in the number of patients who develop pressure ulcers.	15	10	0		Contributory factors to the development of category 2 pressure ulcers including delay to transfer time to pressure relieving mattress, inconsistent repositioning in ED and medical devices (TED stockings and oxygen tubing). Actions to improve the position include: 1. After Action Reviews have commenced and lessons are shared with ward teams and via Operational Patient Safety Group. 2. Improvement plans in place for both

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
							Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses. 3. Following the pilot of Repose wedges to aid pressure relief on two wards, the wedges are now available to order by all wards. 4. A mattress audit with the provider company is due to take place in September 2023 to ensure that mattress remain fit for purpose. 5. The Tissue Viability Nursing (TVN) Team continue to have an increased presence in the Emergency Department. 6. The QI Team are supporting Matrons to monitor the sustainability of the change package. 7. Tissue viability training for preceptorship nurses and international nurses. 8. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
	1.6 We will continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.	Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance. Evidenced through richer learning via new investigation methods including cluster reviews.					**Key Findings:** • Bi-weekly PSIRF steering groups continue to be undertaken across the Trust with key members in attendance. • ESR training is live and being monitored weekly. At the time of reporting training compliance detailed below. • Trajectories are in place to continue to optimise training ahead of the PSIRF go live date – 1st September 2023. • PSIRF local priority meetings with all CBU's have been completed, these have supported the analysis and review of data alongside use of local intelligence. • Local priorities have been discussed and agreed. These being: - Missed or delayed diagnosis of a cancer. - Delay in the identification, recognition, and response to patient deterioration, resulting in delayed escalation and treatment. - Delay in risk assessment and or management of a patient with underlying mental health concerns, resulting in delayed treatment. **Improvement outcomes** • Monitoring trends and themes in Safety Summit meetings weekly with Care Group Leads and the Associate Director of Governance. **Key Learnings** • PSIRF is going live on 1st September 2023. Continuation of work supporting CBUs. • Weekly meetings with the Executive Teams with updates for care group leads to support implementation and feedback.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
							• The policy and plan have been approved by the Executive Team and ICB. • Clinical Quality Focus Group updated. **Have all measures / monitoring been achieved.** • Investigations are discussed at the weekly patient safety summit meetings and at the Executive Led Safety Oversight Group. • New methodologies are in use as part of implementation phase. • HSIB training access has been provided to relevant parties and will be complete by October 2023. • Feedback from patients and families has been positive since utilising the new methodologies and Patient Safety Partners have been recruited.
2. Clinical effectiveness: We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.	2.1 We will continue to utilise and evidence best clinical practice through the evidencing of compliance with guidance, such as the National Institute for Clinical Effectiveness.	NICE compliance	91.65%	92.67%	90%		• The Trust's performance as of September 2023 in relation to NICE compliance is 92.67%, which is over the 90% target for compliance. • There are currently 582 pieces of NICE Guidance applicable to the Trust on the NICE database. • Of those, 39 are partially compliant which has decreased by 1. The Clinical Effectiveness Manager has sent reminders for all partial compliance action plans. • There are currently 2 NICE guidelines under review and awaiting confirmation of compliance from the leads of which 1 is overdue. • 1 guideline is overdue, a task and finish group has been created to ensure completion of the assessment.

	2.2 We will continue to embed a positive risk management culture from ward to board.	Flexibility in risk appetite is recognised, this will be informed by the management of risk registers at service level, corporately and through the Board Assurance Framework.					The Risk Management Strategy provides a framework for managing risk across the Trust. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust. Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the Corporate Risk Register and Strategic Risk Register where required. The Trust employs a number of systems to ensure that risk management is embedded within the organisation including business planning, performance management frameworks and clinical information systems. Regular reports are also available to the various committees responsible for aspects of risk management. There are corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements. Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for

							opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board. Risk appetites are determined by the Trust Board. The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Committee. Partners and Governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors and includes: the identification of the key risks to the achievement of the Trust strategic objectives and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation. The Board Assurance Framework is reviewed by the Board of Directors at each of their meetings and the Audit Committee, and bi-monthly by the Board Committees, which provides additional challenge and scrutiny of the risks identified.
	2.3 We will recover core services and improve productivity	% of plans on track to deliver annual operational improvement trajectories	0	44%	100%		Recovery in line or ahead of plan within radiological specialties and endoscopy.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
	in line with targets set in the NHS Long-term plan.						Recovery behind plan within daycase and elective inpatient procedures; outpatient activity; and flexi sigmoidoscopy and gastroscopy
	2.4 We will improve a culture of quality, safety and learning through the consistent application of LOCSIPs, achieving >90% compliance in documentation and observational audits.	Implementation and audit of LOCSIP safety standards, with focus on non theatre areas. 90% compliance to be achieved in the following areas for 23/24 • Endoscopy • Cardiac Catheter Lab • Ophthalmology • Paediatric • Gynaecology • Neonatal • Breast Screening • Interventional radiology • ITU • B18	N/A - areas currently measured as high, medium or low instead of a percentage baseline.		90%		LOCSIPS Data suggests good compliance however procedural never events draw this into question Deputy AMD Clinical Effectiveness for Procedural Safety Appointed Externally facilitated theatres procedural safety review 8/12/23
		Audit of WHO checklist effectiveness with evidence of effective operative and a focus upon theatre culture.					
		Systemisation of safety improvement, evidenced through robust system controls and incident response processes.					
	2.5 We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.	Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95%.	74.40%	79.60%	95%		GIRFT projects continue and are reported through FSC GIRFT reporting structure under review with Director of Recovery Trust signed up to Cohort 2 of GIRFT Further, Faster Program
		Improved access to Elective Care through reduced waiting times - eliminating 65+ week waits by March 2024	376	1,324	0		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
		Improved access to Elective Care through improved theatre productivity to 85%.	90%	91%	85%		
		Improve ED waiting times so that no less than 76% of patients are seen within 4 hours	69.80%	68.97%	76%		
	2.6 We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).	Increase QI capability and capacity to 10% (400) for QI Foundation and 2.5% (100) for QI Practitioner programmes.	Foundation 6.3% (252) Practitioner 0.6% (23)		10%		We continue to work with the Head of Compliance to develop a robust methodology for self-assessment against the CQC criteria demonstrating a mature QI approach, linked to the broader mock inspection programme, and Moving to Outstanding (M20) work. The QI questionnaire used by CQC was added to the inspection checklist pack for the ED mock inspection in June as an initial scope of baseline reviews to assess QI maturity within the organisation. Initial findings would suggest there is a broad understanding about Quality Improvement work. Operational front-line staff, as well as senior leaders, know about QI work and there was evidence of Quality Improvement projects taking place, with good support from the central team. Everyone asked was aware of the Quality Strategy and where it could be found. The senior team gave good examples of QI work and how they support projects. More detailed questions focussing on quality improvement were incorporated into the Triumvirate interview questions. The team were able to answer key questions with knowledge and confidence, as well as by outlining examples of improvement work. This is a work in progress, as embedding a QI approach
		Achieve 80% Quality Improvement assessment score in line with CQC requirements.	In development		80%		
		Evidence learning and improvement through Quality Improvement Projects and assurance of actions					

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
							and changing culture takes time. However, it is clear that staff can see the value in this approach and how the methodology can support positive change, with evidence-based decisions having been tested and implemented. Although it has not been possible to fully complete a representative baseline assessment across the organisation to date, QI questions will continue to feature in all future mock inspections. There is also a scoping exercise being undertaken presently, to critically explore the specific elements of evidence required, and focus on how we strengthen key aspects, as well as considering what success looks like in terms of a measure. Additionally, the NHS Impact Self-Assessment requested from all acute trusts by 31 October 2023, will provide additional information to identify our strengths and opportunities for further development of our organisation-wide approach to improvement.
3. Patient experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	3.1 We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care.	A reduction in both PALS and complaints in relation to communication as a key theme.	9.4% (Complaints with a primary theme of communication)	7.69%	> 9.4%		
			22.75% (PALS with a primary theme of communication)	22.58%	> 22.75		
	3.2 We will ensure an inclusive	Evidenced through improved use of interpreters for both					The graph demonstrates a 9% increase in Language Line usage between September

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
	communications method for each patient, taking into account their personal circumstances, using clear and easy to understand language.	people of whom English is not their first language and British sign language users					2022 and August 2023 where a full calendar months data can be analysed. The Trust have commissioned monthly deaf awareness training sessions to run until March 2024 clinical and non-clinical staff across the Trust. The aim of this programme is to: ▪ Understand the importance of the role of the BSL interpreter ▪ Learn about different types of deafness and appropriate language to use ▪ Dispel myths around hearing loss ▪ Learn basic sign language.
	3.3 We will create first and lasting impressions which contribute towards a positive experience of care.	Monitored by: - Ward accreditation - Leadership observations - Patient experience walk round - Governors walk rounds. - Feedback received at Patient experience sub committee					Ward accreditation programme, Leadership observations, Patient experience walk rounds, and Governors walk rounds all in place and reporting via Patient Experience Committee. FFT response from August (latest data available): Inpatients: 98% positive recommendation Outpatients: 95% positive recommendation ED: 79% positive recommendation
	3.4 We will improve patient experience for those with mental health attendance.	Training package to be developed specific to the care of mental health patients in an acute trust with evidence of evaluation.					Training on mental health has been delivered to senior managers and the senior nursing teams. Feedback is being reviewed and will be used to inform the development of future training, which will be rolled out across other staff groups. Additionally, a training needs analysis is being conducted to ensure staff receive the training they feel will be most valuable in supporting the delivery of safe and effective care for patients with mental health presentations.
		All staff in the Emergency Department to be compliant with the training package and trajectories in place for compliance across all wards.	0		100%		
		Ensure consistency in the assessment of patients with	KPIs of Core 24		100% where		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
		mental health needs, evidenced through the 1-hour time to review standard where clinically appropriate.	service being reviewed.		clinically appropriate		Training needs analysis currently underway. This is being delivered via a number of methods to gain an understanding of what training is required across all staff groups. The training package is currently being developed. Joint working with Mersey Care NHS Foundation Trust is ongoing looking at the patient pathway for those that present to the Emergency Department with mental health concerns. Referral rates are monitored at mental health steering group and performance data has been requested from the Mersey care management team.
	3.5 We will reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.	Patients with a learning disability are referred and reviewed by the Specialist Nurse/team to ensure that communication needs are met >90%.	In development via audit	See narrative	90% of patients reviewed		All patients with learning disabilities are reviewed by senior nursing team. Lorenzo alert in place and training completed, with ongoing support and training guide available. Daily review of Alert system to be undertaken to assess improvement in utilisation. Clinical Audit commissioned to review and assess usage of interpretation services and numbers on alert system.
		Embed an alert system for patients, where English is not the first language including British Sign Language.					
		Audit of patients requiring interpretation services as identified through the alert system and actions taken	In development via audit	See narrative	90%		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
	3.6 We will improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours.	Evidence of Improved patient/ family experience through patient feedback.					**Key Findings:** The access line intent will now be considered as 'Call 4 Concern' in accordance with the national programme. This will provide: • Supplementary support in the provision of a telephone line where service users, relatives and their carers can contact a senior member of staff, if they require an immediate service managed resolution. • Support if there is a noticeable change in the clinical condition and concerns are ongoing after having spoken to the ward nursing and/or clinical team. • This is not intended to replace local departmental /ward resolution, however, enable the provision of immediate supplementary support. • Contact will be made by a dedicated smart phone telephone, which is on order. The mobile phone will have a text facility, voicemail, and WhatsApp to support patients who may have greater accessibility needs to access for example but not limited to patients who are deaf. • Stakeholders have been identified and a stakeholder analysis undertaken.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
		Feedback from staff to support focused learning and improvement.					• Initial meetings have taken place with key individual stakeholders and Care Group Leads to discuss thoughts on initial concepts. • Meetings have been undertaken with external organisations to understand the Call 4 Concern model rather than an access line in accordance with national pilot. • The role of who will hold the access line phone and be the point of contact has been discussed as part of further initial stakeholder engagements (this being the Clinical Site Managers and Acute Care Team). • A communication plan is being finalised and includes planned engagement events. Initial measures have been defined to understand improvements, these include: • Obtaining two-week data capture to understand baseline -reviewing existing concerns that have been received out of hours [currently being collated by PALS] • Obtaining two-week data capture to understand baseline demand by reviewing the night report/log and out of hour requests to the Acute Care Team • Pilot areas to be identified. • Monitoring the number of out of hour queries received for any reduction (quarterly) • Auditing what concerns are raised out of hours via patient access line, what was the action taken, were they standardised and was the issue resolved. • Qualitative feedback, further engagement events with staff and communities.
		Results from evaluation to support Trust wide implementation.					

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
							• Survey monkey to be shared with patients (when access line is used) to seek feedback on if the out of hours access line was helpful and asking for consideration of how we could improve. **Improvement outcomes:** • Improved accessibility for patient to access senior staff out of hours and resolve any concerns. • Improved patient experience and satisfaction • Reduced number of complaints /PALS/ incidents linked to clinical deterioration. **Improvement Action Plan:** • Project initiation document will be developed by the end of August with the details of pilot areas identification, staff survey design and timescales of project implementation.
4. Research, Development and innovation: We will work in partnership on high quality clinical research for the benefit of patients, public and staff.	4.1 We will continue to create opportunities for members of the public to gain access to clinical research trials contributing to the health of our population.	Increase Pathway to Research participants	8	205	250		Community and engagement events contributed to increase in registrations. On target to reach 250
		Increased awareness of research across the Trust, evidenced through annual research survey					
		Continue to operate as part of a wider research Board, embracing commercial, non-commercial and academic opportunities.					
	4.2 We will further develop and grow our research capability through the application and	Commercial studies will achieve minimum income target (approx. £600k) to sustain Halton Clinical Research Unit infrastructure with additional funding to	£0k	£539,532 available carry forward into 2024.25	£600k		On target with studies in pipeline

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Sep-23)	Target	RAG	Comments
	selection for clinical trials.	invest in capacity and capability building initiatives.					
		Working in partnership with providers and across sectors.					
	4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.	Annual increase in 20% of Principal Investigators.	27	30	20% (+4 Principal Investigators)		3 new PIs (2 AHPs) on target for 20%increase with new studies in pipeline
	4.4 We will grow the academic research portfolio supporting staff recruitment and retention.	Formal arrangement established with Higher Education Institutes e.g. Chester Medical School, Edge Hill Faculty of Health					Establishing relationships with Chester University – regular meetings with Dr Claire Lucas (Medical School) in place
		Submission of relevant research grant applications.					
		Growth in workforce involvement in academic research.					
	4.5 We will seek to expand our research offer seeking opportunities for further collaboration through the Halton Clinical Research Unit.	Established formal agreements with Clinical Research Organisations and commercial sponsors to identify relevant studies secure preferred site arrangements.					Established presence on Shared investigator platform COGNIZANT connecting WHH to Commercial sponsor organisations Signed master confidentiality agreement with PPD - a Leading Global Contract Research Organization Focused on Delivering Life-changing Therapies. Enables WHH to access confidential study protocol
		Increase opportunity for further expansion in collaboration with other research partners.					
		Increased number of Participant Identification Centre agreements signed between Primary Care and Halton Clinical Research Unit	1		3		

Table 1: The H1 KPIs against the Strategic Priorities for the Quality aims 2023/24

The H1 KPIs against the Strategic Priorities for the People aims were reported on 12th December 2023.

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.	5.1 We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.	Reduction in sickness absence	5.60%	5.42%	4.2% supporting attendance		Development of WHH Leaders to Support Staff's Health and Wellbeing - 38% implemented
	5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.	Improved Retention	83.36%	88.85%	86% retention		Embed the NHS Health and Wellbeing Cultural Framework - 40% implemented
	5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.	Reduction in bank and agency reliance	17.00%	16.57%	9% reliance		Develop Bespoke Health Promotion Programmes to Address Population Health Inequalities - 43% Implemented
	5.4 We will equip line managers to use person centred engagement practices which improve employee experience.	Reduced turnover	15.98%	12.91%	13%		Empower Managers to Enhance Employee Experience - 0% Implemented
	5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.	Reduction in vacancy rate	11.53%	9.61%	9%		Promote Employee Recognition and Appreciation Schemes - 22% Implemented
	5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff.						Onboarding - Create a Great First Impression - 29% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
6. Innovating the way we work: We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.	6.1 We will develop strategic workforce plans which are reflective of current and future needs.	Reduction in Vacancy Rate	11.53%	9.61%	9%		Development of Workforce Plans - 43% Implemented
	6.2 We will participate in system wide workforce planning.	Reduced Staff Turnover	15.98%	12.91%	13%		System wide approach to Education that enables Fair and Equitable access - 0% Implemented
	6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.	Improved Retention	83.36%	88.85%	86% retention		Embed Agile Working Principles - 50% Implemented
	6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.	Reduction in bank/agency reliance	17%	16.57%	9% reliance		Equip the Workforce to review Models of Care - 0%
	6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.						Enhance the Digital Capability - 40% Implemented
	6.6 We will enhance digital capability, skills and leadership which embrace digitally enabled services.						Improve Attraction and Retention - 43% Implemented
7. Growing our workforce for the future: We will support personal	7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.	Improved mandatory training compliance	86.11%	89.94%	85% compliance for mandatory		WHH Leadership Development Programme - 40%

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.	7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans.	Improved role-specific training compliance	84.21%	87.71%	85% compliance for role specific training		Widen Participation in Development Programmes - 40% Implemented
	7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.	Reduction in Vacancy Rate	11.53%	9.61%	9%		Review Mandatory and Role Specific Training - 50% Implemented
	7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.	Reduced Staff Turnover	15.98%	12.91%	13%		Scope for Growth Appraisal Implementation - 33% Implemented
	7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.	Improved Retention	83.36%	88.85%	86%		WHH Career Development - 50% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
	7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system.	Reduction in bank/agency reliance	17.00%	16.57%	9%		Team Development - 25% Implemented
		Improved appraisal compliance	64.24%	77.85%	79%		
8. Belonging in WHH: We will enable staff to have a voice through the development of a just and learning culture.	8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.	Reduction in Vacancy Rate	11.53%	9.61%	9%		Staff Able to Speak Up and Feel Heard - 67% Implemented
	8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.	Reduced Staff Turnover	15.98%	12.91%	13%		Create a culture of Psychological Safety - 0% Implemented
	8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.	Improved Retention	83.36%	88.85%	86%		Compassionate Leadership - 40% Implemented
	8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.	Reduction in bank/agency reliance	17.00%	16.57%	9%		Access to Co-Created Resources to Assist in the Delivery of Compassionate and Inclusive People - 60% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
	8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.	Reduction in sickness absence	5.60%	5.42%	4.20%		Adopt Principles of a Restorative and Just Culture - 0% Implemented
	8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.						Behavioural Framework Embedded for Each Trust Value which Promotes Civility, Kindness and Respect for all Staff - 0% Implemented

Table 2: The H1 KPIs against the Strategic Priorities for the People aims 2023/24

The H1 KPIs against the Strategic Priorities for the Sustainability aims were reported on 29th November 2023.

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.	RTT – Number of patients patient waiting 65+ weeks will be 0 by March 2024	478	1090	0		RTT performance has worsened as a result of industrial action. Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre. • Restoration and recovery plans for 2023/24 have been drawn up in line with Operational Planning Guidance.
	Volume and Impact of collaborative projects being delivered with partners to reduce care backlogs to reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.					
9.2 We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector to support the provision of integrated care in the community and prevention of ill health. It is proposed that this includes relocation of	Increased number of clinical appointments in off-site locations	**27,078** (Total number of **face-to-face** appointments, including DNAs & cancellations **2022/23**)	15,469	5% increase (28,431)		**Updated metric** Currently on track for c. 15% increase in activity. All projects named currently on track for delivery as per timescales.
	Deliver Living Well Hub in 2023/24.					
	Deliver Runcorn Town Hub by end of 2025/26.					
	Deliver phase 1 and 2 of new Community Diagnostic Centre in 2023/24.					

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
appropriate secondary care into the community, following the principle of right service, delivered in the right place to deliver excellent patient care and experience and to improve access and address health inequalities.	Deliver phase 3 of new Community Diagnostic Centre in 2024/25.					
	Deliver breast screening reconfiguration at Bath Street by 2023/24.					
	Actively contribute to delivery of projects at place and regional level which seek to improve access and address health inequalities					
9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts. This would be approached on a service-by-service basis to ensure the best outcomes for patients and our regional healthcare system.	Proactively review repatriation opportunities at service level.					Active discussions with Alder Hey to identify repatriation opportunities and potentially develop a paediatric surgical hub. The Trust continues to play an active role in clinical pathway redesign through CMAST.
10.1 We will work in coordination with our system and place partners to prioritise the five strategic	Support both Warrington and Halton to develop place maturity.					The Trust jointly leads work across Halton identifying interventions to reduce health inequalities as part of the Wider Determinants workstream within One Halton.
	Deliver our Core20PLUS5 objectives.					

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.	Deliver community spirometry services on behalf of Warrington and Halton.					Delivery of community spirometry has begun as part of the CDC programme at Halton, and in community locations across Warrington.
10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.	Heat decarbonisation plan in place by end of 2023/24 for Halton and Warrington sites.					Requirements for production of Heat Decarbonisation Plan identified but funding for external expertise not yet secured. Projects are underway to reduce carbon footprints in specific procedures / departments. This currently includes laparoscopic cholecystectomy and the usage of dressing packs in ITU.
	Annual reduction in CO2 emissions	14,200tCO2e	Measured annually	5-10% reduction by 2025		
	Number of procedures/care pathways with carbon footprints calculated.	0	2 (in progress)	5		
10.3 We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.	Maintain the number of local people employed by the Trust	**67.3%** (staff with a Warrington or Halton postcode)	65.4%	77.05%		**Updated metric – metric amended to maintain rather than increase the number of local people employed by the Trust.** **Updated metric – metric amended to provide increased footfall as a whole number rather than percentage improvement.** Both CDC and Warrington Living Well Hub projects have created a number of
	Prioritise spend with local suppliers in Cheshire and Merseyside					
	Jobs created as a result of projects.					
	Increased Town centre footfall as a result of enhancing service	0	+3,000 (Halton Health Hub)	+5,000		

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	provision within community locations.			(Halton Health Hub per annum) +45,000 (Warrington Living Well Hub, footfall by March 2026)		temporary jobs within Warrington and Halton through planning and construction. Town Centre footfall increased within Runcorn (c. 3,000 additional visits to Runcorn Shopping City in H1 2023/24)
	Learning opportunities created and supported to support people into education and jobs					
10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045	Staff-led initiatives/Quality Improvement projects incorporating sustainability.					Initiatives identified by Theatre Team, ICU team and IPC team not yet formally registered with QI team.
	Green ambitions included within corporate paperwork (job descriptions, Trust induction etc)					
	Assessment criteria for environmental impact included in capital project proposals					

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.	Delivery of prevention pledge action plan.					Delivery of the Prevention Pledge Action Plan is on track.
11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.	Submit bids at all available opportunities. Delivery of case of need communications plan. Explore alternative funding options to deliver new hospitals and estates enablers.					Updated estates strategy due for ratification January 2024. Updated estates strategy supports a phased redevelopment approach for which funding sources and development opportunities are being actively explored.
11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and	Deliver TIF Deliver CDC Deliver Living Well Hub Deliver Runcorn Health & Education Hub. Deliver Trust Capital Programme Refresh Trust Estates Strategy and develop opportunities.					Updates from key projects below. TIF: • Currently in construction for the daycase unit and theatre 5 at CSTM. • Works have started to prepare areas in Nightingale Building for TSSU development.

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
effective use of clinical space, whilst we work towards our realisation of our new hospitals.	Work with partners at place and in C&M to maximise public sector estate utilisation.					• Design works completed for additional Endoscopy rooms and Theatre 3. CDC: • The **Phase 2** works is scheduled to complete in early December 2023. • Cost estimates for **Phase 3** completed • Additional funding from national team verbally agreed to offset latest version of cost estimates Living Well Hub: • All major structural works on the building are now complete • Work with a broad range of partners continues to develop and finalise the operating model for the Hub from go-live. Planned services offers include Families and Children, Pre-Frailty/Falls/Dementia, Women's Health, Care Leavers and Healthy Lifestyles. An updated Estates Strategy due for ratification January 2024, which supports describes how the Trust will make effective use of clinical space, whilst we work towards our realisation of our new hospitals.
11.3 We will enhance our digital infrastructure to ensure it is reliable,	**WGLL Digital Maturity Assessment (DMA) - Smart Foundations.**	**DMA Overall 2.9**	Smart Foundations 3.6	Smart Foundations 4.6		**Updated metric - Digital Services KPIs are now aligned to What Good Looks Like (WGLL) and Digital Maturity Assessments (DMA).**

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.						Major Infrastructure Upgrade has been prioritised and funded
11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised though Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.	**WGLL Digital Maturity Assessment (DMA) - Empowering Citizens**	**DMA Overall 2.9**	Empowering Citizens 1.9	Empowering Citizens 4.0		**Updated metric** Patient Engagement Portal externally funded

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
12.1 We will deliver the Trust's agreed financial plan.	Achievement of CIP programme		CIP performance at Month 6 £5.4m against £5.4m target (£2.4m recurrent)	£17.9m	YTD - Green Forecast - Red	CIP: Best case forecast £15.6m in year and £9.6m recurrently. Likely forecast £13.8m in year and £8.3m recurrently. Worst case forecast £12.6m in year and £7.1m recurrently. Financial Plan: The Trust has recorded a deficit position of £15.82m at 31 October 2023 against a deficit plan of £11.96m. The main drivers for the deficit being worse than plan are Industrial Action (IA) costs, activity delivered under plan and the cost of additional capacity in A&E. The Trust is forecasting delivery of the forecast £15.7m deficit, however there are significant risks to achieving this plan.
	Achievement of agreed financial plan		£15.8m (October 2023)	£15.7m deficit		
12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.	Actively participate and contribute to the delivery of the ICS Procurement 34 Point Action Plan.					The Trust is playing an active role in the development of the ICS procurement programme. Alison Parker is the lead for the data & Systems subgroup. The Trust has now adopted Atamis, a centralised contract tender management system across the ICS to include trusts workplan's and contract registers.
	Actively participate and contribute to the development of procurement within the ICS.					
	Successful in leading on the introduction of a single Contract Management platform across the ICS.					

Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
12.3 We will deliver value for money by ensuring efficient use of resources	Amber or Green rating achieved in the Value for Money assessment undertaken by the Trust's external auditors and reported in the Auditor's Annual Report	Amber	N/a – annual assessment next due June 2024	Amber or Green rating	N/a – annual assessment next due June 2024	N/a – annual assessment next due June 2024

Table 3: The H1 KPIs against the Strategic Priorities for the Sustainability aims 2023/24

3. MONITORING/REPORTING ROUTES

The monitoring and reporting route for the Trust Strategy is described in the diagram below:

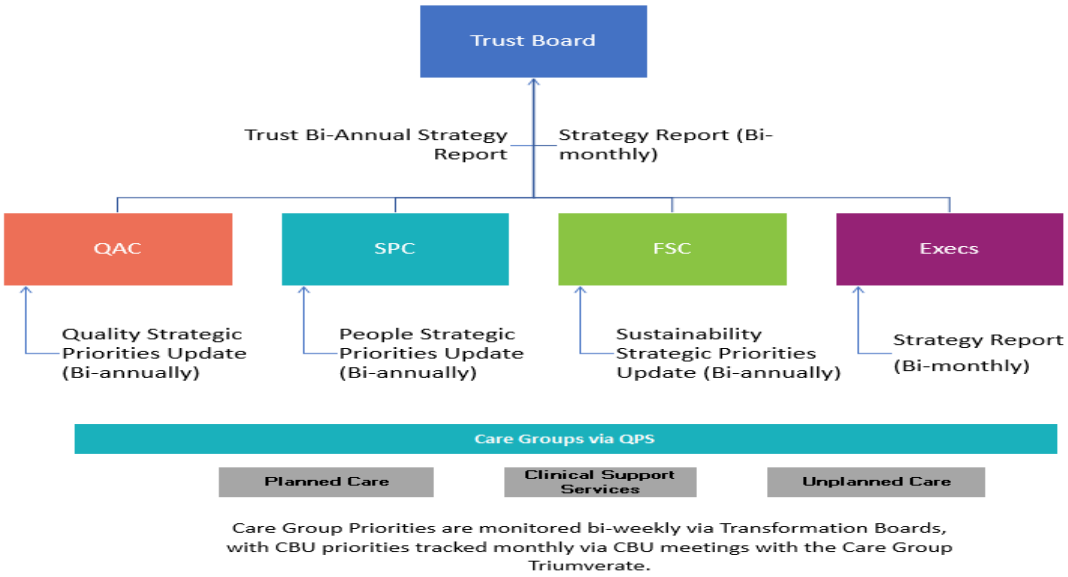


Figure 2: Monitoring and reporting arrangements for Trust Strategy 2023-25

4. TIMELINES

The strategy spans a two-year timeframe from 2023-25. The measures of success/KPIs will cover the duration of the strategy with bi-annual monitoring of delivery through each committee of the Board. The KPIs will be reviewed and refreshed as appropriate.

A further update on the final position 2023/24 will be presented to Board after May 2024.

5. ASSURANCE COMMITTEE

All as noted above.

6. RECOMMENDATIONS

The Trust Board is asked to note progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/173**			
SUBJECT:	**Enhancing Board Oversight – The Trust's approach to Non-Executive Director Champion Roles**			
DATE OF MEETING:	7th February 2024			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	Following the release of ***'Enhancing Board Oversight – A New Approach to Non-Executive Director Champion Roles'*** by NHS England & NHS Improvement in December 2021, a new approach was set out to ensure Board oversight of important issues by discharging the activities and responsibilities held by some NED Champion roles through Committee structures. The paper sets out the current arrangements that enhance board oversight for key issues, by ensuring they are embedded in governance arrangements and assurance process, and			

	through providing an audit trail of discussions and actions identified by Committees.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the arrangements		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Enhancing Board Oversight – The Trust's approach to Non-Executive Director Champion Roles	AGENDA REF:	BM/24/02/173

1. BACKGROUND/CONTEXT

Over time and following on from high-profile failings in care and leadership, several national reviews and reports established a requirement for Trust Boards to designate Non-Executive Director (NED) Champions for specific issues to deliver change. This led to an increasing number of roles spanning quality, finance and workforce. As a result, the high number of NED Champion roles, some of which had been in place for over a decade, made it difficult for Trusts to discharge them all effectively and consequently measure their impact on delivering change.

Following the release of ***'Enhancing Board Oversight – A New Approach to Non-Executive Director Champion Roles'*** by NHS England & NHS Improvement in December 2021, a new approach was set out to ensure Board oversight of important issues by discharging the activities and responsibilities held by some NED Champion roles through Committee structures. The guidance further described which of the NED Champion roles should be retained. This approach helps enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by Committees.

The Care Quality Commission (CQC) was engaged throughout the development of this new approach and CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts are expected to demonstrate how they provide this.

Table 1 over the page highlights which NED Champion roles were retained and which transitioned to be to Committee structure oversight.

Table 1

Roles retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management ** Does not apply to Foundation Trusts**
Roles transitioned to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

2. KEY ELEMENTS

Retained NED Champion Roles

Retained NED Champion Roles				
NED Champion Role	**Type of Role**	**Legal Basis**	**Role Summary**	**Current NED in role**
Maternity Board Safety Champions: Maternity NED role descriptor	Assurance	Recommended	In response to the Morecambe Bay Investigation (2015),, this role was established through Safer Maternity Care 2016, which stated that "Senior trust managers will want to ensure unfettered communication from 'floor-to-board' by appointing a board level maternity champion". The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended. The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes. The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided trusts ensure that the clinical director and director of midwifery are integral to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9.	Jayne Downey
Wellbeing Guardian:	Assurance	Recommended	This role originated as an overarching recommendation from the Health Education England 'Pearson Report' NHS Staff and Learners'	Cliff Richards

Guardian community website and role description			Mental Wellbeing Commission and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for all of us'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision. The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.	
FTSU Champion: FTSU supplementary information	Functional	Recommended	The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why.	Julie Jarman
Doctors Disciplinary Champion	Functional	Statutory	Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS: and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.	Jayne Downey

Security Management Champion	Assurance	Statutory	Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.	****Not required by a Foundation Trust**

Issues that can be overseen through Committee Structures

The table below outlines those issues that reports or reviews previously suggested should be overseen by a NED Champion, but which are now considered best overseen through committee structure. Each Trust can determine whether each issue is relevant to their Trust and how best they should be allocated to their Committee structure.

Issues to be overseen through Committee structures			
Issue	**Oversight Committee**	**Recommended approach**	**Executive Lead**
Hip Fracture, Falls & Dementia	Quality Assurance Committee	All trusts and health boards should have a director with responsibility for falls and the 'National Audit of Inpatient Falls Audit (NAIF) Report 2020' recommends a patient safety group which is overseen by a member of the executive and non- executive team. **This could be fulfilled by an executive** rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice. Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The Board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed. The Quality Committee may wish to ensure that the executive lead for dementia attends the Quality Committee and, in acute trusts, that they also attend the Dementia Steering Group, reporting issues into the Quality Committee. The NAIF audit has produced a useful information guide for healthcare champions which could be accessed to support this work	Chief Nurse

		<u>Trust position</u> • Chief Nurse (executive lead for dementia) is a member of the Quality Assurance Committee (QAC) • QAC receives specific bi-annual and annual dementia reports • Details of falls, including lessons learned, included in the quarterly Learning From Experience (LFE) report received by the QAC • LFE received by the Trust Board • Falls data included in IPR received by the Boar at each meeting and bi-monthly by QAC • Details of hip fractures included in the LFE and reported via the Patient Safety & Clinical Effectiveness Sub-Committee (PSCESC) exception report to QAC. • #NOF Deep Dive received by QAC in July 2023	
Palliative and End of Life Care	Quality Assurance Committee	The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis. The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include: • attendance of a NED from the Quality Committee at the PEoLC Executive Committee • ensuring the board is aware of standards of care in PEoLC • reviving PEoLC complaints to see where improvements could be made. <u>Trust position</u> • Bi-annual reports, including complaint information, received by the QAC • Details of complaints, included thematic analysis and trends, detailed in the quarterly LFE report received by QAC and Trust Board	Exec Medical Director

Resuscitation	Quality Assurance Committee	Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework. This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Assurance Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board. Trust position • Bi-annual Cardiopulmonary Resuscitation report received by the QAC • Policy approved by PSCESC that reports to QAC	Exec Medical Director
Learning from Deaths	Quality Assurance Committee	Executive and Non-Executive Directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible. In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Assurance Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: includes some useful questions that NEDs may wish to ask in relation to these responsibilities. Trust position • Learning from Deaths (Mortality Review) quarterly reports presented to QAC • Learning from Deaths (Mortality Review) quarterly reports received by the Trust Board • Details of complaints, included thematic analysis and trends, detailed in the quarterly LFE report received by QAC and Trust Board	Exec Medical Director
Health & Safety	Quality Assurance Committee	Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut	Chief Nurse

		across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks. Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed. Trust position • Annual report presented to QAC • Annual report received by the Trust Board • Employment & Public Liability claims, including details of slips, trips and falls for example, reported to Audit Committee (attended by all NEDs)	
Safeguarding	Quality Assurance Committee	Safeguarding Children and Young People: Roles and Competencies for Healthcare suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people. This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding. The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility. Trust position • Safeguarding Adults & Children Level 1 part of mandatory training for all members of the Trust Board • Safeguarding Bi-annual reports presented to QAC	Chief Nurse

		• Safeguarding Annual Report received by the Trust Board	
Safety & Risk	Audit Committee / Quality Assurance Committee	The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit Committees as examples. CQC have endorsed the new approach recommended in this guidance. However, should Trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice. <u>Trust position</u> • Annual assessment of internal system of internal control, risk management and governance takes place via the Head of Internal Audit (HOIA). Latest assessment resulted in substantial assurance. • Monthly Risk Review Group in place • BAF/Strategic Risk register presented to each Trust Board Meeting • BAF/Strategic Risk register presented to each Audit Committee meeting • BAF/Strategic Risks and Corporate Risk Register presented to each sub-committee of the Board (relevant to each Committee) • Oversight from the Chair of Audit Committee	Chief Nurse
Lead for Children & Young People	Quality Assurance Committee	The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice. <u>Trust position</u> Regular reports presented to QAC including the following in 2023: • Paediatric Audiology • Paediatric Ophthalmology Deep Dive	Chief Nurse

		• Paediatric Sepsis Improvement project • Oversight from NED member of Quality Assurance Committee (JD)	
Counter Fraud	Audit Committee	The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud. NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme. Trust position • Annual Counter Fraud plan approved by Audit Committee • Counter Fraud Annual Report presented to Audit Committee • Counter Fraud progress update presented to each meeting of the Audit Committee • Anti-Fraud Specialist (AFS) in place	Chief Finance Officer
Emergency preparedness	Finance & Sustainability Committee / Audit Committee	The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a Board level Director with Executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. The Framework suggests that a NED or other appropriate Board member should support the AEO and endorse assurance to the Board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR. The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on appropriate	Chief Operating Officer

		committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually. Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential. <u>Trust position</u> • Chief Operating is the AEO for EPRR • New EPRR process announced in May • Annual EPRR report presented to the Finance & Sustainability Committee (FSC) • Annual EPRR report received by Trust Board • EPRR Assurance Letter/ Statement of Compliance approved by Trust Board • Core Assurance reports presented to FSC and Trust Board	
Procurement	Finance & Sustainability Committee	Procurement should be seen by the board as a value-adding function. The Finance & Sustainability Committee should help raise awareness of commercial matters at Board and Director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The Committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement. Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity. <u>Trust position</u> • PTOM no longer exits; therefore, the procurement team itself will raise the profile of procurement. • Procurement key performance indicators are reported monthly to the Finance & Sustainability Committee via the Monthly Finance Report	Chief Finance Officer

		• Procurement is responsible for the timely renewal of contacts, the timely processing of orders, the receipt and distribution of goods and the provision of a material management service. • The Procurement Team will develop a local workplan and as part of the Cheshire & Merseyside Procurement Network will support the development of collaborative procurement workplans. • Procurement will engage with the Collaborative Commercial Function (CCF) to improve procurement practices.	
Cyber Security	Finance & Sustainability Committee	Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the Board than a Committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced. Each trust should have a Senior Information Risk Owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber- security standards are followed throughout their organisation. The Board/Committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following: • Removal of unsupported systems from trust networks. • Timely patching of systems and prompt action on high severity Alerts when they are issued. • Ensuring robust and immutable backups are in place. It is also recommended that Boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual Board members are required to complete. <u>Trust Position</u> • Annual SIRO report presented to QAC • Annual SIRO report received by the Trust Board	Exec Medical Director

		• Specific Cyber Security risk included on the BAF/ Strategic Risk Register, updated to which are presented to FSC on a monthly basis and at each Trust Board and Audit Committee meeting. • Digital Strategy Group (DSG) report, including updates on cyber security presented to FSC monthly • Digital Strategy Group (DSG) report received at each Trust Board meeting	
Security Management – violence & aggression	Strategic People Committee	As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the Board may wish to ensure the following: • The Trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the Board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the Board. • Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders. • A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board. The Strategic People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence <u>Trust Position</u> • Violence Reduction report present to QAC bi-annually • Bi-annual Violence Reduction reports received by the Trust Board • Violence Reduction Strategy approved by QAC (August 2022) and shared with the Trust Board (September 2022) • Inequality and disparity in the experience of any staff groups completed with the strategy implementation.	Chief Operating Officer

3. RECOMMENDATIONS

The Trust Board is asked to note the current NED Champion role arrangements.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting - Part 1

Wednesday 7 February 2024
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

Supplementary Pack

BM/24/02/174 – Digital Strategy Group Update *(Finance & Sustainability Committee 24.01.24)*
BM/24/02/175 – Infection Prevention & Control Board Assurance Framework Compliance *(Quality Assurance Committee 09.01.24)*
BM/24/02/176 – Mortality Review – Learning from Deaths Q2 Update *(Quality Assurance Committee 12.12.23)*
BM/24/02/177 – Guardian of Safe working Q2 Update *(Strategic People Committee 17.12.23)*
BM/24/02/178 – Trust Senior Managers Organograms
BM/24/02/179 – (FULL) Care Group Presentations – Quality, Performance & Governance with respect to:

- Urgent & Emergency Care
- Medicine
- Surgery

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/174 – BM/24/02/179**	
SUBJECT:	**Supplementary Papers**	
DATE OF MEETING:	7 February 2024	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
	SO1: We will.. Always put our patients first delivering safer and effective care and an excellent patient experience.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All Risks	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			
Further Information: ***Each paper is individually marked from September 2023***			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			
3. Foster good relations between people who share a protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			

EXECUTIVE SUMMARY *(KEY ISSUES):*	In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 7 February 2024 No actions are required from the Trust Board they are provided for information only. The papers provided are: • **BM/24/02/174 – Digital Strategy Group Update** *(Finance & Sustainability Committee 24.01.24)* • **BM/24/02/175 – Infection Prevention & Control Board Assurance Framework Compliance** *(Quality Assurance Committee 09.01.24)*

	• **BM/24/02/176 – Mortality Review – Learning from Deaths Q2 Update** *(Quality Assurance Committee 12.12.23)* • **BM/24/02/177 – Guardian of Safe working Q2 Update** *(Strategic People Committee 17.12.23)* • **BM/24/02/178 – Trust Senior Managers Organograms** • **BM/24/02/179 – (FULL) Care Group Presentations – Quality, Performance & Governance with respect to:** - Urgent & Emergency Care - Medicine - Surgery *(Presented to CQC Engagement & Risk Meeting 29.01.24)*		
PURPOSE: ***(please select as appropriate)***	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above	
	Agenda Ref.	As listed above	
	Date of meeting	As noted above	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REF:	**FSC/24/01/203**			
SUBJECT:	**Digital Strategy Group (DSG) update**			
DATE OF MEETING:	24 January 2024			
ACTION REQUIRED:	**To note**			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on 8th January 2024. This report provides a summary of the updates received from the DSG feeder groups, providing the following assurance status for key delivery areas: ○ **Digital Transformation Highlight Report** Moderate Assurance ○ **Digital Service Delivery Highlight Report** Moderate Assurance ○ **Digital Analytics Highlight Report** Moderate Assurance ○ **EPCMS (Electronic Patient Care Management System)** Moderate Assurance ○ **EBCMS (Electronic Bed Care Management System)** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): ○ Laboratory Information Management System (LIMS) is the digital system that supports all pathology disciplines. Cheshire and Merseyside pathology network are undertaking procurement of a system-wide solution for this, working to tight			

<table>
<tr><td></td><td colspan="3">timescales to spend the allocated capital by the end of the financial year. The business case will go through the usual WHH governance process and is scheduled for Trust Board on 8th February.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
√</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Finance and Sustainability Committee is asked to note the contents of the report, including assurance levels.

