Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 2nd August 2023
10.00am -12.30pm
Trust Conference Room Warrington/Via MS Teams

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 2nd August 2023, 10.00am – 12.30pm
Trust Conference Room/Via MS Teams

AGENDA ITEM	TIME	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
BM/23/08/78	**10:00**	Engagement Story - The Impact Research had on Me.	***To Note***	**Presentation**	Jen McCartney - Head of Patient Experience and Inclusion Kirsty Pine - Associate Director of Research Layla Alani
BM/23/08/79	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chair
BM/23/08/80	**10:17**	Minutes and Action Log of the previous meeting held on **7th June 2023**	***For decision***	***Minutes***	Steve McGuirk Chair
BM/23/08/81	**10:20**	Matters Arising	***For assurance***	***Verbal***	Steve McGuirk Chair
BM/23/08/82	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/23/08/83	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Steve McGuirk Chair
BM/23/08/84	**10:45**	Board Assurance Framework	***For approval***	***Report***	John Culshaw, Company Secretary

Quality People Sustainability

BM/23/08/85	**10:50**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports – Quality and Assurance Committee (QAC) – 13.06.23 & 11.07.23	***For assurance***	***Report & Presentation***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO; Dan Moore, Chief Operating Officer; Paul Fitzsimmons, Exec Medical Director
(b)		**People Dashboard** **Including** Assurance Report - Strategic People Committee (SPC) – 21.06.23 & 19.07.23	***For assurance***	***Report & Presentation***	Michelle Cloney, Chief People Officer Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard** **Including** Assurance Report – Finance and Sustainability Committee (FSC) – 28.06.23 & 26.07.23	***For assurance***	***Report & Presentation***	Andrea McGee, Chief Finance Officer & Deputy CEO John Somers, Committee Chair
(d)		Assurance Report – Audit Committee (AC) – Year End 21.06.23	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair

Quality

BM/23/08/86	**11:20**	Maternity Update including. I. Ockenden Review Updates II. Maternity Incentive Scheme Year 5 Overview of Requirements III. Avoiding Term Admissions into Neonatal units (ATAIN) Q4	***To note for assurance***	***Report***	Ailsa Gaskill-Jones, Director of Midwifery
BM/23/08/87	**11:30**	Quality Strategy Update – Annual Report	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/88	**11:40**	Fragile Clinical Services Update	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO/Paul Fitzsimmons Executive Medical Director
BM/23/08/89	**11:50**	Patient Safety Incident Policy & Plan (PSIRF)	***To approve***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

People

BM/23/08/90	**12:00**	Communications & Engagement Dashboard Q1 Update	***To note for assurance***	**Paper**	Kate Henry, Director of Communications & Engagement
BM/23/08/91	**12:05**	Working with People & Communities Strategy - Annual Report	***To note for assurance***	**Paper**	Kate Henry, Director of Communications & Engagement

Sustainability

GOVERNANCE					
BM/23/08/92	**12:10**	Quality Assurance Committee Annual Report	***For approval***	***Report***	John Culshaw, Company Secretary

FOR APPROVAL					
BM/23/08/93	**12:15**	Trust Organograms - Updated	***For approval***	***Report***	John Culshaw, Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

TO NOTE FOR ASSURANCE					
BM/23/08/94	Annual Complaints Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/06/129 Date of Meeting: 13.06.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/95	Safeguarding Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/07/151 Date of Meeting: 11.07.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

BM/23/08/96	Infection Prevention and Control Board Assurance Framework Compliance – Bi-annual report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/07/153 Date of Meeting: 11.07.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/97	DIPC Infection Control Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/07/152 Date of Meeting: 11.07.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/98	Annual Health & Safety Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/07/154 Date of Meeting: 11.07.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/99	Risk Management Strategy Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/07/156 Date of Meeting: 11.07.23 Outcome: Approved	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/100	Digital Strategy Group Update Report	***To note for assurance***	Committee: Finance & Sustainability Committee Agenda Ref: FSC/23/06/59 Date of Meeting: 28.06.23 Outcome: Noted	**Paper**	Paul Fitzsimmons Executive Medical Director
BM/23/08/101	Emergency Preparedness Annual Report	***To note for assurance***	Committee: Finance & Sustainability Committee Agenda Ref: FSC/23/07/72 Date of Meeting: 26.07.23 Outcome: Approved	**Paper**	Dan Moore, Chief Operating Officer
BM/23/08/102	Learning from Deaths Q4	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/07/149 Date of Meeting: 11.07.23 Outcome: Noted	**Paper**	Paul Fitzsimmons Executive Medical Director
BM/23/08/103	In-Patient Survey & Action Plan	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/06/132 Date of Meeting: 13.06.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/104	Perinatal Mortality Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/04/76 Date of Meeting: 11.04.23 Outcome: Noted	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/105	Patient Experience bi-Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Agenda Ref: QAC/23/04/82 Date of Meeting: 11.04.23 Outcome: Approved	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/08/106	Guardian of Safe Working – Annual Report	***To note for assurance***	Committee: Strategic People Committee Agenda Ref: SPC/23/07/95 Date of Meeting: 19.07.23	**Paper**	Paul Fitzsimmons Executive Medical Director

			Outcome: Noted		
CLOSING					
BM/23/08/107	**12:20**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/23/08/108		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting - 4 October 2023, Trust Conference Room – Warrington Site					

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 29 March 2023 Halton Education Centre/Via MS Teams	
Present	
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director (Chair)
Simon Constable (SC)	Chief Executive
Julie Jarman (JJ)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Andrea McGee (AM)	Chief Finance Officer & Deputy Chief Executive
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
Michelle Cloney (MC)	Chief People Officer
Dan Moore (DM)	Chief Operating Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
Apologies	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Jen McCartney (JMcC)	Head of Patient Experience and Inclusion (*in attendance for Agenda Item BM/23/06/49)*
Emily Kelso (EK)	Corporate Governance & Membership Manager **(minute taking)**
Observing	
Norman Holding	Lead Governor
Anne Robinson	Public Governor
Michelle Smith	AHP Lead /Head of Therapy Services

Agenda Ref	Agenda Item
BM/23/06/49	**Engagement story – Zack's Story** JM introduced the presentation, which was narrated by Lyndsey Price Zack's Mum, with professional input by Jill Thomas Matron Child Health. It was explained that Zack had suffered from a significant brain injury at birth, but that despite his injuries Zack and his family made every effort to ensure Zack could live life, as a regular boy. It was explained that overall, the experiences Zack and his family had at WHH were good. However, on Zack's final admission to WHH when 24/7 care was required a number of issues were experienced.

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

	These were described in detail following which the Board reflected, particularly around the lessons learned and improvements made. It was noted that Zack's mother had been instrumental in helping to raise awareness and improve experiences for patients and their families at WHH. The key highlights from the Boards discussion were as follows: • DT recommended the use of Charitable Funds to purchase equipment to improve both patient and families' experiences during hospital stays. It was agreed this would be considered. • The Board agreed it was essential to improve access for Personal Care Assistants to enable them to accompany patients and their families to hospital particularly during long stays to enable respite and support. JT confirmed this was being taking forward with staff on admissions. • It was agreed that the input of Zack's Mum should be recognised for example at the WHH Thank You Awards • The Board took reassurance of the work of the Experts by Experience who helped to shape and improve services at the Trust. • KSJ provided the Board with reassurance on Matrons and senior staff availability, should families feel their needs were not being met, it was noted that most of the time problems were resolved locally, however the Trust complaints process and procedure were followed for those issues that were not able to be resolved. **The Trust Board discussed and noted the Patient Story**
BM/23/06/50	**Welcome, apologies and declarations of interest.** The Chair welcomed the 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/23/06/51	**Minutes and action log from the previous meeting held on 29 March 2023.** The minutes of the meeting held on 29th March were agreed as an accurate record with no amendments. The Action Log was reviewed, completed actions were noted, there were no outstanding/ongoing actions. **The Trust Board approved the minutes of the meeting held on 29 March 2023 and noted the Action Log.**
BM/23/06/52	**Matters Arising** MC informed the Board that following the Engagement Story of military veteran, Sgt Jo Pickstock presented at the March Trust Board meeting, Jo had now taken up the position of Chair of the Trusts Armed Forces Network. **Shadow Board - NHS Leadership Academy** JS reflected on the Shadow Board development programme which he

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	Chaired. He explained that yesterday had been the first meeting of the programme, the agenda was a reduced Trust Board agenda and covered items such as; IPR, Committee Assurance Reports, Ockenden and the National Staff Opinion Survey. It was noted that as best practice, discussions from the Shadow Board meetings would be fed into the Trust Board meetings, it was agreed that input including questions raised would be provided per relevant agenda item throughout the meeting. JS detailed the positive feedback received from the NHS Leadership Academy around the quality of the first meeting, It was noted that there would be 4 Shadow Board meetings in total, prior to Trust Board meetings in August, September, and December. SC commented that as the programme progressed, input from Shadow Board into Trust Board would be formalised. MC commented that that this would be supported by the Shadow Board Terms of Reference. **The Trust Board noted the matters arising.**
BM/23/06/53	**Chief Executives Report** SC introduced the paper, which was taken as read. The Trust Board were asked for any questions relating to items in the papers. The following key points were taken from the questions raised and Trust Board discussions: • It was noted that following the Government announcements and the stepping down of Covid-19 NHS incident level to 3, future reports would not include a separate section on Covid. • The Trust Board discussed the announcement by the Secretary of State for Health and Social Care in the House of Commons, that WHH had not been included in the latest funding round of the Government's New Hospitals Programme. Work with partners on next steps would continue to maximise opportunities to progress plans by changing and adapting how and where the Trust delivers care. • Parking was discussed specifically the difficulties experienced by Blue Badge holders given the inadequacy of spaces. SC commented that car parking was an issue well sighted by the Executive Team and that work around Trust staff and patients utilising appropriate spaces based on their individual needs was essential to ensure those less able were not being impacted. It was noted that a multistorey car park would be high on the agenda for discussions around New Hospital development programmes. • LG provided some insight into the Cheshire and Merseyside Estates Strategy whist still very high level, the Trust were vocal around estates issues, and ensured where opportunities around TIF were available these were taken advantage of. It was further noted that further work on detail within the revised WHH Strategy would enable the Trust to impact the C&M Estates Strategy. SC reiterated that the Trusts Estates issues were recognised by the System. It was noted that there had been some improvements in PLACE based

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	working on no criteria to reside patients in Warrington, less so in Halton. DM added that this year had seen the first coordinated system effort on super stranded and no criteria to reside patients, noting there was now enough data now available to analyse trends which had evidences an improvement against trajectories is evidenced. However, assurance against sustainability remained uncertain. **The Trust Board noted the Chief Executive's Report.**
BM/23/06/54	**Chair's Report** The report was taken as read; no further questions were raised. **The Trust Board noted the Chair's Report.**
BM/23/06/55	**Board Assurance Framework (BAF)** JC presented the BAF update and highlighted the following proposed updates since the last Board meeting, the following key points from the report were highlighted: • It was proposed to add one new risk, in relation to securing sufficient funding for a new hospital, at a rating of 12. • 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** from 25 to 20 (L5xC4) • The reduced ratings of three further risks: - **Risk #1215** - in light of plans to address the capacity deficit, for example TIF, CDC, mutual aid, GIRFT, validation; it was proposed to reduce the risk rating from **25 to 20**. - **Risk #1275 -t**he number of cases of COVID-19 has reduced and there are currently no outbreaks. As a consequence, the operational impact has reduced, and contact bays are not being closed. It was proposed to reduce the rating from **16 to 9** - **Risk #1846** Further to the additional controls that are now in place, it was proposed to reduce the rating of the risk from **16 to 12** • De-escalation of **Risk #1275** in relation to the prevention of nosocomial infection as described in section 2.2, which would be monitored through the Corporate Risk Register, going forward. DT commented that following the Leadership Observational Visits prior to Trust Board, it had been noted by Trust staff members that Covid cases were rising. MC provided assurance that sickness levels as reported through the IPR were coming down in month. KSJ added that this was an isolated incident in Halton Urgent Care where the spike had been recorded (4 staff members) and was not representative of the Trust as a whole. JD queried the rating of new risk asking and ask the Board to consider whether a rating of 12 was high enough. The Trust Board discussed and agreed that both Likelihood and Impact should be equal at 4, giving the Risk a score of 16.