○ EBCMS – We received the notification from NHSE that there were funding difficulties therefore the funding for this work was being removed by which the trust has taken the decision to pause the project.

○ EPCMS – We have paused the ITT published on 2 November whilst it seeks advise on a number of points raised as part of bidders clarification process and determine how to refresh the tender documentation – bidders have been asked to pause work and stand down returning ITT on 3 January 2024. A meeting is scheduled on 23 January with Frontline Digitisation to agree away forward to enable the Trust to re issue ITT in January 2024

○ CIO and DCIO to look at clinical leadership structure which will be needed to roll out new EPR.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td></td></tr>
<tr><td colspan="2">Date of meeting</td><td></td></tr>
<tr><td colspan="2">Summary of Outcome</td><td></td></tr>
<tr><td>NEXT STEPS: State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Share with Finance & Sustainability Committee</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Section 43 – prejudice to commercial interests</td></tr>
</table>

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF:	FSC/24/01/203

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

Digital Strategy Update

The new Digital Strategy was circulated by Simon Constable to the trust for information on 9th January 2024. This has been signed off and approved to progress. This is important and we will need to align our highlight reporting initially to ensure we're reflecting the priority initiatives.

The Trust approved our proposed digital vision in early 2023, linked to the national "What Good Looks Like" standards for digital and the ICS Digital & Data Strategy for Cheshire & Merseyside

The new Digital Strategy provides a continued focus on replacing Lorenzo with a new EPR system and refreshing our technology infrastructure – but a wide range of other digital programmes too, including patient-facing solutions and quality and safety developments.

Working with Channel 3, we have engaged with clinical, operational, and corporate staff over the last 4 months in developing future state goals, a range of initiatives to deliver the goals, a roadmap, high-level indicative costs and benefits, and a delivery approach.

Priorities for 23/24 include:

- EPCMS Preparedness/Business Case
- Procure and Implement PEP
- Clinical Digital Safety Compliance
- Accelerate Paperless review programme.
- Migration to new PACS cloud hosted solution
- eBCMS

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- Paperless Care – There were no project go lives since December's update. The team continue work on the remaining projects in the paperless programme and to support the upcoming EPR Procurement. The trust successfully filled the project manager vacancy with immediate start date.

- Warrington Together - Bridgewater are the digital lead for shared 2 care which is the clinical portal, a business case was circulated and is under review for comments/feedback in advance of next meeting.

- EPCMS Readiness - Simon Constable launched our EPR comms out to the trust. We are mobilizing our EPR team to go out to all areas in the trust to process map starting with the women's and children's and clinical support services. Current state process mapping in progress and on track with current plans in readiness for EPCMS.

- Digital Infrastructure - eOutcome data migration dress rehearsal was successful and will conduct again in January and have agreed the cutover will be on the 25th of January then phase 1 will be complete.

- Electronic Bed Capacity Management System (eBCMS) - We received the notification from NHSE that there were 2023/24 funding difficulties therefore the funding for this work was being removed by which the trust has taken the decision to pause the project. Although the business case was approved internally, and submitted to NHSE for review we are still awaiting to receive comments.

- Digital Diagnostics LiMS: Cheshire and Merseyside pathology network is currently undertaking procurement of a system wide solution set by national governing bodies to spend the allocated capital by the end of the financial year. The trust has currently been evaluating the suppliers for which the recommendation of a preferred supplier can be made. The business case for WHH approval is in final draft, but clarifications required at ICS / Path Network level before it proceeds for Board approval as per the C&M timetable – contract aware March 2024. There is significant concern regarding the scheduling of the LiMS implementation. For WHH this must be aligned with other digital programmes inc. of EPR replacement. We need to replace Lorenzo/ICE before we replace LiMS otherwise we will potentially incur additional costs, risks, delays. The earliest we could agree to a go live is Q4 2026/27 it has been agreed to increase contingency fund in the FBC expected to be approved January 2024.

- Patient Engagement Portal (PEP): Procurement is finished. We have our preferred supplier. We are issuing our congratulations and regret letters w/c 8th January. We are finalising the recommendation report to go to board, and we have completed our 10-day standstill period by which we can progress with the chosen supplier.

Items for escalation:

- Connectivity out in the community for therapy services is inadequate, a creative solution is needed to complete the digital transformation of AHPs. A further

meeting scheduled in January to discuss what can be achieved within digital services solutions and budgets.
- Infrastructure CDC phase 3 implementation – will add additional pressures supplying adequate IT services in growing community clinical services. Awaiting final business case decision for extra resources which will be required.

Digital Service Delivery Highlight Report (Moderate Assurance)

- Operational report for the month of December was quieter than November and October with the Christmas period. Good improvement in regard to the service desk response times as for quite some time there were high call wait times/abandonment rate. IT service desk are now answering within 10 mins, and this is further improving.
- The Digital developments group reviewed the draft of the Printer Reduction Policy, and this was approved. Ideally policies will have been approved and implemented before formal launch for SLAs in February.
- Our aim is to introduce Service level agreements where we outline the framework around these metrics and KPIs, this is something most service providers already have in place. Initiatives, process improvements. Following strategy group approval, we will ask other colleagues to sign up for our customers to acknowledge the service levels were offering. This will help us compare ourselves with peers and comparatives.

Items for escalation from the Digital Service Delivery Group

- Cyber security systems are operating as required and there have been no national security alerts relevant to WHH during the last 2-3 month period.
- The approach to vendor management needs to be further strengthened, with discussion about the requirement for robust and consistent RAG rating of 3rd party vendor performance. Issues relating to delayed software enhancements and fixes to be escalated with the main vendors for Maternity, Radiology and Order Comms with a view to increasing focus on vendor performance management on behalf of WHH
- A review of IT Change Management (ITIL) policy, processes, SOPs and change activity during 2023 confirmed very good progress with improvements and operating ITSM (IT service management) best practice at the trust (reducing incidents, timetabling clashes, minimising impact on operational services wrt planned downtime etc.)
- Service Desk performance was improved during December 2023 with average 5 minute wait times and reduced number of abandoned calls. SLA performance is satisfactory with reference to response and fix times, with plans under development for further improvement
- A fix for the ongoing performance issues with eOutcome (Fraxinus) is scheduled for w/c 22nd January, this server migration will improve cyber security compliance and provide tangible speed improvements for clinical end users of the system
- This group still requires attendance and input from CBU Managers, which will be arranged when a draft Digital Services SLA document is ready for review and sign off in March 2024

Digital Analytics Highlight Report (Moderate Assurance)

- The major workstream is the ability to move fraxinus from data warehouse. They team have had two successful dress rehearsal's where a decision has been made to move forward with the dates of the 25th of January.

- Since having our same day emergency care facility Digital Analytics have not been able to provide a live dashboard to produce the rest of ED data specifically the type 5's so needed a 3rd party supplier. There has to be data flowing before the team can add a dashboard. Therefore, the team are communicating with the supplier to retrieve dates for that data which would be helpful if it was done in advance of the CQC visit on 29th January.

Items for escalation

- **None**

Digital Care Delivery Highlight Report (Moderate Assurance)

The Digital Care Delivery Group didn't meet due to a refresh on the Terms of Reference for this feeder group as the current chair has now left the trust. A temporary chair is agreed, and normal business will resume in February.

Items for escalation

- **None**

EPCMS Electronic Patient Care Management System Report (Moderate Assurance)

- WHH have paused the ITT published on 2 November whilst it seeks advise on a number of points raised as part of bidders clarification process and determine how to refresh the tender documentation – bidders have been asked to pause work and stand down returning ITT on 3 January 2024

Items for escalation

- **A meeting with Frontline Digitisation and the Trust is arranged for 23 January to agree away forward and enable the Trust to re issue the ITT.**

EBCMS Electronic Bed Care Management System Report (Moderate Assurance)

- Notification received from NHSE that there were funding difficulties therefore the funding for this work was being removed by which the trust has taken the decision to pause the project.
- The internal business case for EBCMS now on hold although the business case was approved internally.

Items for escalation

- **At the moment EBCMS is at a pause status.**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only:

4. MEASUREMENTS/EVALUATIONS

Routine highlight reporting (RAG status) to DSG sub-groups.

5. TRAJECTORIES/OBJECTIVES AGREED

n/a

6. MONITORING/REPORTING ROUTES

Digital Strategy Group

7. TIMELINES

Ongoing - Digital Strategy

8. ASSURANCE COMMITTEE (IF RELEVANT)

9. RECOMMENDATIONS

The FSC is asked to note the contents of the report, including internally assessed assurance levels.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/24/01/282**			
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Report**			
DATE OF MEETING:	9 January 2024			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		N/A	N/A	N/A
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	N/A	N/A	N/A
	Further Information/Comments:			
EXECUTIVE SUMMARY	This report provides a compliance assessment with the Code of Practice on Prevention and Control of Infections and related guidance and implementation of the national Infection Prevention and Control Manual. This Document replaces the previous Covid-19 Board Assurance Framework. There are 7 minor partial compliance points relating to: • Alignment to the Patient Safety Incident Response Framework • Completion of action plans following IPC audits • Prioritising backlog estate maintenance • Alignment of the NHS waste management strategy • Provision of information to visitors • Details on clinical competency assessments • Policy/guideline updates			

PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Infection Control Sub-Committee		
	Agenda Ref.	ICSC/23/12/211		
	Date of meeting	21 December 2023		
	Summary of Outcome	Submit to Quality Assurance Committee		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Board Assurance Framework Assessment	AGENDA REF	QAC/24/01/282

1. BACKGROUND/CONTEXT

This report provides details of a compliance assessment with the Code of Practice on Prevention and Control of Infections and Related Guidance 2015. This Code of Practice links to regulation 12 of the Health and Social Care Act 2008 and is used by regulatory bodies to assesses registered providers compliance.

The assessment has been completed using an assessment tool, published by NHS England, which autogenerates summary plots and a red, amber, green status for each criterion. Use of this framework is not compulsory, however there is a recommendation it is used by registered providers to ensure compliance with infection prevention and control (IPC) standards.

Summary compliance information is displayed below, and the full assessment is included at appendix 1.

Figure 1 Overall compliance

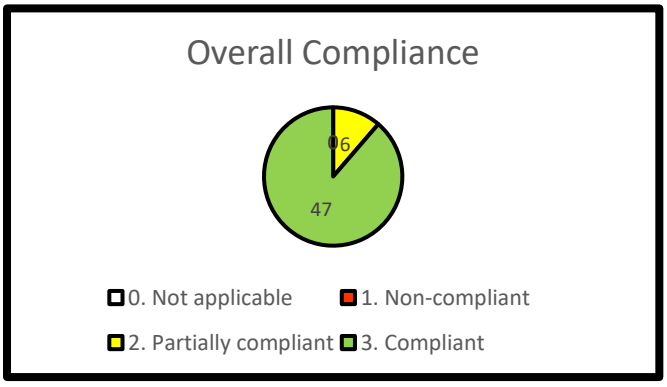
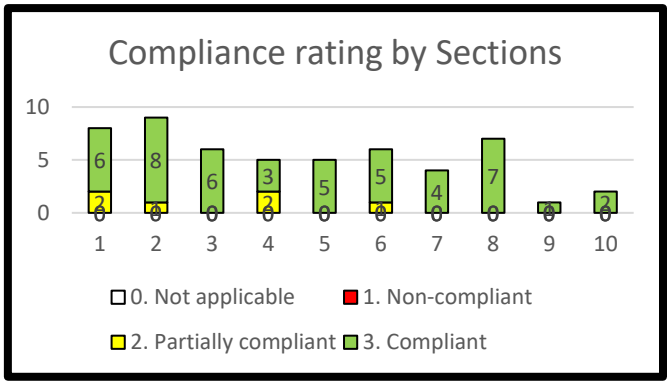


Figure 2 Compliance by section



An action plan is in place, which is monitored by the Infection Control Sub-Committee to ensure that activity is undertaken to achieve full compliance.

2. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies recovery plan
- Delivery of the Infection Prevention Strategy
- Provision of infection prevention and control expert advice to colleagues

3. IMPACT ON QPS?

- Q: A reduction in healthcare associated infections (HCAI) will demonstrate a positive impact on patient outcomes
- P: Attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability and the green plan

4. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of HCAI to UK Health Security Agency
- Surveillance of nosocomial Covid-19 cases/reporting Covid-19 outbreaks
- The Infection Prevention and Control Team monitor HCAI. Action is implemented in response to increased incidences of infection/infection control related events
- The Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI events, reports, audits and agreed actions to support care improvements
- HCAI data is included in the ward dashboard data

5. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy Objectives

- Prevention of healthcare associated infections

Table 8 HCAI Thresholds 2023/24

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

- Strengthening Antimicrobial Stewardship – Participation in the IV Oral Switch CQUIN CCG3
- Improving standards of environmental cleanliness
- Implementing action in line with the NHS Waste Strategy

6. MONITORING/REPORTING ROUTES

High level briefing papers from Infection Control Sub-Committee are submitted to:-

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Infection Control Sub-Committee, Quality Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

Monitoring by the Senior Executive Oversight Group.

7. TIMELINES

2023 – 2024 Financial Year

8. ASSURANCE COMMITTEE

Infection Control Sub-Committee

9. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported, and progress made.

Appendix 1 Compliance Assessment and Action Plan Infection Prevention and Control Board Assurance Framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include - an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	- Infection Control Sub-Committee - Chief Nurse/Deputy CEO is DIPC IPC infrastructure and reporting lines organisation chart for the IPC Team WHH Internal Governance Structure				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Compliance with mandatory reporting of HCAIs to UKHSA HOHA COHA cases are reported on the digital incident reporting system Surveillance data is reported and discussed at Infection Control Sub-Committee				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Digital incident reporting system Task and Finish Group working to implement PSIRF	Healthcare associated infection safety incident response is being aligned with PSIRF to promote systemic, compassionate, and proportionate responses	Healthcare associated infection matrix in development detailing alignment of IPC with PSIRF, which will be agreed with the Patient Safety Incident Director		2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Policies, guidelines, and SOPs in place aligned to the National Infection Prevention and Control Manual Programme of Matron and IPC monthly visits implemented Programme of infection prevention audits in place	Action plan development following audits	Review of IPC audit programme, support being offered to Ward Managers to develop action plans and Matrons to provide leadership oversight on implementation		2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Compliance with mandatory reporting of HCAIs to UKHSA HOHA/COHA healthcare associated infection cases are reported on the digital incident reporting system Surveillance data is reported and discussed at Infection Control Sub-Committee HCAI Prevention Plans are in place and are reviewed and updated 3 times per annum Quarterly DIPC reports are submitted to Trust Board				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Infection Control Policy outlining responsibilities Managerial responsibilities are included in the risk management framework for vulnerable staff				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the	Mandatory training Level 1 and Level 2 Additional training - Single point lessons				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	risks of infection transmission.	Care support worker specific sessions Contractors Information leaflet				
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Managerial responsibilities are included in the risk management framework				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g., ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Commitment to cleanliness charter implemented Functional risk categories agreed and auditing in place Star ratings are displayed in all areas	Functional Efficacy Audits not in place	Head of facilities is arranging PLACE and drawing up a plan for functional audits	Awaiting implementation date	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE report and action plan to address findings				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Roles and responsibilities are included in the cleaning standards policy				3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Ventilation Safety Group Ventilation assessments Authorising Engineer (ventilation) included in all capital projects Water Safety Group Water Safety Plan Legionella Policy				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Planned preventative maintenance policy	Backlog maintenance	Prioritisation plan to rectify areas identified for improvement		2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Laundry Policy				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste Policy Waste Segregation Guidelines	NHS Waste Strategy not fully implemented to meet the ambition of 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste	Task and finish group established and plan to trial implementation of offensive waste stream		3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	External sterile services provided for decontamination of surgical instruments				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations.	Food Safety Policy				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
System and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	A Consultant Microbiologist is the nominated lead for AMS. Antimicrobial Management Steering Group (AMSG) minutes. AMSG Terms of Reference, meeting agendas and meeting minutes.				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	An annual account of antimicrobial stewardship activity is included in the DIPC annual report				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	DIPC has responsibility for AMS				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes.	Prescribing advice is included in the Trust Antibiotic Formulary (Micro-guide) Antibiotic ward rounds are conducted (ICU daily - weekdays) C. difficile cohort ward weekly by Consultant Microbiologist Consultant Microbiologist and Antibiotic Pharmacist ward rounds twice				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	• to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	weekly				
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Quarterly point prevalence audits IVOS CQUIN03				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Micro-guide (Antibiotic Formulary) 24/7 access to antimicrobial prescribing advice				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion						
System and process are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient information leaflets are shared with a reader group by the Communications Team Review in progress to use NHS Choices information				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g., digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/ visitor/advocate.	Communications and Patient Experience Team support for accessible formats				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	WHH Website Visiting guidance	Website IPC information requires review	Communications team contacted to update information		2. Partially compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting		Sharing information to service users on participation in national campaigns	Communications team contacted to update information on patient facing website		2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g., AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and	Visitor guidance Cleanliness reporting Signage during outbreaks				

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	improve the knowledge of patients/service users, care givers, visitors, and advocates to minimise the risk of transmission of infections.					
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Digital tie to share information with community IPC Team and GPs Development and sharing of urinary catheter passport across Cheshire and Merseyside				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of	Admission infection risk assessment		Close liaison with the Patient Flow Team on safe patient placement Side room audit tool to support reviews		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.					
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Infection risk assessments included in digital care plans Cohort bays for C. difficile and Covid-19. Escalation plan for winter respiratory viruses				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	SBAR transfer form includes section on infection status				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage in place when there are outbreaks of infection ED triage tool				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	C. difficile surveillance Covid-19 surveillance Incidents are reported on the digital incident reporting system, escalated to DIPC internally and where appropriate reported to UKHSA				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
System and process are in place to ensure that:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and	Mandatory training level 1 and level 2 Additional training - Single point lessons Care support worker				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	controlling infection within the context of the care setting.	specific sessions Contractors Information leaflet				
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Audit programme in place, ANTT competency programme in place				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Compliance with mandatory training is monitored at Infection Control Sub-Committee The packages are updated annually in line with Core Skills for Health guidance				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Included in mandatory training presentation				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements	Programme of FFP3 Fit testing in place	Revision to denominator baseline to ensure accuracy of reporting	Development of an escalation plan to support response to future pandemics		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	and that a record is kept.					
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Clinical skills training records Aseptic non-touch technique	Return of completed competency assessments for central recording			2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Infection control admission risk assessment in the electronic patient records				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Infection prioritisation standard operating procedure Daily side room audit Winter respiratory virus escalation plan				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Isolation door notices			Refresh of isolation signage in progress	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	SBAR transfer form includes section on infection status				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Microbiology laboratory has UKAS accreditation				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	On call consultant Microbiologist On call IPC service				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract	Microbiology Department SOPs				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	monitoring and laboratory accreditation systems.					
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	All SOPs, policies, guidelines are aligned to national standards				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Local testing protocols in place				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Support offered to partner organisations for outbreak investigation				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Laboratory Users Handbook	Testing of the protocol	Review of incident reporting		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
Systems and processes are in place in line with the NIPCM to ensure that:						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and	Policies, guidelines, and SOPs in place Surveillance in place to detect outbreaks Reporting is in line with UKHSA requirements	Some policies beyond review date	Recovery plan in place		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation, and reporting of an outbreak/incident by the registered provider.					

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Included in Risk Management Framework				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Blood borne virus policy in place Sharps injury data is reviewed at the Health and Safety Sub-Committee and at Infection Control Sub-Committee				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Health clearance policy in place for pre-employment checks				

Action Plan for the IPC BAF 12/2023

Criterion	Key line of enquiry/standard required	Action required	Lead	Review date	RAG
	Change approach to review of HCAI incidents	Align IPC incidents with PSIRF	ADIPC	31/03/2024	
1	Return of action plans following IPC audits	IPCNs to support Ward Managers with development of action plans	IPCNs	31/03/2024	
	Efficacy cleaning audit programme	Implement programme of efficacy audits	HoF	31/10/2023	
	Backlog maintenance prioritisation schedule	Agree priorities and implement schedule of works	HoEMCR	31/03/2024	
2	Implement NHS Waste strategy	Task and Finish Group - deadlines to be set up	FMC	31/03/2024	
4	Provision of information to visitors/carers	Update to Trust patient facing website	IPCNs	31/03/2024	
6	Recording of clinical competency assessments	Assurance on completion of competency assessments and sign off following clinical skills training	HoCE	31/03/2024	
9	IPC policies	Policy recovery action plan	IPCNs	31/03/2024	

ADIPC	Associate Director of Infection Prevention & Control
FMC	Facilities Manager Contracts
HoCE	Head of Clinical Education
HoEMCR	Head of Estates Maintenance, Compliance & Risk
HoF	Head of Facilities
IPCNs	Infection Prevention & Control Nurses

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/12/259**			
SUBJECT:	**Learning from Deaths Report Q2 2023-2024**			
DATE OF MEETING:	12 December 2023			
ACTION REQUIRED:	**To note the contents of the report**			
AUTHOR(S):	Dr Lalitha Chinnappan, Consultant Gastroenterology and Trust Mortality Lead. Dr Judith Raper, Palliative Care Consultant and Deputy Trust Mortality Lead Emily Barnett, Clinical Effectiveness Manager			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper summarises 'Learning from Deaths' for Q2 2023 / 2024, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths.			
PURPOSE: (please select as appropriate)	Approval	To note √	Decision	
RECOMMENDATION:	Quality Assurance committee is asked to note the contents of the paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Deaths Report Q2 2023 / 2024	AGENDA REF	QAC/23/12/259

1. BACKGROUND/CONTEXT

The National Guidance on Learning from Deaths requires all Trusts to have processes and systems in place to review, investigate and learn from deaths that occur with due focus on:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved families and carers.

The Trust is committed to learning from both positive and negative aspects of a patient's care with clear processes in place for completing mortality reviews. Learning identified during mortality reviews allows individual specialties to improve their processes; collated learning provides corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

This report provides an overview of the processes and systems that are in place to ensure that deaths are reviewed appropriately and summarises the data for this quarter.

2. KEY ELEMENTS

WHH uses the HED (Healthcare Evaluation Data) system to assess overall mortality data, highlighting any themes or trends that support the requirement for reviews of deaths. The HED report also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report includes:

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

The Mortality Review Group (MRG) at the Trust reviews the HED report monthly. Deaths subject to a Structured Judgement Review (SJR) as per the criteria defined in the Learning from Deaths policy are reviewed at MRG to identify learning and improvement actions.

3. MEASUREMENTS/EVALUATIONS

A Structured Judgement Review will be completed if a patient death meets one or more of the below criteria:

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

NB: If a death is subject to a PSII (Patient Safety Incident Investigation or other Learning Response then an SJR is not undertaken.

MRG – Forward planning

1) Themed workstream continues to be undertaken ensuring that any common pattern in issues identified are addressed with the aim to bring about clinical changes and positively impact both patient care and trust mortality. The current list of workstreams are as follows:
   - DNACPR.
   - Patient Transfers
   - Specialty Input
   - DoLS/ Capacity
   - SAFER
   - Trainee related learnings
   - Good practice- for positive commendation

2) The following changes were made to the allocation criteria of DOLs cases for SJR:
   - Only a 10% random selection of 'standard' DOLs cases will be referred for SJR.

- The Clinical Effectiveness Coordinator liaises weekly with the Safeguarding Team weekly to gain clarification on the correct DOLs cases.

These changes continue to have a positive reduction on the number of deaths that require SJR. We continue to work with zero backlog of SJR's awaiting review. This has enabled MRG reviewers the capacity to work on focused reviews when required.

3) The Learning from MRG continues to be shared quarterly to the Palliative and End of Life Care Steering Group and hence informs developments including review of P&EOLC Strategy to encourage timely referral to specialist palliative care, recognition of dying, and early Treatment Escalation Planning, and the CPR Decision Making and Discussions Workstream and associated education.

4) Speciality M&M Meetings continue to take place each month ensuring that the monthly MRG Newsletter, death report relating to the specific speciality and speciality relevant learning from MRG is shared to ensure learning is widely disseminated. As a Trust we are making those improvements to better our patient safety, quality and experience by dissemination of learning from death.

5) Good practice continues to be highlighted by MRG certificates being issued to members of staff who have been noted during review of a SJR to have demonstrated good clinical practise including documentation & communication within the patient's records.

6) Formal SJR training day took place on 28th September 2023. The training was provided by a National Training Group and 15 members of WHH staff attended to ensure as a Trust we are undertaking reviews in a standardised pattern in keeping with national learning from death policy. The training was well received, and the Trust received excellent feedback for the way in which we manage our Mortality governance for the Trust.

During Quarter 2 there were between 17 - 19 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring a SJR per month are 17 which is the same as the last reporting period. Currently we have 7 Mortality reviewers, with them being allocated 5 cases per month, allowing a total monthly allocation of 35 SJRs.

We continue to remain up to date in the allocation of SJR's with currently no major delay from patients death to ensure timely review. This is due to the changes as mentioned above and has allowed for more focused learning to be shared with the relevant teams to better improve our Quality of Care.

3.1 Mortality Review Data Q2 2023/2024

- During Quarter 2, 52 deaths met the criteria to be subject to a Structured Judgement Review (SJR). A reduction of 1.
- During Quarter 2, 61 deaths were allocated to a review for a Structured Judgement review.
- 74 SJRs have been completed in Q2, which is a reduction of 19 from Q1– This is due to the reduction of SJRs being allocated.

- Of the 74 SJRs completed, 40 were allocated in Q2 2023 / 2024 and 34 were allocated in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q2	Total LD Deaths Q2	PSII's commenced in Q2 relating to patient deaths	Those meeting SJR criteria Q2	Number of SJR reviews completed in Q2	Number of SJR Reviews that were allocated in Q1 23/24 and completed compared to Q4 22/23	
256	3	2	52	74	Q1 23/24 Total SJR Completed – 93 SJRs were completed on 67 out of the 93 assigned in Q1.	Q2 23/24 Total SJR Completed – 74 SJRs were completed on 40 out of the 74 assigned in Q2.

Cases rated by reviewers as *1**: overall care very poor*** or *2: **overall care poor*** are reviewed by MRG to agree the overall care rating and then referred to the Governance Department if the consensus rating is Very Poor/Poor for further investigation.

A sample of cases rated as *3: **Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

Cases rated as *4: **Good*** and *5: **Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

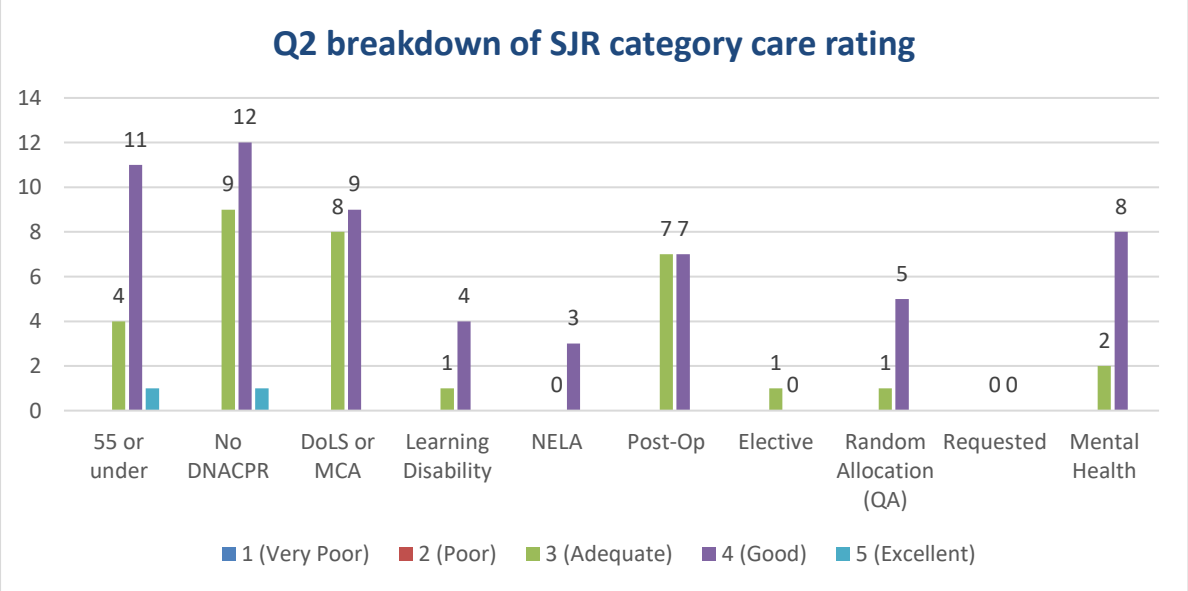
ig. 2 – Shows the overall and phase of care ratings of the 74 SJRs completed in Quarter 2.

Phase of Care *	N/A	Very Poor	Poor	Adequate	Good	Excellent
First 24 hours/admission	0	0	0	17	54	3
Ongoing care	15	0	1	21	36	1

Care during procedure	61	0	1	4	8	0
End of life care	32	0	2	12	28	0
Patient records/documentation	2	0	1	12	57	2
Overall care	**2**	**0**	**0**	**26**	**45**	**1**

- In SJRs completed within Quarter 2, there has been no 'very poor' or 'poor' care at any stage of admission.
- All phases of care and documentation records including overall care had a majority of 'good' ratings with 2 receiving 'excellent' ratings.

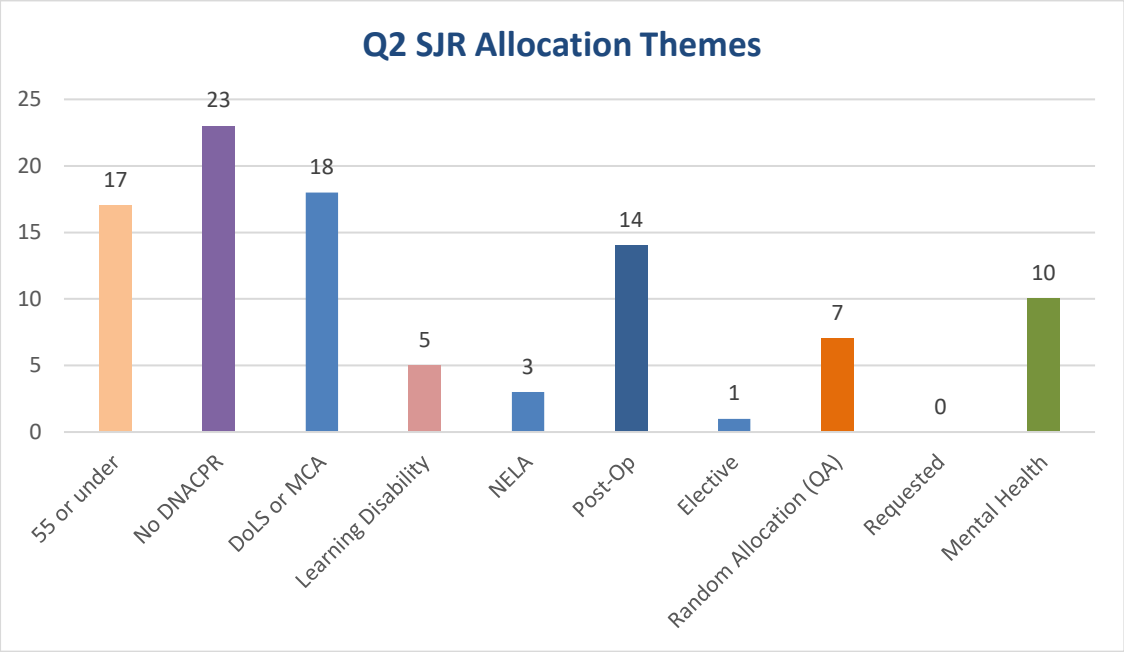
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 2.



- All categories except are predominantly receiving good / adequate care.
- Random Allocation patient shown one 'adequate' and 5 'good' care ratings. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

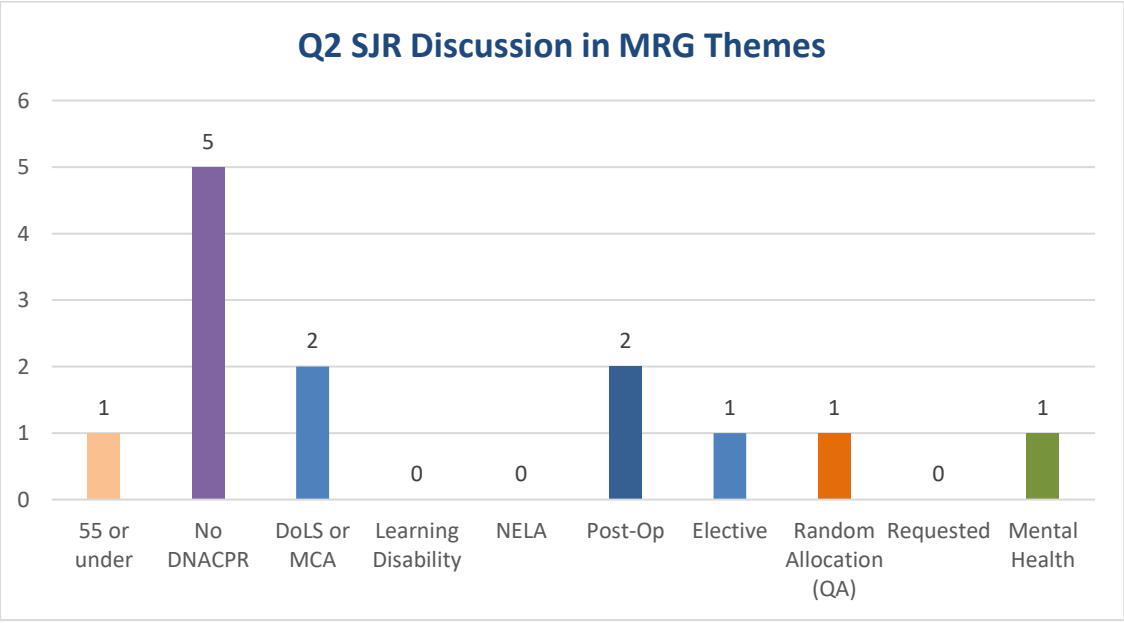
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 2



- 'No DNACPR' was the most frequently allocated category to reviewers in Q2.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 2.



- The category with the highest number of SJR's requiring further discussion at MRG in Q2 is patients with 'No DNACPR'. This corresponds to the number that are allocated.
- There is DNACPR workstream within MRG to collate this learning for the Trust's DNACPR lead.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
• 73 year old patient. • Admitted with Atypical chest pain and main complaint was a 3 week history of pain in shoulder. • PMH of T2 DM, Hyperlipidaemia and pain in shoulder after a fall. • Given likelihood of success, policy and case law and national guidance dictates that a CPR decision should have been made prior to the arrest.	• This was added to the DNACPR workstream and the SJR was shared with the Cardiology Department with feedback. Targeted training will be offered further to the Cardiology Department by the Trust Deputy Mortality Lead and Palliative Care Consultant.
• 81 year old male admitted with leg swelling and shortness of breath. • PMH of AF, gout, CCF, HTN, high lipids, CKD, HypoT. • Patient was given 2x antibiotics by GP but no symptoms of urinary tract infection. • No AMBER Care bundle so no appropriate discussions and decisions around treatment escalation planning.	• The Trust Deputy Mortality Lead and Palliative Care Consultant will share the SJR with the Team who provided the care to the patient prior to death to ensure the learning is fully captured and delivered.
• 82 year old admitted via ED. • Patient was known to have ovarian cancer, had two abdominal drains and resided in a care home. • Patient's symptoms uncontrolled and referral to palliative care team not made until son requested and until identified as dying.	• This case has been added to the Palliative Care workstream. • This case was used to share learning through the Monthly MRG Newsletter – see appendix.
Themes **Appendix 1** – MRG Newsletter 'She spend her last days in hospital with unmanaged pain'. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

A total of 2 PSII's were reported during the quarter 2 period relating to a patient's death.

Mortality Indicators

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation.

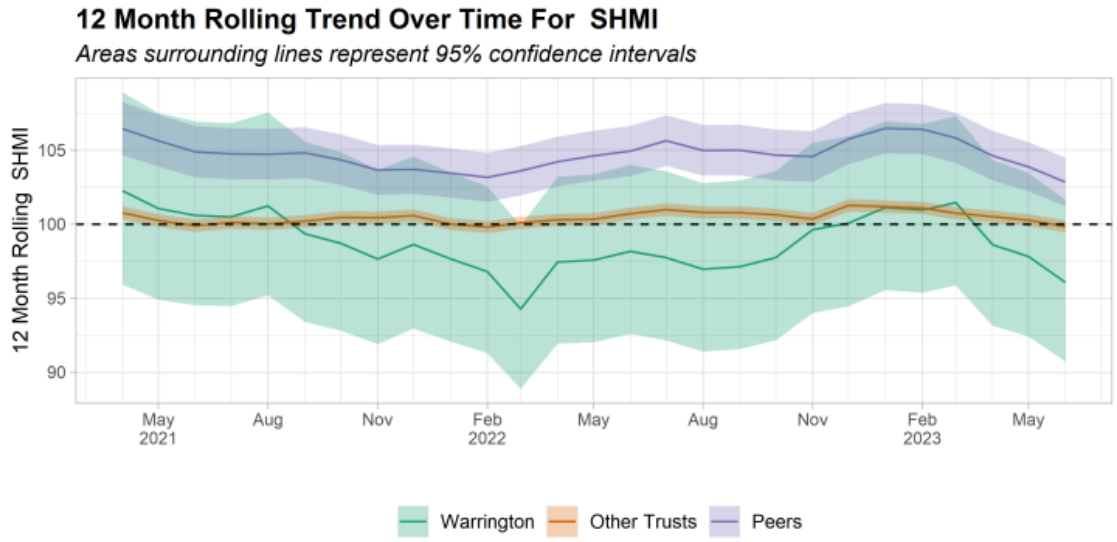
To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

The SHMI data is the ratio between the actual number of patients who die within 30 days 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 patients treated there.
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'.

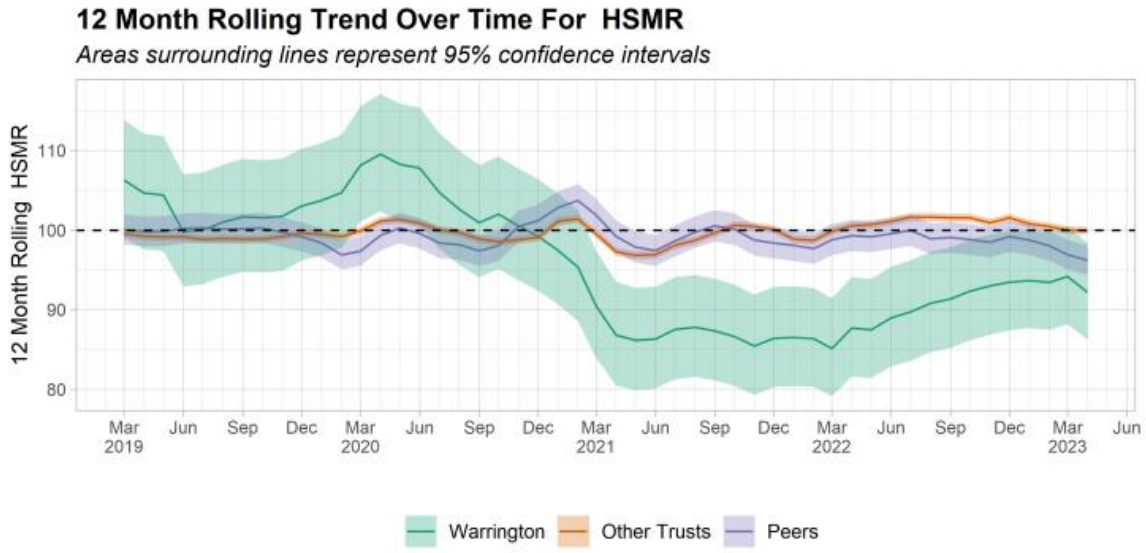
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
May	93.52	98.98	95
June	93.10	99.38	95
July	90.76	97.07	83



HES SHMI (which is based on 12 months data up to and including June 2023) is 96.07. This result is not an outlier using an overdispersed funnel plot and is not an outlier based on the stricter Poisson method.



Standard 56 CCS group HSMR (which is based on 12 months data up to and including July 2023) is 90.69. This result is a low value outlier based on the 95% Poisson method.

- SHMI for Warrington is lower than other acute trusts on average, and lower than the average for the peer group.
- The 12-month rolling SHMI value has declined since the year ending March 2023.

4. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub Committee, quarterly to the Quality Assurance Committee and annually to both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

5. TIMELINES

Ongoing - the Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

6. RECOMMENDATIONS

The Quality Assurance Committee is asked to note this report.

Appendix One: Monthly MRG Newsletter

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MRG Newsletter - October 2023

She spent her last days in hospital with unmanaged pain

83 year old lady
Known ovarian cancer
Already identified as approaching the end of her life
Had two indwelling ascitic drains to manage her abdominal symptoms related to malignant ascites

She was admitted via the Emergency Department from her Care Home
Abdominal pain, one drain draining purulent fluid, inflammatory markers raised
Treated as bacterial peritonitis with likely blocked drain.

The following day, the Warrington team were unable to remove the drain and she was referred to Whiston.
Meanwhile, pain was increasing and her son was frustrated, feeling his Mum needed a syringe pump for symptom management.
It became clear to everyone that she was not well enough to withstand a trip to Whiston.

She was eventually referred to the specialist palliative care team and her symptoms managed. By then, she was too poorly to return to her usual place of care and she died in the hospital.

Learning:

- It is often appropriate for patients approaching the end of their life to come into hospital- IV antibiotics and drain removal may have helped managed her pain and other symptoms- never write in a discharge summary, "not for readmission to hospital"- this can make it very difficult for health professionals in the community when an unexpected crisis develops, but consider instead, "aim to avoid hospital admissions unless symptoms cannot be managed in usual place of care."

- It is not acceptable to leave patients' symptoms unmanaged and delay referral to the specialist palliative care team until it is clear that other interventions are not reversing the situation, or unless the family request referral.

- The specialist palliative care team is not only for patients who are identified as dying. It is not infrequent for nurses and trainee doctors to raise that the patient needs palliative care, but the senior doctor declines because, "the patient is not dying" or "we are still giving antibiotics."

- Palliative interventions do not shorten life and can even prolong life. For example, there is good evidence that morphine and midazolam can be given at appropriate doses to manage pain and agitation well, without leading to any objective signs of respiratory depression, even in those with chronic respiratory disease. To withhold such medications in such patients when they need it is not acceptable.

- Patients do not "become palliative"- ideally palliative care is an approach which should start at the point of diagnosis of a life limiting illness and continue alongside potentially life prolonging and disease modifying interventions.

- The hospital specialist palliative care team would like to be more proactive "at the front door" and is working towards this. Meanwhile, an alert system highlights when patients already known to the hospital SPCT arrive in the emergency department, but there is currently no good way of alerting those patients who are on their GP's palliative care register or Gold Standards Framework- so the patients rely on you all making appropriate referrals.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/23/12/177**			
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q2, 2023/24**			
DATE OF MEETING:	20 December 2023			
ACTION REQUIRED:	**To note the report**			
AUTHOR(S):	Dr Rachel Wallis, Guardian of Safe Working Hours			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of exception reports via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 2 (July 23 – Sept 23) 2023-24, 87 exception reports were submitted of which 0 were highlighted as an immediate safety concern. The majority (79 individual reports, equating to 90.8%) of exception reports relate to hours of working. 4 exception reports related to patterns of work, 2 relate to missed educational opportunities and 2 exception report submitted related to service support available to the doctor. The total number of exception reports for this quarter has decreased significantly which is in line with trends from previous years.			

PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The Strategic People Committee is asked to note the report findings and progress made with implementation of the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health and wellbeing, and the safety of patients.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.		
	Choose an item.		

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Guardian of Safe Working for Junior Doctors Combined Report for Q2, 2023/24 (1 July – 30 September 2023)	AGENDA REF:	SPC/23/12/177

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

Most junior doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

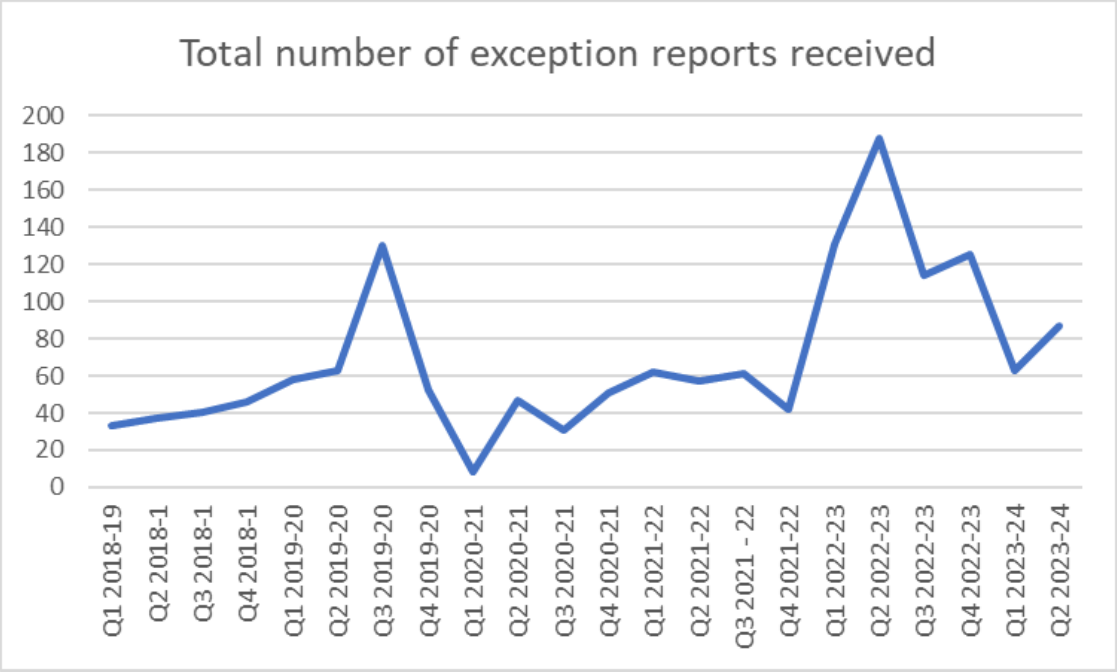
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

Exception Reporting (July 23 –Sept 23)

During Q2, 2023-2024, 87 exception reports (ERs) were submitted. Although this is an increase from Q1 in comparison to Q2 2022 there is a large decrease (Q2 2022 188). Following change over as can be noted from previous years there is a predictable increase in exception reports which generally reduce/resolve following a period of settling in. Please see Chart 1 for exception reporting trends over previous years.

Chart 1 below illustrates reporting trends:



Fines

The GSW has responsibly for protecting the safeguards contained in the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.

As per the TCS above any of the following breaches will incur a financial penalty.

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13-hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours rest in a 24-hour period has not been achieved (excluding on[1]call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

During Q2, no fines were levied by the GSW.

Themes for Q2 (Jul 23 – Sept 23)

For this quarter there has been wide spread exception reporting which may reflect the promotion of the GSW role and all Junior Doctor/trainee induction. Reports have been from many specialties and grades of doctor. There are numerous rota gaps in all specialities, and this is impacting junior doctors across the board.

General Medicine

It is noted that there are number of exception reports relating to General Medicine and in particular the Foundation Y1 (FY1) trainees (27 in total). As August is the main changeover it is predicted that a large proportion of this relates to a general settling in

period and in particular for the FY1 group this is their 1st placement within the secondary care setting and therefore can be expected. I will however continue to monitor this for the subsequent quarters to ensure that this is not an ongoing or repeating trend.

I am pleased however to note that there have been no further exception reports for Ophthalmology leading me to believe following the work schedule review concerns have been resolved. This will remain under the review and monitoring of the GSW.

Summary

- Number of exception reports raised = 87
- Number of work schedule reviews that have taken place = 0
- ERs flagged as immediate safety concerns = 0
- Fines that were levied by the Guardian = 0

Exception Reports (ER) over past quarter	
Reference period of report	01/07/23 - 30/09/23
Total number of exception reports received	87
Number relating to immediate patient safety issues	0
Number relating to hours of working	79
Number relating to pattern of work	4
Number relating to educational opportunities	2
Number relating to service support available to the doctor	2
***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*	

We continue to monitor any delays in signing off ERs and regular reminders are sent by the Medical Trainees Workforce Administrator. At the end of Q2 there were 43 unresolved ERs. Due to a changeover of GSW and Medical Trainees Workforce Administrator with the new candidates taking up post in Dec 2023 monitoring of this area was temporarily paused. The new GOSW will monitor outstanding ERs and encourage continued engagement from both trainees and educational supervisors. This has however continued to improve compared to previous quarters as both educational supervisors and juniors' complete documentation prior to juniors rotating on to new roles.

The 1ST JDF meeting was on the 12/9/23 for the new cohort and was well attended and with strong engagement between the new Junior Doctors' Representatives, the Medical Education Manager and GSW. The GSW will continue to provide pastoral support to juniors throughout the difficult period of strike action and the JDF remains a lively and productive meeting resulting in positive change.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To continue to monitor exception reports in General Medicine to ensure no emerging trends requiring more in depth review.

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	30
Total number of overtime payments	22
Total number of work schedule reviews	3
Total number of reports resulting in no action	10
Total number of organisation changes	1
Compensation	0
Unresolved	43
Total number of resolutions	**66**
Total resolved exceptions	**68**

Note *:*

** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

6. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours' Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

7. TIMELINES

Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q2 – (end of September 2023) – Submit December 2023
- Q3 – (end of December 2023) – Submit February 2024
- Q4 – (end of March 2023) – Submit May 2023
- Q1 – (end of June 2023) - Submitted August 2023

8. ASSURANCE COMMITTEE (IF RELEVANT)

Strategic People Committee

9. RECOMMENDATIONS

The Committee is asked to consider the contents of the report and consider the assurances made accordingly. The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/02/178**			
SUBJECT:	Trust Senior Management Organograms			
DATE OF MEETING:	7 February 2023			
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust Board is presented with the updated Trust Organograms. Each of the Organograms has been approved by individual Executive Leads.			
PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note the updated WHH Senior Management Organogram for publishing on the Trust Website			

PREVIOUSLY CONSIDERED BY:	**Committee**	Trust Board
	Agenda Ref.	BM/23/08/93
	Date of meeting	2nd August 2023
	Summary of Outcome	Approved/noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

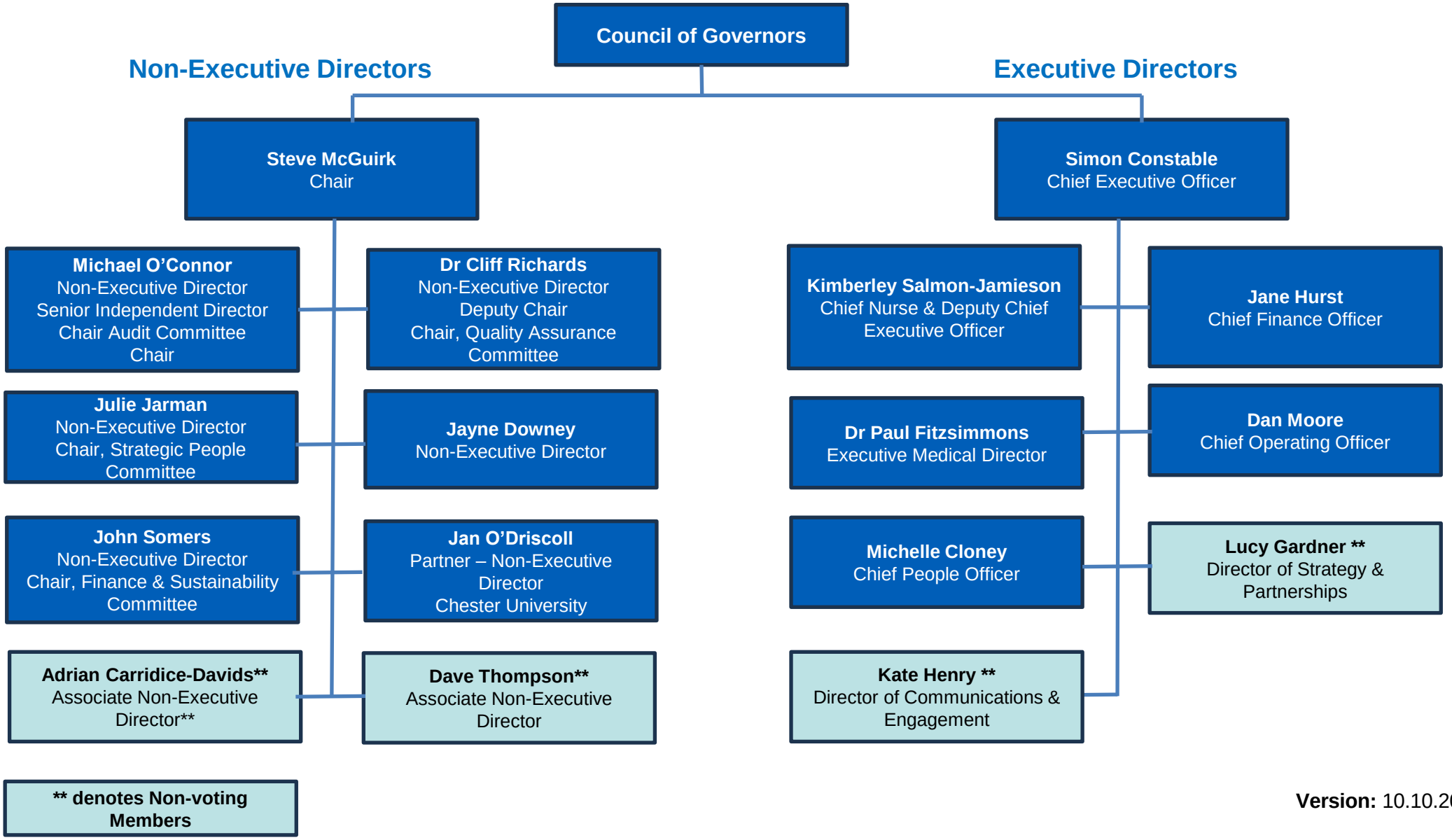
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS FT

Organogram

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

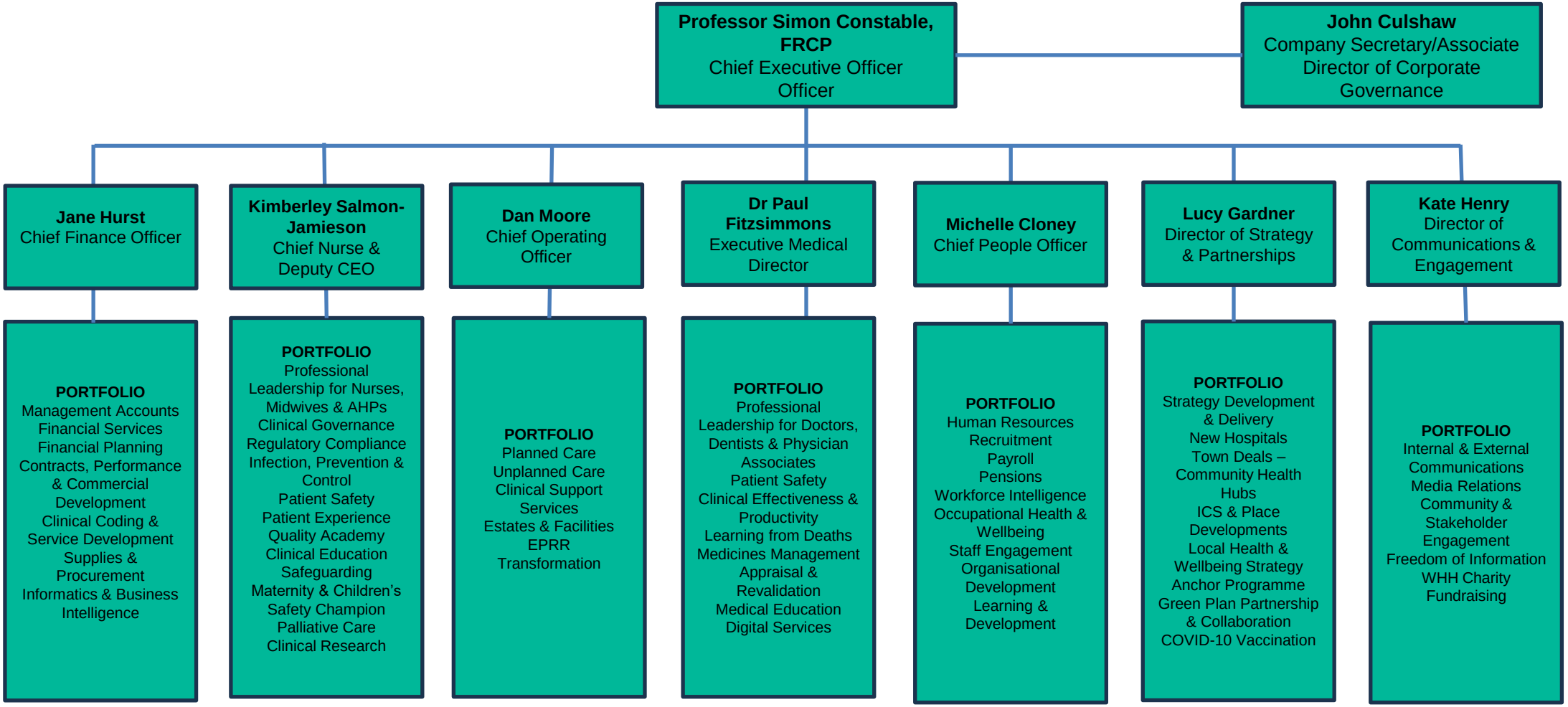
Trust Board



Version: 10.10.2023

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

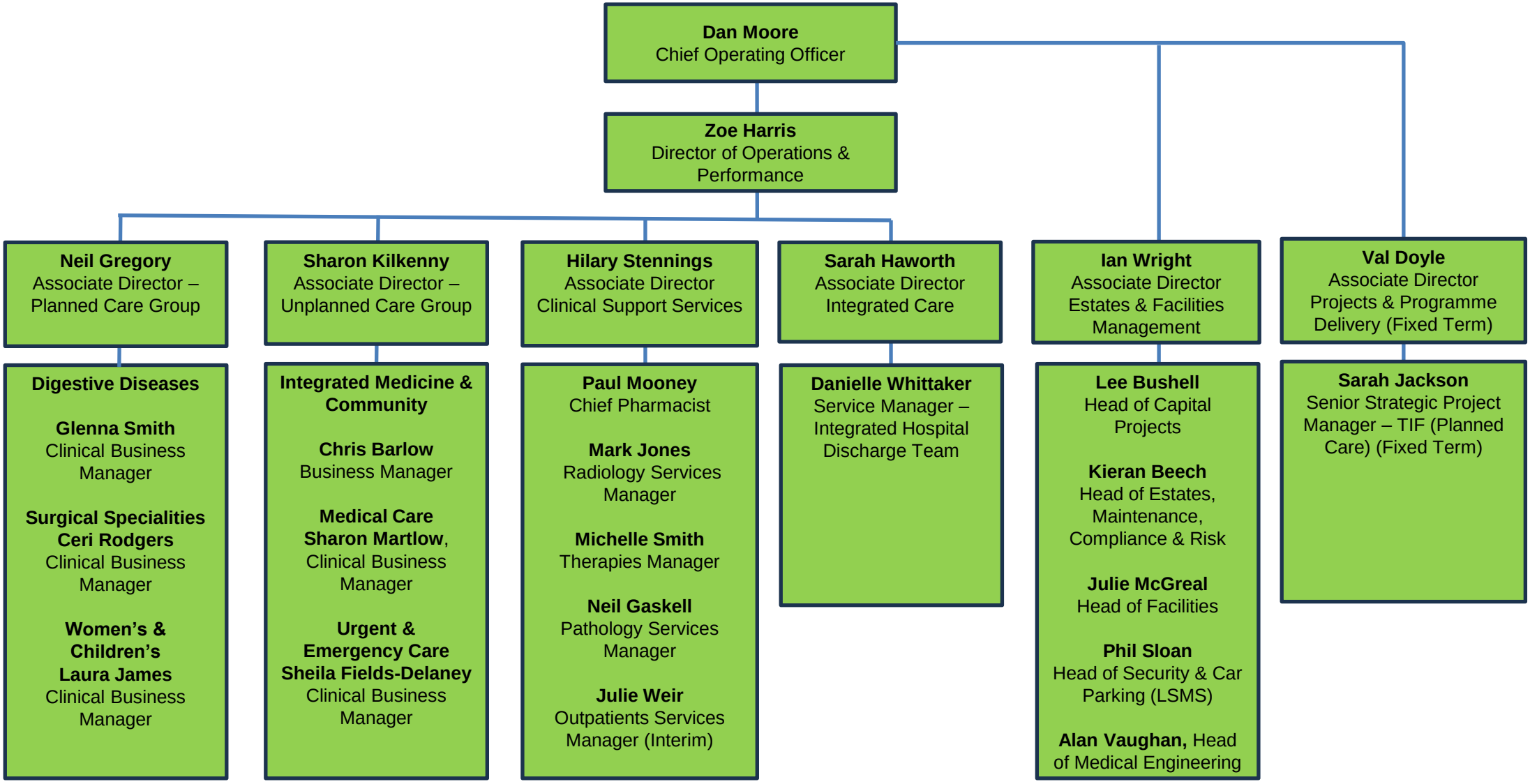
Executive Team



Version: 10.10.2023

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Operations



Version 3: 30.01.2024

Care Groups and Clinical Business Units

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Dan Moore
Chief Operating Officer

Zoe Harris
Director of Operations & Performance

Planned Care Group

Neil Gregory
Associate Director

DIGESTIVE DISEASES
James Melling
Clinical Director
Glenna Smith
Clinical Business Manager
Lucy Parry
Lead Nurse

CLINICAL SERVICES
Gastroenterology
General Surgery
Upper Gastro-intestinal Surgery
Colorectal Surgery
Endoscopy
Anaethetics
Liaison Pain Management
Pre-Op Assessment
Ward A4
Ward A5 Gastro
Ward A5 Elective
Ward B4
Planned Investigations Unit
Theatres
Post Anaesthetic Care
CT Room

Dr Eshita Hasan
Associate Medical Director

SURGICAL SPECIALITIES
Anna Vondy
Clinical Director
Ceri Rodgers
Clinical Business Manager
Carol McEvoy
Lead Nurse

CLINICAL SERVICES
Gastroenterology
Trauma & Ortho
Ophthalmology
Urology
ENT
Audiology
Maxilofacial Surgery
Orthodontics
Ward A6
Ward B3
Captain Sir Tom Moore Ward

Natalie Crosby
Associate Chief Nurse

WOMEN & CHILDREN's HEALTH
Dr Satish Hulikere
Clinical Director
Laura James
Clinical Business Mngr
Ailsa Gaskill Jones
Director of Midwifery
Jill Tomlinson
Lead Nurse Women & Childrens Gynae

CLINICAL SERVICES
Midwifery
Obstetrics
Gynaecology/Assessment Unit
Colposcopy
Paediatrics
Neonatology/Neonatal ITU
Antenatal Day/Clinic
The Nest//Birth Suite
C23
Ward 20
Wards B10 & 11
Children's Outpatients

Unplanned Care Group

Sharon Kilkenny
Associate Director

MEDICAL CARE
Dr Laura Langton
Clinical Director
Sharon Martlow
Clinical Business Manager
Claudine Reynolds/Ellis Clarke, Lead Nurses

CLINICAL SERVICES
Critical Care Medicine
Cardiology
Respiratory Medicine
Cardio Respiratory Investigations
Diabetes & Endocrinology
Nephrology
Rheumatology
Neurology
Dermatology
Acute Care Team
Intensive Care Unit
Acute Cardiac Care A3
Acute Respiratory B18
Ward C21

Dr Mark Forest
Associate Medical Director

URGENT & EMERGENCY CARE
Dr Saagar Patel
Dr Adebole Adebowale
Associate Clinical Directors
Sheila Fields-Delaney,
Clinical Business Manager
Yasmin Habib
Lead Nurse

CLINICAL SERVICES
Emergency Medicine
Acute Medicine Emergency Department
Same Day Emergency Care Unit
Runcorn urgent Treatment Centre
Acute Medical Unit A1
Ward A2
Patient Flow Team

Emma Painter
Associate Chief Nurse

INTEGRATED MEDICINE & COMMUNITY
Pradeep Magapu
Clinical Director
Chris Barlow, Clinical Business Manager
Janey Pye, Lead Nurse

CLINICAL SERVICES
General Medicine
Care of the Elderly
Palliative Care
Frailty Assessment Unit Ward A7
Wards A8 & A9
Forget Me Not Unit B12
Stroke Unit B14
Ward B19 & K25
Discharge Suite
Integrated Discharge Team

Clinical Support Services

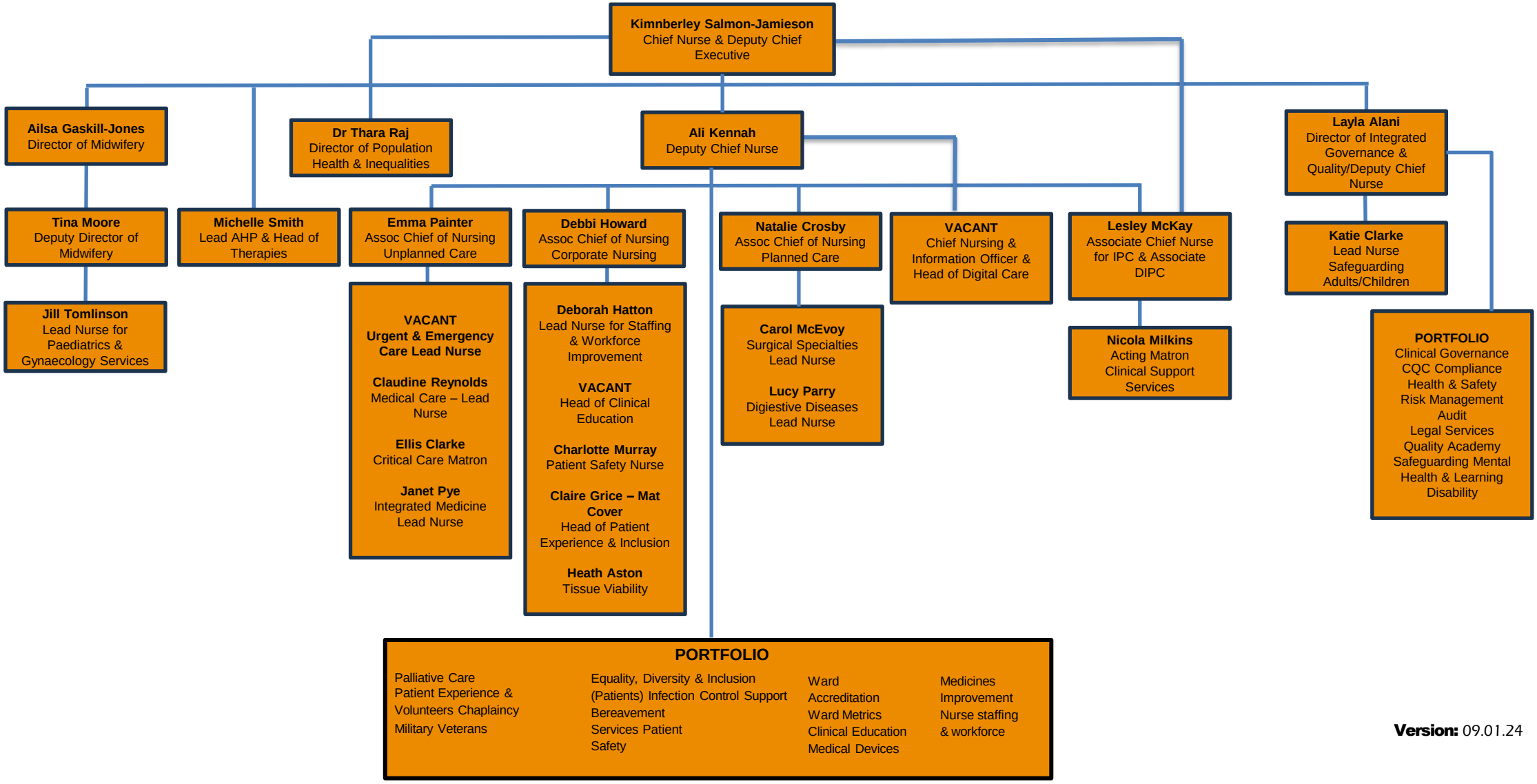
Dr Alison Davis, Clinical Director
Hilary Stennings
Associate Director
Nicola Milkns, Matron
Paul Mooney, Chief Pharmacist
Michelle Smith
Head of Therapies
TBC
Lead Nurse
Mark Jones
Radilology Services Manager
Neil Gaskell
Pathology Services Manager
Lesley McKay
Associate Director, Infection, Prevention & Control (IPC)

CLINICAL SERVICES
Haematology
Microbiology
Clinical Chemistry
Imaging
Histopathology
Radiology
Breast Screening
Infection Prevention & Control
Outpatients
Pharmacy
Therapies

Version 2: 25.01.2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

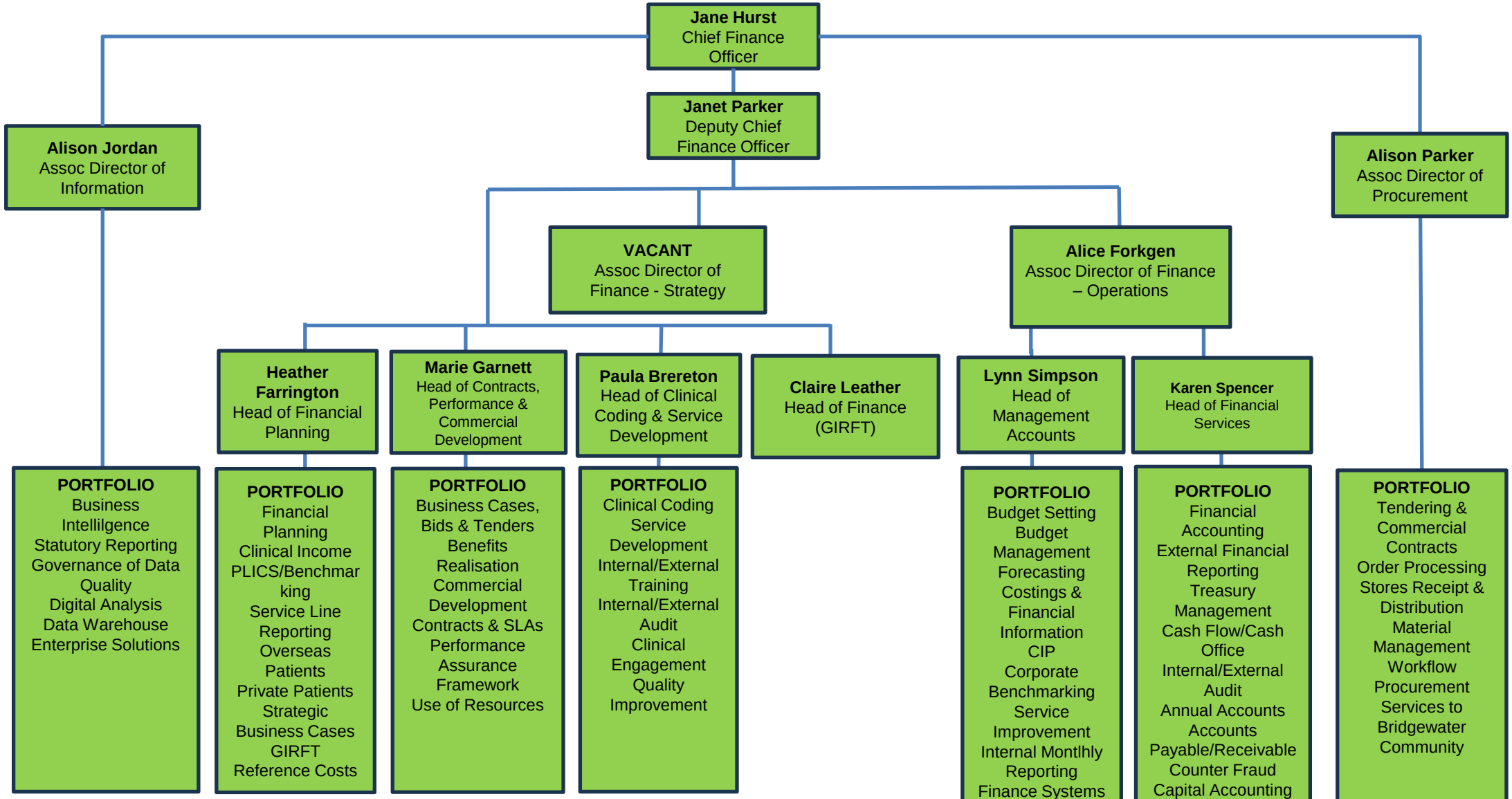
Nursing and Clinical Governance



Version: 09.01.24

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Finance



Version: 30.01.2024

Medical Cabinet

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Dr Paul Fitzsimmons
Executive Medical Director
& Chief Clinical Information Officer