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	The Trust Board discussed and noted the report and supported the proposed changes to the risks highlighted and the increase on the scoring on the New Risk to 16 (4Lx4I)
BM/23/06/56	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance, it was highlighted that the report would be taken as read with key highlights by Executive Leads and any questions on the report content from Non-Executive Directors. ***Access & Performance (DM)*** SM confirmed that within Access and Performance there were a number of targets not being met, which historically the Trust would have delivered and were impacting performance in other domains for example workforce and finance. ***Quality of Care (KSJ)*** JD questioned the medications safety reconciliation within 24 hours, which was reporting a deteriorating position since January 2023. PF responded that a focused recruitment campaign for pharmacists was in place and whilst recruitment had been successful, other pharmacists had left, meaning the position had levelled but not improved. Work was ongoing to ensure WHH pharmacy posts were as attractive as possible including agile & flexible working, use of robots, virtual wards, and professional development opportunities to aid retention. JD further queried when the Trust would expect to see an improvement. PF responded that it was hoped July would show an improvement however the position would remain a challenge. It was noted that mutual aid had been considered but that the system as a whole was struggling with pharmacy recruitment. JS commented on the discussion around the IPR that had taken place at the Shadow Board meeting, and the tendency to focus on the negative from a regulatory point of view, rather than the positive work of the Trust. SC commented that the IPR was an essential part of Board reporting to provide a snap shot of performance and risk, but that other mechanisms were used to provide a more insight into the performance of the Trust. JD referred to the language used within the IPR, for example in relation to Sepsis, which was not achieving target but also not deteriorating, it was clear that staff were working hard towards to support the position. The Board discussed the importance of communicating good news stories and highlighting the work of high performing teams across the Trust, to promote best practice. ***People (Workforce) (MC)*** JS quired how the Trust measured performance around staff culture. MC explained that the workforce team were currently pulling together a WHH culture plan, the plan would be going to the Executive Team for support. MC went on to provide details of the quarterly Staff opinion survey, and that consideration was being made to increase the frequency to monthly. It was noted that a culture survey was being developed to be rolled out within the coming month, SPC would agree questions and would receive a report on

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survey outputs. MC explained other methods of measuring and supporting culture such as Freedom to Speak Up, supporting leaders to lead well and increasing PDR compliance.

MOC queried the deteriorating position in regard to staff turnover, MC explained that the figures in the IPR were reported retrospectively and that the position for June was showing an improved trajectory. This was a result of recruitment activities.

The Board discussed the complexities behind IPR data and agreed that the simple red, amber and green rating did not provide information around benchmarking or insight on whether the Trust was failing but improving.

The Board discussed the ongoing issues and underperformance on Bank and Agency reliance, it was noted that Industrial Action had impacted the position and there was likely to be ongoing deterioration with strike action planned for June. DT queried if the Trust would ever be in a position to say they were unable to deliver a particular service due to staffing pressures. SC confirmed that this would not happen despite financial pressures because the Trusts FT Provider Licence requires that services are delivered.

MOC queried whether the Trust was seeing its own staff doing agency shifts. MC confirmed that Trust staff were often used for bank shifts but not agency and that agency staff particularly in acute wards and the Emergency Department often went on to become permanent members of staff. KSJ added that Agency staff were not used for midwifery wards. However, agency staff were more likely to be used in challenging areas such as ITU, and ED as many permanent staff had left opting to work away from acute care.

Finance & Sustainability (AMcG)

AMcG highlighted several areas for noting which included:

- The 2023/24 plan of £15.8m deficit was accepted, and approved by the system
- The month 1 position was off plan by £500k with deficit £2.5m, the deficit plan would likely become more challenging as the year went on.
- At Month 1 the plan is a £2.0m deficit, however the actual deficit was £2.5m with the overspend being due in the main to industrial action costs and continued escalation in A&E. The position assumes no clawback of PBR relating to an underperformance on activity. At month 1 this is a risk of circa £1.2m.
- April's activity figures were likely to improve slightly as there had been some coding issues identified. Month 2 was looking much closer to plan at this point but still with some specific areas of concern.
- Industrial Action had not been included in planning, the Trust had been told to exclude, national conversations taking place and further guidance was expected from the ICS with the coming week.
- At 30 April 2023, the Trust has delivered a CIP of £0.6m against a target of £0.6m. The full year CIP target is £17.9m of which £13.8m has been identified (77%). However, of the £13.8m £11.4m is non recurrent CIP which is a significant issue of concern.

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	JS sought clarity around coding, noting that the Shadow Board had discussed in detail particularly the impact coding errors had on finances, AMc confirmed that PBR was a product of coding, and that a lot of focus was on education and training for staff around accurate coding. JS queried whether CIP incentives could be considered to drive delivery and improvements. AMc confirmed that this approach had been used in the past and was an option which could be discussed further. MOC queried the budgeted income for 2023/24 and the percentage costs of staffing. AM confirmed a £330M income budget and that staffing costs were around 75%, which was normal when benchmarked against acute providers, and would be higher for specialist Trusts. The Board discussed the low margins left once staffing had been taken out and the importance of efficiency across staff groups, AMcG agreed and confirmed that opportunities to increase efficiency were being explored i.e., new MRI scanners. It was confirmed that capital was not included in the £330m income, and that bids would be made throughout the year when opportunities arose. DM added that in terms of capacity Month 2 was reporting an improved position at 95% of the plan. The roadmap had aimed to hit 108% a key driver would be GIRFT efficiency throughout the Trust, along with reducing cancellations and DNA rates, and increasing capacity/activity. The Trust Board were reassured that the Trust were utilising any opportunities to increase activity and drive recovery. **Finance & Sustainability Committee (FSC) Assurance Reports** JS highlighted the items of low and no assurance no assurance, which had been discussed throughout the IPR, it was recognised that the Trusts financial position was challenging but that there was a vast amount of work being undertaken around GIRFT and CIPs and activity capacity to improve. **Clinical Recovery & Oversight Committee Assurance Report** Was taken as read, with no further questions. **Strategic People Committee** Was taken as read with no further questions. **Audit Committee Assurance Report** Was taken as read with no further questions. **The Trust Board discussed and noted the report**
BM/23/06/57	**MATERNITY UPDATE** **Ockenden** KSJ introduced the report which provided an update in relation to Ockenden recommendations for the end of January, highlighting: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 94.91% compliant and on trajectory to be 100% compliant by 30th December 2023. • **Ockenden 2**: WHH is 68.53% compliant and was on trajectory to be

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	100% compliant by 30th November 2023. This trajectory has been impacted by cancellation of a Training Programme scheduled for Band 7 staff, which had now been rescheduled for completion by November. It was noted that Ockenden 2 did not have any national timelines. **Perinatal Mortality Review Tool (PMRT)** The report was taken as read KSJ reassured The Trust board that the Reports were also robustly monitored through the Quality Assurance Committee and external reviews by the LMNS. It was noted that the Trust were reporting a good position when benchmarked and that there were no areas of concern to alert the Board to as detailed within the paper. It was further noted that where panels were involved for PMRT, professionals from other organisations formed part of the panel to ensure independence of scrutiny. **The Trust Board noted the updates in relation to Maternity.**
BM/23/06/58	**National Staff Opinion Survey** MC introduced the report which provided an overview of the annual NHS Staff Survey results for the Trust from 2022, which were aligned to the NHS People Promises as set out in the NHS People Plan. It was noted that the low 35% participation rate would be a focus for improvement. In summary, the results showed that WHH: - was better than the Acute Trust average 5 themes - the same as other acute trysts in 3 themes - worse than the Acute Trust average score, in relation to one theme 'we are always learning'. It was noted that data had been analysed as requested by SPC, around specific CBU areas for improvement and actions plans would be shared and monitored. The following key points were highlighted from the report and the Trust Boards Discussions: - Generational differences had been noted in the responses received, indicating that the Trust needed to be more dynamic in its approach to listening to staff, listening events were planned to capture – views of younger workforce. - The concerns around the deteriorating position of some WRES WDES questions was discussed, it was noted that throughout the months of June and July 2023, the Workforce Equality, Diversity and Inclusion Team in conjunction with Staff Network leads will be holding listening forums with focused topics of race, disability and sexual orientation. It was thought that the issues could be isolated as they were not reflected in Datix or Freedom to Speak up Data. - KSJ refereed to the survey results around bullying, confirming that two cohorts had been identified and that details of the programme of work to improve the position would be presented p SPC. It was noted that some open and honest sessions with cohorts had taken place and that it had

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	been identified that sponsorship programmes had a positive impact on staff experience. It was also noted that bigger NHS wide issues such as no criteria to reside, A&E demand and length of stay were all issues that impacted staff experience and survey outputs. **The Trust Board noted the bi-annual report for assurance.**
BM/23/06/59	**Trust Strategy - Bi-Annual Update** LG introduced the presentation which provided the Board an update on the governance and delivery of the Trust's strategic objectives, included in the Trust's strategy which was approved in May 2018 and refreshed in July 2021. The report explained that at the end of Q4 2022/23 the Trust was ahead of plan or on track to deliver the outcome/KPI on 16 indicators, behind plan with mitigation on 20 indicators, and behind plan with significant challenges to recovery on 0 indicators. LG further explained that agenda item BM/23/06/64 would present details of the proposed updated governance arrangements following the recent refresh of the Trust's strategy, which the Board would be asked to approve. **The Trust Board noted the progress against delivery of the strategic objectives and the governance arrangements in place.**
BM/23/06/60	**Compliance with Licence Annual Return – completion of General Condition 6 (G6(3)) and Continuity of Service Condition (Cos7)** JC introduced the report which detailed the requirement of NHS Foundation Trusts to self-certify whether or not they have complied with the conditions of the NHS provider licence (as detailed within the paper), have the required resources available if providing commissioner requested services, and have complied with governance requirements. It was noted that the Chair and Chief Executive approved the self-certification on behalf of the Board. It was further noted that the Trust was also required to publish the declaration on the Trust website. **The Trust Board noted the compliance with NHS Conditions G6 and CoS7**
BM/23/06/61	**Revised Provider Licence** JC introduced the reports explaining that The NHS Provider Licence forms part of the oversight arrangements for the NHS. It was noted that changes from the previous iteration of the Licence largely related to system working and references to Monitor updated to NHS England. It was further noted that all changes were made following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS provider licence and the NHS controlled provider licence.

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	The Trust Board noted and approved the signed provider licence certificate, for publishing on the Trust website.
BM/23/06/62	**Committee Annual Reports** JC introduced the reports which provided the Trust Board with evidence that the Committees had met their Terms of Reference and had gained assurance throughout the reporting period of the Trust's performance. **The Trust Board agreed that assurance had been received that , the:** • **Finance & Sustainability Committee, and** • **Strategic People Committee** **Were meeting their purpose as per their Terms of Reference.**
BM/23/06/63	**Finance & Sustainability Committee** JC introduced the report explaining that, the Board were required to review and approve the Committees Cycles of Business on an annual basis. The Cycle of Business for the following committees were presented: • **Terms of Reference** • **Cycle of Business** It was noted that each had been reviewed and approved by the committee, prior to recommendation to the Trust Board. **The Trust Board approved the 2023-2024 Terms of Reference Cycles of Business, for the Finance & Sustainability Committee.**
FOR APPROVAL	
BM/23/06/64	**Trust Strategy: measures of success and governance arrangements** LG introduced the report which described the measures of success/KPIs relating specifically to sustainability and outlined the recommendations and implications of all strategic objectives being monitored through a Board Committee. It was noted that since approval of the refreshed Trust Strategy at Board 31st March 2023, proposed measures of success/KPIs for each of the Trust's strategic objectives and priorities had been drafted and discussed in detail at the Finance and Sustainability Committee meeting on 25th May, following which a couple of amendments had been made, these were: 9.3 Wording had been revised, so as not to imply that the Trust was looking to increase market share. 10.3 Wording of KPIs had been amended to - Maintain the number of local people employed by the Trust, the Current baseline figure of local people employed was 77%. - Prioritise spend with local suppliers In Cheshire and Merseyside. To confirm the Trust commitment Cheshire and Merseyside system working rather than just Warrington and Halton. The Trust Board noted that each Committee and the Board would receive biannual reporting going forward.