Dr Paula Chattington
Director of Medical Education

Kate Davidson
Medical Education Manager

Dr Anne Robinson
Deputy Medical Director &
Responsible Officer

Debbie Mallet
Medical Cabinet Business Manager

Dr Mark Forrest
Associate Medical Director
Unplanned Care Group

Dr Alison Davis
Clinical Director
Clinical Support Services

Dr Eshita Hasan
Associate Medical Director
Planned Care Group

Dr Laura Langton
Clinical Director
Medical Care

Dr Adebola Adebowale & Mr Saagar Patel
Associate Clinical Directors
Urgent & Emergency Care

Dr Pradeep Magapu
Clinical Director
Integration Medicine & Community

Dr Anna Vondy
Clinical Director
Surgical Specialities

Mr James Melling & D r Andrew Langdon
Clinical Director
Digestive Diseases

Dr Satish Hulikere
Clinical Director
Women's & Children's

Portfolio Associate Medical Directors

Dr Eshita Hasan
Associate Medical Director
for Patient Safety

PORTFOLIO

VTE
Medicines Governance
Infection Control/Sepsis/UTI
CQUINS
Discharge Communication
Diagnostic Testing Policy
Incident Investigation
CQUIN
Patient Safety Specialist
Mortality, Learning from Deaths
Serious Incidents

Mr Mithun Murthy
Associate Medical Director
for Clinical Effectiveness

Dr Kevin Tan
Deputy AMD
CE – Procedural Safety

Dr Tim Furniss
Deputy AMD
CE – Research & Development

PORTFOLIO

Clinical Audit
NICE
LocSSIPs
Consent
Clinical Ethics Committee
Research
7 Day Services
Trust-wide Trauma Group
Cancer

Mr Pranesh Nagarajan
Associate Medical Director
Clinical Productivity &
Strategy

PORTFOLIO
Clinical Productivity
Getting It Right First Time (GIRFT)
Strategy

Dr Hilary Furniss
Associate Medical Director –
Medical Appraisal &
Revalidation

PORTFOLIO

Medical Appraisal Standards
Responsible Officer (RO)
Documentation and Reporting
Support for Doctors Revalidation
Support & Professional Development for Doctors

VACANT
Chief Nursing Information
Officer & Head of Digital Care

Dr Rita Arya
Associate Chief Clinical Information Officer – Women's & Children's Health

Dr Damian Stansfield
Associate Chief Clinical Information Officer – Medical Specialties

Dr Phyu Wai
Associate Chief Clinical Information Officer – Medical Specialties

Mr Gareth Stables
Associate Chief Clinical Information Officer – Surgical Specialties

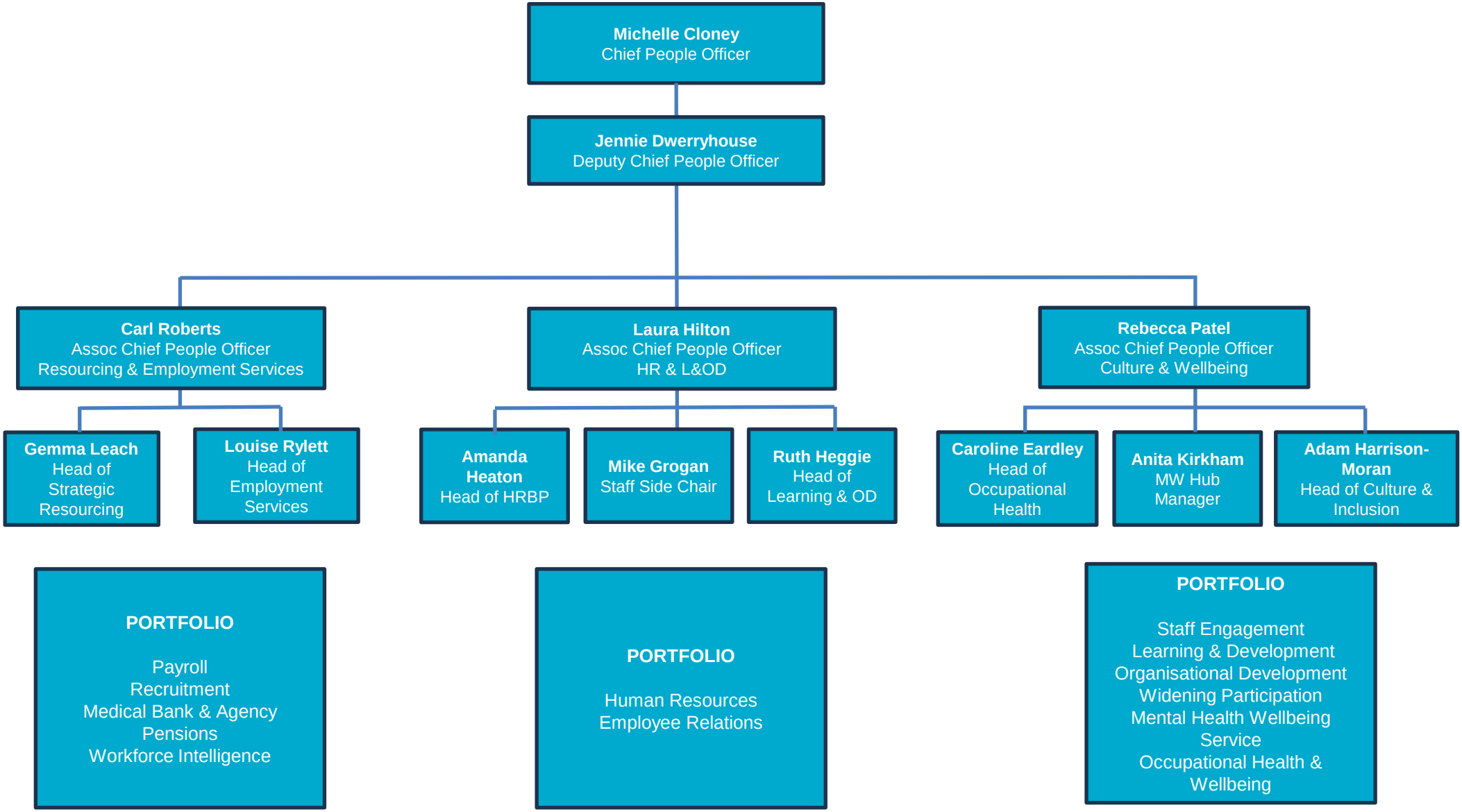
Miss Virag Varga
Associate Chief Clinical Information Officer - Surgical Specialties

PORTFOLIO
Clinical Information

Version: 17.01.2024

People

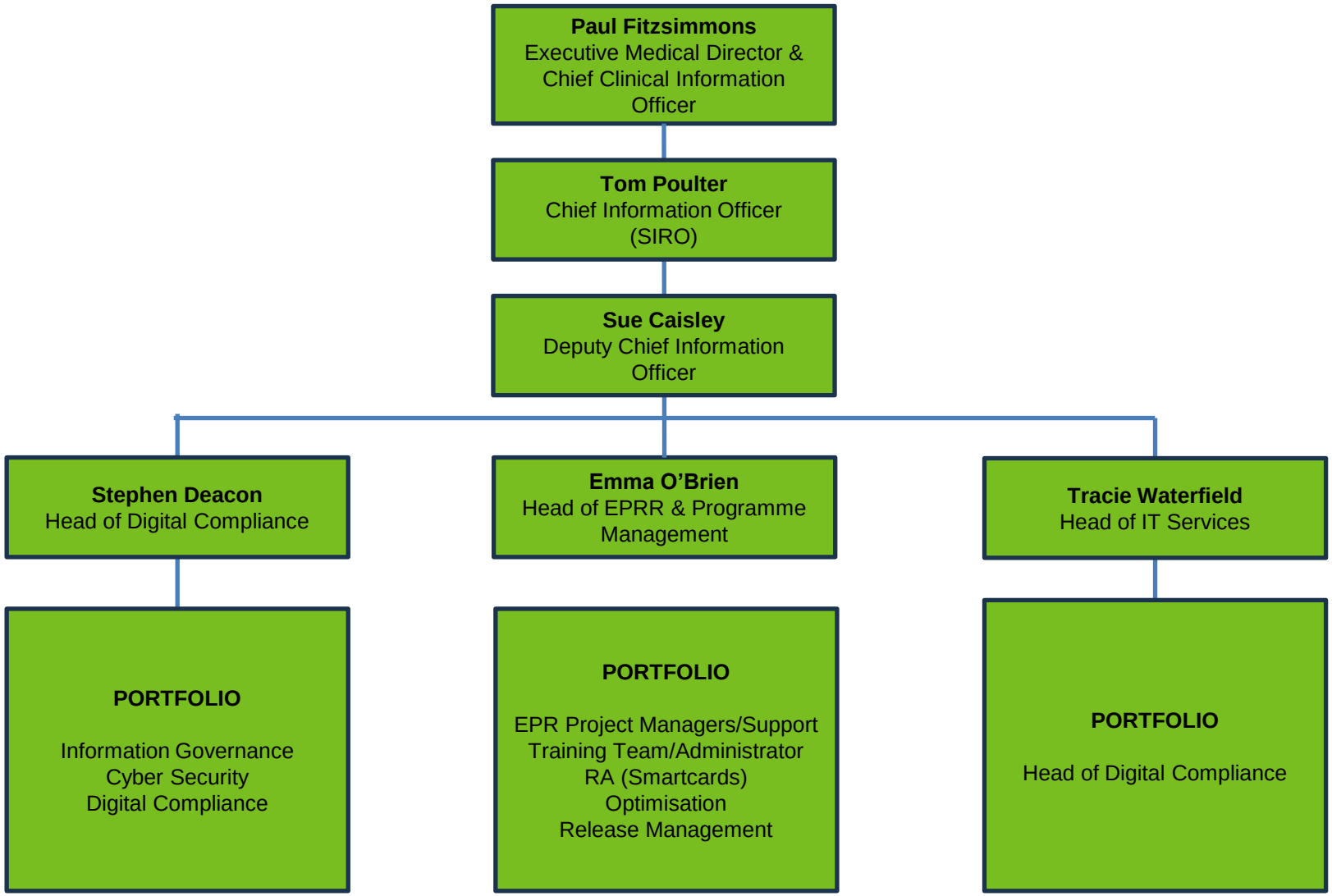
Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 10.01.2024

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

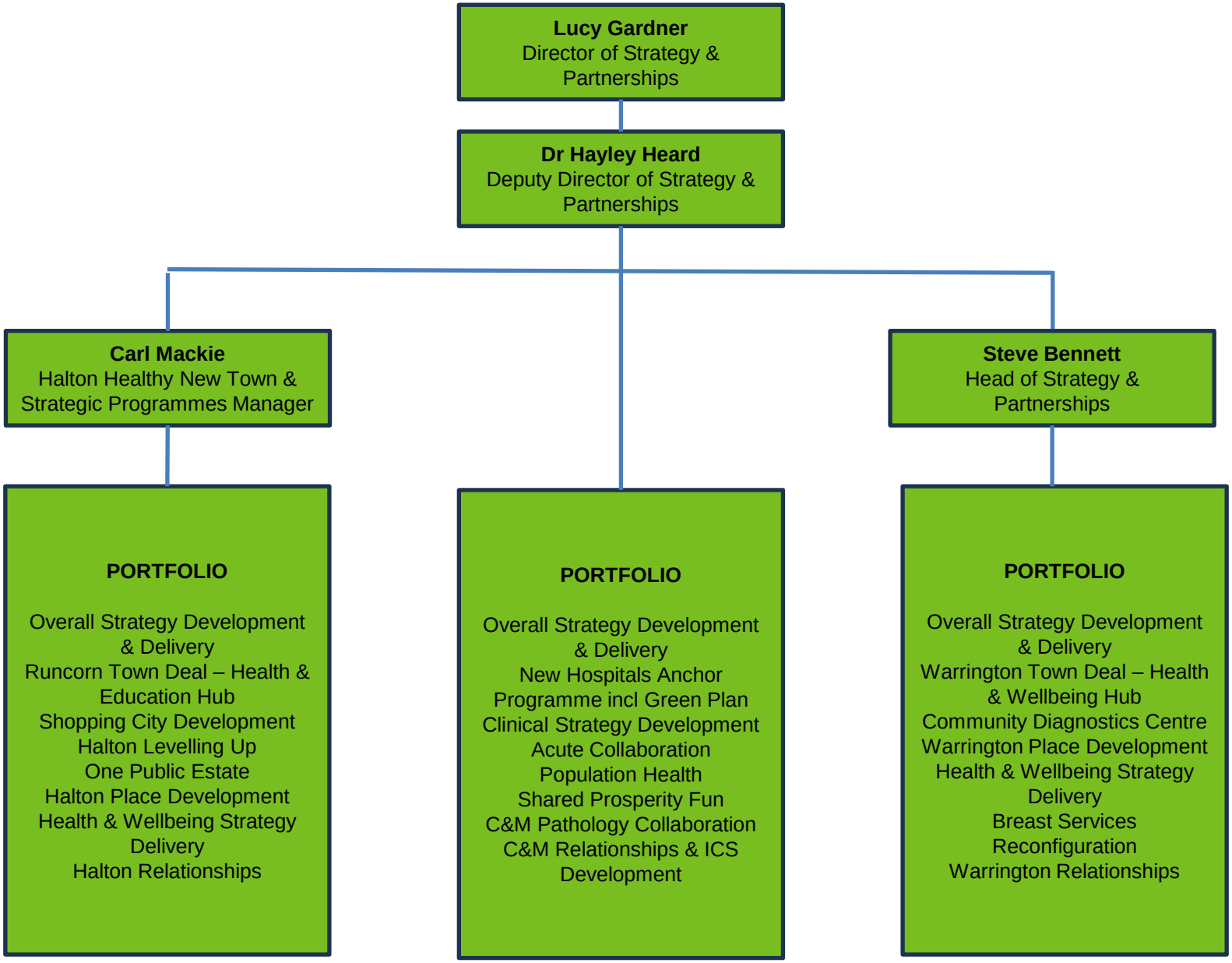
Digital Services



Version: 10.01.2024

Strategy and Partnerships

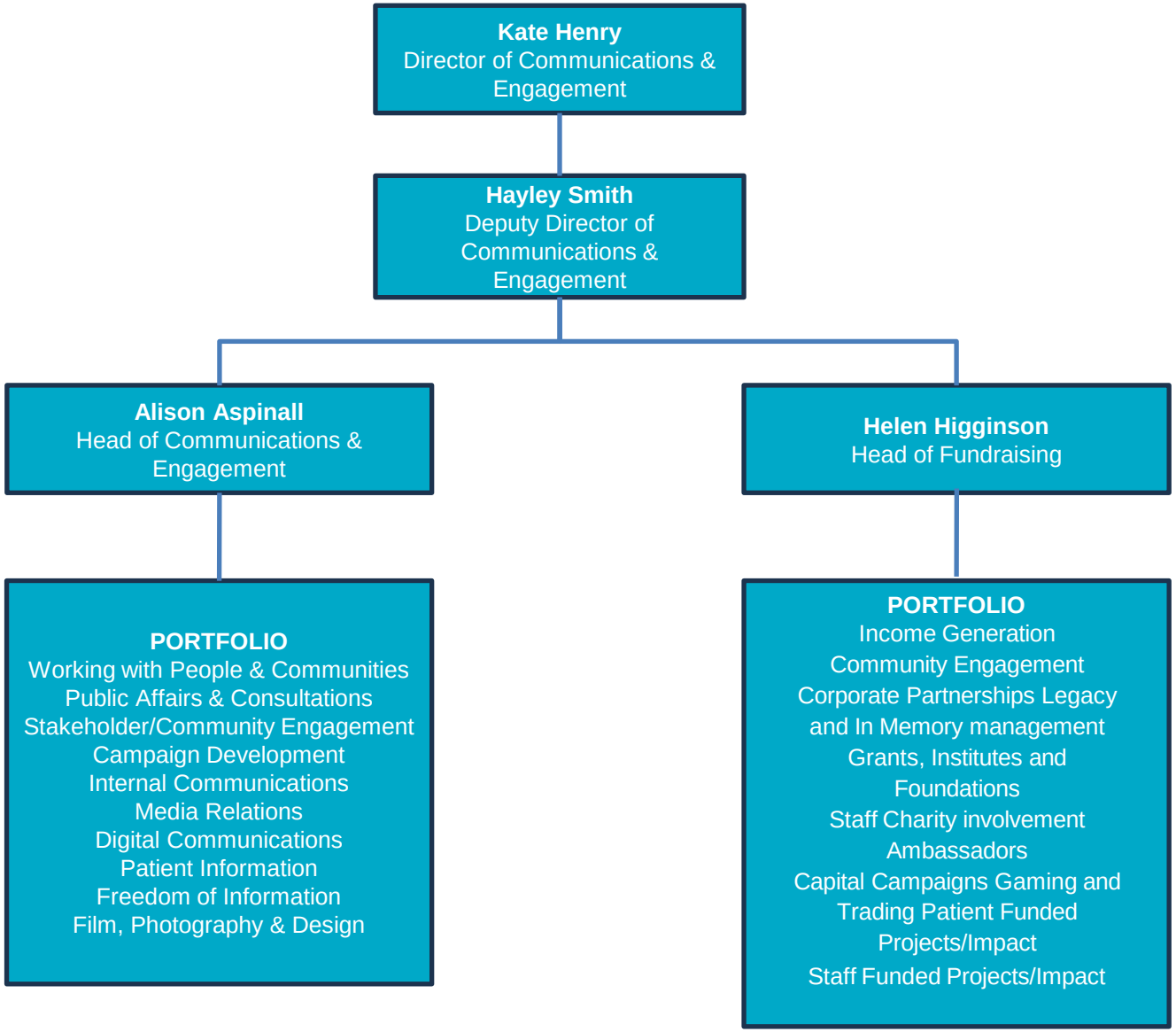
Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 10.01.2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

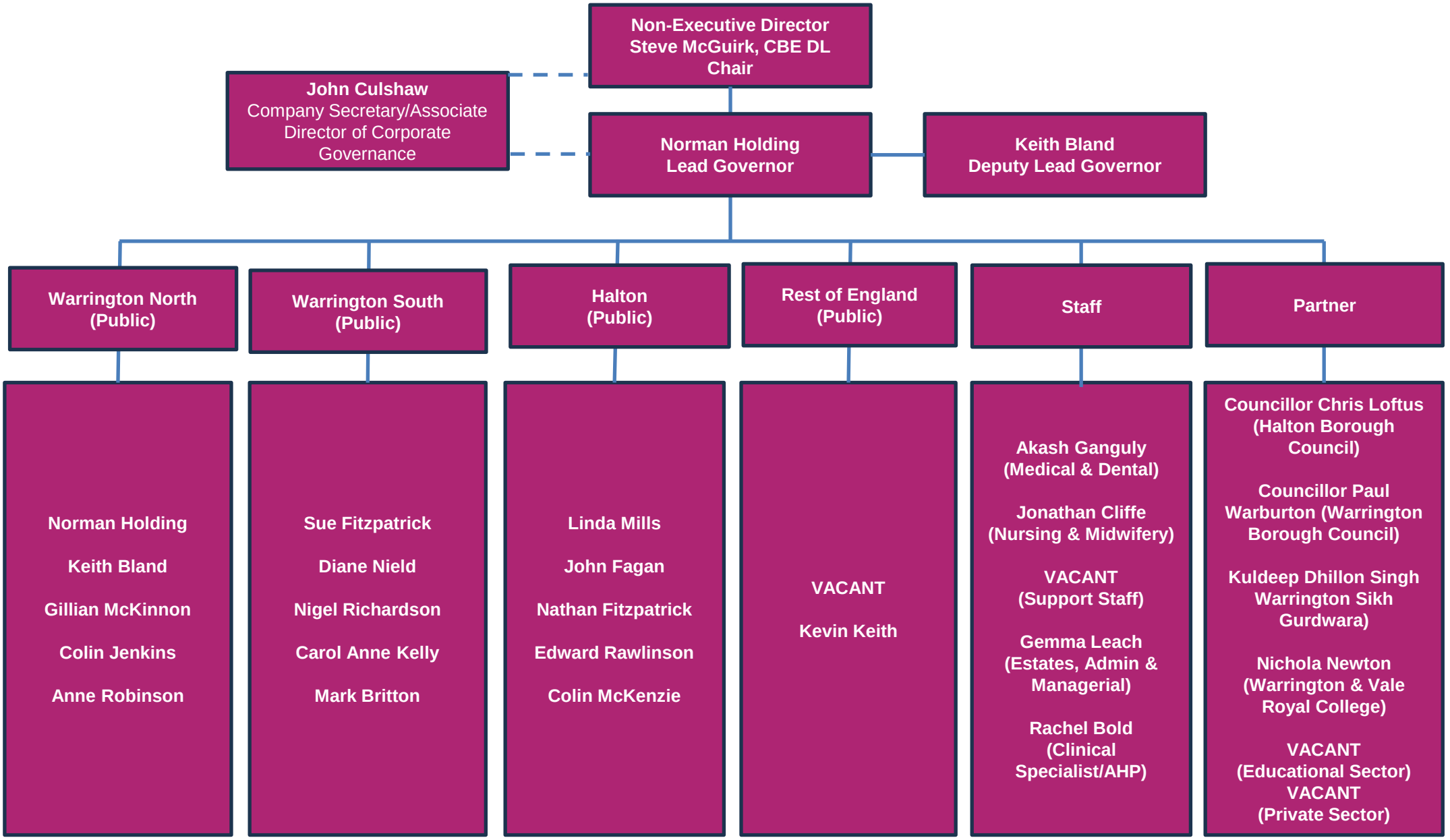
Communications and Engagement



Version: 11.01.2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Governors



Version: 12.11.2023

Overview

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Maternity Services Update
- CQC Engagement and Risk meeting held at Warrington Hospital on 29th January 2024
- Slides presented are included in the presentation for:
    - Urgent and Emergency Care
    - Medicine
    - Surgery
- Next steps

Maternity

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- CQC Maternity Inspection was undertaken on 14th September 2023
- Factual accuracy concluded and final report published on 17th January 2024
- 0 Must Do's identified
- Should Do's identified are as follows and will be progressed within the service:

  - The service should continue to improve training compliance rates for all staff in all relevant areas
  - The service should ensure all policies and procedures are in place and reflect current evidence-based best practice and are fit for purpose
  - The service should ensure that electronic patient records are integrated as far as is possible to avoid the risk of missed information.
  - The service should continue to develop, communicate, and embed the transitional care provision
  - The service should ensure that all staff complete regular simulation training/Skills and Drills training, such as regular pool evacuation and abduction drills

CQC Engagement and Risk meeting

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Held on 29th January 2024 at the request of the CQC as part of new inspection and review methods
- CQC identified 3 core services and requested additional assurance
- CQC Engagement and Risk meeting was scheduled and took place on 29th January 2024
- All core services present their current position, challenges and plans in place for assurance
- Further information requests will be provided as they are received from CQC following receipt of identified next steps

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Urgent and Emergency Care

Unplanned Care Group

Sharon Kilkenny, Associate Director of Operations

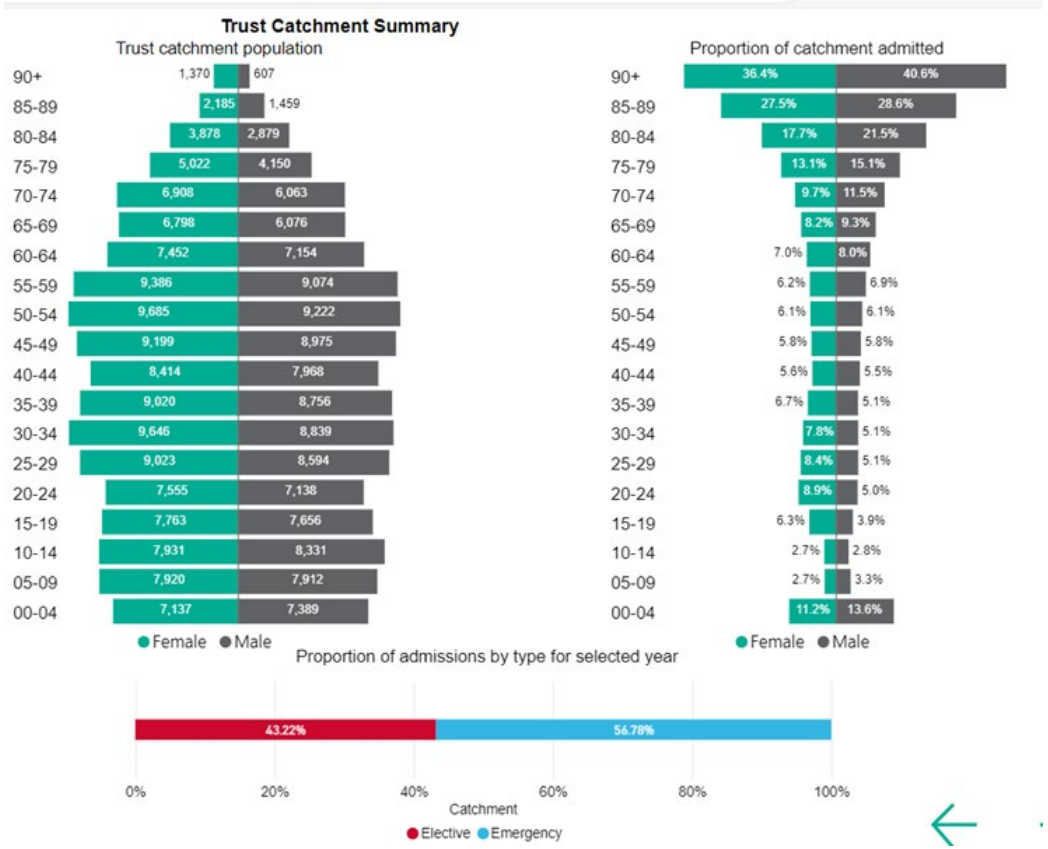
Mark Forrest, Associate Medical Director

Emma Painter, Associate Chief of Nursing

CQC engagement meeting

29 January 2024

Population demographics and associated challenges



Population of 330,000 - Halton & Warrington

Over 100,000 A&E attendances/year, >270/day

Biggest challenges relate to age & deprivation

Percentage of adults reporting a mental health problem

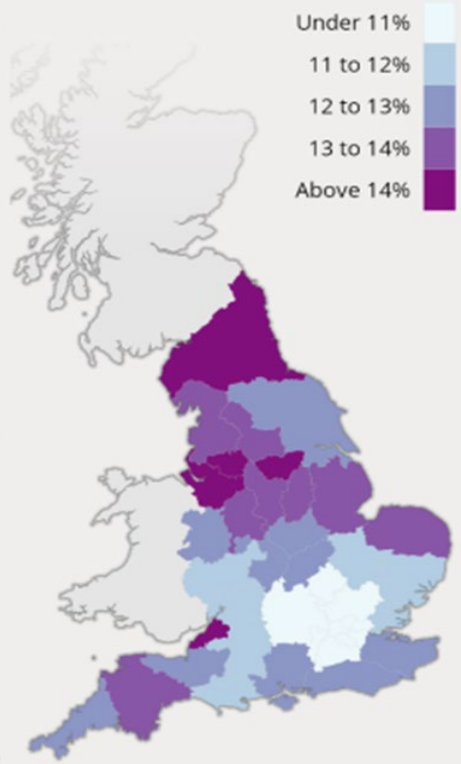
By Integrated Care Board, England, age 18+, GP patient survey, 2022

Highest reported prevalence

North East & North Cumbria	15.6%
South Yorkshire	15.3%
Cheshire & Merseyside	15.3%
Greater Manchester	14.3%
Bristol, N Somerset & S Gloucs	14.1%
Derby & Derbyshire	14.0%
Lancashire & South Cumbria	13.8%
West Yorkshire	13.7%
Nottingham & Nottinghamshire	13.7%
Norfolk and Waveney	13.4%

Lowest reported prevalence

North West London	9.1%
Surrey Heartlands	9.1%
South West London	9.2%
Frimley	9.5%
North East London	9.5%
North Central London	9.8%
Bedfordshire, Luton & MK	10.0%
Hertfordshire & West Essex	10.1%
South East London	10.7%
Bucks, Oxfordshire & Berkshire W	10.9%



Cheshire and Merseyside has one of highest proportions of adults reporting a mental health problem

Urgent care – structure

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Unplanned Care Group Triumvirate

Sharon Kilkenny
Associate Director of operations

Mark Forrest
Associate Medical Director

Emma Painter
Associate Chief of Nursing

Clinical Business Unit (CBU) Triumvirate

Sheila Fields-Delaney
CBU Manager

Adebola Adebowale
Interim Associate Clinical Director

Yasmin Habib
Lead Nurse

Urgent & Emergency Care (UEC) Team

Michelle Catterall, UEC Matron

Melanie Frangleton
UTC Nurse Manager

Ashley Halliday
ED Department Manager

Jill Nuckley
SDEC Department Manager

Jade Robinson
Senior Assistant CBU Manager

Sarah Kennedy
Assistant CBU Manager

Urgent care – overview of services

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

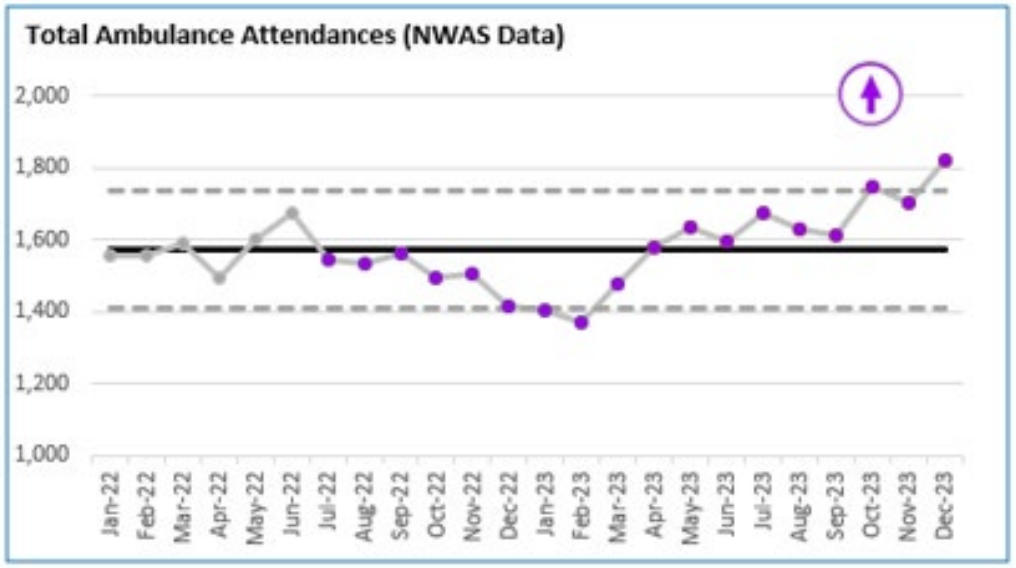
Emergency Department, Warrington Hospital (incl. minor injuries, ED adults and paediatrics)

Same Day Emergency Care (SDEC), Warrington Hospital

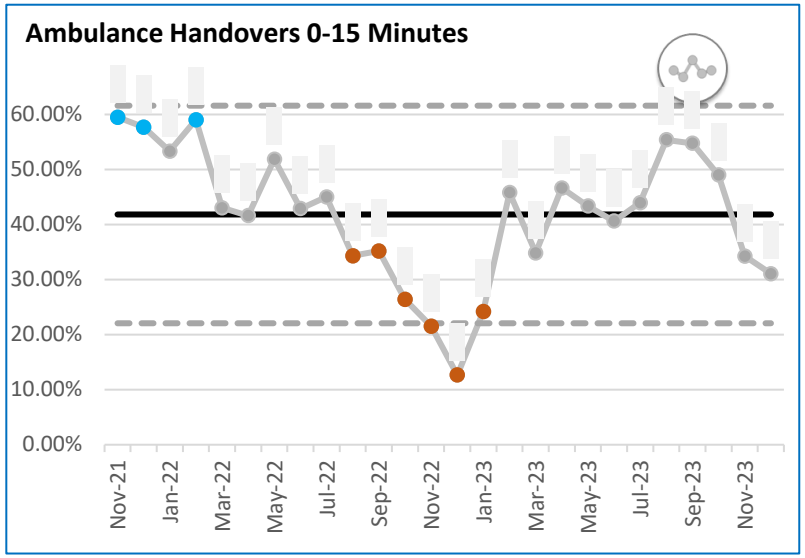
Urgent Treatment Centre, Halton Hospital

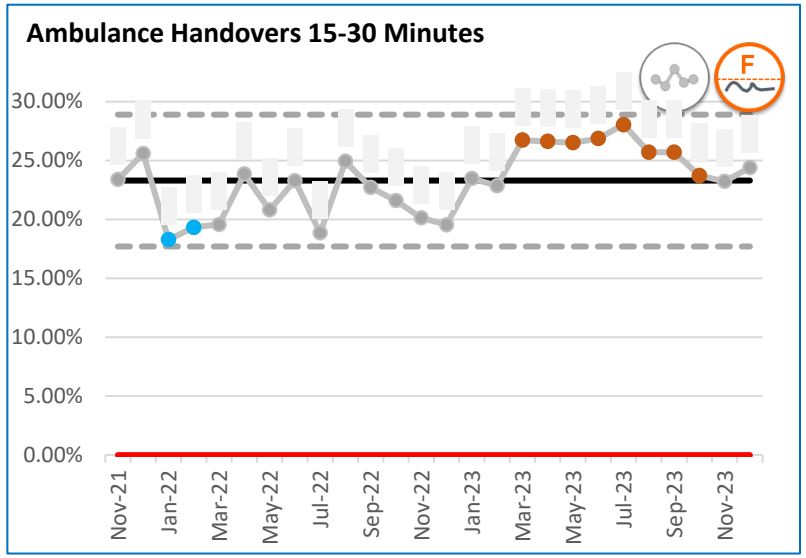
An exemplar for ambulance handovers

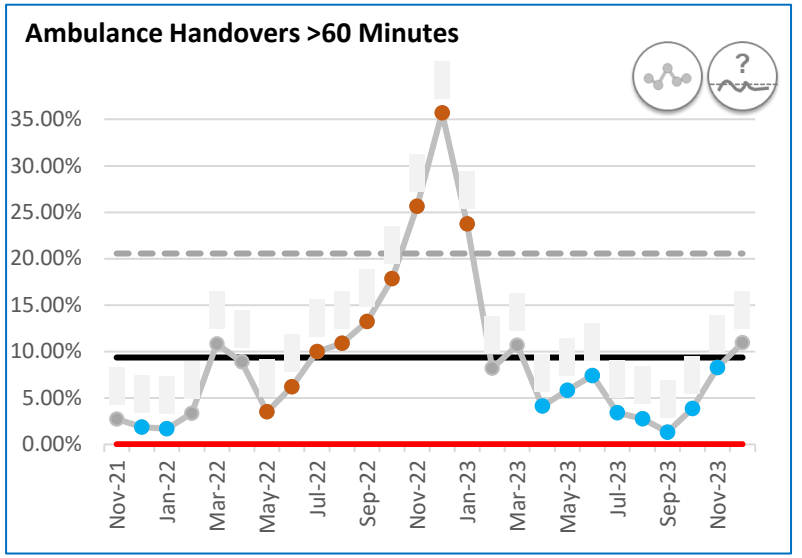
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



- Sustained performance despite a 17% increase in attendances over the last 12 months, and a 4% increase from November 2023 - December 2023.
- Significant improvements in performance winter 23/24 compared to 22/23

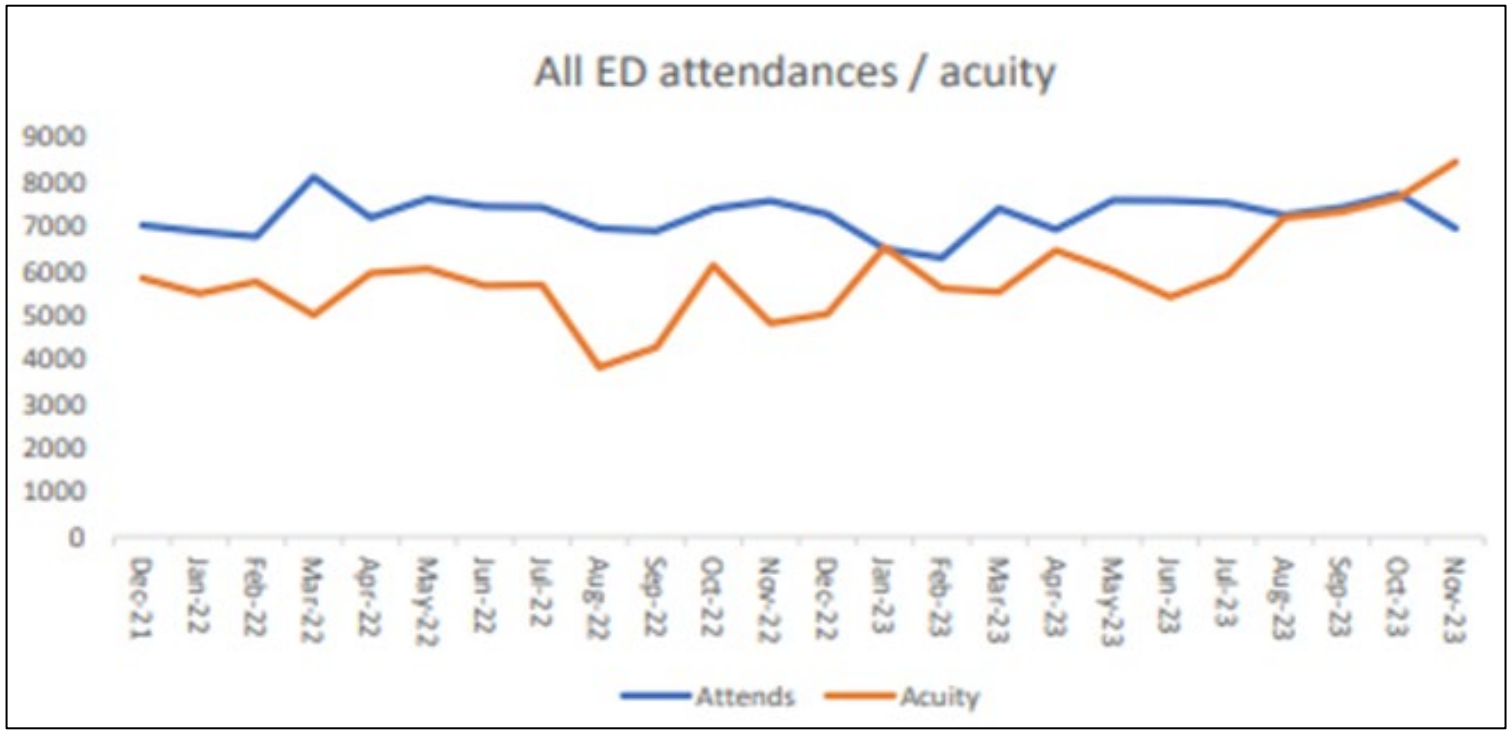






ED attends and acuity

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



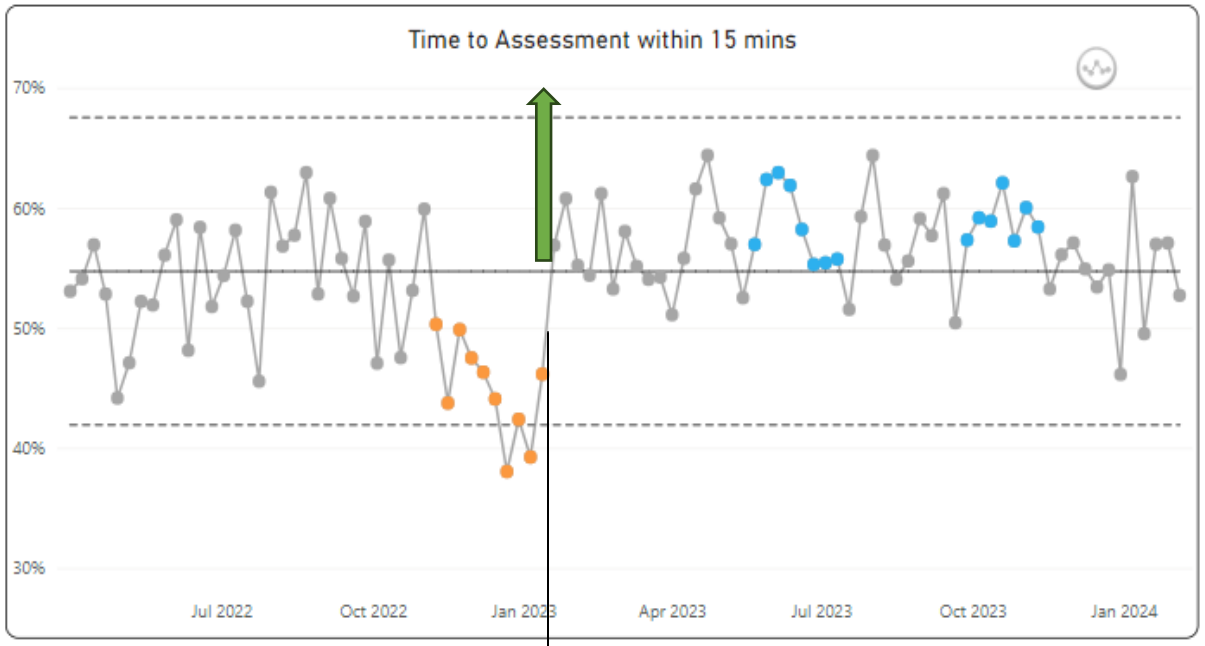
Data as reported via SAPIT (summary acute provider indicator table), derived from SEDIT data

- The increase in acuity correlates with the increase in ambulance attends – June to Dec 2023
- SDEC activity recorded as type 5 activity from November 2023 (direct streamed patients not included in ED attendances)

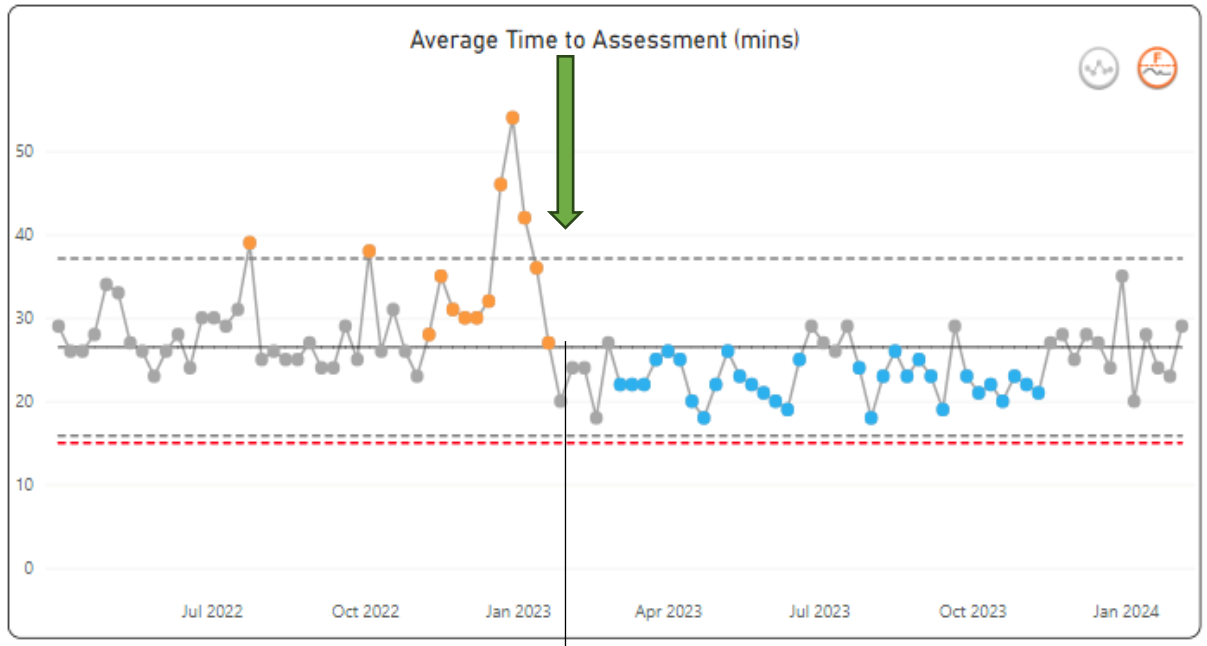
Time to initial assessment

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

An improving position



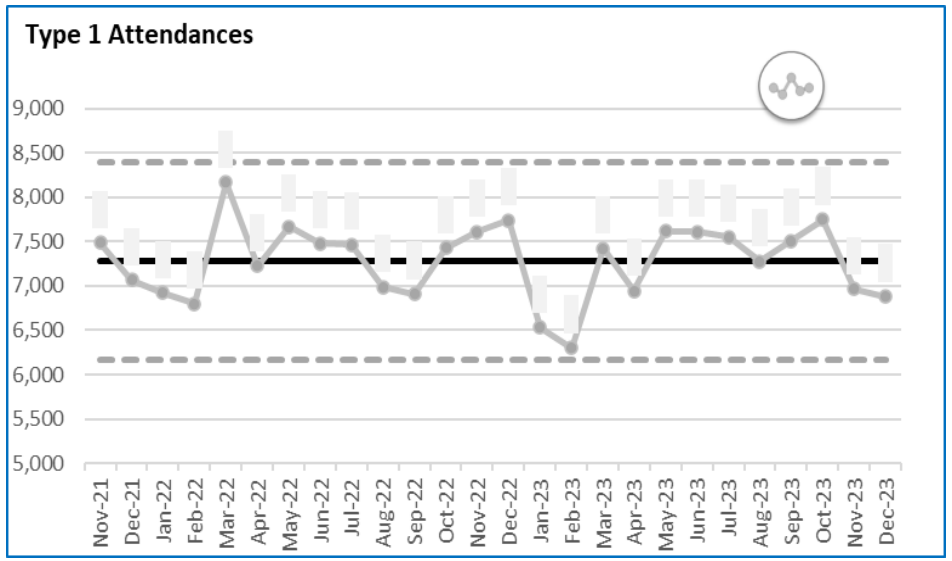
Increased nurse staffing in ED

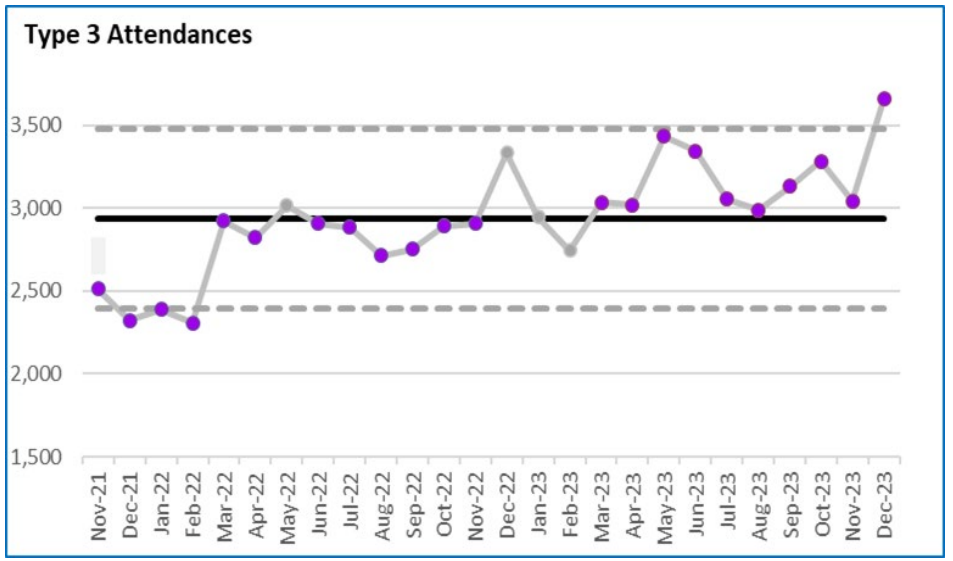


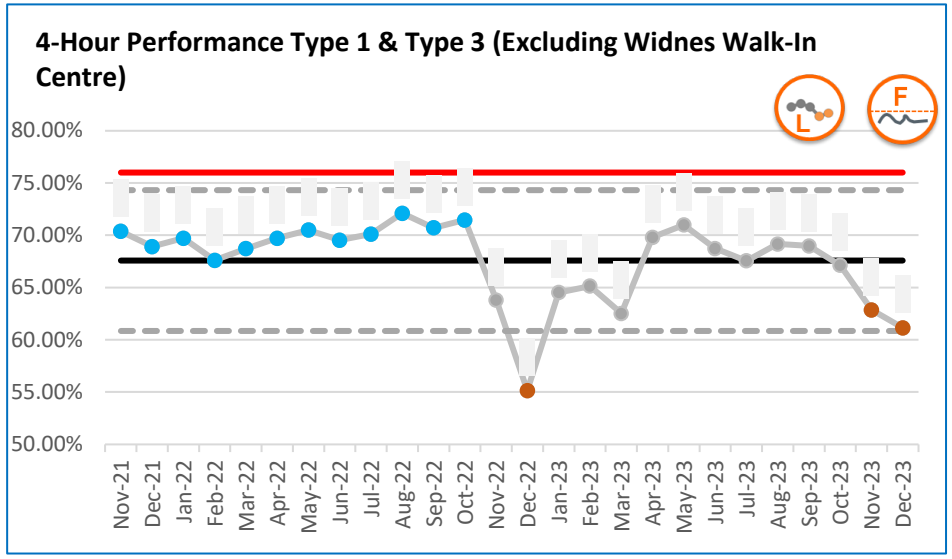
Increased nurse staffing in ED

4-hour performance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust







Sustained 4-hour performances despite:

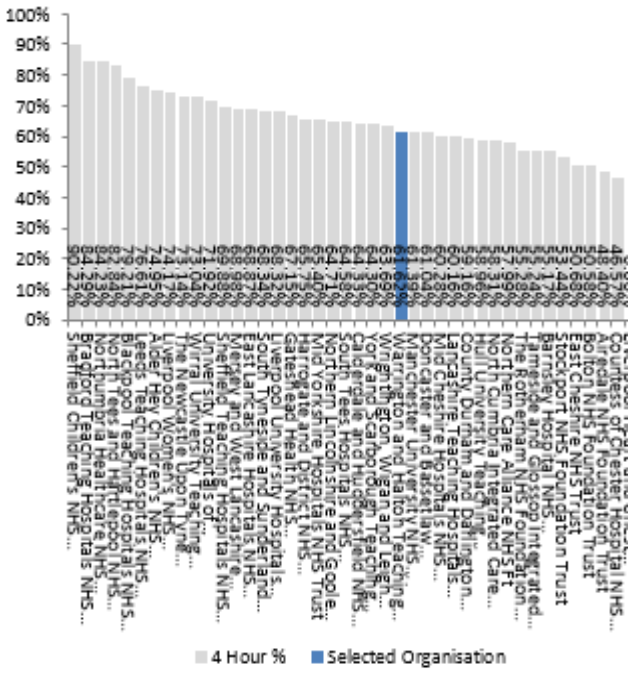
- No UTC in Warrington resulting in type 3 attendances to main Emergency Department = impacting occupancy
- Increase in ambulance attendances = increased occupancy
- Increase in acuity

Benchmarked 4-hour performance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

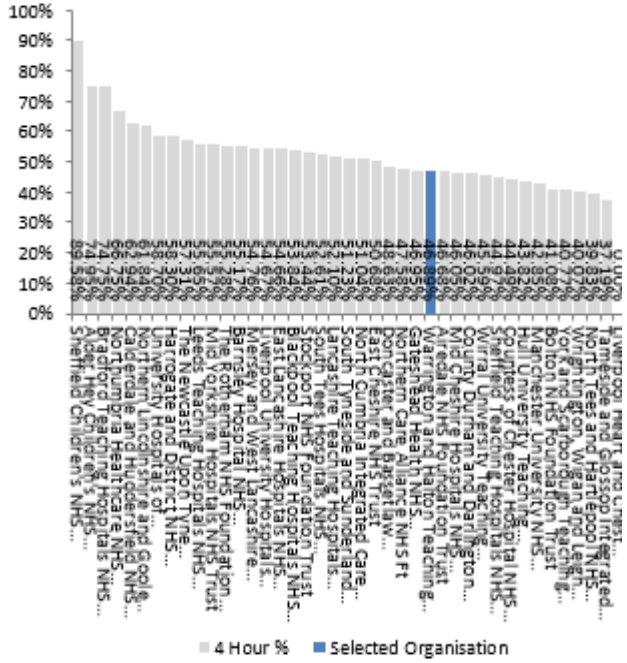
4hr performance weekly rank (all	
Region	National
25 / 45	85 / 126

4hr performance - all



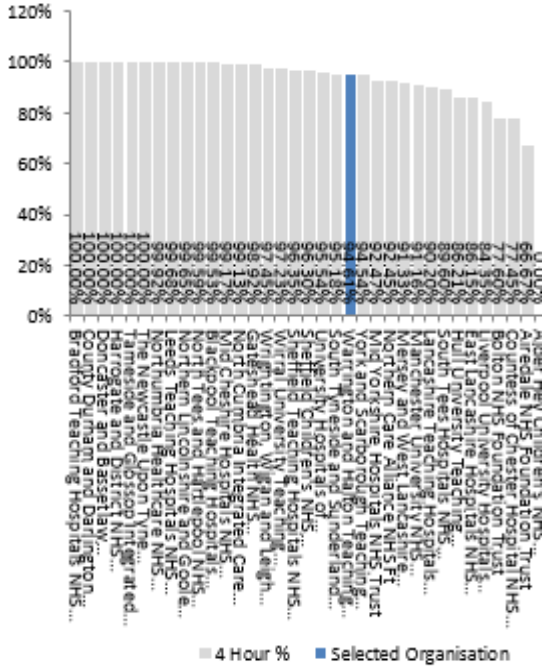
4hr performance weekly rank (Type	
Region	National
27 / 45	88 / 126

4hr performance - Type 1



4hr performance weekly rank (Type	
Region	National
21 / 45	68 / 127

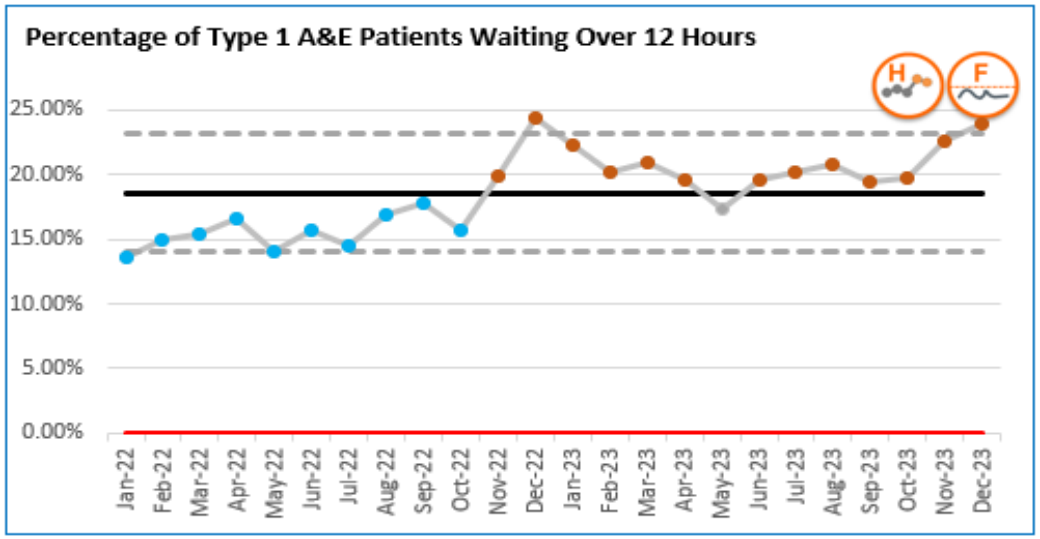
4hr performance - Type 3



ECIST UEC Dashboard, 25/01/2024

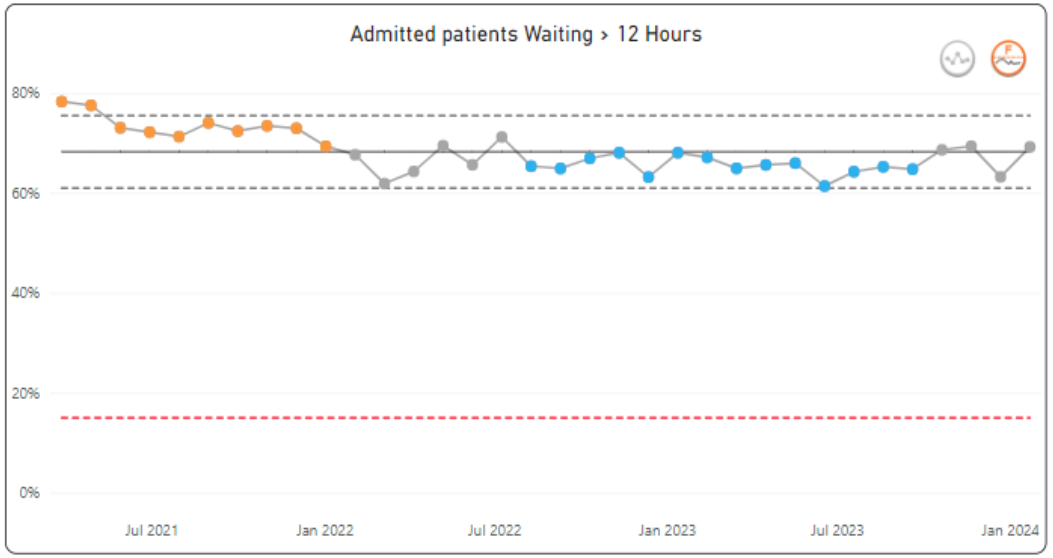
12-hour total time in department – top metric

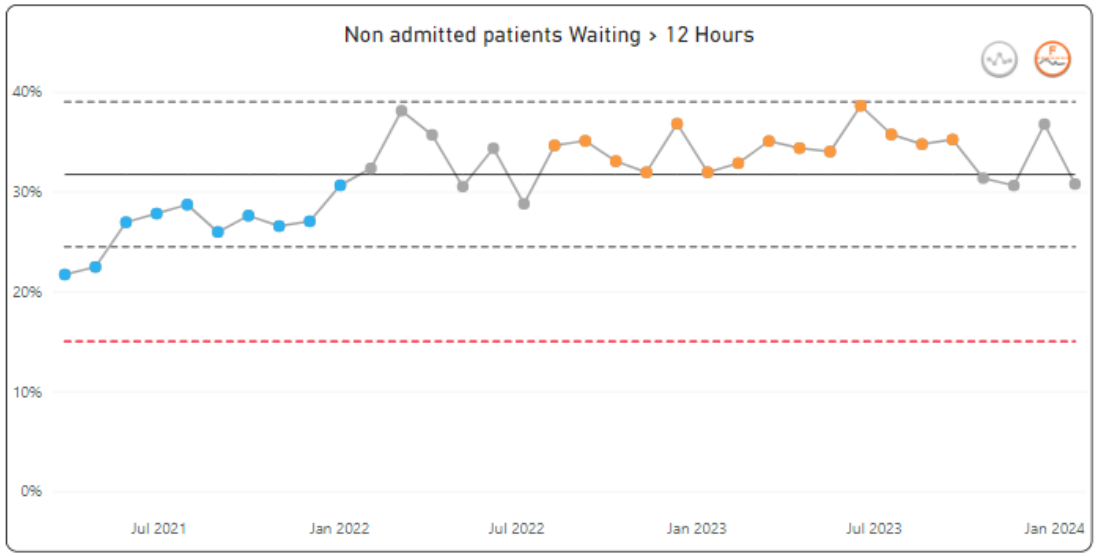
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Implemented schemes to improve admitted performance:

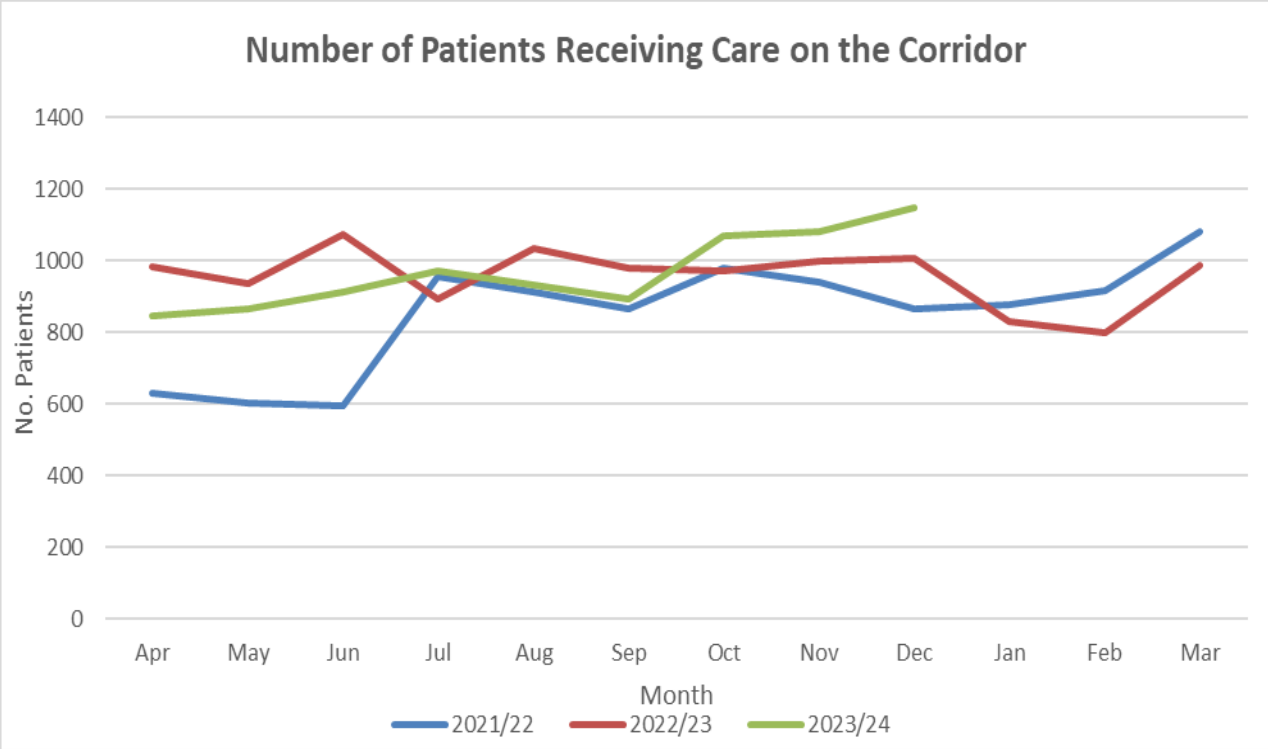
- Continuous flow
- Emergency Admission Unit





Care on the corridor

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



October to December 2023 demonstrates an increase in number of patients receiving care on the corridor contributed to by:

- Increase in ambulance attends and Trusts commitment to ambulance handover times
- Increase in acuity

Trust response and mitigation:

- Escalation within the bed base
- Reverse cohorting
- Intentional rounding

ED improvement schemes

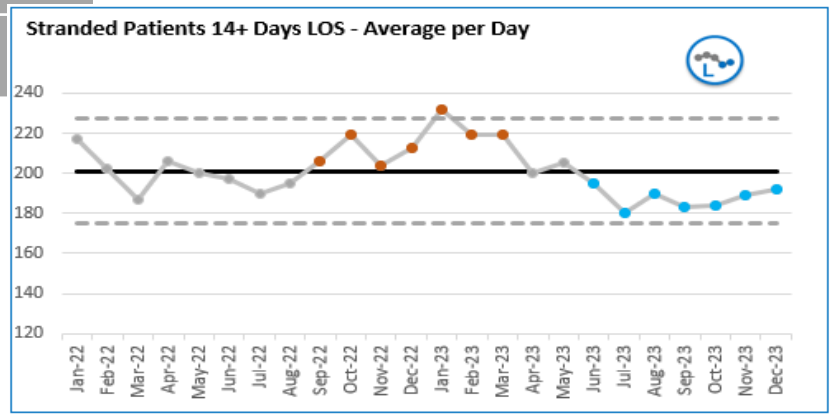
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

No	ED Improvement Project	Plan details	Link to Tier 1 Metric	Delivery of Action	Scheme Performance
1	Continuous Flow	Full role out to all unplanned care wards	Time in ED		
2	Emergency Admissions Unit	Opened Wednesday 8th November	LoS		
3	ED CT Scanner	Co-location of a CT scanner from Aug 23	Time in ED		
4	Collaboration with NWAS	Collaboration to implement direct SDEC access from NWAS	Amb Handover		
5	ED Footprint/Minors	To be completed February 2024 following estates work	Amb Handover		
6	Streaming	Decision to merge SDEC and Ed Ambulatory.	Time in ED		
7	Triage	Implement Manchester Triage process from March	Time in ED		
8	Newton	Findings presented to WHH Board	Amb, TiED, LoS		

- Following the initial 8 schemes agreed with ECIST, 5 have completed and the impact is being monitored via the Trust ED Improvement Group.
- The remaining 3 are set to complete or start in Q4.
- Sustained Improvement in Ambulance and 14 Day LoS

Focus - 12 Hour TiD

	Type 1 A&E Performance (ECDS		Over 12 Hours (ECDS)		% Beds Occupied by Patients 14+ LOS (UEC Daily SitRep)	
Trust Tier Score (Weighted) *based on Type 1 Performance, %> 12h and LOS 14+	Type 1 A&E Performance (ECDS)	Type 1 A&E Performance (ECDS) Tier	% Over 12 Hours (Type 1) (ECDS)	% Over 12 Hours From Time of Arrival (ECDS) Tier	% Beds Occupied by Patients 14+ LOS (UEC Daily SitRep)	% Beds Occupied by Patients 14+ LOS (UEC Daily SitRep) Tier
1.00	45.9%	2	21.5%	1	40.4%	1



Next steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Newton, ECIST, GIRFT & internal data review to improve 12 hour time in dept.

Scheme	Opportunity	Target Impact	Timescale
Increase streaming direct to assessment areas (SDEC/ED ambulatory, FAU)	Support decision makers in **SDEC** to take risk informed decisions around admission, access and refer to community services where appropriate	10% increase in SDEC activity	March 2024
	Support decision makers in **FAU** to take risk informed decisions around admission, access and refer to community services where appropriate	increase utilisation from 7 to 10 admission avoidance patients per day	March 2024
Time to Triage – principles of Manchester Triage	Improve time to initial assessment	Improvement from 22 minutes to 15 minutes	March 2024
Specialty input into ED	Decrease time in ED for patients waiting specialty review	Audit response times against internal professional standards	February 2024
Utilisation of alternatives to ED – UCR	Attendance / admission avoidance into ED	Increase NWAS referrals into UCR by 11 per week	Q1 24/25
Criteria led discharge	Improve flow of medical reviews over the course of the week through Criteria led discharge	Make earlier decisions on discharge to support ED flow	Q1 24/25
Decrease time in ED for non-admitted patients	Support deflection and alternatives to ED to decrease time in department for low acuity patients	Reduction in the number of patients with low acuity waiting > 12 hrs in ED by 80%	Q1 24/25
	Reduce time in ED for paediatric patients	Zero tolerance to paediatric patients > 12 hrs	Q1 24/25

Supported by ECIST Work plan:

Regulatory update

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Regulation 18(1) – There are sufficient numbers of suitably qualified, skills and experienced doctors and nurse to meet the needs of patients in the Emergency Department

- Revenue requests approved to value of £455k for medical staffing
- Significant investment to the value of £3.62m made in Emergency Department Nursing in last 4 financial years
- Reduced agency utilisation in nursing and medicine
- SDEC and UTC fully established
- New roles for Senior Nursing team - opportunities for nursing staff development
- Expansion of ACP workforce
- Improvements in digitised medical and nursing rota management

Regulation 12 (2)(a)(b) – Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals.

- Monitoring equipment in all acute areas of ED
- Newly appointed Resuscitation Specialist Nurses
- E-Obs now implemented in all areas; tailored escalation process for early identification of the deteriorating patient
- Weekly, monthly NEWS2 audits carried by team with biannual peer audit as part of Trust wide NEWS2 audit
- Updated NEWS2 criteria for ED

Regulation 17(2)(a) – Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team

- Electronic Dashboard provided in 4 areas providing accurate, real time performance in ED - providing live data and overview of ED capacity and demand

Regulation 12 (2)(b) – Crowding in the Emergency Department is reduced so that patients do not have to wait on trolleys in corridors.

- Review of Navigator role and triage process
- 24/7 Same Day Emergency Care (SDEC) to stream specialty patients
- Streaming to other assessment areas

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Safe

Safe – processes in place to maintain safety

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk	Mitigation	Assurance	Oversight
Clinical oversight of the department and recognition of deteriorating patients	Intentional rounding by nurse and medical coordinator, with immediate action if concerns identified	Intentional rounding audits completed weekly	Reviewed by matron and themes triangulated with relevant actions
Recognition of deteriorating patients	Weekly and monthly audits on NEWS2, with biannual peer audit as part of Trust wide NEWS2 audit	All audits completed with real time feedback to staff. Overall themes triangulated and action plan in place	Reviewed by Associate Chief of Nursing with action plan in place
Safe and effective management of those with mental health presentations	Mental health triage tool. Co-located Core 24 service in ED. ICE referral process embedded. Strong working relationships. Intentional rounding	All mental health concerns or delays escalated via bed meeting. Escalation to system. Intentional rounding	Reported via bed meetings to tactical manager of day. Reviewed at intentional rounding
To ensure timely handover from NWAS	24/7 NWAS handover nurse Handover times monitored by Nurse in charge with escalation to tactical manager	Handover times monitored in real time with escalation processes in place	Monitored on daily system calls, via PRG and FSC
To ensure oversight of escalation areas	Staffing of escalation areas, including corridors	Reviewed at twice daily staffing meeting with staffing escalation plan in place	Senior nurse staffing lead daily

Safe

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Processes and systems

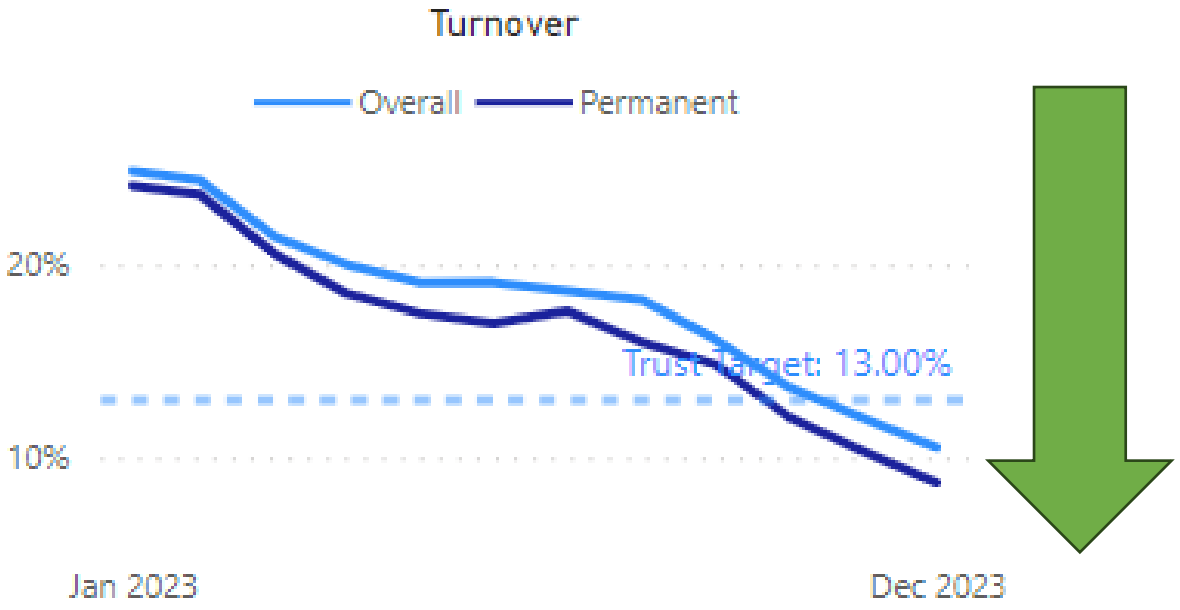
- Oversight of vulnerable patients and escalation made at each bed meeting
- Emergency Department escalation tool and Trust escalation policy, Full Capacity protocol, System escalation
- Newly implemented role of waiting room nurse
- Risk assessments completed in ED
- Daily Safety Huddle – Inclusive of MDT
- Integrated working with safeguarding team
- Embedded NWAS Handover process
- Positive reporting culture
- PSIRF implementation
- Robust governance processes to ensure:
    - effective and responsive management of risks
    - timely responses to incidents, PALS and complaints - sharing of learning

Staff knowledge and training

- Specific ED training package for new starters
- Compliance with training (trajectories for improvements in place)
    - CSTF: 86.98%
    - Role-specific: 83.18%
    - Safeguarding: 71.64%
    - DoLS: 91.70%
    - Mental Capacity act: 94.24%
    - Acute Illness Management: 91.30%
    - Sepsis: 89.16%
    - NEWS2: 91.25%

Safe

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



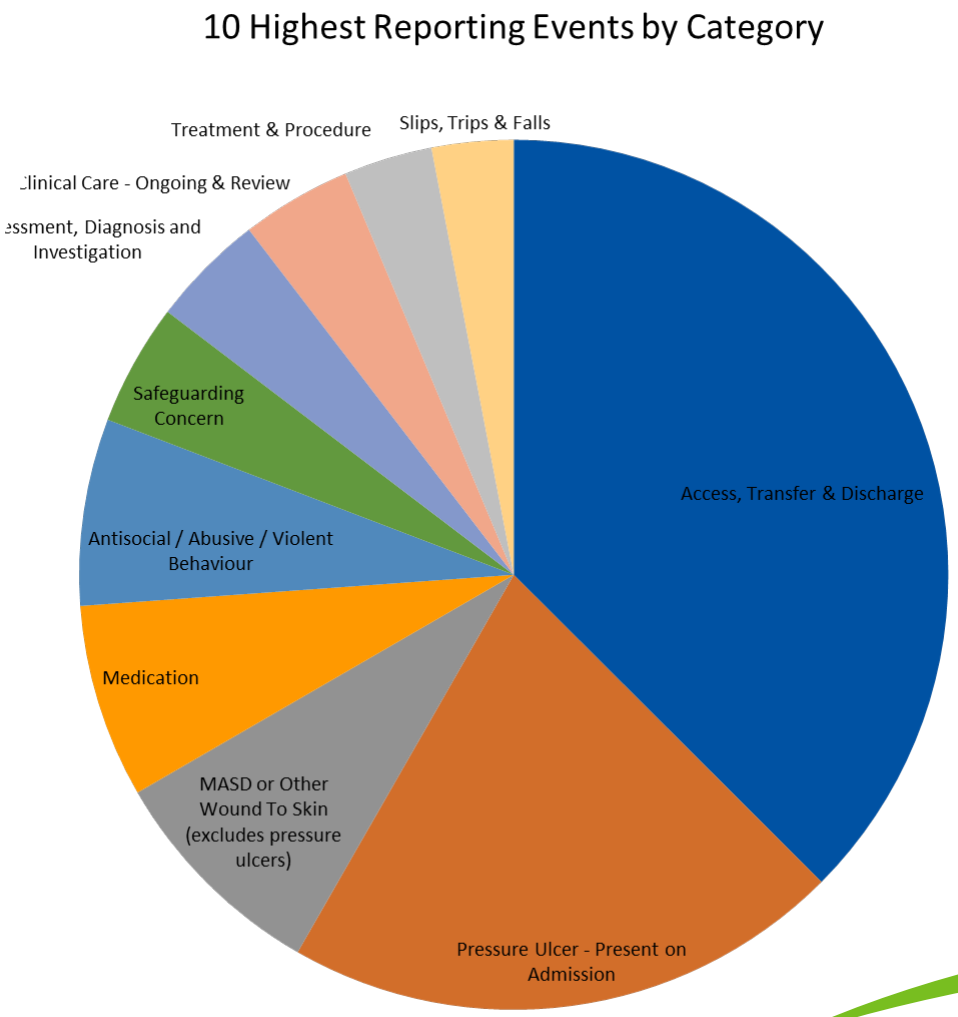
Recurrent investment: £455k in medical staffing and £3.62m in nursing in the last four financial years

Safe – incident profile

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Of 131,754 attendances:

- 2603 incidents reported (1 Jan 2023 – 1 Jan 2024)
- 99.4% of incidents reported were low or no harm
- 15 – Moderate Harm
- 3 – Severe Harm
- 1 – Fatal Harm



Safe – challenges and risks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Challenge/risk	Actions
Delayed flow = Crowding = Care on corridor	ED escalation tool, escalation at bed meeting, Trust response – Full Capacity Protocol, System Escalation
Deteriorating patients	Escalation to nurse and ED clinician in charge, intentional rounding, reverse cohorting as required
Estate	Floorplan reviews being undertaken with a view to improve capacity and “flow” through department e.g. CT scanner in department
NEWS2 compliance	NEWS2 focus week planned, auto-population of frequency being developed with system suppliers

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Effective

Effective

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- **Care Support Worker allocated to meals and drinks to ensure patients nutrition and hydration needs are being met**
- **SDEC unit 24/7 allowing easy access to the service and improved streaming**
- **Embedded processes for assessing capacity and applying best interest where needed**
- RCEM audit and action plans
- Emergency department M&M meeting
- National audit data – SDEC report/ NHS benchmarking
- NICE compliance
- Quality metrics
- Ward accreditation – UTC - silver, SDEC - silver, ED paeds - silver, ED: bronze
- Practice Based Educator's and protected teaching

Effective – challenges and risks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- **Appraisal data (72.47%)**
  - Trajectories in place for improvement
  - Compliant by March 2024

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NHS Foundation Trust

Caring

Caring – our patients and staff

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Mental Health room
- High Intensity User Group
- Learning Disabilities/autism
- End of life care
- Safeguarding Link nurse
- Protected teaching
- Staff wellbeing and support

"My daughter came to A and E with very complex additional needs. We were all treated with respect during a challenging time. A and E staff were very accommodating of her needs and understanding. Treatment was started quickly."