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	The Trust Board approved: • **the recommended measures of success/ KPIs for each of the strategic objectives and priorities.** • **the governance arrangements for the strategy.**
SUPPLEMENTARY PAPERS	

BM/23/06/65
BM/23/06/66
BM/23/06/67
 	
BM/23/06/68
BM/23/06/69
BM/23/06/70
BM/23/06/71
 	
BM/23/06/72
BM/23/06/73
BM/23/06/74
BM/23/06/75
	• Digital Strategy Group Report
	• Learning from Experience Q4 Report
	• DIPC Q4 Report
	• Violence Reduction Strategy Bi-Annual Report
	• Move to Outstanding Update Report
	• Senior Information Risk Owner Annual Report
	• Engagement Dashboard
	  ○ Q4 Update
	  ○ Year End Report
	
	• Guardian of Safe Working Q4 Report
	• Arbury Court
	• Hospital Volunteer Annual Report
	• Wellbeing Guardian Annual Report

BM/23/03/76	**Review of the Meeting** SC noted that there would be a more formal process for the next Trust Board meeting on Shadow Board meeting outputs.
BM/23/03/77	**Any Other Business** LG invited and Trust Board members that were interested in having a site visit of the almost completed phase 1 of CDC could join her in the lunch break. **The meeting closed at 12:28**
The Date and Time of the next Trust Board Meeting is Wednesday 2nd August 2023 Trust Conference Room, Warrington	

Approved …… Dated ……

Chair/Senior Independent Director: Mike O'Connor

DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/23/08/80	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	2 August 2023

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/03/26	29.03.23	Chief Executives Report	Place-Based Partnership updates to be included in Bi-monthly strategy reports	Lucy Gardener	August 2023		LG informed that Trust Board that PLACE and ICS development updates would be included in future reports from **October 2023**	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/03/28	29.03.23	Board Assurace Framework	Review of Risk #145 to consider separating the risk around the new hospital.	Lucy Gardender John Culshaw Dan Moore	June 2023	7th June 2023	Agenda Item BM/23/06/55	
BM/23/03/26	29.03.23	Chief Executives Report	High Level CMAST briefings to be produced for future meetings.	Simon Constable	June 2023	7th June 2023	Agenda Item BM/23/06/53	

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 BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/08/82**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will... Always put our patients first delivering safe and effective care and an excellent patient experience. ✓ SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. ✓ SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities. ✓			
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/23/08/82

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 7th June 2023, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

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

As I have stated previously, our single most important operational performance challenge remains length of stay, and there has been improvements in recent weeks (albeit during summer months), for both Warrington and Halton residents. Our total number of super-stranded patients with a length of stay greater than 21 days remains high at 124 (in my last Board report this figure was 118). However, the number of patients that do not meet the criteria to reside (NCTR) has come down substantially to 92 (in my last Board report this figure was 137). For Warrington Borough Council residents in hospital, this latter number is currently 51 (15.0%, the national average); for Halton Borough Council residents in hospital, it is 22 (21.6%). We are working the partners on improving these figures further, as well as working on own processes with regards to length of stay more generally.

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

2.2 Senior Leadership Changes

After seven years as Chief Finance Officer, and more recently as Deputy Chief Executive, Andrea McGee, will be leaving the Trust at the end of September to embark on a new life in Gibraltar.

Jane Hurst, Deputy Chief Finance Officer and Freedom to Speak Up Guardian, will be taking on the role of Acting Chief Finance Officer from 1st October whilst the process to make a permanent appointment is completed. Andrea will continue to work closely with Jane on ensuring a smooth transition and handover in the coming weeks.

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

The CMAST Leadership Board met on 7th July 2023 and considered a number of important issues which included an update on the progress being made through the Diagnostics Programme Board and a number of upcoming key infrastructure decisions which relate to:

- Prioritisation of multi-year system imaging capital allocations
- Process for managing system bids for endoscopy hubs and prioritisation of funding
- Pathology consolidation options appraisal and laboratory information management systems (LIMS) development

In addition, the CMAST Leadership Board received an update on the ICS and ICB Children's and Young People's (CYP) agendas and considered and supported proposals for the establishment of a CMAST paediatrics network which will enhance the collaborative's focus and delivery of this agenda.

Finally, the CMAST Leadership Board considered the dialogue taking place in different parts of the country in respect to bank workers and pay awards and the preparation for and approach to managing industrial action.

The CMAST Leadership Board also received the following documents:
- C&M ICS Activity Summary Report
- C&M ICS Finance Report

2.4 BMA Consultant Industrial Action

Hospital consultants across England began strike action for 48 hours from Thursday 20th July to Saturday 22nd July. This followed industrial action by junior doctors for a period of five days the week before.

This represents industrial action in the NHS on a scale we have not seen previously, with new and different challenges to which to respond. Consultants are our most senior doctors with many other staff groups dependent upon consultant supervision in order to be able to carry out many aspects of their roles. Our treatments and procedures are listed under, and supervised by, consultants and it has been important in our planning to ensure we provide only those clinical activities where we are assured there will be sufficient consultant supervision and service delivery in each of our specialty areas.

However, thanks to colleagues from across the Trust working tirelessly to ensure that our patients remain safe and well cared for, we had robust plans in place with as much assurance as possible so that we could continue to maintain safe care.

Our plans during consultant industrial action included:
- We provided, as a minimum, 'Christmas Day' consultant cover throughout, with additional cover as agreed with the BMA where required to ensure patient safety.
- Emergency and critical care cover was maintained throughout.

- Detailed plans were agreed in each Care Group to ensure sufficient consultant cover to keep our patients safe and deliver effective care.
- With elective care we prioritised patients with urgent, time sensitive conditions using the consultant cover we had available.
- All consultant sessions, clinical or not, were worked on site to ensure availability in case of an emergency.
- Any appointments or procedures that have been postponed due to industrial action have been rescheduled as soon as possible.

I would like to thank colleagues for their continued professionalism and unwavering commitment to providing the best care possible to our patients and keeping them safe throughout.

2.5 The NHS at 75

5th July 2023 saw the celebration of the 75th anniversary of the National Health Service.

Hospitals, especially district general hospitals, have been described as the cornerstone of the NHS since its inception in 1948. Our world is however changing rapidly. In 1948, the health service existed mainly to provide treatment for infections and injuries. The success of modern science and medicine, and specifically the NHS in rapid implementation and translation into everyday clinical practice is stark. Diseases like heart attacks, strokes and cancers, that would once upon a time shorten the lives of those in their forties, fifties and sixties, are now eminently treatable and people live another decade or two (or three). Now, most of the work of the NHS involves managing chronic long-term conditions such as diabetes, arthritis, lung and heart disease; mental health and obesity are growing problems and the number of people aged 85 and older is due to double over the next two to three decades, meaning social care is an urgent priority.

Healthcare in the NHS is better - safer, more effective and with a better patient experience - than ever before. One of the really big changes over the decades is the recognition of the importance of setting standards in patient care. The NHS only acquired a statutory duty of care quality in the late nineties, underpinned by the principles of clinical governance - effectiveness, risk management, patient experience and involvement, and communication.

Since the NHS was founded on 5th July 1948, it has always innovated and adapted to meet the needs of each generation. The founding principles remain as relevant and valued today as they were 75 years ago.

A range of national events took place on 5th July 2023, including an NHS75 service at Westminster Abbey alongside a Reception in Downing Street. WHH was well represented by staff at both of those national events.

WHH marked the occasion suitably, including (but not limited to), a ceremonial cutting of the cake.

2.6 Fourth Quality Academy Showcase

On 6th July we held our fourth annual WHH Quality Academy Showcase. This was our first face-to-face showcase event since the Covid-19 pandemic and it was wonderful to see so many people coming together to learn, reflect and celebrate many of the impressive efforts and achievements from our staff over the last year.

We were treated to two inspiring and thought-provoking keynote talks from Professor Michael West and Julia Wood, highlighting the importance of compassionate leadership, the value of focussing on joy in work, and some of the practical steps we can all take to promote both. Both keynote speakers set the scene so very well for the work we are taking forward on both the Patient Safety Incident Response Framework and the WHH Culture programme of work. Developing a culture of openness and learning will further enable improvement, together with a better and shared understanding of the issues we face. At this event we also hosted a series of 'breakout sessions', together with partner organisations, focussing on learning from claims and inquests, national clinical audit, research and development opportunities, quality improvement and innovation, and exploring tools to gather and learn from knowledge and experiences to help us tackle some of our big challenges.

Oral presentations from WHH colleagues included:

- Strategies for Improving Psychological Safety in an Acute Therapy Team (Joanna Thomas).
- "Sip 'til Send": Safe, Simple, Kind. Improving Preoperative Hydration (Dr Gemma Roberts and Rhianna Jones).
- WHH AHP 18 Month Strategic Workforce Plan - What, Why and Why Now? (Nisha Agarwal)
- Acute Kidney Injury - Improving Outcomes (Rebecca Hossbach, Dr Neil Bailey, and the Acute Care Team)
- Virtual Fracture Clinic: Reversing the Trend (Dr Morgan Marshall and Mr Curtis Robb).

The winners of the poster presentation competition were:

- First Prize: Molecular Testing for Enteric Pathogens Using the Serosep EntericBio® Gastro Panel 2 System (Charlie Fogg, Lauren McAdam, Graham Marshall, Hannah Gill - Microbiology Department)

- Highly Commended: A QIPP programme for monitoring diabetic retinopathy using OPTOS virtual clinics (Kirsty Eagers, Paras Agarwal, Ms Kaveri Mandal - Department of Ophthalmology)

- Highly Commended: Pre-Op Medications Advice QIPP (Dr S. Kim, E. Hill)

- People's Choice Winner (voted by attendees): A review of national and local guideline compliance for adult patients attending CAU/SDEC for IV Ferinject, with a focus on patient centred care and service improvement.

(Emma Ridley, Jaclyn Proctor, Dr M Amin, Dr D Barahman, Dr M A Islam, Dr C Muckian, Dr M Cooper, Jill Nuckley, Alicia Jones – CAU/SDEC).

2.7 Research & Development

Research & Development sits under the auspices of our Quality Academy and our drive for continuous quality improvement more generally.

We are pleased to be able to continue offering research participation to more and more of our population. In FY21-22, we recruited 742 participants, a figure we nearly doubled in FY22-23 to 1444.

Our Research Team were awarded the Research Delivery Team of the Year Award at the North West Coast Research Innovation Awards. This team are really going from strength to strength, with lots of collaborative working, not only within the Research Team directly but also across the wider organisation, including our finance team, medical and pharmacy colleagues. The success of building research through a supported system approach alongside Liverpool University Hospitals NHS Foundation Trust and the Clinical Research Network demonstrates the importance of relationships and cohesive working. It is wonderful to see our Trust recognised so directly.

I would like to highlight some of the studies of which we have been part:

- Dr Rita Arya, Consultant Obstetrician, is the lead for a study looking at implementing a screening programme for Group B Streptococcus for women in labour. It is an important study to help prevent maternal and infant sepsis. So far, nearly 1200 women have gone through the screening programme, with recruitment to this study expected to end in January 2024.

- Dr Tim Furniss, Consultant in Critical Care, and team have developed the critical care portfolio over the past 3 years, taking participants in research per year from 0 in FY19-20 to 106 in FY22-23. These studies are key to understanding how to manage some of our most unwell patients, including studies such as MARCH, looking at the use of mucoactives in acute respiratory failure. The team were recently commended by the MARCH study for recruiting 20 participants so far, making them joint 9th out of 55 sites that have recruited to this study.

- Gastroenterology Consultants Dr Patani and Dr Ramakrishnan, R&D Senior RN Rebekah Chan have been working with pharmacy, contracts, and finance, to be the first site to set up for an intervention for moderate to severe ulcerative colitis. Consequently, WHH was the first site to set up and recruit the first patient globally onto this trial in December 2022. This is massive achievement for WHH. This meant the team were the first and only place in the world able to deliver potentially life-changing medication to this participant. We now hope to be able to recruit more people to this trial.

2.8 Bowel Cancer Screening

It has been a year since we launched the Bowel Cancer Screening Colonoscopy Programme (BCSP colonoscopy) in the Warrington and Halton endoscopy units. Prior to April 2022, people in Warrington and Halton, over 60 and who were eligible for screening and had a positive stool FIT test (faecal immunochemical test - a screening test for colon cancer) were referred for colonoscopy in the main Hub centre at Aintree hospital. After taking bowel cleansing medications, they had to travel to Aintree. This obviously put many people off from opting into the screening programme.

In 2021, we decided to get our endoscopy units at Warrington and Halton accredited through a rigorous process. We are pleased that our JAG-accredited Endoscopy unit is now an accredited BCSP unit. This was the first step. The next step was to get BCSP accredited colonoscopists in our unit.

Three senior consultant endoscopists – Dr Bharathi, Dr Patani and Mr Pranesh decided to apply for the bowel cancer screening colonoscopist accreditation. They took an exam to test their knowledge about cancer, polyp recognition, and procedure complications. They had to have performed more than 1000 lifetime colonoscopies and have prior high JAG key performance standards (KPI). They then took the 'colonoscopy driving test' – involving doing two colonoscopies and a polypectomy while being assessed by two external BCSP colonoscopists in our regional centre at the Aintree endoscopy unit.

They all passed the tests, and we commenced the programme at WHH in April 2022. We have two BCSP lists at Warrington and one list at Halton with a view to extending the service to do more lists in future especially given that the screening programme has been recently extended to 56 years of age. Since we started doing these procedures locally, we have noted an increased uptake of colonoscopies as people prefer to get the procedures done locally.