"From start to finish everyone was very kind, polite and helpful. The waiting room was very airy and clean."

"Every single member of clinical staff across ED Ambulatory and MRI were polite, compassionate and very clear about what was happening - a credit to the NHS."

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NHS Foundation Trust

Responsive

Responsive – person-centred care

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Patient-centred

- Early recognition of most unwell
- Specific patient needs – EDI
- Frail patients
- Directing to specialist units
- Admission avoidance

Responsive – person-centred care

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Staff-centred

- Supportive leadership
- Hot debriefs/TRIM support
- Welfare Hub
- Rugby League Cares –
- 2023 HPMA Excellence in People Runner up

Responsive – provision, integration & continuity

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Increasing demands

Joint Strategic Needs Assessment
Office of National Statistics
Public Health England

Increasing Ambulance attends -17% rise

Higher age attendances

Integration

Working with People and Communities Strategy 2022-25

WHH Equality Duty Assurance Report

Community ‘Anchor institute’

Responsive – providing information

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Accessible Information Standards:
-Ask, record, Alert, Share, Act

Accessibility tools on trust extranet

Web Content Accessibility guidelines 2.1AA

- IPC guidance
90% reduction - 3 yr

Partnerships

Warrington Disability Partnership & Independent Living Centre

START dementia programme

Chaplaincy/Multi-Faith

WHH ‘Carer Hubs’ & Coordinators

Responsive – listening and involving people

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Urgent & Emergency Care

‘Care opinions’

163 complaints
Jan 23 - Jan 24

Duty of Candour 100%

None >40 days

Themes

Clinical treatment

Communication/
staff attitude

Long waits

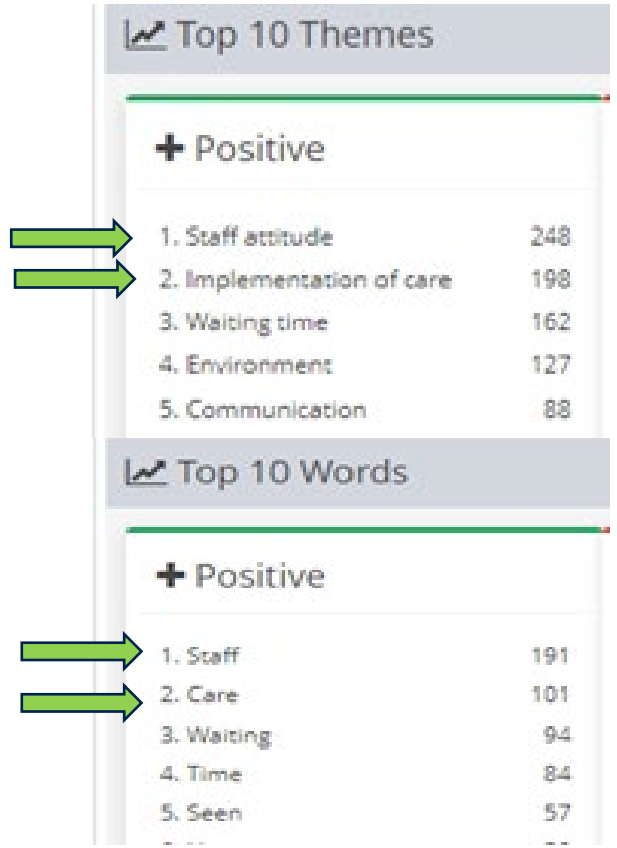
Responsive – listening and involving people

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

‘Friends and family’

4777 responses

Positive feedback



Responsive – equity in access, experience and outcomes

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Timely

Initial triage

Secondary triage

Assessment areas

CT scanner in dept

Access

Hot Clinics

Urgent Care centre

Virtual Wards

Community care

Progress

Booked clinic slots

E- board updates

Verbal updates

SoMe updates

Reverse Cohorting

Responsive – equity in access, experience and outcomes

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Well-Led

Well-Led – shared direction and culture

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Patient specific needs
Regulatory breaches
Harm profiles
Local intelligence
Patient safety
Staff safety
Mental health
Reducing over-crowding
Reducing admissions

Flow improvements

Utilisation of space

Sharing the vision

Executive visibility

Freedom to challenge

Well-Led – learning, improving and innovation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Learning

Identified patient needs

GIRFT

Learning lessons

Trust Simulation Lead

ED Practice Educator

SDEC sim/training rooms

MTS training

Improving

Senior doctor at Triage
Manchester Triage System
Streaming
Assessment Units
Intentional rounding
Ambulatory Care/SDEC
Continuous flow
Emergency Admissions Unit
Clinically Ready to proceed
Medical LOS triage
Positive bypass

Innovation

Design of Paediatric ED

Continuous flow

Design of SDEC

ECIST

Plans for ED re-design

‘Patient-centred and inclusive’

Well-Led – equality, diversity and inclusion

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

New Equality and Diversity Strategy 2022-25

'To be the best place to work with a diverse, engaged workforce fit for the future'

- New Trust Strategy

People Promises

Belonging in WHH staff

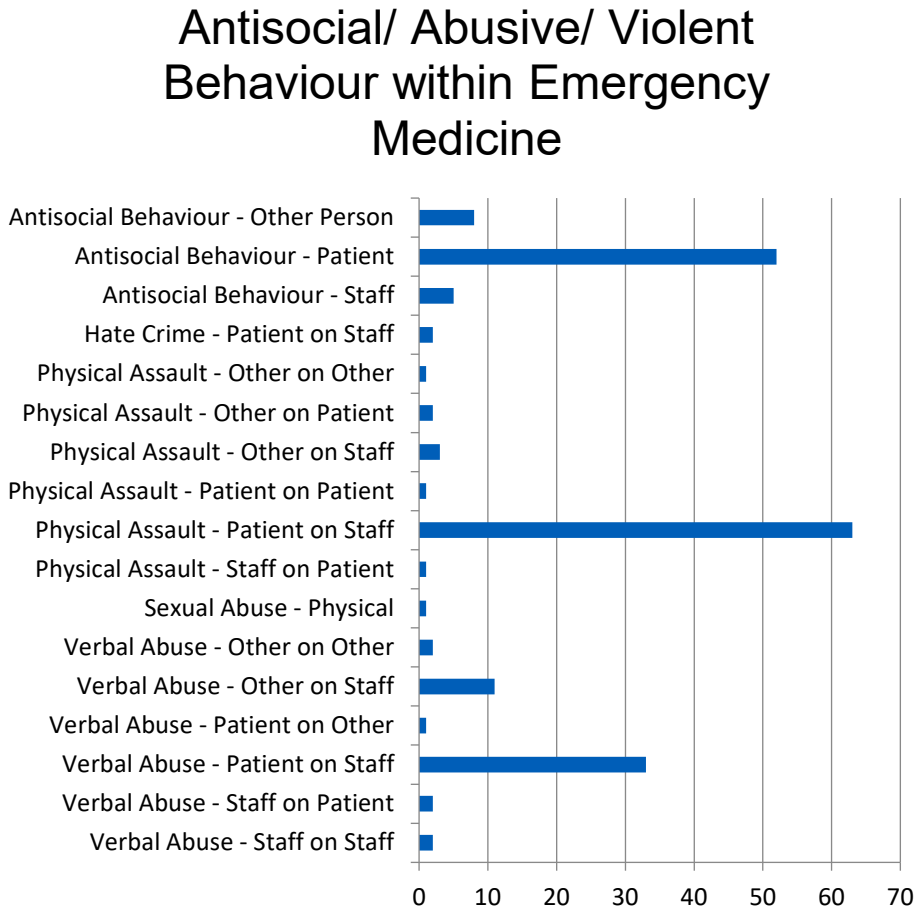
Zero tolerance

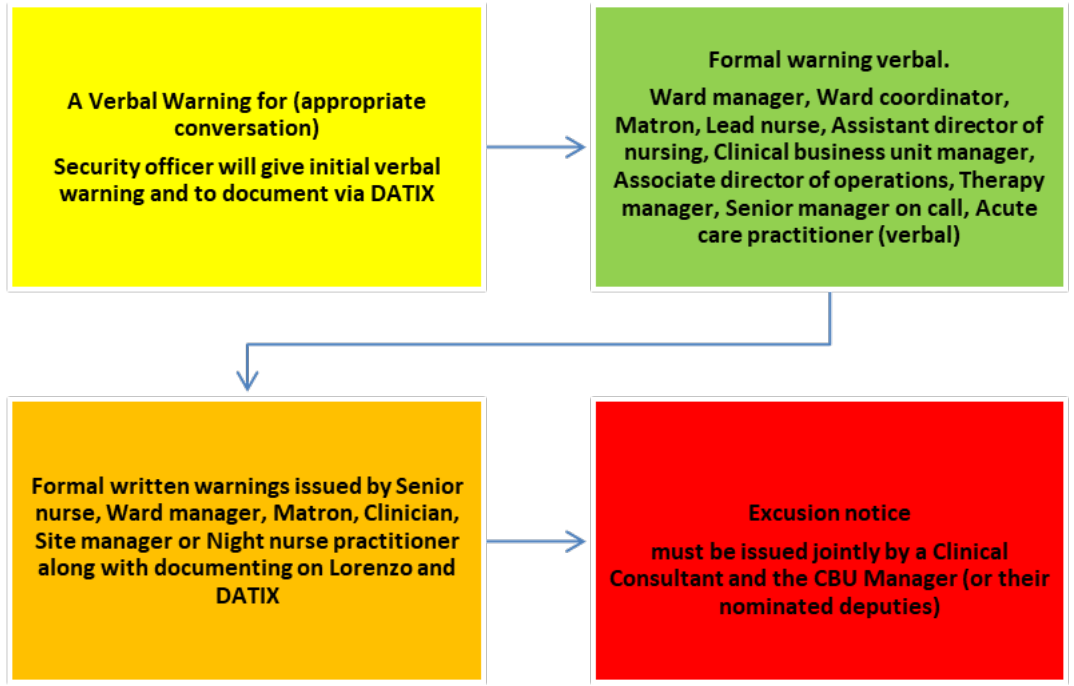
Well-being Guardian

Protected characteristics

Well-Led – abuse of staff (protection)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

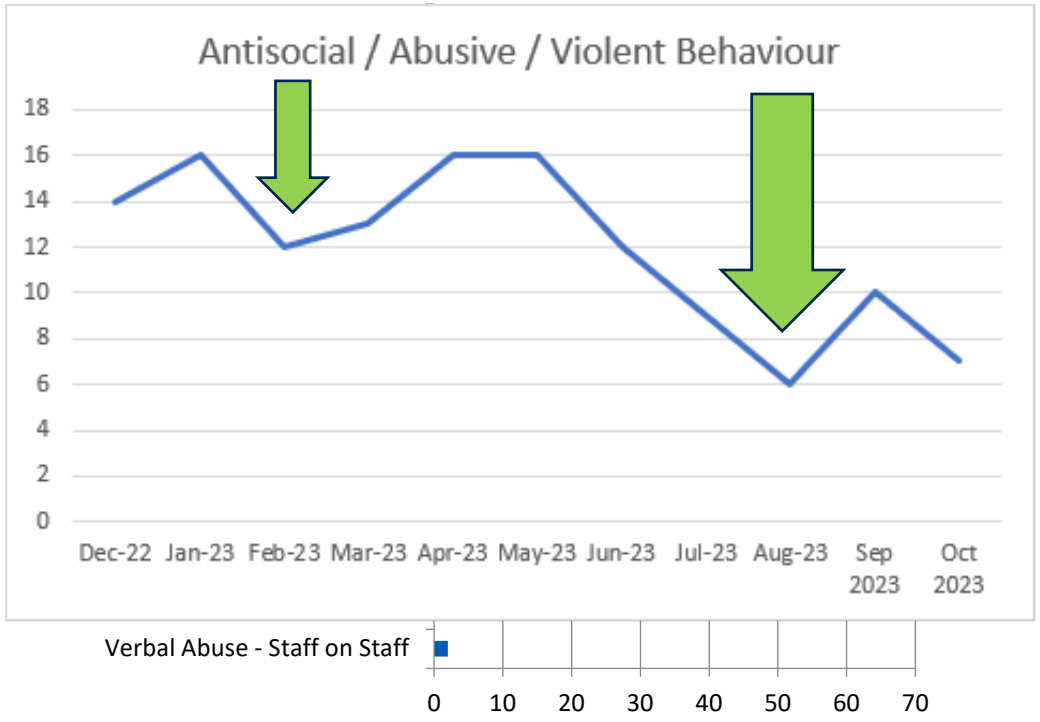




Well-Led – abuse of staff (protection)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Antisocial/ Abusive/ Violent Behaviour within Emergency Medicine



A Verbal Warning for (appropriate conversation)

Security officer will give initial verbal warning and to document via DATIX

→

Formal warning verbal.

Ward manager, Ward coordinator, Matron, Lead nurse, Assistant director of nursing, Clinical business unit manager, Associate director of operations, Therapy manager, Senior manager on call, Acute care practitioner (verbal)

↓

Formal written warnings issued by Senior nurse, Ward manager, Matron, Clinician, Site manager or Night nurse practitioner along with documenting on Lorenzo and DATIX

→

Excusion notice

must be issued jointly by a Clinical Consultant and the CBU Manager (or their nominated deputies)

Well-Led – inclusive

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MESN
MULTI ETHNIC STAFF NETWORK

WHH PROGRESS NETWORK

Visible And Hidden Disabilities Disability Awareness Network

VETERAN AWARE

ARMED FORCES COVENANT
EMPLOYER RECOGNITION SCHEME
SILVER AWARD 2022

Stonewall DIVERSITY CHAMPION

BRONZE AWARD
NHS RAINBOW BADGE

Staff networks

Freedom to speak up

Gender pay gap (23.7% improvement)

WRES, WDES, EDAR

Staff survey

Well-Led – staff cascade

Warrington and Halton Teaching Hospitals
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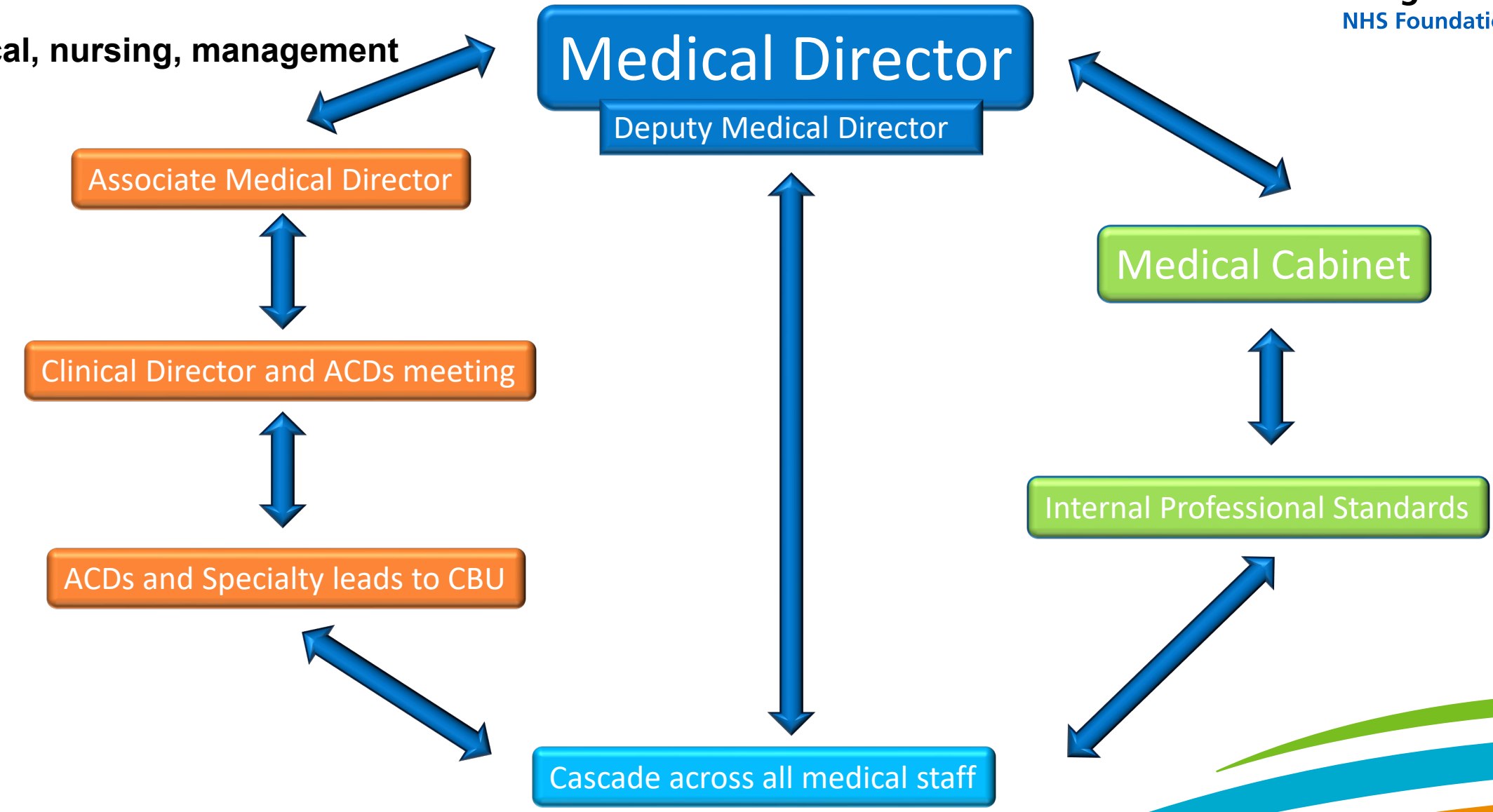
Medical, nursing, management



What are we most proud of?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Medical recruitment

Awards

Waiting room

CT Scanner in ED

The new Emergency CT department has opened this month!

This £1.9m department will reduce the time to transfer ED patients to CT whilst improving patient dignity and experience as patients will now stay within the ED footprint for all CT imaging, 24/7.

The purpose-built Emergency CT department will serve both inpatients and ED patients for the Trust.

The department has been designed with a two-bed waiting bay with ambient and skylight ceiling lighting to help put patients more at ease.

SDEC

SIM-room

Paeds ED

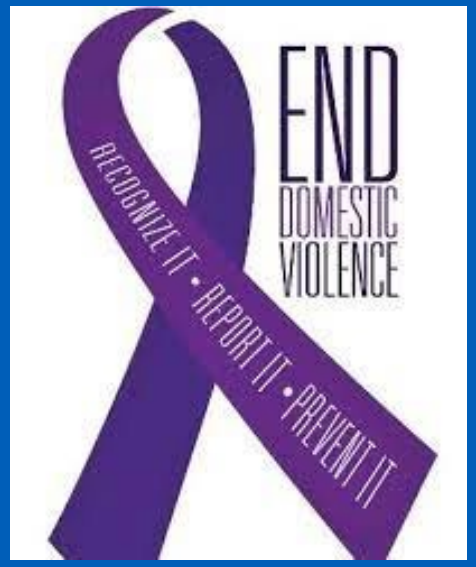
Nurse recruitment and retention programme

Our staff – a patient story

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Situation: Patient attended the Emergency Department with clinical presentation of abdominal pain. Attended with family members who were also present at assessment. Triage nurse in ED felt that there wasn't something "quite right" and asked relatives to leave the area whilst triage assessment continued. After some resistance, relatives left and nurse continued assessment.

After some questioning, it became apparent that the patient had been part of an arranged marriage against her wishes and that she had been subject to domestic violence. The nursing team in ED dealt with this quickly, sensitively and safely, ensuring that the necessary security measures were put in place. The family was large and continued to try to gain access to the patient by booking in as patients themselves.



Outcome: The staff dealt with this situation professionally but with the upmost respect for the original patient's safety and dignity. They involved all necessary agencies, including safeguarding, police, local **authority and** relevant teams to ensure that this patient was safely looked after in the Emergency Department until she could gain access to a women's refuge as a place of safety.

The staff supported this patient to contact her Mother, who lived in Pakistan. They also recognised that the patient may be practising Ramadan at the time. After confirming that this was the case, they were able to ensure that they fulfilled the patient's nutrition and hydration needs by ensuring that the patient was provided with a Halal meal at a time that was appropriate with Ramadan.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Medicine

Unplanned Care Group

Sharon Kilkenny, Associate Director of Operations

Mark Forrest, Associate Medical Director

Emma Painter, Associate Chief of Nursing

CQC engagement meeting

29 January 2024

Structure

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Unplanned Care Group Triumvirate

Sharon Kilkenny, Associate Director of Operations
Dr Mark Forrest, Associate Medical Director
Emma Painter, Associate Chief of Nursing

Medical Care Triumvirate

Sharon Martlow, CBU Manager
Dr Laura Langton, Clinical Director
Claudine Reynolds, Lead Nurse

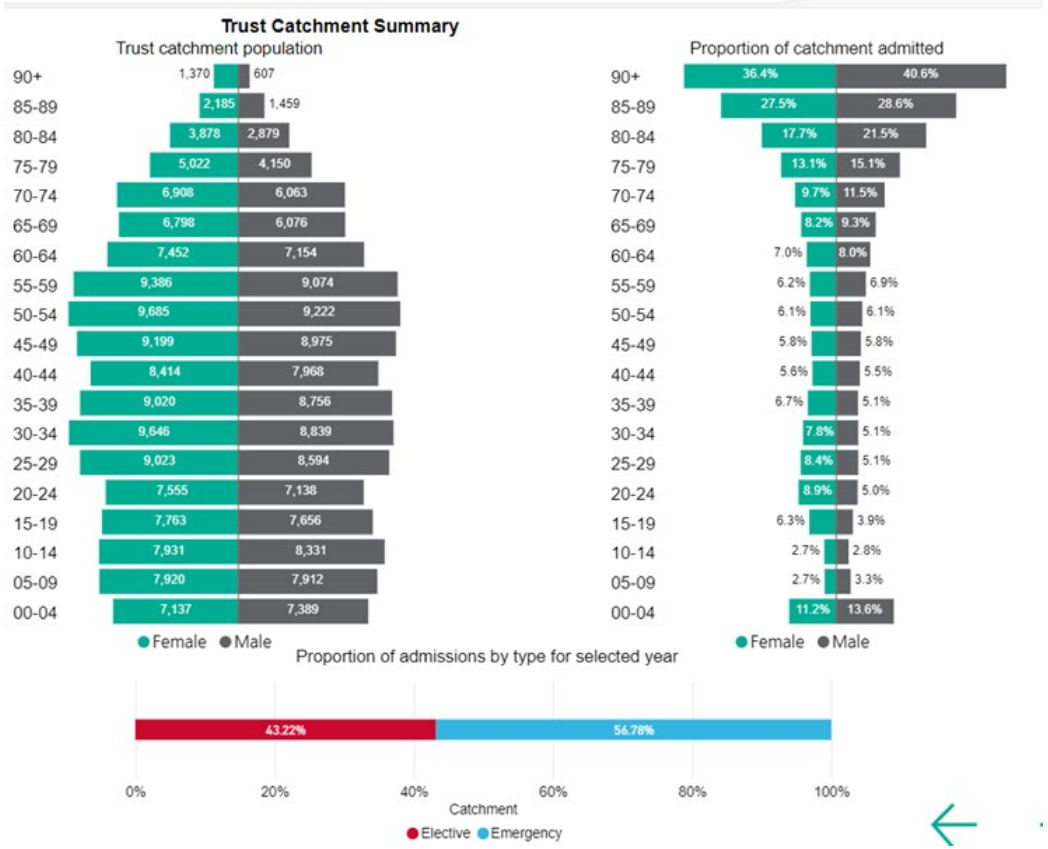
Integrated Medicine & Community (IMC) Triumvirate

Chris Barlow, CBU Manager
Dr Pradeep Magapu, Clinical Director
Janet Pye, Lead Nurse

Urgent & Emergency Care (UEC)Triumvirate

Sheila Fields-Delaney, CBU Manager
Dr Adebowala, Interim Associate Clinical Director
Dr Saagar Patel, Associate Clinical Director
Yasmin Habib, Lead Nurse

Population demographics and associated challenges



Population of 330,000 - Halton & Warrington

Over 100,000 A&E attendances/year, >270/day

Biggest challenges relate to age & deprivation

Percentage of adults reporting a mental health problem

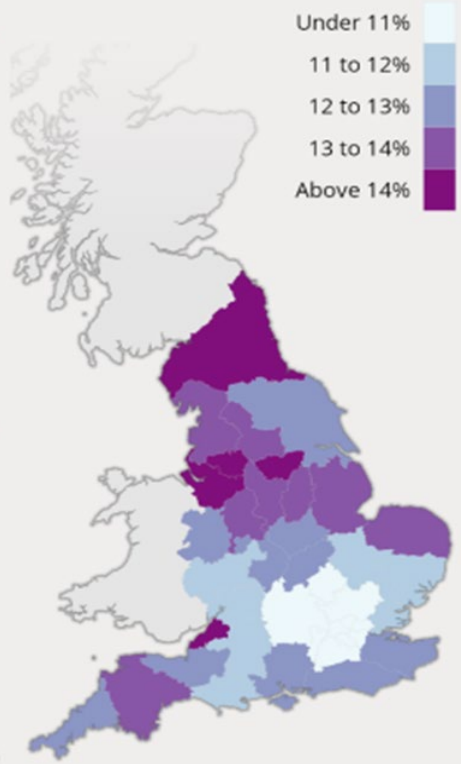
By Integrated Care Board, England, age 18+, GP patient survey, 2022

Highest reported prevalence

North East & North Cumbria	15.6%
South Yorkshire	15.3%
Cheshire & Merseyside	15.3%
Greater Manchester	14.3%
Bristol, N Somerset & S Gloucs	14.1%
Derby & Derbyshire	14.0%
Lancashire & South Cumbria	13.8%
West Yorkshire	13.7%
Nottingham & Nottinghamshire	13.7%
Norfolk and Waveney	13.4%

Lowest reported prevalence

North West London	9.1%
Surrey Heartlands	9.1%
South West London	9.2%
Frimley	9.5%
North East London	9.5%
North Central London	9.8%
Bedfordshire, Luton & MK	10.0%
Hertfordshire & West Essex	10.1%
South East London	10.7%
Bucks, Oxfordshire & Berkshire W	10.9%



Cheshire and Merseyside has one of highest proportions of adults reporting a mental health problem

Overview of Unplanned Care Group

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Medical Care CBU		IMC CBU		UEC CBU
• Respiratory • B18 –Acute Respiratory unit • Community and Inpatient Respiratory specialist nurse team • Acute Respiratory Infection Virtual Ward • Cardiology • Acute Cardiac Care Unit (ACCU) • Cardiac specialist nurse teams • Cardiorespiratory service	• Intensive Care Unit • Acute Care Team • Rheumatology • Palliative Care Team • Diabetes and endocrinology • Neurology	• General Medicine, including Wards A8, A9, B19, K25, A10 (winter escalation) • Care of the Elderly, including Frailty Assessment Unit (FAU) and Ward A7 • Discharge Lounge • Transfer of Care Hub	• Dementia/Cognitive Assessment Team (CAT) • Ward B12 (Dementia 'Forget Me Not' unit) • Stroke service, including Ward B14	• Acute Medical Unit (AMU) • Ward A2 (General Medicine and Endocrinology)

335 core medical beds

41 winter escalation beds

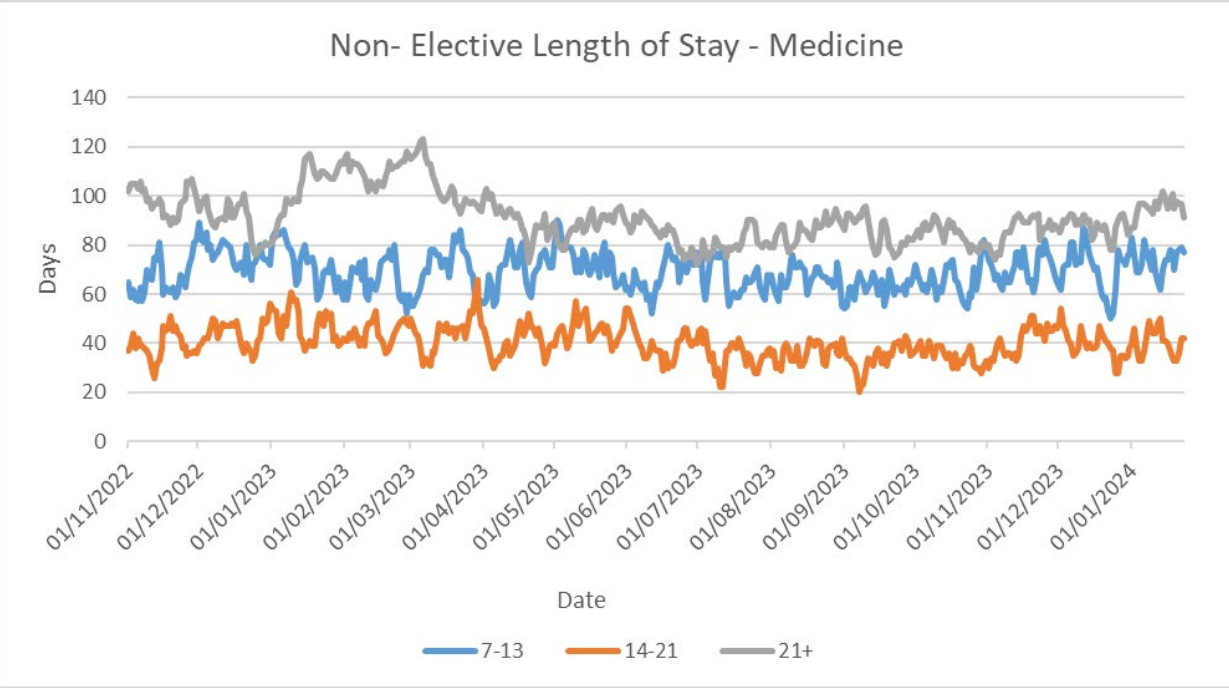
1327 staff

(December 2023 data)

Non-elective care

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

No criteria to reside and length of stay - Medicine



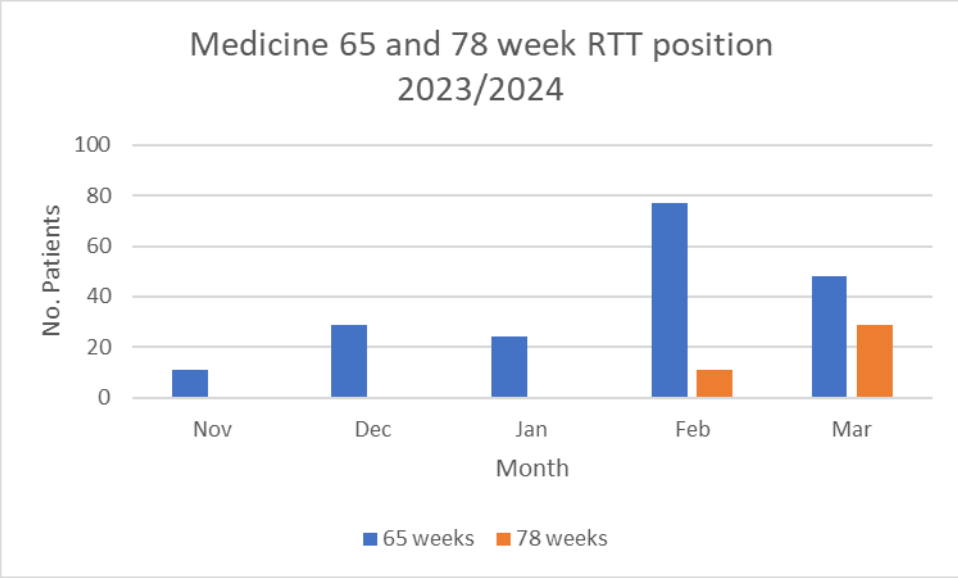
Data as at 25/01/24

Reside Status	No Criteria to Reside	
Discharge Route	Current Inpatients	%
Not Recorded	0	0.00%
Pathway 0	9	2.16%
Pathway 1	37	8.89%
Pathway 2	38	9.13%
Pathway 3	35	8.41%
Total	**119**	**28.61%**

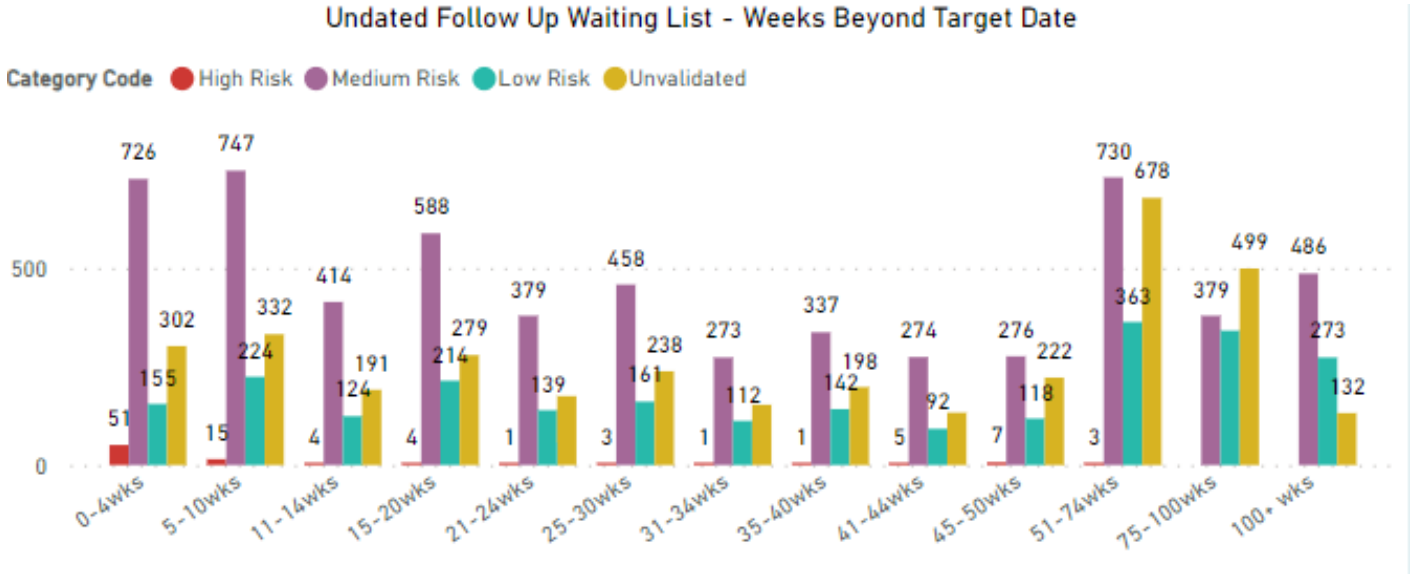
Data as at 25/01/24

Elective care

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Data as at 25/01/24



Data as at 25/01/24

Specialties

- Endocrinology
- Cardiology
- Respiratory
- Respiratory Physiology

Diagnostic activity - Medicine

Warrington and Halton Teaching Hospitals
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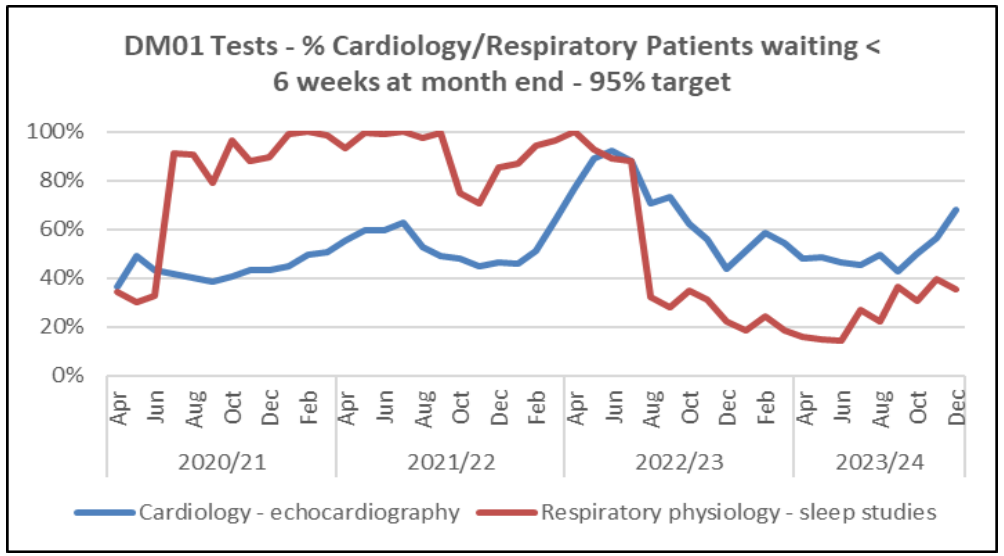
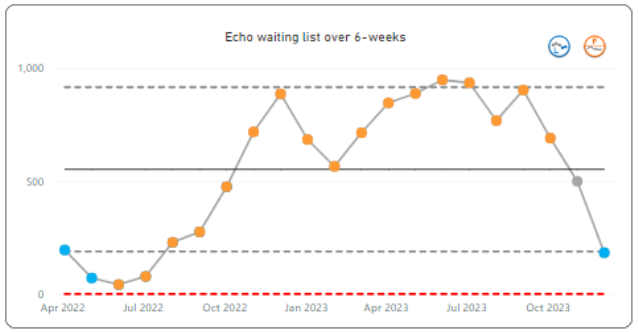
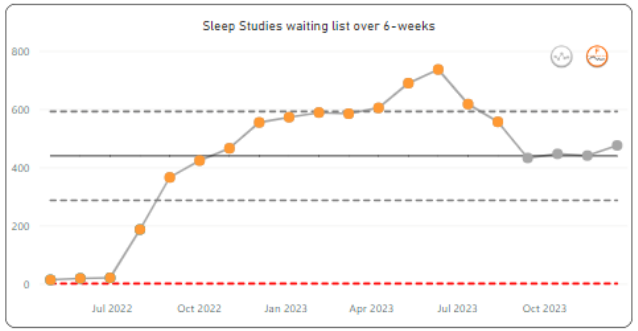
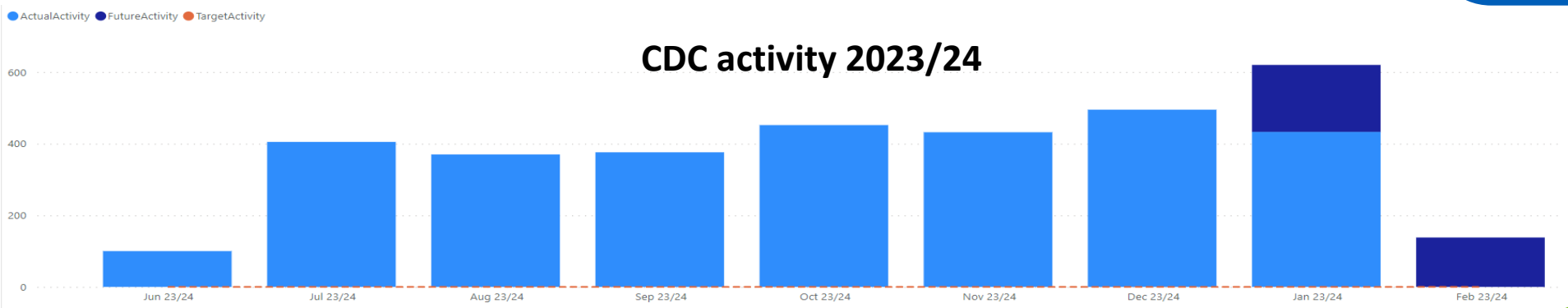






Recovery being achieved through:

- Insourcing/outsourcing
- Mutual aid
- Increasing CDC capacity (echocardiography, sleep studies and spirometry)



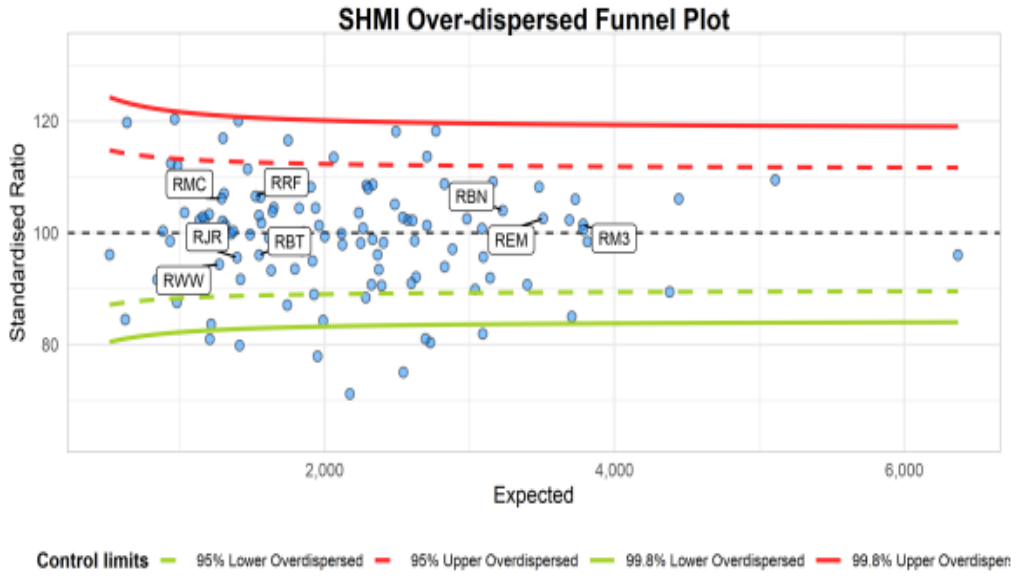
All data as at 25/01/24

Mortality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

5.1 Funnel Plot

The trust is given a green rating for this indicator with a SHMI of 94.37 based on 95% over-dispersed funnel plot limits.



SHMI is within expected levels.

Organisation
RBN - MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
RBT - MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
REM - LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
RM3 - NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST
RMC - BOLTON NHS FOUNDATION TRUST
RRF - WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
RWW - WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

Hospital Episode Statistics (HES), Dec 2023

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Safe

Safe – elective activity challenges and risk

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Ambulatory ECG	Diabetic Foot Clinic	Sleep Service
Current position	Total waiting 1177 Longest wait 30 weeks	0 referrals waiting	Total waiting 766 Longest wait 23 weeks
Risk	Risk ID 2003 Risk rating 16 extreme risk	Risk ID 1782 Risk rating 8 high risk	Risk ID 1921 Risk rating 8 high risk
Harm profile	0 events reported to date	2 Serious Incidents 1 harm 1 no harm	0 events reported to date
Plans for improvement	Service redesign using new technology and software	Full review of pathway with robust safety netting in place. Relocation of Diabetic Foot Clinic	Service pathway redesign
Oversight	Care Group KPI Performance Review Group	Daily monitoring Care Group KPI Performance Review Group	Care Group KPI Performance Review Group

Safe – audit and governance

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- **Monthly audits of NEWS2 for all wards with associate action plans**
- **MDT daily board rounds – using SAFER principles**
- **Medicines storage – monitored via Duthie audits**
- Care provided in appropriate and safe environments
- Embedded processes for safety and infection, prevention & control
- Robust governance processes – ensure effective & responsive management of risks
- Individualised action plans for falls & pressure ulcers Reduced inpatient falls
- PSIRF implementation – Trust priorities
- Staff confident about reporting safeguarding concerns - adults and children

Safe – staff training

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Training	Medicine compliance
Appraisal	74.44%
CSTF	91.23%
Role-specific	88.13%
Safeguarding	81.80%
DoLs	92.23%
Mental Capacity Act	91.96%
Acute Illness Management	85.84%
Sepsis	87.84%
NEWS2	94.3%

Trajectories in place for improvement

Safe – staffing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Improvements seen in key workforce metrics
- Increased substantive recruitment – nursing and medical
- Reduced agency staff utilisation

Medicine - Medical

Medicine - Nursing

Medicine – All staff

Safe – challenges and risks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Challenges

Delayed discharges
- Increased length of stay
- Impact of prolonged hospital admission

Patients with mental health presentations
- Impact on staff
- Provision of specialist/therapeutic care
- Environmental risks

Increased demand on medical take
- Impact on staff

Risk

Top three incident themes in medicine (excluding COVID-19)
- Antisocial/abusive/violent behaviour
- Slips/Trips/Falls
- Medication

Pressure ulcers
- Action plans in place
- Improving position

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Effective

Effective

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Embedded assessments for decision-specific mental capacity and applying DOLS
- Processes for staff to access interpreters quickly
- Daily report for patients with dementia – including ‘This is Me’ document compliance
- Ward accreditation: 7 silver wards and 5 bronze wards
- Monthly quality metrics
- Dedicated Practice Based Educator - AMU and A2
- NICE guidance compliant
- M&M specialty meetings, feeds to Mortality Review Group
- Improved compliance with DC summaries in timely manner
- Echo services accredited by British Society of Echo
- GIRFT – improvement plans for Medical specialities

Effective – challenges and risks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Completion of MUST scores in a timely manner:

- Reported to nutrition and hydration steering group.
- New dashboard created to support monitoring of compliance in real time
- Quality priority for 2024/25

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Caring

Caring – our patients and our staff

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

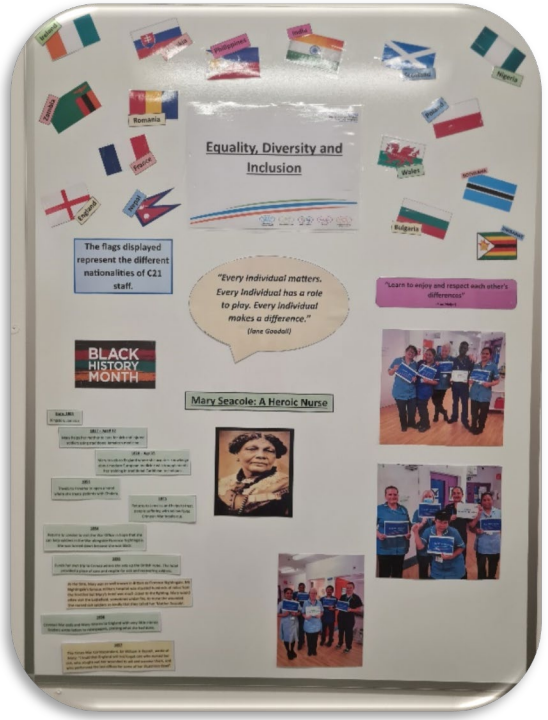
Our patients

- Compassionate Care
- Patient, family & carer feedback
- Privacy, dignity & confidentiality – low profile in incidents, complaints & PALS
- Governor & walkaround feedback
- Patient experience team feedback

Our staff

Staff Health & Wellbeing

- Trust Wellbeing offer
- Trust values – awards & badges
- Staff survey – individualised action plans per CBU. Ownership from the CBU Leadership teams
- Targeted support when needed
- Team & Employee of the Month



Example of ward EDI board

Caring – patient case studies

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Situation:
Complex patient - 24 failed community placements admitted to Warrington Hospital
Lengthy discharge planning process as lack of suitable community services to meet needs

Outcome:
•The transfer to Freshfields went well using option1 in conveyance plan
•Patient X packed majority of her own belongings before we travelled. With a lot of time, encouragement and reassurance the transfer was smooth

Patient X was welcomed by friendly staff at Freshfields with hamper full of her favourite goodies and 'Take That' pictures which went "down a treat"

Situation:
Patient Y admitted to B11 under paediatric team with decline in mood and suicidal ideation. Identified as male but was biologically female at birth. Patient Y had been a looked after child.
During admission Patient Y turned 18. Case was complex with mental health issues, safeguarding, social housing placements and need to transition from child to adult services.

Outcome:
Staff engaged with patient to ensure care was in a suitable environment in hospital with therapeutic care given whilst providing enhanced care due to risk, individualised risk assessment and care plans put in place

Patient Y felt this was first time he had ever been asked what he wanted and what he needed to keep himself safe - felt empowered by this.

NHS
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NHS Foundation Trust

Responsive

Responsive – listening

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Service developments

- Acute Respiratory Care Unit
- Virtual wards implementation respiratory - highest occupancy across C&M ICS in Respiratory
- Virtual wards implementation –frailty
- CDC Spirometry service
- Osteoporosis Clinic
- Metabolic clinic
- ‘Call 4 concern’ – pilot
- Cardiac MRI Service
- Stroke Pathway development
- Clinical research

Listening to our patients and their families

- Friends & Family Test
- Involvement in MDTs
- Involvement in discharge planning processes,
- Increased resolution in real time of issues/concerns – reducing complaints
- Open and honest culture

Listening to our staff

Staff surveys
Individual CBU action plans
Monthly Care Group ‘People’ meeting
Senior nurse walkabouts
Medical CD meetings
Freedom to speak up
Medical Cabinet
Your Future Your Way engagement across all CBUs

Responsive – challenges and risks

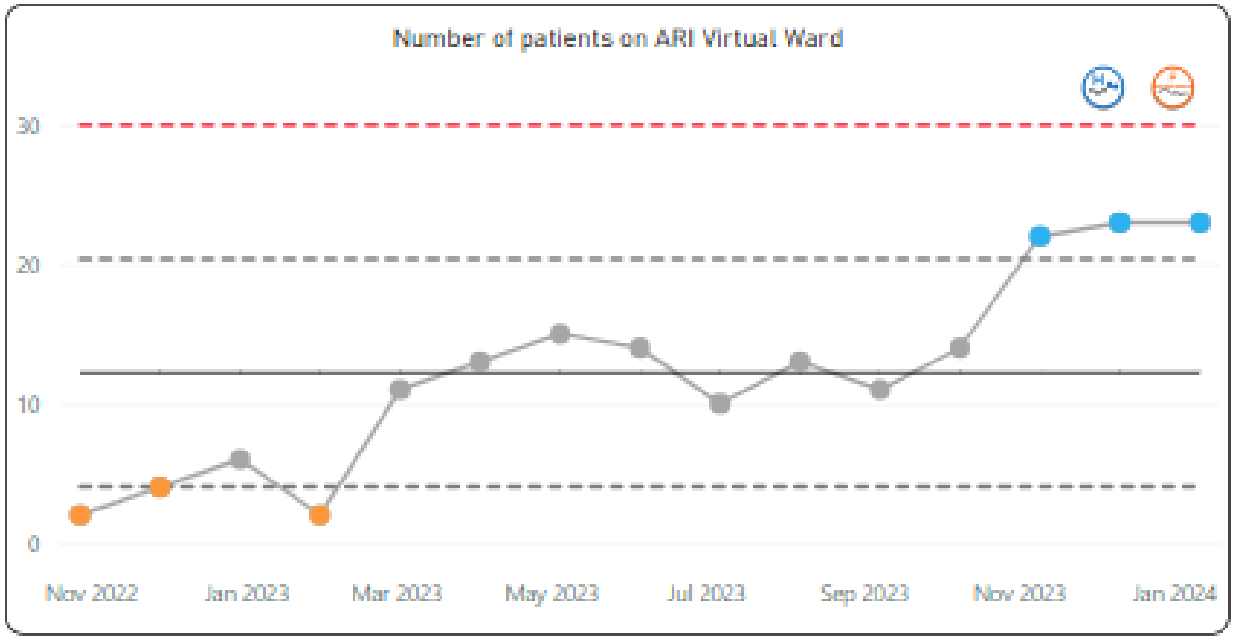
Warrington and Halton Teaching Hospitals NHS Foundation Trust

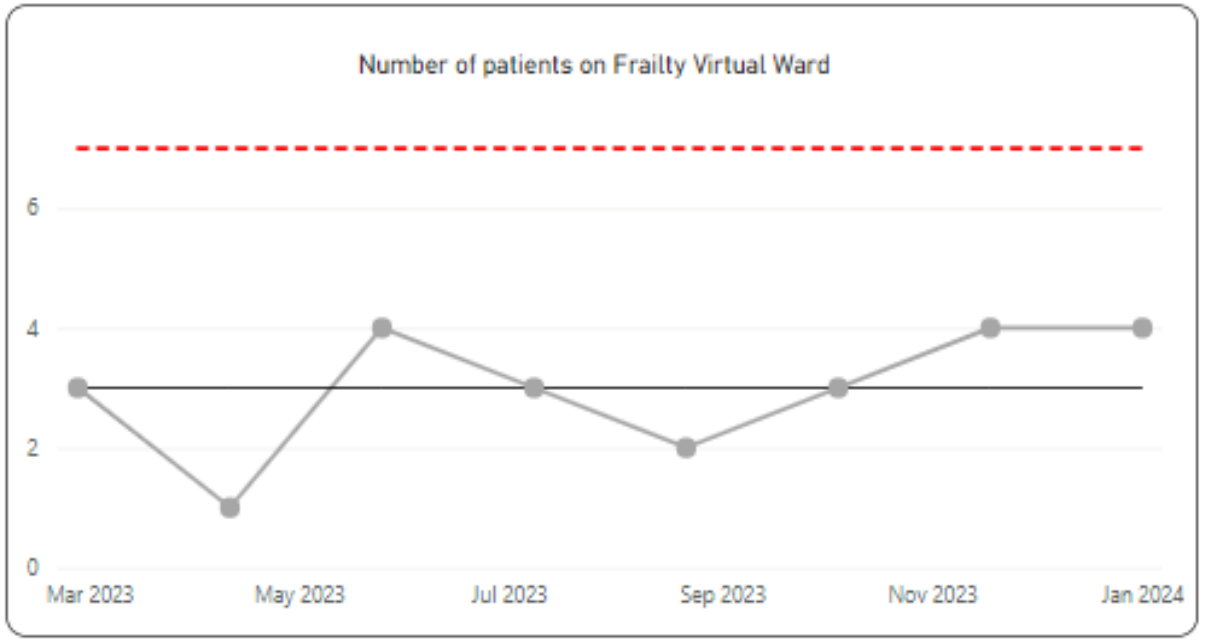
Elective programme	Mitigation
RTT Long waits	Internal additional activity Expansion of CDC capacity Insourcing/outsourcing Mutual aid Considering AI options Clinical alternative options
Diagnostic Delays	
Overdue follow ups	

Flow & discharges	Mitigation
Length of stay	Medically fit step-down wards B3/B4 SAFER Daily Monitoring Med/Nurse director rounds Earlier mobilisation
No criteria to reside	
Deconditioning	

Responsive – respiratory and frailty virtual wards

Warrington and Halton Teaching Hospitals
NHS Foundation Trust





Highest occupancy across C&M Integrated Care System in respiratory virtual ward

Responsive – Respiratory Support Unit (B18)

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NHS Foundation Trust

- New location
- 28 beds – up to 14 ‘enhanced care’
- 7 isolation rooms
- 4 Bioquell negative pressure pods
- Physical link to Critical Care
- Step up or down support
- State of the art procedure room
- Relatives ‘quiet room’

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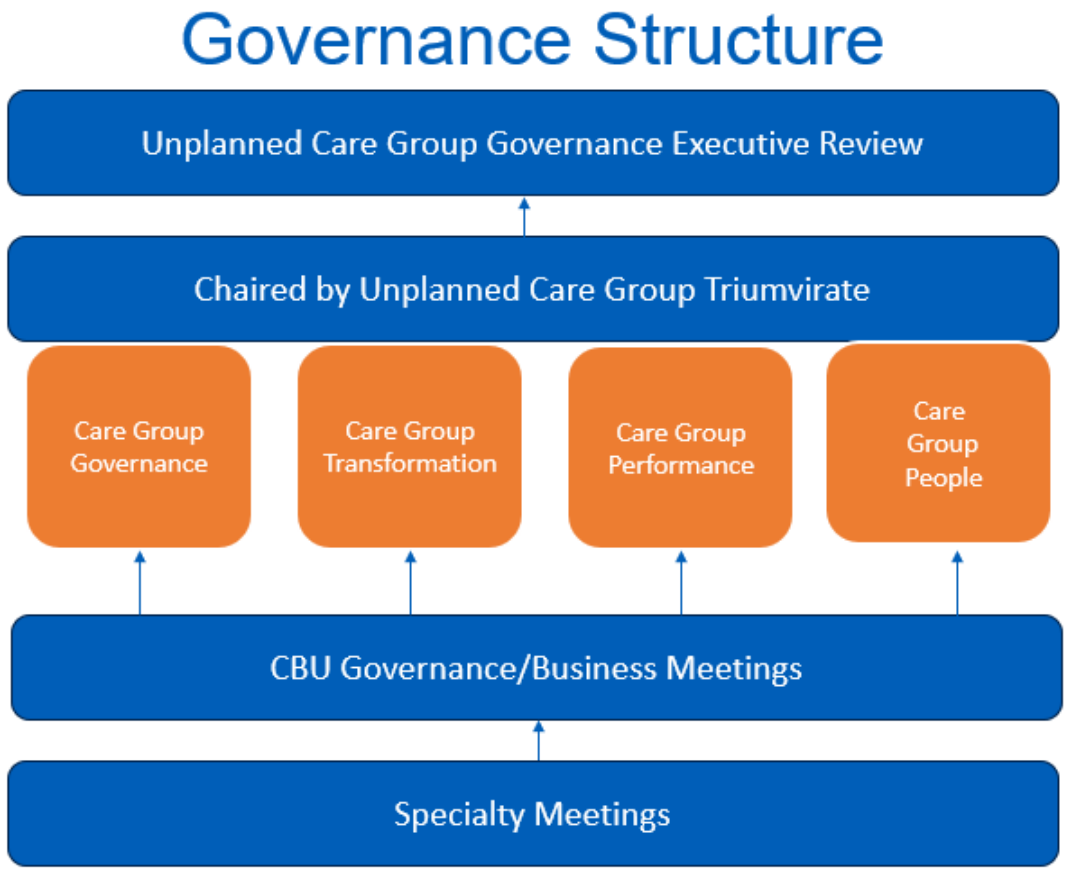
Well-Led

Well-Led – clear structure and aims

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Leadership:

- Ensure CBU & Care Group strategies align with Trust strategy
- Experienced leaders with right skills, knowledge and integrity
- Development opportunities encouraged and supported
- Strong collaboration ethos and focus on system working
- Improving workforce metrics

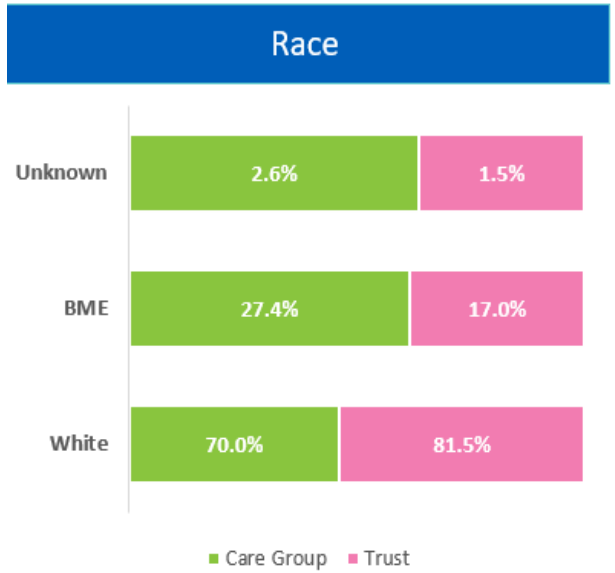
Future focus:

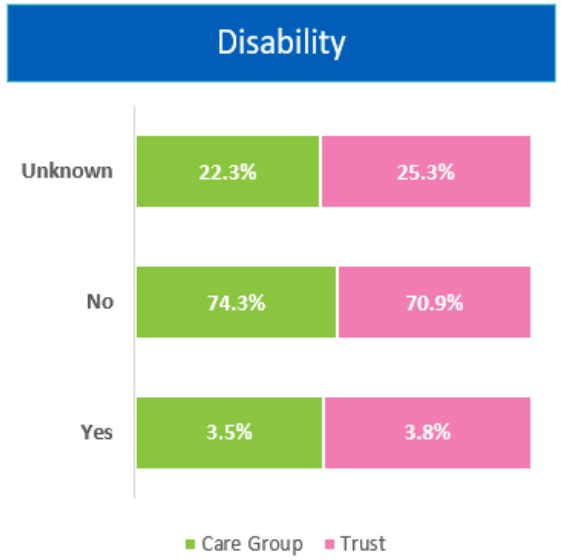
- Improve appraisal compliance
- Leadership development for new medical leaders
- Improve the non-disclosure rates around disability and sexual orientation
- Further improving communication and engagement

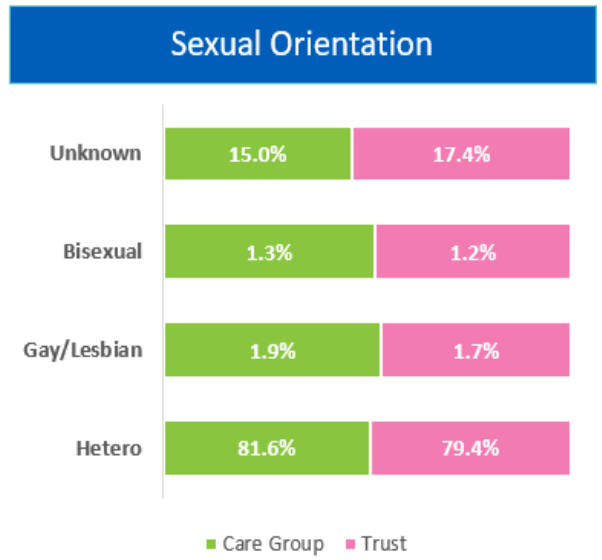
Well-Led – inclusive and open

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MESN MULTI ETHNIC STAFF NETWORK
WHH PROGRESS NETWORK
VETERAN AWARE







Leadership team
63% female

Team building

Escalation of concerns to and from the Care Group

Freedom to speak up
Open Door Policy

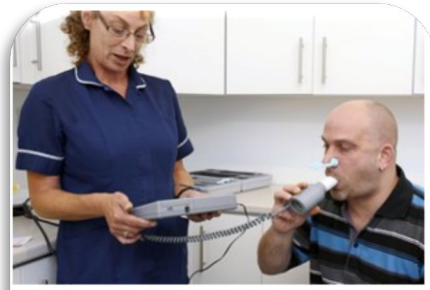
Visible and approachable leaders

What are we most proud of?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

10 years of B12 – 'Forget Me Not' Unit

Medical staff recruitment

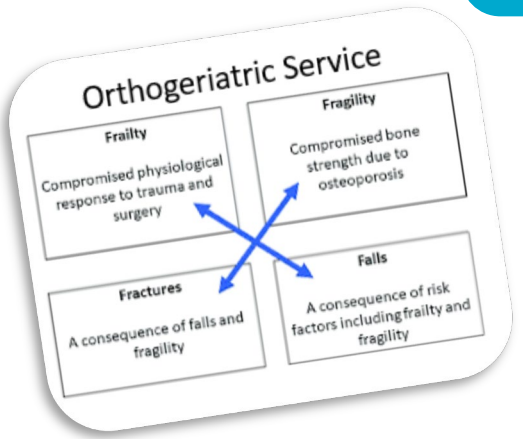


CDC Spirometry service

Enhanced respiratory care unit – B18

The 'Transfer of Care Hub' is a multi-organisational health and social care team

Nurse recruitment



Frailty Virtual Ward

Consultant of the week model in medical specialties

Respiratory Virtual Ward

Warrington and Halton Teaching Hospitals
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Surgery

Planned Care Group

Neil Gregory, Associate Director of Operations

Natalie Crosby, Associate Chief Nurse

Eshita Hasan, Associate Medical Director

Overview of Planned Care Group

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Planned Care Group Triumvirate					
Digestive Diseases		**Surgical Specialities**		**Women's and Children's**	
CBU Manager: **Glenna Smith** **Lead Nurse:** **Lucy Parry** **Clinical Director:** **James Melling** **Andy Langdon**		**CBU Manager:** **Ceri Rogers** **Lead Nurse:** **Carol McEvoy** **Clinical Director:** **Anna Vondy**		**CBU Manager:** **Laura James** **Director of Midwifery:** **Ailsa Gaskill-Jones** **Clinical Director:** **Satish Hulikere** **Deputy Director of Midwifery: Tina Moors** **Lead Nurse Paeds/Gynae: Jill Tomlinson**	
• Anaesthetics • Breast Surgery • Colorectal Surgery • Endoscopy • General Surgery • Gastroenterology • Hepatology • Paediatric Surgery • Pain Management • Upper GI surgery • Vascular Surgery	• Theatres • Elective and non-elective inpatient surgical wards • Daycase ward • Pre-Operative Assessment • Post Anaesthesia Care Unit (PACU) • Planned Investigation Unit (PIU)	• Audiology • ENT • Maxillo-facial surgery • Oral Surgery & Orthodontics • Ophthalmology • Trauma & Orthopaedics • Paediatric Trauma & Orthopaedics • Urology	• Elective and non-elective Trauma & Orthopaedic wards • Daycase ward • Medically Optimised Stepdown Ward • Orthopaedic Outpatients • Virtual Fracture Clinic	• Gynaecology • Paediatrics • Maternity	• Gynaecology Assessment Unit • Gynaecology ward • Women's Day Care • Elective paediatric surgery ward • Non-elective paediatric ward • Children's Outpatients • Neonatal Unit

- 101 general and adult beds plus elective capacity across Warrington, Nightingale and Captain Sir Tom Moore (CSTM)
- Workforce headcount: 1354

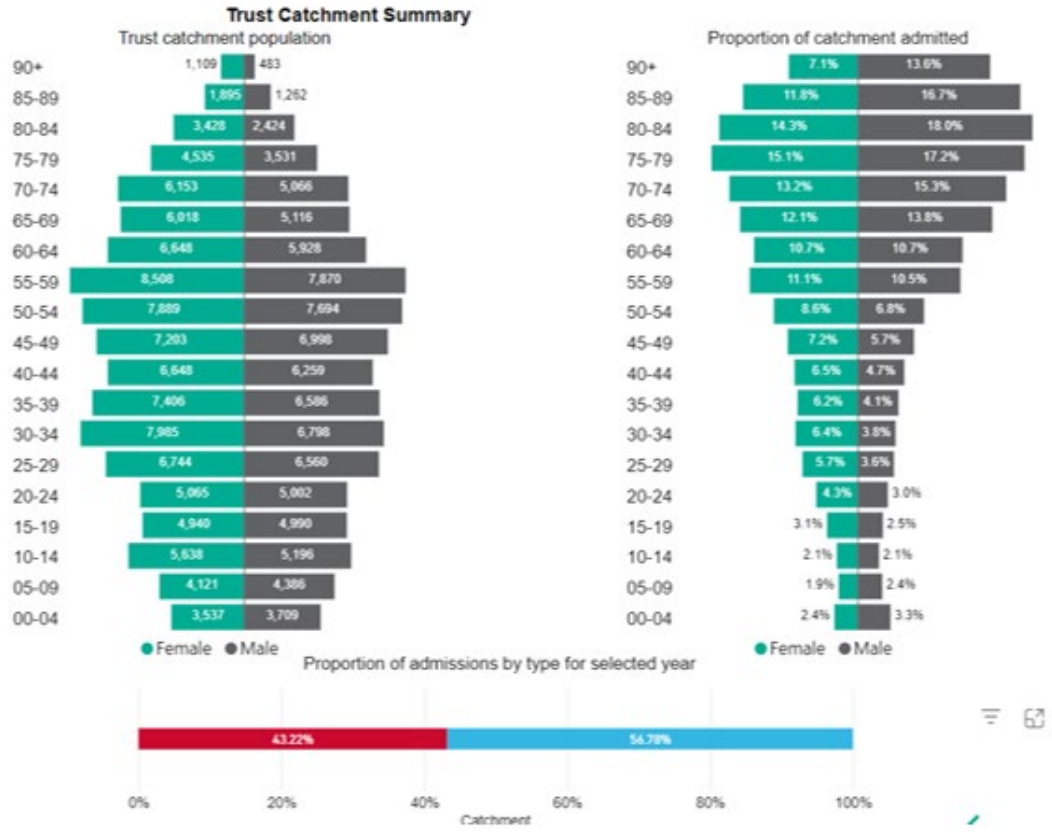
Population demographics

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Summary and challenges

- The Trust serves a population of 330,000 across both Halton and Warrington boroughs
- Some of our biggest challenges relate to age and deprivation
- We have ageing populations which are set to increase substantially over the next 20 years, particularly in our older cohorts
- The highest proportion of admissions (and repeat) is amongst our oldest population cohorts
- The bulk of elective admissions is in the 76-79-year-old population
- Our population health outcomes are broadly similar or worse compared to England
- We are using population health insights to identify opportunities for prevention and early intervention and are working with our Place partners to achieve this

Proportion of elective admissions



Key challenges and improvement goals

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

1. **Improvement of fragile service performance within Surgery**
   Reduction of risk to the quality of patient care, patient safety and risk of harm
2. **Elective restoration**
   78ww, 65ww and 52ww by March 2025
3. **Elimination of Never Events in Theatre**
   Establishment of Procedural Safety Steering Group and Theatre development work
4. **GIRFT/ Improvement work**
   Improving service delivery to support elective restoration
5. **Cancer**
   Maintaining low 62-day backlog and good compliance against 28-day Faster Diagnosis Standard

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Safe

Safe – challenges and risks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Fragile services

- ENT, Fractured Neck of Femur Best Practice, Gynaecology, Paediatric Ophthalmology, Urology (AMD May 2023 – Sept 2023)

Never Events

- Retained foreign body (ophthalmology), Jan 2023
- Transfusion of ABO-incompatible blood, May 2023
- Retained swab (breast surgery), Jun 2023
- Wrong site procedure (pain), Dec 2023

Audiology

- National service review – auditory brainstem response (ABR) testing

Serious Incident themes

Last 12 months, excluding Never Events:

- Urology service (5), including delayed urological cancer diagnosis, delayed follow-up cancer surveillance and delayed ureteric stent management
- Category 3/Unstageable pressure ulcers (3)
- Treatment and procedure within T&O service (2)
- Clinical care/ongoing review (2)
- Unexpected death post elective surgery (2)
- Fall with moderate harm (1)
- Assessment, diagnosis, investigation (1)

Theatre

- Safety and workforce culture

Fragile Services	Neck of Femur Best Practice Tariff (March 2023)	Urology (June 2023)	Gynaecology (July 2023)	ENT (November 2023)	Paediatric Ophthalmology (February 2023)
Why?	• Failure to meet the criteria for Fractured Neck of Femur Best Practice.	• Capacity and demand deficit • Increased harm profile • Workforce gaps	• Capacity and demand deficit • Workforce gaps • Equipment replacement delays (scopes)	• Capacity and demand deficit • Workforce gaps	• Lack of Paediatric Ophthalmology Consultant
Harm Profile	• Unstageable pressure ulcer due to extended time on traction awaiting surgery	• 3 x delayed cancer diagnosis • Delay in follow-up cancer surveillance and ureteric stent management	• 3 Incidents of moderate harm related to a delay in diagnosis with no further ongoing harm • 2 incidents related to cytology	• No harm	• No harm
Risk	• 1725 (16)	• 1820 (20) Surveillance • 1048 (20) Workforce • 1957 (16) Transperineal biopsies • 1977 (16) Capacity and Demand • 1477 (15) Stent	• 1935 (16) OPD • 1735 (9) Hysteroscopy	• 1889 (5) Microscope • 2021 Backlog	• 1726 (20)
Current position and plan	• **Latest available data (November 2023):** 16.2% Best Practice 70% Orthogeriatrician review 27% prompt surgery <36hrs 5 elements of best practice achieving 96% or greater • Time to theatre remains key area of focus: Extended job plans for trauma theatre Continuous flow T&O ward to ensure patients in the right place QI project to improve the continuity of trauma theatre sessions • Mortality is in line with national average	• Surveillance update – reduction in backlog, currently 70 patients undated • Stent register: review SOP in place and lead by the Specialist Nurse. • TP biopsies: reduction in the backlog • Business case approved by the Trust. 3 substantive middle grades appointed AND a locum consultant. • GIRFT further faster programme of work initiated	**Waiting list:** • Engaging with the Independent Sector for additional capacity • 2WW position recovered • GIRFT further faster initiated • Workforce: 3 Consultants starting in Q4 of 23/24, will be fully established • Equipment: The service now has its full complement of equipment	**Waiting list:** • Engaging with the Independent Sector , who are delivering additional capacity • GIRFT further faster programme of work initiated • Locum Consultant commencing in Jan 2024 on a 12 month contract • Action being undertaken to reinstate the training post, whilst, as an interim putting in place plans to offset the gap in the rota from Aug 2024.	• Consultant appointed and starts in Feb 2024 • Monthly review of all high risk and/or 17+ week overdue patients • Interim orthoptic and or optometry appointments for children at risk of sight loss to ensure no deterioration • Escalation protocol for urgent paediatric ophthalmology patients • ROP screening is being covered by the Associate Specialist and Alder Hey Consultant • Working with Alder Hey who are supporting OPD and theatre sessions • ACP progress
Reporting Structure	Risk Review Group → Planned Care Improvement Group → Trust Patient Safety Clinical Effectiveness Sub-Committee → Quality Assurance Committee → Trust Board				

Theatre procedural safety and safety culture

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Concern

- Quarterly Safe Surgery Audits reported to Patient Safety and Clinical Effectiveness Sub-Committee demonstrate good compliance
- Three Theatre never events without commonality
- Conflict between assurance from robust audit process and incidence of never events

Response

- Theatres Safety Day and External Review (Dec 2023) reporting to QAC (Jan 24):
  - Review of incident investigations
  - Theatre tour and observation of safety processes
  - Safety checklist review
- Review found robust checklists and processes with some reported variability in adherence and psychological safety in theatre Teams
- Theatres development programme
- Theatre Procedural Safety will be included within Trust Quality Priorities 2024/25