2.9 Same Day Emergency Care (SDEC)

In July, SDEC also celebrated its one-year anniversary having seen just under 10,000 patients to date.

Same Day Emergency Care (SDEC) is the "provision of same day care for emergency patients who would otherwise be admitted to hospital" and allows for patients presenting at hospital with relevant conditions to be rapidly assessed, diagnosed and treated without being admitted to a ward, and, if clinically safe to do so, they will go home the same day their care is provided.

We have developed an innovative new referral pathway that enables local GPs to directly refer patients to SDEC, thus eliminating the need for review in Emergency Department first. During the consultation process with GPs when establishing SDEC there was an overwhelming request for a direct referral pathway which would eliminate the current antiquated, time-consuming and inefficient method of referral involving calling the Patient Flow Team to refer every patient. We worked closely with our GP partners to develop an ICE referral the GPs and AHPs could complete in the GP surgery, sending the patient directly to SDEC.

The referral pathway was initially trialled with one PCN (primary care network) and after a successful pilot was rolled out across the whole local system in October 2022. Since then, we have reviewed the referrals received via this pathway and they have largely been appropriate and suitable for management in an SDEC setting (less than 1 in 10 deemed inappropriate).

We maintain good links with our GP partners with monthly operational meetings and system reviews. Feedback from GPs has been overwhelmingly positive. We are now working with oncology colleagues to create a comparable pathway for oncology patients presenting with clinical conditions that can be managed as same day emergency care.

SDEC sits within the much wider Urgent & Emergency Care service across both hospital sites – our Warrington ED and Runcorn Urgent Treatment Centre, both of which have seen relentless pressure over many months (like much of the country).

We have continued investment in Urgent & Emergency Care over the last 12-24 months:

- £6.1m capital investment into SDEC build (as above)
- £2m capital investment for ED CT scanner
- £455k revenue investment for ED medical staffing
- £976k revenue investment for acute medical staffing
- £450k revenue investment in for further ED nurse staffing
- Ongoing recruitment for speciality doctors to support the emergency department
- Advanced Clinical Practitioner training programme supported across the CBU

2.10 Breast Screening

The Warrington, Halton, St. Helens, and Knowsley Breast Screening Service (WHSKBSS) is delivered by the team at WHH. This service provides routine breast screening, diagnostic and onward referral services to a population of approximately 92,000 from across the four boroughs. This service is commissioned by NHSE Specialist Commissioning and during a visit back in 2018, it was commented that the current aged estate in Kendrick Wing (from where the service was delivered) could be improved upon. Work then began to move clinical activity out of Kendrick Wing in two phases. Phase 1 being the creation of the Breast Care Centre within the Captain Sir Tom Moore Building at Halton and phase 2 being the expansion of breast screening services at Bath Street.

We have reconfigured how and where we deliver our breast services in Warrington and Halton. These changes were widely supported by two separate public consultations for both phase 1 and phase 2 of the changes. Additionally, during phase 2, previous service users were engaged through the Experts by Experience panel, ensuring that the patient voice was heard during the design phase of the project.

These changes have now been completed resulting in two exciting new facilities, one within the Captain Sir Tom Moore building (opened in Summer 2021) and the other an

expanded and new facility at Bath Street Health and Wellbeing Centre in Warrington (opened in May 2023).

Phase 1 was completed in the summer of 2021, at a cost of £1.8million. This Breast Care Centre at Halton provides breast assessment and symptomatic clinics in a modern, state of the art facility. Phase 2 of this project involved the creation of a new, expanded, and improved breast screening service at the Bath Street Health and Wellbeing Centre in Warrington. Previously, breast screening was split over the two sites - Kendrick Wing at the hospital and a smaller space at Bath Street. The completion of phase 2 means that this activity is now delivered from the one site, in a modern and more accessible facility.

This offers great improvements from both an efficiency and environment perspective for both staff and service users.

2.11 WHH Brand Refresh 2023

One of the areas where we have taken stock most recently, and listened to valuable feedback, is with our Trust brand.

Our brand is our identity; it's who we are and what we represent. It is how we are perceived and viewed by our patients and those who rely on our services, as well as the wider community. It is also the visual branding you see when you walk the corridors of our hospitals and wards or read one of our Trust letters and documents.

With that in mind, our Communications and Engagement Team have been busy working behind the scenes on refreshing our branding. The justification is three-fold: our branding needs to be consistent; it needs to be aligned with national NHS guidelines; and most importantly of all, it needs to be accessible – particularly for those with visual impairments. For instance, our previous colour schemes have not helped provide clarity where it is most needed.

Having a clear and uniform visual identity also means patients feel reassured that they will receive the best care and support from us (lots of research has been done nationally on this, and the NHS brand is one of the most widely recognised brands in the world). Such standards can often be perceived as surrogates for quality of care and service delivery. Our updated branding ticks all these boxes.

For clarity, this is very much a case of evolution, not revolution, and there is simply progression from what we have done before. The rollout has begun but I will stress that we will not be making these changes overnight. This will be a gradual process over a number of weeks and months, and any associated costs will be kept to an absolute minimum. We will not be wasting anything of which we have an existing supply.

To make the process as user friendly as possible we have created a WHH Brand Guidelines document as a reference point when producing accessible, visual content. It includes guidance on the use of colours (to ensure a big enough contrast for those with visual impairments), logo usage, imagery and other elements that reflect our Trust aims and values.

We have also taken this opportunity to develop our first WHH Style Guide. The WHH Style Guide is designed to support written content, again helping to make sure that everything we do is as accessible as it possibly can be.

This is an evolving process and feedback is always incredibly useful. This is another positive development for the Trust and another step forward on our 'moving to outstanding' journey.

2.12 Special Days/Weeks for professional groups

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

National Volunteers' Week: 1st – 7th June 2023
National Carers' Week: 5th – 11th June 2023
Clinical Audit Awareness Week: 19th – 23rd June 2023
National Estates & Facilities Day: 21st June 2023
South Asian Heritage Month: 18th July – 17th August 2023

2.13 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.

2.14 Employee Recognition

Our *You Made a Difference Awards* are now about to enter their third year of operation. Nominations are reviewed and awards are made by a multi-professional panel. The Award for June 2023 is to be announced next month.

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

Chief Executive Award (June 2023): Halton Catering Team
I was delighted to give my own award to the Halton Catering Team for consistently getting some really great feedback from patients and staff (and their own management team). The Trust Board occasionally have patient food tasting sessions and we have been catered for by the Halton Catering Team more than once now, with some very tasty examples of patient food of which we can be proud.

Chief Executive Award (June 2023): Halton Catering Team

I was pleased to make a Chief Executive Award to Anaesthetic Department Administrator Kayleigh Barton. Kayleigh is not medically trained, but recently she was called to help as her next-door neighbour (in their forties) had collapsed. She found them in cardiac arrest and started CPR. This went on for over 30 minutes and when the first responders arrived from NWAS, she continued to do CPR. Due to her bravery and hard work in challenging circumstances, the neighbour was successfully resuscitated, has made a good recovery and been discharged from hospital. For anyone, let alone someone who doesn't do this for a living and who has simply completed her in house mandatory life support training, this must have been a daunting experience, but Kayleigh is to be commended for having had the composure and skills to save a person's life.

Appreciation of WHH staff from patients, family, visitors and colleagues
I have also specifically recognised the work of the following colleagues:

Karen Eccles, Medical Secretary (Ophthalmology) - Surgical Specialities
Joanne McDonagh, Upper GI Cancer Navigator - Cancer Services
Karen Farnworth, Healthcare Assistant - Integrated Medicine & Community
Christine Shone, Appointments Clerk (Outpatients) - Clinical Support Services
Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
Nadine MacDonald, Appliance Officer - Orthotics
Kathleen Parry, Healthcare Assistant (A3) - Medical Care
Paula Atherton & Audiology Team, Clinical Support Services
Layla Alani, Director of Integrated Governance & Deputy Chief Nurse
Thomas Fitzpatrick, Senior Safety & Risk Manager - Corporate Nursing
Dr Phyu Wai, Consultant Physician - Integrated Medicine & Community
Tom Coalbran, RTT Business Manager – Clinical Operations
Dr Alejandro Gomez, Consultant Physician - Integrated Medicine & Community
Ernesto Quider, Associate Director of Quality
Dr Mithun Murthy, Consultant Physician & Associate Medical Director

2.16 Signed under Seal

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

- Warrington Town Deal Living Well Hub build contract

3) MEETINGS ATTENDED/ATTENDING

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

- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)
- CMAST Clinical Pathways Programme (Various)
- 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 3 (June 2023)

Appendix 1 - CEO Dashboard Month 3 – June 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	74.38%	F
RTT 18 Weeks	92.00%	52.53%	F
RTT 65+ Weeks	0	469	F
A&E % patients seen within 4 hours	75.00%	68.74%	F
A&E % waiting longer than 12 hours	< 2.00%	19.34%	F
Cancer 14 Days	93.00%	83.62%	F
Breast Symptomatic 14 days	93.00%	66.67%	F
Cancer 28 Day Faster Diagnostic Standard	75.00%	74.72%	?
Cancer 62 Days Urgent	85.00%	53.62%	F
Ambulance Handovers within 60 mins	100%	75.64%	F
Discharge Summaries 24 hours	95.00%	91.05%	F
Cancelled Operations – 28 days	0	0.04%	P
Super Stranded Patients	Trajectory	117	No SPC
Theatre Utilisation	85.00%	86.40%	?
Day cases	85.00%	89.89%	P

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	P
Sepsis Screening Emergency	90.00%	76.00%	F
Sepsis Screening Inpatients	90.00%	76.00%	F
Sepsis Antibiotics Emergency	90.00%	80.00%	F
Sepsis Antibiotics Inpatient	90.00%	68.00%	F
Inpatient Falls	20.00% reduction	31	?
VTE	95.49%	95.49%	?
Pressure Ulcers	10.00% reduction	12	?
Medication Reconciliation (24 hrs)	80.00%	50.00%	F
Complaints over 6 months	0	0	P
Healthcare Infections - MRSA	N/A	0 YTD	P
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	4 YTD	?
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	22 YTD	?
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	3 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	2 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	4.39%	No SPC
Maternity 3rd and 4th Degree tears	Less than 1.85%	0.87%	No SPC
Maternity Pregnancy Bookings before 10 weeks	75%	38.80%	No SPC
Maternity Pregnancy Bookings before 13 weeks	90%	82.50%	No SPC
MUST nutritional assessment completion	85%	60.72%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (culm)	-£6.17m	-£7.95m	No SPC
Capital Spend	£6.34m	£2.31m	F
Cash Balance	£24.59m	£30.39m	P
Better Practice Payment Code (culm)	95.00%	93.00%	F
CIP In Year Delivered (culm)	£1.80m	£1.80m	P
CIP Forecast (Recurrent)	£0.90m	£1.80m	F
Agency Ceiling	Less than 3.7%	4.6%	F

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.90%	F
Retention	85.00%	85.25%	F
Core/Mandatory Training	85.00%	88.81%	P
PDR Compliance	79.00%	71.95%	F

Strategy

Strategy

- **Community Diagnostic Centre (CDC)** – Phase 1 of the CDC programme at the Nightingale building went live on the 19th of June, including phlebotomy, ultrasound and spirometry services. Works to deliver Phase 2 at the Halton Hub (Shopping city) have commenced and clinical service delivery will commence this Winter. The design for Phase 3 (New Build CDC) is progressing with the planning application submission scheduled for August.
- **Runcorn Town Deal Health and Education Hub** – RIBA Stage 3 floorplans and spatial designs signed off by all stakeholders. Cost plan ratified by cost consultant and projected to be within Town Deal programme budget.
- **Overall Trust Strategy** – The refreshed Trust Strategy for 2023-2025 has been approved, along with outcome measures and KPIs, which will be monitored bi-annually to ensure delivery.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/83**	
SUBJECT:	**Chair's Report**	
DATE OF MEETING:	2nd August 2023	
AUTHOR(S):	Steve McGuirk, Trust Chair	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will…Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will…Be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓
	SO3 We will…Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to draw attention to matters that the Chair believes are of particular significance to the Board of Directors and not covered elsewhere on the Board agenda. This update draws attention to: • Honour for WHH governor • New University NED to the Trust Board • Research Award • Paediatric Audiology situation update • Breast screening reconfiguration • Covid Public Inquiry • Long term Workforce Plan • Board Development Day • Governor Guidance • Industrial Action • CMAST Update • ICS Update • COG matters inc. Governor Focus Conference - NHS Providers	

PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note X	Decision

RECOMMENDATION:	The Trust Board is asked: i) To note the matters being brough to the attention of the Board. ii) To make any comments or ask any questions arising from the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

SUBJECT	Chair's Report	AGENDA REF:	BM/23/08/83

1. BACKGROUND/CONTEXT

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

2. MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

The table outlining the activities of the Chair has not been possible to produce for this report but will be included in the next report.