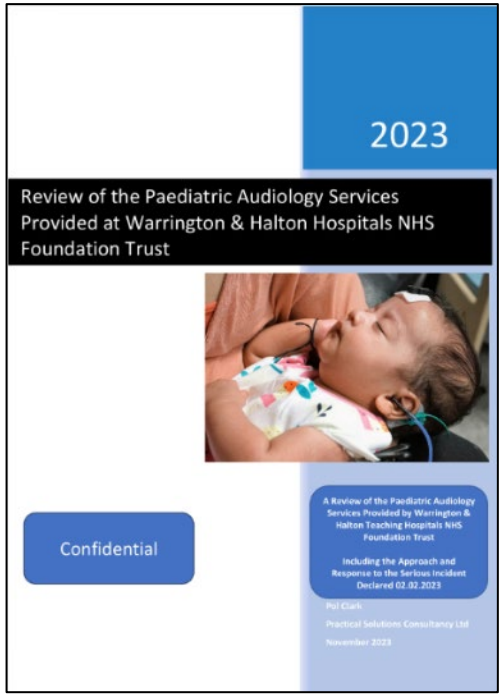
Actions

- Deputy AMD for Procedural Safety appointed Nov 2023
- Establishment of Procedural Safety Steering Group, Chaired by Deputy AMD (Jan 2024) - responsible for oversight of procedural safety improvement programme and triangulation of theatre safety data with onward assurance reporting/escalation to Patient Safety Clinical Effectiveness Sub-Committee and Quality Assurance Committee
- NatSSIPS2 implementation (2024/25)
- Baseline assessment of Theatre safety culture and psychological safety to be undertaken by Planned Care Theatre culture working group (in development)
- Further medical leadership development - ‘Capacity for Courageous Conversations’ (Feb 2024)
- MIAA external audit programme to include procedural safety standards in theatres (2024/25)

Auditory Brainstem Response testing – national service review

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- British Audiology Association undertook an independent review in 2021 following Scottish Service Ombudsman report
- Engagement sessions and audit of sites with low levels of yield
- February 2023: WHH declare serious incident and pause ABR testing service
- Full review of ABR cases from 2018-2023 – **200 cases identified** (some joint with Bridgewater Community Healthcare NHS FT)
- Mutual aid package agreed with Northern Care Alliance (NCA)
- March 2023: ABR service recommenced supported by NCA team
- Proactive case reviews, communication with families and stakeholders
- Two cases of low harm and two cases of moderate harm identified
- October 2023: NCA mutual aid concluded
- December 2023: Service and incident review full report to Quality Assurance Committee
- Nine children continue with ongoing monitoring to conclude February 2024
- Project Manager recruited to support Improving Quality in Physiology Services (IQIPS) accreditation



Safe – overview

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Positive workforce metrics with sustained improvement in key areas to ensure delivery of safe, quality care
- Compliance with mandatory (89%) and role-specific (86%) training – current focus on improving medical workforce compliance
- Strong understanding of safeguarding (81%), DoLS (92%) and mental capacity (92%) to ensure protection and safety for our vulnerable patients
- Positive safety response
- Robust governance processes to ensure effective risk management, incident and complaint investigation, escalation and learning
- Top three incident themes last 12 months across surgery:
    - Access, transfer and discharge
    - Infection prevention and control
    - Medication
- Engagement with PSIRF implementation
- Oversight and scrutiny of harm free care data
- Clinical harm review process for delayed treatment in place, based on C&M approved AI tool
- Embedded learning from deaths by Structured Judgement Reviews at Mortality Review Group
- HSMR and SHMI (mortality rates) are “as expected”
- Care provided in safe environments with embedded review processes to maintain safety, infection prevention and control

Safe – staffing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Positive recruitment to vacancy profile
- Response to key medical vacancies within fragile services
- Robust reporting and escalation process
- Safer Nursing Care Tool and establishment review systems in place
- Senior collaboration and support to maintain safety across site on a daily basis with clear escalation guidance
- Senior oversight at CBU and Care Group level via Workforce Review Group with escalation to Strategic People Committee and Trust Board

All staff turnover

All staff vacancy

Nursing/midwifery vacancy

Medical/dental vacancy

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Responsive

Responsive – challenges and risks

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Restoration of elective recovery

- 78ww, 65ww and 52ww by March 2025

Cancer

- Maintaining low 62-day backlog and good compliance against 28-day FDS

Surveillance

- System in place to track and schedule patients and identify any risk, use of AI, Access Policy

Triangulation with fragile services

Responsive – overview

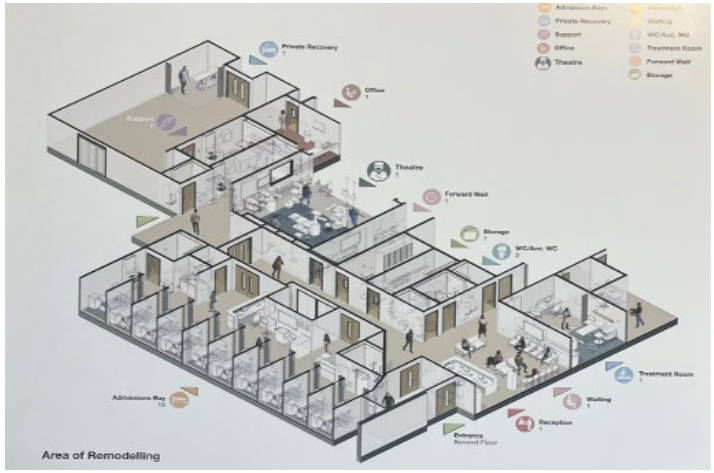
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Delivery

- Additional capacity: Use of independent sector/ Waiting List Initiatives – We have contacted 1249 patients and 908 have moved to the IS. Weekly Insourcing for ENT, Urology and Gynaecology
- Faster Diagnosis Standard work
- Transformation quality improvement projects
- Fragile services – Trust investment in Urology, AMD, ENT
- Theatre utilisation improvement focus
- Post Anaesthesia Care Unit on Halton site
- Urology Investigation Unit
- Virtual Fracture Clinic
- Response to Age-related Macular Degeneration service challenges - stepped down from fragile service
- Reconfiguration of CSTM ward to enable surgical specialty daycase work segregation from elective T&O

Targeted Investment Fund

- Fifth theatre and dedicated daycase unit at CSTM
- Upgrade of Nightingale Theatres
- Endoscopy Hub for Cheshire and Merseyside
- Submission of high-level schemes for future funding



Responsive – overview

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Listening to patients and families

- Top three complaint themes last 12 months:
  - Clinical treatment (58)
  - Communication (7)
  - Date for appointment (7)
- Focus on resolution in real time and full compliance with response timeframes
- Senior oversight and checks to ensure lessons learnt embedded
- Example of family meeting impact statement

Listening to staff

- Staff survey – increased response rate in 2023
- Your Future Your Way engagement across the Care Group
- Introduction of Peer Support Café
- Freedom To Speak Up awareness and response

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Effective

Effective – challenges and risks

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Current performance

78/65 weeks:

- Forecast to have < 100 78 ww by end of March
- Forecast to have < 300 65ww by end of March
- Industrial Action biggest impact

Cancer:

- Low 62-day backlog
- Good compliance against 28-day FDS, improving 62-day

Diagnostics (DMO1):

- Trust, we are 81.9%, performance improving

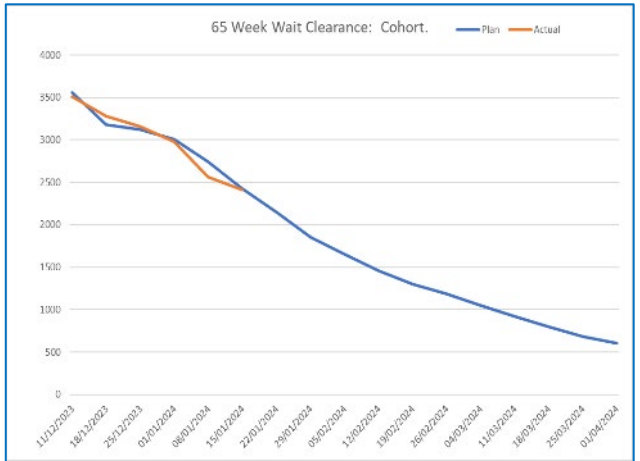
Plan

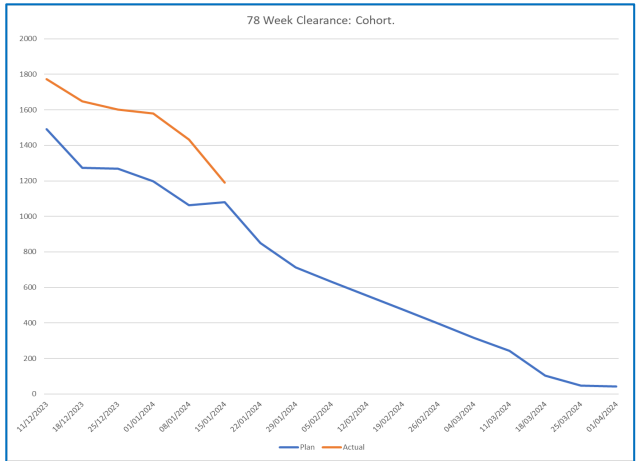
2023/24:

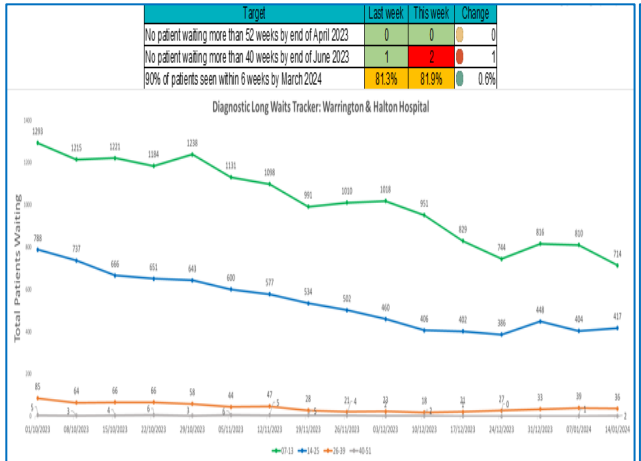
- Committed resource of up to £1.4 million to support additionality, which has involved:
  - Engaging with the independent sector
  - Mutual aid with NHS partners within C&M
  - Additional WLI across all specialities

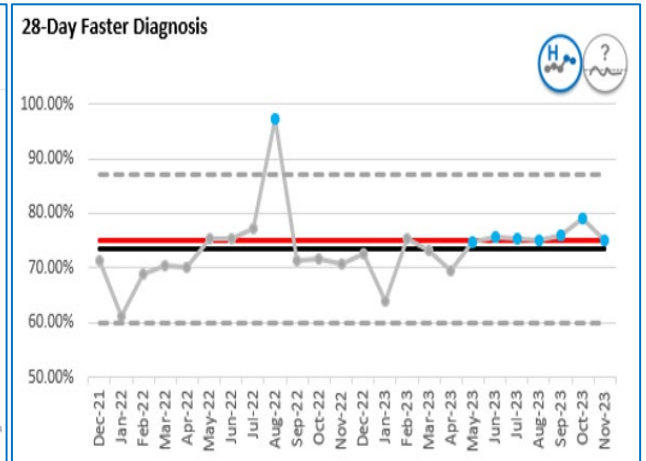
2024/25:

- We know our patient numbers: 3000 52ww by Mar 25 forecast. £2m+ required to clear all 52ww by Mar 25
- Delivery and financial plans being developed









Effective – overview

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- GIRFT priorities:
  - Consultants to deliver against planned 42-week Clinical Theatre Activity
  - Improve day-case activity rates
  - All theatres will start before 9am
  - List planning - improve standardisation and theatre utilisation
  - Improve Fractured Neck of Femur best practice compliance
- Model Hospital
- Outcomes/readmission rates
- Ward Accreditation – 4 x Gold awards, remaining areas Silver
- Quality metric process embedded
- Endoscopy Joint Advisory Group accreditation
- Anaesthesia Clinical Services Accreditation
- Examples of effective MDT planning for patients with protected characteristics

JAG accreditation feedback:

"Both sites operate to an equally exceptional standard and easily some of the highest standards we have seen in the UK... In summary the service epitomises what a quality, safe endoscopy service with embedded standards is all about"

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Well-Led

Well-Led

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Governance Structure

Well-Led

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Leadership:

- Established and embedded leadership structure working together to deliver Planned Care objectives
- Leaders with the right skills, knowledge and integrity
- Development opportunities encouraged and supported – Leader's DNA programme
- Strong collaboration and support across the senior team
- Positive workforce metrics with a focus on reduction of sickness absence
- Knowledge of workforce diversity profile in relation to local population
- Realistic and pragmatic winter people plan to support teams and maintain workforce metric performance

Future focus:

- Proactive and holistic leadership that triangulates all people data
- Improve appraisal compliance (currently 78.59%)
- Bespoke leadership training for new managers
- Medical leadership development
- Improve non-disclosure rates around disability and sexual orientation to ensure staff feel supported

Well-Led

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Sustainability priorities

- Delivery of CIP schemes
- GIRFT priorities
- Elective restoration and recovery
- Improvement work in Theatres and OPD
- Staff Health and Wellbeing
- Agency reduction

Escalation of concern

- Staff aware of informal and formal routes
- Freedom To Speak Up staff awareness and leadership response
- Fluid and proactive leadership response
- Ward Accreditation process assesses staff attitude to escalation of concern and has consistently been found to be positive
- Staff survey results indicate staff feel secure to raise concern

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Caring

Caring

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Compassionate care

- Patient and family feedback
- Friends and Family Test (FFT) data
- Nutrition, hydration and pain management standards supported by matron daily checks and Quality Metrics peer review
- Privacy, dignity and confidentiality standards
- Trust values – staff awards
- Governor/Senior Nurse/Trust Board walkaround feedback
- Accreditation programmes
- Effective complaints response process with a focus on early resolution and lessons learned

FFT feedback

96-98% positive feedback across surgery (last 12 months)

Top 5 Themes - Positive
Staff Attitude
Implementation of Care
Environment
Patient Mood/Feeling
Communication

Caring

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Outstanding practice

- Matron for Gynaecology supported a young patient with autism and Asperger's Syndrome over the course of two years for appointments and procedures. Extensive collaborative working to provide bespoke appointment arrangements and individualised care.
- Received a CEO 'You Made a Difference' Award and Finalist for Warrington Guardian Inspiration Awards 2023 in 'NHS Hero' category

- Examples of preoperative MDT planning for patients with a learning disability undergoing an elective procedure by preoperative assessment and elective ward teams

Staff health and wellbeing – All About You

- Senior team commitment
- Extensive offer – supporting teams to access
- Staff survey – meaningful action plans to provide assurance of listening
- Appraisal and development

What are we most proud of?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our workforce, and their commitment to delivering safe, quality care for our patients and their families

Next steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Maternity to take forward ‘Should Do’ actions
- Await further direction from the CQC following the engagement and risk meeting
    - Likely to receive requests for information relating to the core services
- Moving to Outstanding meeting to be paused and reviewed to consider an alternative approach in accordance with new CQC Inspection Framework (to be implemented across the North-West in January)
- CQC will facilitate a session to update the Trust on the new Single Assessment Framework

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Developmental well-led review

Undertaken by the Good Governance Institute

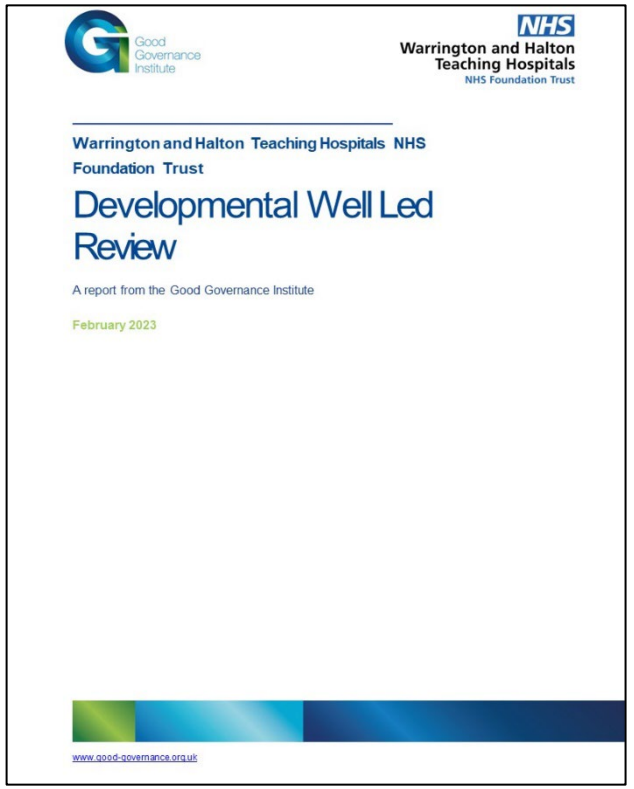
Reported in February 2023

Overview

The Good Governance Institute (GGI) was appointed by the Trust to deliver a developmental well-led governance review using the NHS England well-led framework, taking into account expected changes in the CQC's regulatory approach, and with a focus on working as part of an integrated care system.

The analysis used the eight key lines of enquiry (KLoEs) from the guidance to provide a framework for an assessment of current and future dynamics for well-led development for the Trust.

The review was undertaken between August and November 2022, was grounded on the triangulation of evidence gathered through meeting observations, interviews, focus groups and documentation review.



Summary of findings and recommendations

KLOE 1: Leadership capacity and capability	
Summary findings	The trust has a well-established and highly-regarded executive team, and there is a formal process of succession planning to identify and develop the leaders of the future. Non-executive directors' input is also valued – new appointments have further strengthened the NED ranks and the Chair is respected for his passionate, visible style. However, the visibility of NEDs in the organisation is relatively low, due in part to restrictions imposed because of the pandemic, and could be enhanced.
Recommendations	• The trust should consider how it can raise the profile of non-executive directors within the organisation, for example through more frequent site visits.
Comments / progress and evidence to support	• Onsite Leadership Observation visits re-started in August 2022 following lessening of COVID restrictions, these take place prior to each Board meeting. • 'Meet the Board' posters are on display across the Trust • Regular NED Maternity Champion visits • Chair undertakes monthly ward visits with senior nurses
KLOE 2: Strategy and vision	
Summary findings	The trust's strategy is well understood and supported by stakeholders both inside the organisation and outside. As it is approaching the end of its lifespan, it is being reviewed and refreshed. Key strategic challenges for the near future include financial sustainability, the trust's role at place and system level, the condition of the estate and the prospect of replacing the hospital building. The vision and values appear to be widely shared by staff.
Recommendations	• The trust needs to develop an interim plan for the estate prior to the new hospital becoming a reality. • The trust should consider how best it can communicate the financial challenge which it faces, and the measures needed to tackle it, to internal and external stakeholders.
Comments / progress and evidence to support	• New Estates Strategy 2024-2029 approved • The Trust Communicate to a variety of stakeholders, through CPG, FRG, Recovery Wednesday, Committee and Trust Board. Finance is included in the monthly team brief. Externally the financial position is shared with both Warrington and Halton Place through SSG and One Halton, along with monthly returns and meetings with the ICS. • New Trust Strategy 2023-25 (with focus on system working and aligning with local and regional planning) presented to and approved by the Trust Board 29th March 2023.

Summary of findings and recommendations

KLOE 3: Culture	
Summary findings	We found the trust to have a friendly, welcoming culture. Leaders are seen as approachable, and staff feel comfortable to raise issues with them. Quality criteria are seen as "first among equals" when important decisions are taken. Diversity and inclusivity issues have an appropriate profile although there is always more that can be achieved. Employee wellbeing is a prority for the board and staff recognise the work being done in this area.
Recommendations	• The trust should consider whether the current time allocation for the FTSU Guardian role is sufficient, or if an additional post is needed to support the guardian's work. • The trust should ensure that as many professional groups as possible are represented among the Freedom to Speak Up champions who support the guardian. • The trust should continue its efforts to ensure greater ethnic diversity in the senior levels of the organisation and consider what more needs to be done drawing on best practice from elsewhere.
Comments / progress and evidence to support	• A substantive FTSU Guardian and Deputy have been appointed • FTSU continues to recruit FTSU Champions currently circa 30 across different professions and groups including Chair for BAME and LGBTQ staff groups • FTSUG or nominated Champion speaks at junior doctor, international nurse and preceptorship inductions • The Trust continued to run the Inspiring Leaders Network (ILN) Shadow Board Programme in 2023/24 • Bespoke EDI Board Member training delivered • A range of programmes have been developed to ensure an intersectional lens to development opportunities eg: • Your Future Your Way • Refresh of recruitment & selection training to include inclusive recruitment best practice • Development programme for Staff Network Chairs & Vice Chairs • Insourced Reciprocal Mentoring Programme pending awaiting BAME Assembly review of reverse mentoring. During this time the Trust is investing in a senior leadership development programme which includes an element of sponsorship from Executive Team members. This will be reviewed in line with the Reciprocal Mentoring programme in March 2024. • Introduced targeted marketing of employment opportunities to support increase in diversity via implementation of TRAC, on-going redesign of Trust website, review of external facing materials, accreditations and interview format & language • Attained Cheshire & Merseyside Navajo Charter mark • Recognised as a Disability Confident Leader • The Trust is a Stonewall Diversity Champion • Working towards attaining the NHS North West BAME Assembly Anti-Racist Framework in 2023/24, as well as the NHS Rainbow Badge scheme and reaccreditation for the Veterans Covenant.

Summary of findings and recommendations

KLOE 4: Governance	
Summary findings	There is open discussion and constructive challenge at board and committee meetings, with an appropriate balance between strategic and operational matters. However, the papers for meetings do not always enable this as they can be excessively detailed and lacking in focus. Papers are sometimes circulated late and some meetings have been cancelled or rearranged at short notice. While the trust has a commendably open and positive culture, more could be done to hold individuals to account, e.g. for meeting deadlines and taking agreed actions.
Recommendations	• The trust should commission or deliver training for those who write reports for the board or its committees, with an emphasis on writing to provide assurance. • Board and committee meetings should include time at the end of the agenda to reflect on the meeting. • The trust should review the structure of committees/groups below board level in the interests of efficiency and providing effective assurance.
Comments / progress and evidence to support	• The Trust commissioned report writing training and attended by staff from across the Trust responsible to composing reports. Ad-hoc advice on report writing is accessible. • All Board & Committee meetings include specific agenda item to reflect on the meeting. • Internal Governance structure in place & regularly reviewed and updated. • Committee Terms of reviewed and refreshed regularly as part of the cycles of business
KLOE 5: Management of risks, incidents and performance	
Summary findings	There is a comprehensive board assurance framework which drives the work of the board and its committees, although the BAF could be refined further, and streamlined to make it a more user-friendly document. There is a shared understanding among directors and senior managers of the key risks facing the trust which broadly reflects what is recorded on the BAF and corporate risk register. A risk review group oversees the management of risks by clinical business units and corporate departments. Committees have commissioned 'deep dives' into cases of poor performance or project failure.
Recommendations	• The trust should further refine the Board Assurance Framework, to streamline the document and distinguish more clearly between controls and assurances. • The BAF should have a more prominent position earlier in the agenda of the board and board committees.
Comments / progress and evidence to support	• All BAF risks have been reviewed and definitions of Assurance vs Controls communicated to risk owners • Board Development Sessions with the Good Governance Institute (GGI). Board approved Trust Risk Appetite Statement which is included in BAF reports • BAF is scheduled as one of the first items on Board and Committee agendas.

Summary of findings and recommendations

KLOE 6: Information management	
Summary findings	The trust is becoming more digitally mature, thanks in part to strong clinical engagement with the digital agenda such as procurement of a new electronic patient record. There is general confidence in the quality of data available to managers and the board, and committees triangulate data from different sources as part of their scrutiny role. The Integrated Performance Report is a work in progress and has recently incorporated statistical process control charts.
Recommendations	• The trust should progress the procurement and implementation of a new electronic patient record, within the constraints of national guidance. • The trust should continue to develop its integrated performance report and its use of statistical process charts. • The trust should identify any areas of the hospital where IT equipment is obsolete or persistently unreliable and prioritise them for replacement.
Comments / progress and evidence to support	• Procurement process in train, OBC supported by NHSE FD Programme, ITT expected to be issued imminently • SPC charts introduced to the Trust Board in July 2022 and subsequently to appropriate Board Committees (including QAC, FSC & SPC) in 2023 • Tech refresh plan agreed. Phase 1 Network Refresh, Phase 2 Hardware Refresh
KLOE 7: Patient, staff and external partner engagement	
Summary findings	The trust's executive directors, and its chairman, play leading roles within the Cheshire and Merseyside integrated care system. Partners appreciate their input and respect WHH's achievements but feel that the trust could be even more ambitious. Patient and public voices are engaged and contribute to improving the quality of care. The foundation trust governors feel valued, informed and involved. Staff are attracted to the trust by its culture and reputation.
Recommendations	• The trust should continue to do all it can to influence and play an active part in systems working, especially clinical strategy. • The trust should continue to pursue recruitment of governors from groups or geographical areas which are under-represented
Comments / progress and evidence to support	• New Trust Strategy 2023-25 (with focus on system working and aligning with local and regional planning) presented to and approved by the Trust Board 29th March 2023. • Executive level attendance and input into Place Partnership Boards, including development of Place strategies and delivery plans • Engagement with ICB Associate Director of Strategy and Collaboration, on behalf of CMAST strategy directors, to ensure that provider priorities are reflected in the ICB 5 year Joint Forward Plan • Chief Executive chairs CMAST Clinical pathways work programme and Director of Strategy and Partnerships chairs CMAST Strategy Directors group. Both contribute directly to strategy development and delivery at C&M level. • Commitment for Chairs and CEOs at both WHH and STHK to work collaboratively to support fragile services. • New Membership Strategy approved by the Council of Governors and Trust Board (Dec 23) • New Governor election material approved by the Governor Engagement Group and Council of Governors, and produced and used for 2023 Governor Elections

Summary of findings and recommendations

KLOE 8: Learning, continuous improvement and innovation	
Summary findings	A learning culture was evident in a number of ways. Staff are supported to learn and to develop – for example, the shadow board programme for high-performing senior staff. Notably, there is a greater emphasis nowadays on research in the trust and some research projects have been recognised with awards. The research programme proved its worth during the Covid pandemic.
Recommendations	• The trust should consider additional ways of communicating safety information and learning from incidents, for example through staff-specific social media.
Comments / progress and evidence to support	• The daily safety briefing provides staff focused update on key safety issues that are taking place today on that day across the Trust, and informing of the appropriate actions put in place to ensure the safety of all staff and patients

GGI's conclusion

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

"The findings of this review are greatly to the credit of the trust. A clear picture emerged during our fieldwork of an organisation with an agreed view of where it is going and what it aims to achieve, and which is well regarded by its peers and partners in Cheshire and Merseyside.

It has worked hard to embed a supportive, collaborative culture and to build a reputation as a place where people want to work.

As such, we have made fewer recommendations than we normally would for this type of review, and the recommendations are about further improving what already exists, rather than taking urgent actions needed to achieve compliance"

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Governance Systems and Processes

Kimberley Salmon- Jamieson, Chief Nurse, Deputy Chief Executive
Layla Alani, Director of Governance, Deputy Chief Nurse, January 2024

Scope of Presentation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Brief description of the trust's governance systems focusing on quality and safety
- A self-assessment of compliance with the key question 'is this organisation well-led?'
- Details of current trust-wide challenges, risks and other issues affecting patient safety and experience
- Details of action taken by the trust to address risks

Governance Structure

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Well established structure with the following committees

Each chaired by a Non-Executive Director, with the exception of the Nominations and Remuneration Committee and the Charitable Funds Committee (Chairman)

The Committees provide assurance to the Board of Directors aligned to the Trust mission and ambition around Quality, People and Sustainability:

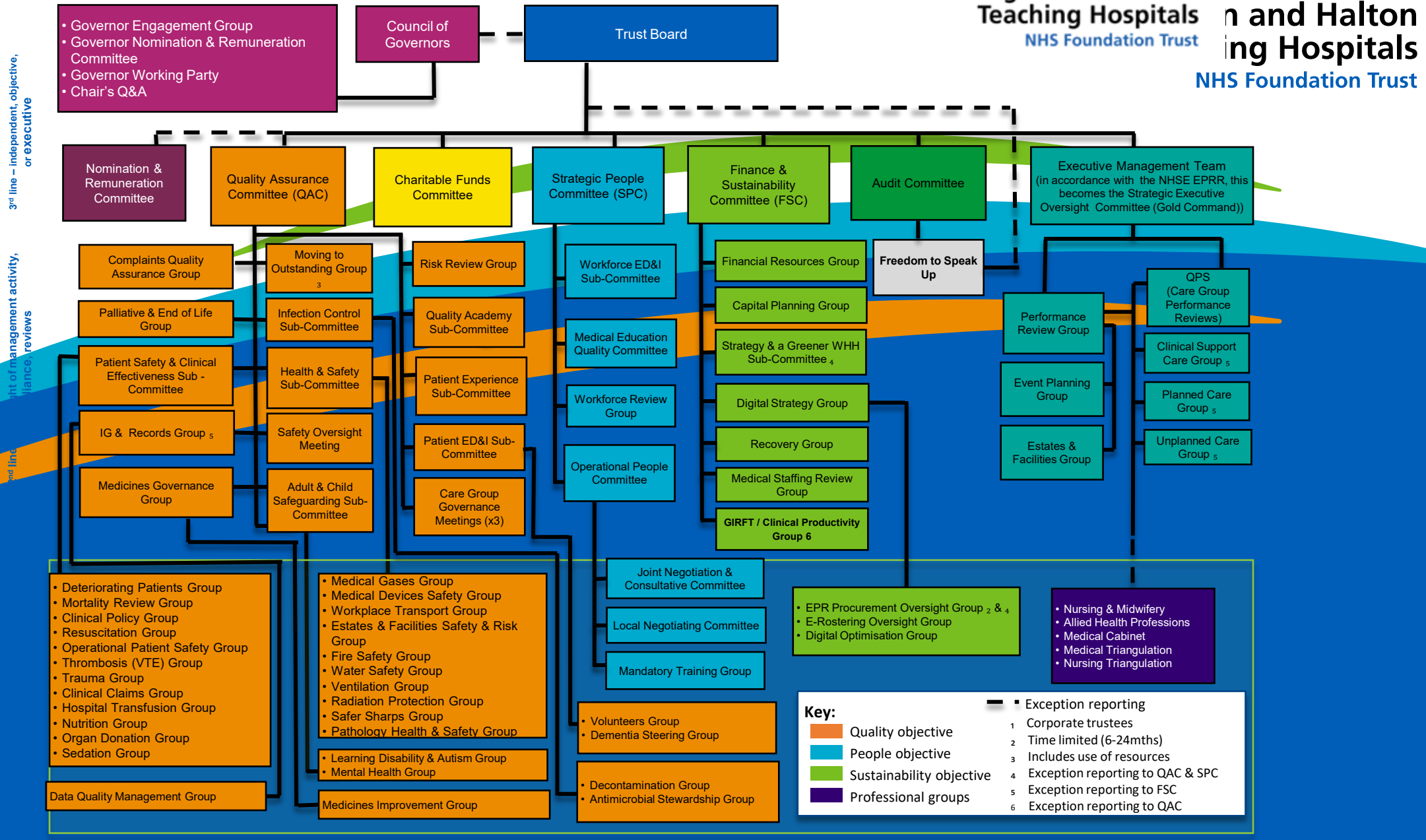
Nominations and Remuneration Committee	Strategic People Committee
Audit Committee.	Quality Assurance Committee
Charitable Funds Committee	Clinical Recovery Oversight Committee (established in April 2021 – disestablished 29th March 2023)
Finance & Sustainability Committee	

The balance, completeness and appropriateness of the members of the Board is reviewed periodically and when vacancies arise among Executive or Non-Executive Directors

WHH internal governance structure – three lines of assurance

The Board ensures appropriate risk management processes are in place.

The Executive Management Team are responsible for the delivery of the Trust's strategy and plans.



System of Internal Control

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Governance structure illustrates the flow of information across a variety of groups to sub-committees of the Board. Escalation to the Board as required
- Twice weekly Executive Team meeting offers agile process for escalation and support
- The Board Assurance Framework (BAF) provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks in achieving strategic objectives
- Audit Committee is charged by the Board in reviewing and evaluating the system of internal control through the delivery of the internal audit plan
- The Audit Committee monitored and tracked governance activity during the last annual reporting period (detailed in Annual Report (2022/2023). Substantial Assurance rating was concluded from the Head of Internal Audit (HOIA)

Oversight of Quality and Safety

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- CBU and Speciality governance meetings
- Care Group Governance meeting (separate to Risk Review Group). Executive led
- Weekly departmental governance meeting. Areas assigned Governance Manager and Complaints handler for consistency
- Twice weekly Executive meeting – escalation and support, governance dashboard
- Monthly Patient Safety and Clinical Effectiveness Sub-Committee – Monthly Quality Assurance Sub-Committee
- Deep dives
- Hot topics
- Fragile services
- Patient stories
- Speciality audit meetings
- Monthly Clinical Quality Focus Group meeting – PLACE
- Quality Academy Sub-committee (Quality Improvement, audit, Knowledge and Evidence Service)
- Research Partnership Board
- Learning forums and mechanisms – showcase events, newsletters, grand round, medical cabinet, nursing and midwifery forum, ‘Education Matters’

Patient Safety Incident Response Framework
WHH Position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Review of 3 years local intelligence, triangulation and engagement with all CBUs to achieve consensus leading to agreed PSIIs:
    - Patients with a missed diagnosis of a cancer
    - Patients who have an underlying MH diagnosis for whom their MH deteriorates during their hospital stay
    - Patients where their assessment was delayed, and timely recognition and response to their deterioration was not identified and/or escalated appropriately

- PSIRF and Learn From Patient Safety Events (LFPSE) went live on the 1st September 2023
- PSIRF Policy and Plan are live on WHH internet site
- Successful implementation of new tools, techniques and methodologies to support learning responses (formally investigations)
- Compassionate engagement with staff and patients/families' model in place
- Governance processes embedding, oversight via operational Task and Finish Group and Executive PSIRF oversight group, Safety Oversight Group
- Mandated Patient Safety Syllabus training figures improving monthly
- Two Patient Safety Partners appointed
- Additional Patient Safety Specialists appointed now 7 in post
- Methodology developed in line with national guidance to support selection of Local Priorities

PSIRF Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- 7 PSII's in progress, 3 are linked to the local priorities
- No remaining Serious Incidents investigations in progress
- Training is being provided to staff to support the PSIRF requirements, and the Patient Safety Training Syllabus has been mandated - available through the Electronic Staff Record
- The Trust Board have participated in oversight training to support their roles in safety. Human Factors training has been provided to staff who are undertaking any safety or learning activities

Training compliance with Patient Safety Training Syllabus

- Patient Safety Essentials for boards and senior leadership - Level 1: 88.08%
- Patient Safety Essentials - Level 1: 89.47%
- Patient Safety - Level 2: 69.26%

Complaints and Patient Advice and Liaison Position

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Complaints

- Work to NHS complaints standards (2021)
- 27 complaints open Trustwide
- Designated complaints handlers alongside CBU = consistency
- All complaints acknowledged within 3 working days
- 0 complaints over 6 months
- All complaints responded to within time frame (30 working days for low and moderate, 60 working days for high risk)
- Number of dissatisfied complainants = 1
- All complainants offered meeting in person
- Monthly Complaints Quality Assurance Group chaired by the Trust Chairman
- Parliamentary Ombudsman = 5
- Monitored via Trust Integrated Performance Report

PALS

- 38 in active resolution

Risk Management

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Board is fully appraised with oversight of key strategic risks and risk appetite
- Risk Review Group – oversight, discussion, flexibility of risk, controls, mitigation, assurance
- Board Assurance Framework - fully reviewed by the Board at each of its meetings and at committee meetings bi-monthly in year. Available in full on Trust website
- Each strategic risk is allocated to a committee for focused oversight and scrutiny.
- The Board Assurance Framework is informed by the Corporate Risk Register and Local Risk Registers
- Monthly Risk Review Group – Executive led
  - Review of local risk registers (cyclical process). Escalation and de-escalation of risk
  - Discussion of corporate and strategic risk register
- Example of risk management and assurance:
  - Urology identified as fragile service through incident profile, identified on risk register locally and on Board Assurance Framework under Fragile Services. Regular oversight through sub committees to Board. Discussion at Risk Review Group

Challenge	Assurance
Capacity and demand in ED • 12 hours time in department • High occupancy/ care on the corridor • Maintaining ambulance handover	• ED improvement group workstreams supported by ECIST/GIRFT: continuous flow, Emergency Assessment Unit, CT scanner, NWAS collaboration, Streaming and triage • Newton system review • Improved position on 4 hour ED standard compared to last winter • Supported £450,170 business case nurse staffing • Same Day Emergency Care Centre • National support (ECIST) for improvement (TIER 1)
Restoration and Recovery, Theatre capacity and Outpatient diagnostics • 78 week delivery • 65 week delivery • ENT • Gynae • Urology	• Invested 1.3 million in additional capacity – supporting reduced long waits • Investment of 7 million – new lamina flow theatre and purpose built daycase facility • Forecasting circa 153 (78 week waiters) and 500 (65 week waiters(-end of financial year • Regional support for improvement (TIER 2) • Mutual aid Cheshire and Mersey • Development of diagnostic cold site (Halton) including establishment of Community Diagnostic Centre • Participation in national productivity and efficiency programmes- theatre improvement, outpatient utilisation (GIRFT)
Clinical workforce staffing –Medical and Nursing	• **2021** Medical staffing review – sustainable funded establishments • **2022 - 2023** Recruitment and Implementation overseen by Medical Staffing Resources Group reporting to OPC and FSC • **2023** – Implementation of e-rostering and e-leave – further safe medical staffing controls in place • **Feb 2024** – Medical staffing strategy refresh workshop to revisit and optimise on call staffing, ward distribution and blended workforce approach to rotation gaps **Nursing** • Senior nurse oversight at 3 x daily staffing meetings with escalation process in place • Allocate system in place to ensure safe staffing in accordance with demand • Enhanced care process in place to recognise patients with greater dependency • Utilisation of temporary staffing where required • Reduction in Nursing and Midwifery Turnover from 16% in March 2023 to 12% in November 2023 • Reduction in vacancy percentage from 18% in April 2023 to 11% in November 2023 • AHP workforce strategy in place

Challenge	Assurance
Industrial Action	• Established planning process with clinical risk based approach to rescheduling activity • MD led pre-action safe IA staffing Check and Challenge sessions • IA control room and 24/7 MD/Deputy MD Medical Commander escalation functions during IA • After action reviews and debrief including DATIX surveillance for harm
Electronic Patient Record	• Existing EPR undergoing ongoing optimisation and continuous improvement • Procurement process underway for new EPR • Clinical input vital to guide selection process • Go Live Q5 2025
Finance and sustainability	• Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning • Weekly CEO led recovery meeting (including finance & operations) in place • Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced. Appointed GIRFT Finance Lead and 5 PAs allocated. • Financial strategy to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • Capital & Revenue Plans for 2023/24 approved by the Trust Board in March 2023. Updated and approved by the Trust Board in May 2023 • New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. • Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023 • CDC phase 2 application approved for £4.5m capital over three years