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

3.1 General Update

British Empire Medal for Governor

It is a pleasure to be able to report that one of our partner governors – Kuldeep Dhillon - was awarded the British Empire Medal (BEM) in the Kings Birthday Honours in June. In fact, Kuldeep's wife was also awarded the BEM, which is in recognition of the big difference they have made to the wellbeing of their local community over the past four decades.

Most relevant to the Trust, Kuldeep and his friends at the local Gurdwara in Latchford were responsible for providing, literally, thousands of meals for staff during the most intensive periods of Lockdown. This was wonderful initiative from our local Sikh community and incredibly well received. Congratulations Kuldeep.

New University NED

Jan O'Driscoll - the Dean of Lifelong Learning at Chester University - has now become the University's NED representative on the Board of Directors. Jan is very welcome, and we look forward to continuing to grow the partnership in the coming years.

Research award

The Trust's research and development department was recently honoured at the Northwest Coast Research and Innovation Awards, being named Research Delivery Team of the Year, at the annual awards event to recognise the best innovators and researchers in health and care across Cheshire, Merseyside, Lancashire, and South Cumbria.

The Clinical Research Unit (HCRU), based in the Nightingale Building at Halton Hospital, opened just over two years ago and during that time it has gone from strength to strength.

Among its achievements to date, it recruited the highest number of volunteers to a commercial Covid-19 vaccine study (sponsored by Moderna). It also secured a 'global first' by recruiting the first volunteer for an international Sanofi gastroenterology study looking at adults with moderate to severe ulcerative colitis.

We very much look forward to being involved in more research and this is also important in the context of our ambition to become a University Hospital in years to come.

Paediatric Audiology.

A national audit of children's specialist hearing testing was conducted towards the end of last year which raised concerns about how tests were performed at several hospitals across the country, including WHH. These are specialist tests known as ABR (auditory brainstem response) assessments and identify hearing loss in children as early as possible, so that they can receive the right support to develop the language and communication skills that are critical to their development.

Because of our concern, we paused our ABR testing service in February for a month (the service wasn't shut down) so we could put plans in place to make sure the testing was being undertaken to a high standard. We've since worked with an accredited organisation to resume our service and provided additional training to our audiology staff.

For most babies and children whose cases have so far been reviewed, the care they received was deemed appropriate and no further action is needed. For a small number, however, (around 40 children) a repeat test was needed to ensure that any potential hearing problems have been identified. There is still work to do as this continues to be an evolving and complex review, however we have already started making improvements and our teams remain as committed as ever to providing a high-quality audiology service for our youngest patients.

Breast Screening Service reconfiguration

Over the last couple of years, we have radically reconfigured our breast screening services, and the final piece of that jigsaw was put in place when we opened an expanded and new facility at Bath St Health and Wellbeing Centre in Warrington in May (though the 'official opening was a few weeks later). Previously, breast screening was split over the two sites - Kendrick Wing at the hospital and a smaller space at Bath St, and the completion the new facilities means that this activity is now delivered from the one site, in a modern and more accessible facility. This offers great improvements from both an efficiency and environment perspective for both staff and service users and sees the culmination of two years of hard work and significant investment in improved care.

Covid Public Inquiry Hearings

This is the independent public inquiry set up to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future, and it is Chaired by Baroness Heather Hallett, a former Court of Appeal judge. The Inquiry has been established under the Inquiries Act (2005), which means that the Chair will have the power to compel the production of documents and call witnesses to give evidence on oath.

The Chair was appointed in December 2021. Following a public consultation, the Chair wrote to the Prime Minister to recommend changes to the draft Terms of Reference. The final Terms of Reference were received in June 2022.

The Modules of the Inquiry are announced and then are opened in sequence, after which Core Participant applications are considered. Each module has a corresponding preliminary hearing and full hearing, details of which are published by the Inquiry. For information Hearings for Module 1 are currently taking place and are available to view either on YouTube, or the BBC also provides regular updates/ reports

Active modules:

1. Resilience and preparedness
2. Core UK decision-making and political governance
3. Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK
4. Vaccines and therapeutics

Future modules:

5. Government procurement
6. Care sector

Further modules will be announced in the coming months. Each module will investigate issues across the UK as a whole, including in the devolved administrations of Scotland, Wales and Northern Ireland, and will cover both 'system' and 'impact' issues including:

- Testing and tracing
- The Government's business and financial responses
- Health inequalities and the impact of Covid-19
- Education, children and young persons
- Other public services, including frontline delivery by key workers.

Long Term Workforce Plan

The first comprehensive workforce plan for the NHS was published in June. It is a comprehensive (and long-awaited) document that seeks to set out a strategic direction for the long term. Additionally, though, it seeks to signal action to be taken locally, regionally and nationally in the short to medium term to address current workforce challenges. The actions suggested fall into three priority areas:

- **Train**: significantly increase education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

- **Retain**: ensuring retention of staff we have by better supporting people throughout their careers, boosting the flexibilities offered to staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

- **Reform**: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

Executive colleagues will work together with colleagues at regional and national level to develop clearer plans and activities to deliver the three priority areas over the coming months and indeed years.

Board Development Day

Members of the Board (including the Lead Governor) undertook an important development/ learning day recently. Key sessions included the new CQC Framework (though at this juncture there is no clear date for its introduction); the need to note the significance of the new NHS ED and I Improvement plan and the need to consolidate that with local planning (for example a new, WHH Mediation Framework), as well as the recent publication of with Northwest BAME Assembly.

3.2 Industrial action

This period has continued to see episodes of industrial action and, indeed, have escalated with the first ever strike action taken by senior consultants. There will be a more comprehensive update in other items on the agenda.

3.3 CMAST Update

The latest CMAST briefing is attached to the Chief Executive's Briefing and, in the spirit of not making comment for the sake of it, I do not propose to repeat that update in my report.

3.4 ICS Update

There was a meeting of the Integrated Care Partnership (ICP) in July and the minutes/ papers may be found here. It would be fair to say that the issues facing the ICP, not surprisingly, mirror those of WHH. The papers speak to the enormous financial challenges facing the system and the partners within it and make it clear that achieving the financial targets set out will be a huge challenge. At the same time, there is the continuing difficulty in trying to deliver recovery targets, a situation even further worsened because of the extensive industrial action. It is important to be upfront that the challenge for the Trust now and for the foreseeable future will be to try to improve but, realistically, to mitigate a worsening of performance in several key areas.

3.5 Council of Governors

A new draft Addendum to the NHSE document, Your statutory duties a reference guide for NHS foundation trust governors was issued by NHS England (NHSE) on 27 May 2022 and was out for consultation until 8 July 2022.

The addendum adds to existing guidance for governors, though it is not statutory guidance, rather Trusts have discretion over whether and how they choose to apply it. The addendum applies solely and exclusively to the Council of Governor's role within WHH.

The guidance reflects the new approach to system working for the NHS and explains the background and role of ICSs and Integrated Care Boards (ICBs,) going on to stress how the success of Trusts and Foundation Trusts, in future (and in the eyes of the regulators), will be influenced by their contribution to system working.

The Council of Governors will receive a paper with further details on the addendum at the Council of Governors Meeting – 10th August 2023.

Governor Observation Visits

There have been two observation visits in this period, the first on 17 June A1(AMU), and the second on 14th July WardA5 on the Halton Campus. In both cases comprehensive reports were completed and have been taken forward for action by relevant Exec colleagues. It is worth drawing especial attention to the July visit as it was deliberately and consciously undertaken to be during a period of industrial action. There were some concerns expressed initially, given the situation and potential sensitivity, but the Executive Medical Director (to his credit) actively supported the visit as he felt it essential for governors (as patient representatives) to

be able to observe for themselves any impact from the industrial action and the mitigating measures put in place.

3.6 Governors Q and A Sessions and Working Group

Governors have held two, Q and A sessions with the Chair since the last meeting - though the first of these was also undertaken as a Governor Nominations and Renumerations Committee Meeting to receive and approve the Chair's Annual Appraisal.

3. RECOMMENDATIONS

The Trust Board is asked:

i) To note and make any comments or ask any questions arising from the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/08/84**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at the relevant Board Committees. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added; • It is proposed to increase the rating of risk #1757 (Effectively plan for and manage Industrial Action) from 16 to 20. • There have been no changes to the descriptions of any of the risks; • No risks have been closed or de-escalated; Notable updates to existing risks are included within the paper.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee		
	Agenda Ref.	Multiple		
	Date of meeting	Multiple		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/23/08/84

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

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

2.2 Amendment to Risk Ratings

It is proposed to increase the rating of risk #1757 (detailed below) from 16 to 20.

This is due to the impact of Industrial Action by Junior Doctors and Consultants and the announcement of further strike action in August. This timing of this Strike action increases the risk of impact on patient care: Details are provided within section 2.5 of the report and Appendix 1.

ID	Risk description	Rating (current)	Rating (proposed)	Executive Lead
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	16 (4x4)	↑20 (5x4)	Michelle Cloney/Paul Fitzsimmons

2.3 Amendments to descriptions

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

2.4 De-escalation of Risks

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

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have 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.	Assurances • 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 and set to go live in August 2023. Gaps in Controls • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants.	20	No impact on risk rating
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm, failure to achieve constitutional standards and financial plans.	Assurances • 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 bid to become a 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 20023 which will increase capacity for diagnostic pathways Gaps in Controls • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants.	20	No impact on risk rating
115	If we cannot provide minimal staffing	Assurances	20	No impact

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	• Reduction in turnover in Maternity (10% reduced over last 12 months to 19.86% April 2023) • Reduction in agency spend of 430k Q1 2023/2024 compared to Q1 2022/2023 • Revenue requests in progress to increase Emergency Department and Acute wards nurse staffing <u>Gaps</u> • Long lead times for staff into post due to waiting for students to qualify and timeframes for overseas recruitment programme • Partially funded revenue requests • 16% vacancy rate for adult nursing May 2023 • 17% vacancy rate for midwives May 2023 • 7% vacancy rate for Health Care Support Workers (HCSW) May 2023 • 9% vacancy rate for Allied Health Professionals (AHP) May 2023		on risk rating
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	<u>Controls</u> • Supporting Cheshire & Merseyside ICS with development of 3 year financial strategy and recovery plan due to be in place in September 2023 <u>Assurances</u> • Unqualified audit opinion (2022/23) <u>Gaps in Controls</u> Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted	20	No impact on risk rating
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial	**Sickness Absence** Has decreased from 7.6% in December 2022 to 5% in May 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. The rolling 12-month sickness absence rate is 6% as at May 2023 and is showing an improving variation. <u>Assurances</u>	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	risk associated with temporary staffing and reliance on agency staff	• The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.9% in May 2023. • 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 87% **Turnover and Attraction** Turnover in May 2023 was 14% compared to 15.87% in December 2022. Turnover of permanent staff in May 2023 was 13% compared to 14.84% in December 2022. <u>Controls</u> • To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice. A dedicated area to supporting Agile/Flexible working is available on the extranet, and in April 2023, a summary of the survey will be provided to the Executive team, before further promotion of the various tools available for managers/employees. <u>Assurances</u> • 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. **Temporary Staffing & Agency Spend** Bank and Agency reliance in May 2023 was 17% compared to 15.84% in December 2022. Reasons for the variation can be attributed to sickness absence, high turnover, industrial action and additional capacity. <u>Controls</u>		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• A Resourcing working group has been established to review any gaps identified through the Agency Controls best practice toolkit. The group are in the process of developing an approach to measuring and monitoring factors influencing temporary staffing spend. Once in place, group members will offer support to improving the measures in the various governance meetings (FSC, Workforce Review Groups and Exec Finance Wednesday). <u>Gaps</u> • Agency spend above the 3.4% target, factors influencing this will be monitored within the new approach developed by the Resourcing working group • Compliance with NHSE Agency Rate card very low, to be measured within the new approach developed by the Resourcing working group		
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> • Resolution of issues regarding security patches on 5 servers 2008 R2: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system. • Full migration off the end of life Office 2010 platform completed through the N365 deployment plan <u>Gaps in Assurance</u> • 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)	16	No impact on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal	<u>Controls</u> • Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board)	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	<u>Gaps in Assurance</u> • Further updated OBC following departure from partnership procurement requires development and Trust Board approval • Further development of financial model for revised OBC required to mitigate for loss of financial benefits of partnership procurement <u>Gaps in Controls</u> • Phasing of frontline Digitisation Funding with funding availability not matching the timing of forecast expenditure • Deficit in programme year 3 • Delays in launch due to abandoned partnership procurement process mean a business case may be required to extend Lorenzo contract to enact option to retain to Nov 26		
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> • Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA • Executive led IA operational task and finish group in place for each Strike with an exec led check and challenge session prior to each strike to ensure Strike rosters allow safe safe staffing • Participation in ICB IA Clinical Cell calls <u>Assurance:</u> • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of Industrial Action <u>Gaps in Assurance</u> •Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. This timing of this Strike action increases the risk of impact on patient care: • The timing of the strike to predominantly impact on out of hours periods significantly increases the risk of elective care requiring rescheduling due to the need to shift consultant medical resource into out of hours periods, often associated with a	16	Proposed to increase rating from **16 to 20**

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		requirement for compensatory rest – further impacting on availability for elective activity • Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extracontractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. • The above is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics • This junior doctor strike occurs during peak consultant annual leave period – whilst rostering rules maintain safe staffing levels throughout annual leave, these do not control for the requirement to cover junior doctor strike gaps at short notice. • From the 10th of August the Trust will be unable to legally engage short term agency locum doctors to backfill for striking staff, it is unclear at present whether HM Government will appeal this High Court decision. • Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. The timing and nature of this strike increase the risk of a direct impact on patient care: • The timing of the Strike, immediately preceding a bank holiday weekend, along with the BMA position on derogations, increases the risk of the strike impacting access to time critical elective interventions • The agreed Derogation process for consultant IA means it is unlikely that the Trust will be granted derogations for critical services. • From the 10th of August the Trust will be unable to legally engage short term agency locum doctors to backfill for striking staff, it is unclear at present whether HM Government will appeal this High Court decision. • Uncertainty whether further IA will be national or regional approach and potential impact for different unions.		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update 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	Assurances • New CT and MR scanner replacement to be undertaken in 2023/24 • Approval received to replace Computer Aided Facilities Management System	15	No impact on risk rating
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	Controls • Business case approved for progression of UKAS IQIPS accreditation, and recruitment of a project manager commenced.	12	No impact on risk rating

3 RECOMMENDATIONS

The Board is asked to discuss and approve the changes and updates to the Board Assurance Framework, specifically the increase in the risk rating of risk 1757 from 16 to 20, as this increase has taken place since the Strategic People Committee meeting on the 19th of July 2023.

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	1	20 (5x4)	8 (2x4)	TBC	Quality Assurance Committee
1215	Daniel Moore	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (4x5)	6 (3x2)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
134	Andrea McGee	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee

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

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

Risk Appetite Statement

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

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

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

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

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

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

<u>Quality</u>

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

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

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

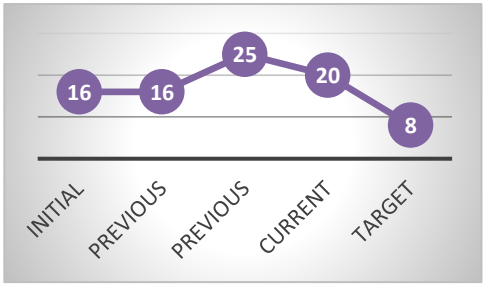
Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If there are capacity constraints in the Emergency Department, Local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

Assurance Details:

Controls

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

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 and set to go live in August 2023.	
Assurance Gaps:	**<u>Gaps in Controls</u>** • 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. **<u>Gaps in Assurances</u>** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care	

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

Board Assurance Framework

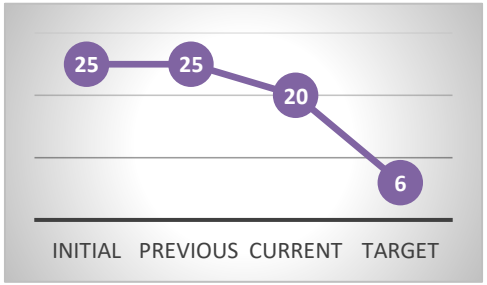
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)

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

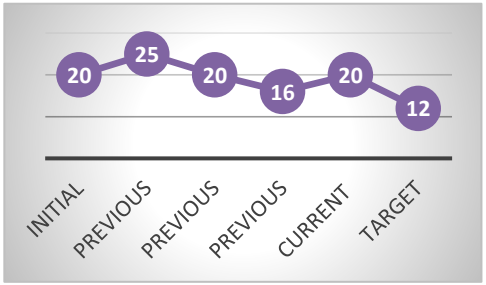


	Assurances • All elective patients have been clinically reviewed and categorised in line with national guidance. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • New Clinical Treatment 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 bid to become a 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 20023 which will increase capacity for diagnostic pathways	
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	31/08/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial:** 20 (5x4) **Current:** 20 (5x4) **Target:** 12 (4x3)
Assurance Details:	**Controls** • 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG) • Progress against recruitment to fill Trust vacancies monitored by Associate Chief nurses and Deputy Chief Nurse at WRG, areas of concern escalated to Chief Nurse, Deputy Chief Executive and local actions plans in place with additional support from Executive Team • Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity • Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels • Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service • Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making • Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust • Workforce plan in place, includes agency reduction plan • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team **Assurances** • 21 new starter band 5 nurses to join the Emergency Department in July/August 2023 • Reduction in experienced midwife vacancies to 4.35 WTE in April 2023 • Reduction in turnover in Maternity (10% reduced over last 12 months to 19.86% April 2023) • Reduction in agency spend of 430k Q1 2023/2024 compared to Q1 2022/2023 • Revenue requests in progress to increase Emergency Department and Acute wards nurse staffing • International Nurse recruitment in place • 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, over recruitment plans approved • Retention – Internal Transfer process in place for staff			
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need (E.g. B3, B4, A10, Catheter Laboratory) • Increased staffing pressures experienced for prolonged periods • Long lead times for staff into post due to waiting for students to qualify and timeframes for overseas recruitment programme • Partially funded revenue requests • 16% vacancy rate for adult nursing May 2023 • 17% vacancy rate for midwives May 2023 • 7% vacancy rate for Health Care Support Workers (HCSW) May 2023 • 9% vacancy rate for Allied Health Professionals (AHP) May 2023			

	• 42% vacancy rate for pharmacists (over 75% for band 6/7s) • Time to post when recruiting new staff

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • 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	31/08/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

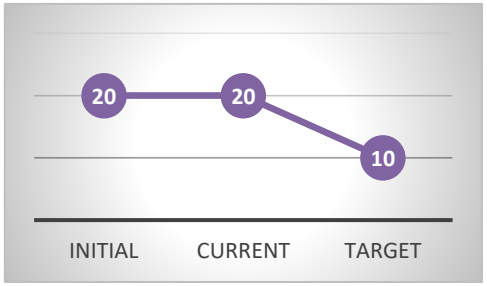
Assurance Details:

Controls

•Core financial policies controls in place across the Trust
•Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning
•Weekly review at Finance Executive Team Meeting of CIP/GIRFT, activity, cost pressure and agency spend
• Procurement/tender waiver training in place
• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years)
• Latest guidance from MIAA Counter Fraud Team circulated
• Counter Fraud campaign took place for national anti-fraud week in November 2022
• Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced.
• Appointed GIRFT Finance Lead and 3 Clinical Leads
• Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022
• CDC phase 2 application approved for £4.5m capital over three years
• Capital & Revenue Plans for 2023/24 approved by the Trust Board in March 2023 & updated and approved by the Trust Board in May 2023
• Introduced system of escalation where there are risks to CIP delivery
• Reviewed of all aspects of 2023/24 operational plan resulting in an improved finance forecast
• New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient safety and consideration whether CIP has been fully identified.
• Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee
• Supporting Cheshire & Merseyside ICS with development of 3 year financial strategy and recovery plan due to be in place in September 2023

Assurances

• Achieved ICS control total in 2022/23
• Delivered 2022/23 Capital Plan
• Unqualified audit opinion (2022/23)
• Completed MIAA Governance Checklist received by Audit Committee
• Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process.
• Capital is reported monthly to F&SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations.
• C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Overall, no change in WTE plan, however there is a plan to reduce agency and bank and increase substantive staffing.



	• HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • We have allocated CIP targets under an approved new methodology for 2023/24	
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 c25% of bed base). Estimated annual cost of at least £11m • Introduction of protocol for changing forecast outturn with the potential impact of restricting financial freedoms and access to capital. • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Not all cost pressures have been funded in plan for 2023/24 • Risk to financial freedoms as the Trust has a deficit plan • Sufficient cash available based on operational plan however, deterioration from plan represents a risk to cash • Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Monitor operational activity delivered under PbR as per plan			Moore, Dan	30.03.2024	
Ensure additional capacity is closed in line with operational plan			Moore, Dan	30.03.2024	
Supporting Cheshire & Merseyside ICS with development of 3 year financial strategy and recovery plan	Participate in workstreams to develop plan	Participate in workstreams to develop plan	McGee, Andrea	30.09.2023	
Respond to Richard Barker and Graham Urwin system letters to demonstrate all financial discipline measures are in place, session to be delivered in Executive Team meeting, FSC and Board and response submitted externally.	Deliver against all requirements in both letters	Evaluate current position, implement any additional controls required	McGee, Andrea	31.08.2023	

Board Assurance Framework

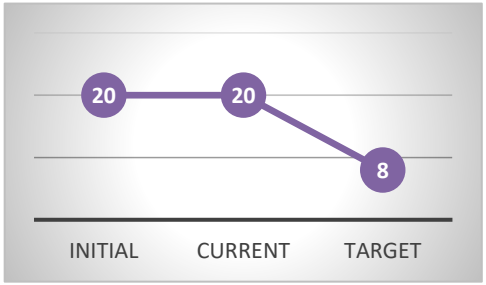
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Control & Assurance Details:

Sickness Absence

Has decreased from 7.6% in December 2022 to 5% in May 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. The rolling 12-month sickness absence rate is 6% as at May 2023 and is showing an improving variation.



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

Assurance

•The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub.
•The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.9% in May 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 87%

Turnover and Attraction

•Turnover in May 2023 was 14% compared to 15.87% in December 2022. Turnover of permanent staff in May 2023 was 13% compared to 14.84% in December 2022.
•Work-life balance continues to be the number one known reason people leave WHH, followed by retirement. A significant number of people delayed their retirement plans in 2020 and 2021, and we have now seen a significant increase in the number of individuals choosing to retire, with some chosing to return to the workplace (retire and return) (these still count as a leaver)

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 •To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice. A dedicated area to supporting Agile/Flexible working is available on the extranet. A summary of the survey is currently being discussed with the Executive team to inform organisational implementation. **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. **Temporary Staffing & Agency spend** Bank and Agency reliance in May 2023 was 17% compared to 15.84% in December 2022. Reasons for the variation can be attributed to sickness absence, high turnover, industrial action and additional capacity. **Controls** •The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies approval o ECF process for bank and agency temporary staffing pay spend approval o Medical Rate Escalations approved by Medical Director •A Resourcing working group has been established to review any gaps identified through the Agency Controls best practice toolkit. The group are in the process of developing an approach to measuring and monitoring factors influencing temporary staffing spend. Once in place, group members will offer support to improving the measures in the various governance meetings (FSC, Workforce Review Groups and Exec Finance Wednesday). **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. This is reflective of sickness absence regionally. • Turnover continuing to be above target, but is showing an improving variance to meet target. • Agency spend above the 3.4% target, factors influencing this will be monitored within the new approach developed by the Resourcing working group • Compliance with NHSE Agency Rate card very low, to be measured within the new approach developed by the Resourcing working group • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Developing an approach to measuring and monitoring factors influencing temporary staffing spend	Through the Resourcing working group establish a process of developing an approach to measuring and monitoring factors influencing temporary staffing spend	The Resourcing working group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: • Agency controls best practice • Rostering compliance • Rate card compliance • Establishment Control compliance (or an alternative approach) • Unplanned absences • Recruitment activity System will ensure the factors are reported to FSC, Workforce Review Groups and Exec Finance Wednesday	Jennie Dwerryhouse	31.08.2023	
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff	Laura Hilton	31.08.2023	
Embed an agile and flexible working culture within all WHH Teams	Through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2024	

Board Assurance Framework

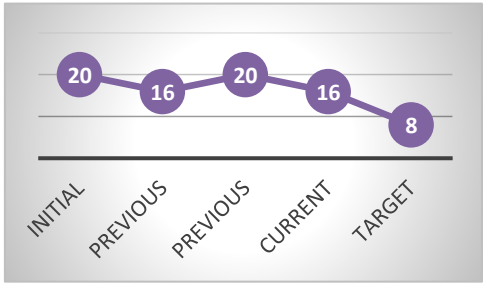
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Assurance Details:

Assurance:

- Risks for Cyber on risk register in line of national requirements of the DSPT & NHS Digital
- **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures).
- **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.
- **Trust benchmarking** activities including Use of Resources reviews (Model Hospital).
- ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.
- Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021)
- Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital
- 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 membership of the **Sustainability Transformation Partnership Cyber Group.**
- **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
- **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training.
- **Cyber Training** for the Trust Exec Board
- The use of automatic patching software to rollout security updates to devices.
- Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links.
- Resolution of issues regarding security patches on 5 servers 2008 R2: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system.
- Full migration off the end of life Office 2010 platform completed through the N365 deployment plan
- Secondary secure backup at Halton Data Centre
- Remote devices no longer bypassing the web proxy
- Active Directory password set to expire again (covid working from home-related).

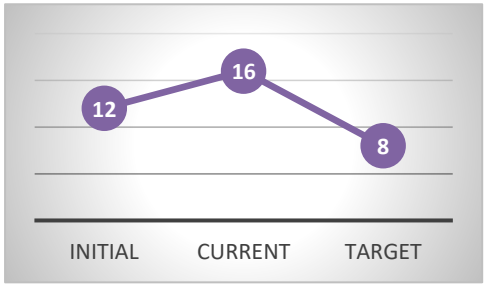
	• Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness. • Local device (PC & laptop) based firewalls now enabled	
Assurance Gaps:	**Gaps In Assurance:** • 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) • ITHealth Assurance Dashboard license expires this financial year **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) • Using SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. • The extension of the mainstream support for SQL Server 2012 ended on 12 July 2022 • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS • Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Version 7 of Clinisys Ice is end of life	

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). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers	Deacon, Stephen	31/07/2023	

		and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Cisco Phase 2 upgrade to replace aging network equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	Waterfield, Tracie	31/07/2023	
Mitigations to be put in for ORMIS security issue	Mitigations to be put in for ORMIS security issue	To set up security groups to stop unauthorised access to the SQL database.	Deacon, Stephen	31/08/2023	
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommsion Server 2012 servers	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to the latest Windows Server operating system or decommission them.	Waterfield, Tracie	31/10/2023	
Upgrade and enable DLP to enable USB read-only. Disabled as its is crashing desktops, needs the ePO agent on the server to be upgraded.	Upgrade and enable DLP	Upgrade and enable DLP	Waterfield, Tracie	31/07/2023	
Renew ITHealth Assurance Dashboard	Renew ITHealth Assurance Dashboard as this provides NHSD, Trust and ICB assurance regarding out Cyber Stance including NHS Digital's Cyber Security Bulletins	Obtain capital and renew the license	Deacon, Stephen	31/07/2023	
Upgrade Clinisys Ice to the new version	Upgrade Clinisys Ice to the new version	Meet with Clinisys Ice regarding funding, contractual questions and V7 End of life	Deacon, Stephen	31/07/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 3: We will…Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety			**Initial:**	12 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	**Assurance:** • Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board) • Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch. **Controls:** • Business case approved and contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling includes 3-year Lorenzo costs • ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance. • 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:** • Further updated OBC following departure from partnership procurement requires development and Trust Board approval • Further development of financial model for revised OBC required to mitigate for loss of financial benefits of partnership procurement • Limited assurance regarding ICS and NHSE sign off revised OBC and support for progression to FBC • 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 • Delays in launch due to abandoned partnership procurement process mean a business case may be required to extend Lorenzo contract to enact option to retain to Nov 26				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Updated OBC requires development and approval	Updated OBC requires Trust Board, ICS and NHSE approval to allow procurement process to commence	Updated OBC to come for approval by Trust Board to allow progression to external approvals	Poulter, Tom	02/08/23	
Ensure financial sustainability of EPR project	Updated OBC requires updated financial model to mitigate for consequences of departure from Partnership Procurement	Development of updated financial model for OBC	Poulter, Tom	02/08/23	
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE Digital leadership fully sighted and remain supportive of procurement approach following departure from partnership procurement model	Ongoing engagement with ICS and NHSE Digital leadership	Fitzsimmons, Paul	02/08/23	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Control & Assurance Details:

Controls

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

• Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA

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

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

- Executive led IA operational task and finish group in place for each Strike with an exec led check and challenge session prior to each strike to ensure Strike rosters allow safe 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

Assurance

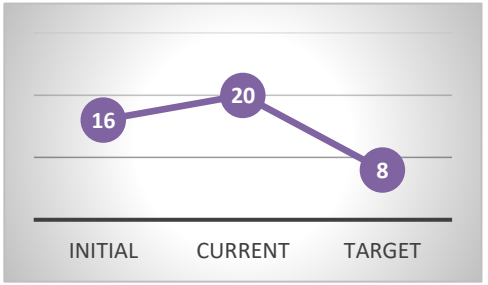
•Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.

•Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.

- Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of Industrial Action

•AfC pay agreement to be implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24

•Current ballots - Junior Doctors re-ballot in progress as only action allowed until late August.



Assurance Gaps:

•Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. This timing of this Strike action increases the risk of impact on patient care:

- The timing of the strike to predominantly impact on out of hours periods significantly increases the risk of elective care requiring rescheduling due to the need to shift consultant medical resource into out of hours periods, often associated with a requirement for compensatory rest – further impacting on availability for elective activity
- Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extracontractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods.
- The above is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics
- This junior doctor strike occurs during peak consultant annual leave period – whilst rostering rules maintain safe staffing levels throughout annual leave, these do not control for the requirement to cover junior doctor strike gaps at short notice.
- From the 10th of August the Trust will be unable to legally engage short term agency locum doctors to backfill for striking staff, it is unclear at present whether HM Government will appeal this High Court decision.

- Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. The timing and nature of this strike increase the risk of a direct impact on patient care:
  - The timing of the Strike, immediately preceding a bank holiday weekend, along with the BMA position on derogations, increases the risk of the strike impacting access to time critical elective interventions
  - The agreed Derogation process for consultant IA means it is unlikely that the Trust will be granted derogations for critical services.
  - From the 10th of August the Trust will be unable to legally engage short term agency locum doctors to backfill for striking staff, it is unclear at present whether HM Government will appeal this High Court decision.

- Uncertainty whether further IA will be national or regional approach and potential impact for different unions.

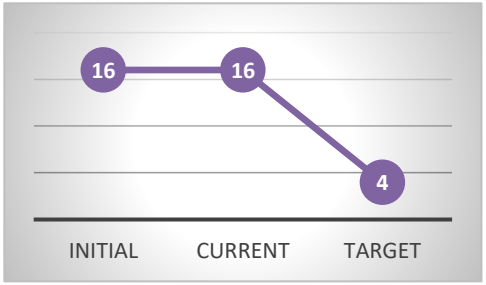
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Weekly meeting with staff side chair and deputy	Weekly meeting with staff side chair and deputy to be diarised to take place with People Directorate in order to plan and update regarding Industrial Action	Weekly meeting to be diarised to include People Directorate representatives and Staff Side	Hilton, Laura	28/07/2023	
Weekly Industrial Action Update to Execs	Executive Management Team to receive weekly updates on Industrial Action	Executive Management Team to receive weekly updates on Industrial Action	Hilton, Laura	28/07/2023	
Participate in regional ICB Workforce Industrial Action preparedness group	Participate in regional ICB Workforce Industrial Action preparedness group	Attending and participating in regional ICB Workforce Industrial Action preparedness group	Hilton, Laura	28/07/2023	

Risk ID:	1898	**Executive Lead:**	Gardner, Lucy	**Rating**

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communit		
Risk Description:	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	**Initial:**	16 (4x4)
		Current:	16 (4x4)
		Target:	4 (1 x 4)
Control & Assurance Details	**Controls** • Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance • Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have been carried out • Estates strategy refresh planned to incorporate options and enablers for new hospitals plans • 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, including extension to CSTM and further development of Halton health hub		
Assurance Gaps:	• Lack of clarity on national decision on sites to receive funding as part on New Hospitals Programme, as was Health Infrastructure Programme		

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
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.	Simon Constable and Lucy Gardner	Bi-monthly and as required.	Bi-monthly

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	125	**Executive Lead:**	Moore, Dan	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns			**Initial:**	20 (5x4)
				Current:	15 (3x5)
				Target:	10 (2 x 5)

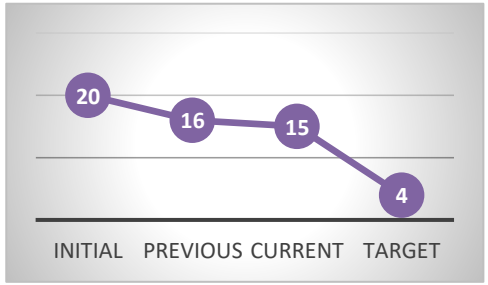
Assurance Details:

Controls:

Annual capital funding is allocated to business critical, mandated and statutory estates projects
Planned Maintenance Program
Reactive maintenance process
Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out
Capital Planning Group and associated capital funding allocation process
Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments

Assurance:

Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers
Non funded capital schemes are risk rated and monitoired through the above group
Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management
PLACE assessment with subsequent action plan
Capital Planning Group – determine how the trust capital is spent
Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks
Cleanliness monitoring identifies estates issues that are addressed through the estates building officer
Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations
Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills
In September 2022 it has been confirmed that phase 1 of the CDC & the Targetted Investment Fund (TIF) for delivery of elective recovery at the Halton site have both been approved. The capital builds in these cases will substantially increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity
New CT and MR scanner replacement to be undertaken in 2023/24
Approval received to replace Computer Aided Facilities Management System
Updated Estates Strategy in development



Assurance Gaps:

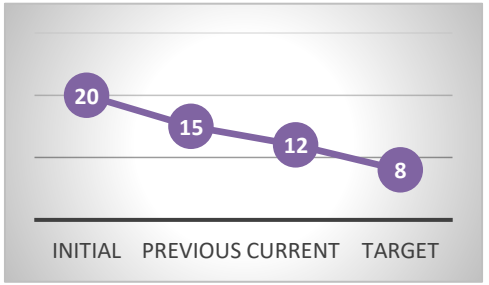
Limited capital funding to address backlog
Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM)
Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers
Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome
Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget
Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	31/03/2024	
Develop estates maintenance compliance monitoring tools	Integrate performance and compliance into0 routing estates maintenance operations	Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance and in turn improve compliance against recommended guidelines and internal KPIs	Ian Wright	02/10/2023	
Develop new estates strategy	Update Estates Strategy	Complete strategy update for approval	Ian Wright	31/08/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

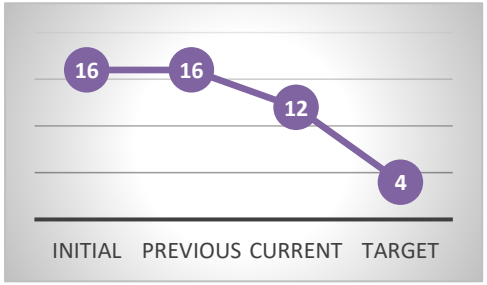
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.			**Initial**	20 (5x4)
				Current	12 (3x4)
				Target	8 (4x2)
Risk Description:	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.				
Assurance Details:	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. • Council and PLACE Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level have been refreshed • Breast Centre of Excellence opened. Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Revised plans for CDC approved by Trust Board and national diagnostics team. • Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. - Full Business Case for the Health & Wellbeing Hub approved by the Government. Contractors appointed to commence the capital works for Health & Wellbeing Hub. • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 presented to Trust Board for approval. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. • Consistent Trust representation within Cheshire & Merseyside ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative.				

	• Trust representation on newly established place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Drafts of both reviews complete. • 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 **<u>Assurances</u>** • 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.	
Assurance Gaps:	• Self assessments of both Warrington & Halton place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy. • Trust's capacity to deliver significant number of capital projects	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/10/2023	
Ensure sufficient capacity to deliver increased number of capital projects	Undertake Gap Analysis of requirements vs resource	Address any gaps identified	Lucy Gardner & Dan Moore	31/08/2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Full investigation to be carried out.	A programme of works to be set out to enable the Trust to carry out a complete and concise investigation of ABR testing since 2018.	An incident cell has been formed to oversee the actions required identified as part of the review. This requires the management of multiple stakeholders across local, regional and national bodies. In addition, there is the requirement to undertake a due diligence exercise for each baby who has had an ABR review since the beginning of 2018 up until 2/02/23.	Deborah Carter	31/08/2023	
Service review to be undertaken	A full service review to be undertaken of the audiology service.	A full service review to be undertaken of the audiology service.	Deborah Carter	31/08/2023	
To establish if any harm has been caused as a result of the issues identified in the incident	To undertake a full review of each individual identified	Clinical MDT established to review all cases	Deborah Carter	30/09/2023	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/23/08/85	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	2nd August 2023	
AUTHOR(S):	Marie Garnett – Head of Contracts, Performance and Commercial Development Bethan Thompson – Senior Performance and Systems Development Lead	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#224** Failure to meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff, and visitors which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	

	#1125 Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer, and ED Performance.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 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 **6 indicators that are both failing and are a variation concern**, these are: ***Quality*** • Medication Safety Reconciliation within 24 hours ***Access and Performance*** • Referral to treatment Open Pathways • A&E Waiting Times – over 12 hour wait • Cancer 62 Days Urgent ***Workforce*** • Bank and Agency Reliance ***Finance*** • Capital Programme At Month 3 the plan is a £6.17m deficit, however the actual deficit was £7.95m with the overspend being due in the main to Industrial Action (IA) costs, activity delivered under plan and additional capacity in A&E. The position includes a tolerance of 7% activity due to the impact of Industrial Action in month 1 and 4% in month 3 equating to £0.6m in total as advised by Cheshire and Merseyside ICS. A coding catch up of £0.1m has also been assumed for month 3. This presents risk in the reported position of £0.7m.

PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note ✓	Decision

RECOMMENDATION:	The Trust Board is asked to: 1. Note the capital request supported by the Finance and Sustainability Committee. 2. Note the contents of this report.

PREVIOUSLY CONSIDERED BY:		
	Committee	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	• Capital Requests Supported

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/23/08/85

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

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

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

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

- Quality
- Access and Performance
- Workforce
- Finance 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 2** contains the number of IPR indicators in each Making Data Count "Variation" category.

Table 1: KPIs by Assurance and Variation Categories

	Special Variation of a Concerning Nature	Common Cause Variation	Special Variation of an Improving Nature	No SPC/Not Enough Datapoints/NA
Consistently Fails the Target (based on the last 7 months)	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 13. Medication Safety - Reconciliation within 24 hours ***(50% - 80% target)*** **A&P** 35. Referral to treatment Open Pathways - ***(53% - 92% target)*** 37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge ***(16.6% - 2% target)*** 45. Cancer 62 Days Urgent ***(54% - 85% target)*** **Workforce** 71. Bank and Agency Reliance ***(21% - 9% target)*** **Finance** 77. Capital Programme ***(£2.31m – £6.34m target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 15. Staffing Care Hours per patient day (CHPPD) 21. Friends and Family (ED and UCC) 23. Sepsis - % screening for all emergency patients. 24. Sepsis - % screening for all inpatients 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis – 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis 33. MUST nutritional assessment completion **A&P** 34. Diagnostic Waiting Times 6 Weeks 37. A&E Wait Times - % patients waiting under 4 hours 39. Cancer 14 Days 40. Breast Symptoms 12 Days 47. Ambulance Handovers within 15 minutes 48. Ambulance Handovers within 30 minutes 49. Ambulance Handovers within 60 minutes 50. Discharge Summaries - % sent within 24hrs **Finance** 78. Better Payment Practice Code	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Workforce** 68. Supporting Attendance 69. Retention 70. Turnover 73. Safeguarding Training 74. PDR	**CONSISTENTLY FAILING TARGET & NO SPC** **Quality** 31a. Maternity Pregnancy Bookings before 10 weeks 31b. Maternity Pregnancy Bookings before 13 weeks **A&P** 58. Elective Outpatient Activity **Finance** 80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m) 81. Agency Ceiling
Inconsistently Passes/Fails the Target	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) 6. Healthcare Acquired Infections (Ecoli) 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 10. VTE Assessment 28. Acute Kidney Injury **A&P** 41. 28 Day Faster Cancer Diagnosis Standard 42. Cancer 31 Days First Treatment 51. Discharge Summaries - Number NOT sent in 7 days 62. Reduction in Outpatient Follow Ups	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 11. Inpatient Falls & harm levels 14. Staffing - Average Fill Rate **A&P** 59. Patients seen in the Fracture Clinic within 72 hours 65. Theatre Utilisation (measured as productive operating time only)	**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)	**Finance** 76. Cash Balance (£m)	**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** 43. Cancer 31 Days Subsequent Surgery 44. Cancer 31 Days Subsequent Drug 46. Cancer 62 Days Screening 52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 54. Urgent Operations Cancelled for 2nd Time	**Quality** 3.Healthcare Acquired Infections (MRSA) 18. NICE Compliance **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 66. Day case (measured as an aggregate of total cases) **Workforce** 72.Core/Mandatory Training	**Finance** 79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)
	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** 16. Mortality ratio – HSMR	**Quality** 4. Healthcare Acquired Infections (MSSA) 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 12. Pressure Ulcers 17. Mortality ratio - SHMI 32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 38. Average time in department ED 55. Super Stranded Patients 64. % Patients discharged to their usual place of residence	**Quality** 16. Mortality ratio – HSMR **A&P** 61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions 67. RTT - Number of patients waiting 65+ weeks	**Quality** 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage 30. Maternity 3rd and 4th Degree tears **A&P** 56. Elective Recovery Activity (Grouped SPCs) 57. Elective Recovery Diagnostic Activity 60. % patients referred to long COVID service not assessed within 15 weeks **Finance** 75. Trust Financial Position (£m)

Key:

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

Areas exceeding the target and continuously maintaining/improving performance

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

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

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

The Income and Activity Statement for June 2023 is attached in **Appendix 5**.

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

- CIP delivery.
- Cost pressures – the Trust was unable to fund circa £8m cost pressures and has put in a process to oversee mitigation plans and risk management.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR) - A tolerance of 7% in month 1 and 4% in month 3 totalling £0.6m has been assumed to mitigate the impact of Industrial Action. A coding catch up of £0.1m has also been assumed for month 3. This presents risk in the reported position of £0.7m. The activity plan steps up from July increasing the challenge of achieving the planned activity and income.
- A&E staffing pressures.
- Additional capacity open due to the levels of no criteria to reside patients.
- Cost of Industrial Action.

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

Cash

The cash balance at the end of June is £30.4m. The cash flow forecast demonstrates sufficient cash levels for the year provided the Trust delivers the plan.

CIP

At 30 June 2023, the Trust has delivered a CIP of £1.8m against a target of £1.8m. The full year CIP target is £17.9m of which £13.8m has been identified (77%). The current level of recurrent CIP is £5.6m, therefore, further work is required to increase recurrent CIP levels.

Capital Programme

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 3		**224**
Proposed changes in month		
Capital scheme completed - underspend to be returned to contingency		
ED Fire Barrier	14	
Repairs to roads & footpaths across both sites	6	
Security - NEST/neonatal unit	10	
Sub Total		**30**
VAT rebate		**3**
Capital scheme supported by FSC - 26 July 2023		
Rigid Ureterorenoscope (linked to Fragile Services)	- 13	
		- 13
Contingency as at end of month 3		**244**

The Trust Board is asked to:

- Note the capital request supported by FSC.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the capital request supported by the Finance and Sustainability Committee.
2. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	QUALITY	Plan/Target	Actual	Period	Variation	Actual	Period	
1	1. Incidents	0	0	Jun-23		0	May-23	
2	2. Duty of Candour (serious incidents)	100.00%	100.00%	Jun-23		100.00%	May-23	
3	3. Healthcare Acquired Infections (MRSA)	0	0	Jun-23		0	May-23	
4	4. Healthcare Acquired Infections (MSSA)	No target set	3	Jun-23		2	May-23	No SPC
5	5. Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	2	Jun-23		1	May-23	
6	6. Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	6	Jun-23		8	May-23	
7	7. Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	2	Jun-23		2	May-23	
8	8. Healthcare Acquired Infections (PA)	Less than 2 - annual	0	Jun-23		2	May-23	
9	9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	2	Jun-23		2	May-23	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

10	10. VTE Assessment	95.00% (quarterly position)	95.49%	Jun-23		94.90%	May-23	?
11	11. Inpatient Falls & harm levels	20% or more decrease from previous year (590 Inpatient Falls in 2021/22)	31	Jun-23	L	38	May-23	?
12	12. Pressure Ulcers	10% reduction based on 91 in 2021/22	12	Jun-23		5	May-23	?
13	13. Medication Safety Reconciliation within 24 hours	80.00%	50.00%	Jun-23	L	33.00%	May-23	F
14	14. Staffing - Average Fill Rate	90.00%	97.77%	Jun-23	H	90.43%	May-23	?
15	15. Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.74	Jun-23	H	7.7	May-23	F
16	16. Mortality ratio - HSMR	No target set	95.39	Jun-23	H	102.57	May-23	No SPC
17	17. Mortality ratio - SHMI	No target set	99.38	Jun-23		98.98	May-23	No SPC
18	18. NICE Compliance	90.00%	91.99%	Jun-23	H	92.16%	May-23	P
19	19. Complaints	Zero complaints open over 6 months old/in the backlog	0	Jun-23		0	May-23	P
20	20. Friends and Family (Inpatients & Day cases)	95.00%	98.00%	Jun-23		98.00%	May-23	P

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

21	21. Friends and Family (ED and UCC)	87.00%	72.00%	Jun-23		80.00%	May-23	F
22	22. Mixed Sex Accommodation Breaches (Non ITU Only)	0	0	Jun-23		0	May-23	P
23	23. Sepsis - % screening for all emergency patients.	90.00%	76.00%	Jun-23		78.00%	May-23	F
24	24. Sepsis - % screening for all inpatients	90.00%	76.00%	Jun-23		84.00%	May-23	F
25	25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	80.00%	Jun-23		62.00%	May-23	F
26	26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90%	68.00%	Jun-23		80.00%	May-23	F
27	27. Ward Moves between 10:00pm and 06:00am	0	57	Jun-23	No SPC	57	May-23	No SPC
28	28. Acute Kidney Injury	Less than previous month	177	Jun-23		187	May-23	?
29	29. Maternity Postpartum Haemorrhage	3.70%	4.39%	Jun-23	No SPC	6.70%	May-23	No SPC
30	30. Maternity 3rd and 4th Degree tears	<1.85%	0.87%	Jun-23	No SPC	1.03%	May-23	No SPC
31a	31a. Maternity Pregnancy Bookings before 10 weeks	10-week Target: >75%	39%	Jun-23	No SPC	48%	May-23	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

32b	31b. Maternity Pregnancy Bookings before 13 weeks	13-week Target: >90%	83%	Jun-23	No SPC		79%	May-23	F
32	32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	14%	Apr-23			7%	Feb-23	No SPC
33	33. MUST nutritional assessment completion	above > 85%	61%	Jun-23			63%	May-23	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	Plan/Target	Actual	Period	Variation	Actual	Period	
34	34. Diagnostic Waiting Times 6 Weeks	95.00%	74.38%	Jun-23		74.66%	May-23	F
35	35. Referral to treatment Open Pathways	92.00%	52.53%	Jun-23	L	53.72%	May-23	F
36	36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	68.74%	Jun-23		71%	May-23	F
37	37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	19.34%	Jun-23	H	17.3%	May-23	F
38	38. Average time in department ED	No Target	378	Jun-23		332	May-23	No SPC
39	39. Cancer 14 Days	93%	83.62%	May-23		62.88%	Apr-23	F
40	40. Breast Symptoms 14 Days	93%	66.67%	May-23		22.03%	Apr-23	F
41	41. 28 Day Faster Cancer Diagnosis Standard	75%	74.72%	May-23		69.60%	Apr-23	?
42	42. Cancer 31 Days First Treatment	96%	95.52%	May-23		94.94%	Apr-23	?
43	43. Cancer 31 Days Subsequent Surgery	94%	100.00%	May-23		100.00%	Apr-23	P

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

44	44. Cancer 31 Days Subsequent Drug	98%	100.00%	May-23		100.00%	Apr-23	P
45	45. Cancer 62 Days Urgent	85%	53.62%	May-23	L	49.43%	Apr-23	F
46	46. Cancer 62 Days Screening	90%	90.00%	May-23		90.91%	Apr-23	P
47	47. Ambulance Handovers within 15 minutes	65%	40.62%	Jun-23		43.36%	Apr-23	F
48	48. Ambulance Handovers within 30 minutes	95%	67.48%	Jun-23		69.87%	Apr-23	F
49	49. Ambulance Handovers within 60 minutes	100%	75.64%	Jun-23		78.38%	May-23	F
50	50. Discharge Summaries - % sent within 24hrs	95%	91.05%	Jun-23		89.57%	May-23	F
51	51. Discharge Summaries - Number NOT sent within 7 days	0	0	Jun-23		0	May-23	?
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%	0.04%	Jun-23		0.08%	May-23	P
53	53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	2	Jun-23	L	100.00%	May-23	?
54	54. Urgent Operations Cancelled for 2nd Time	0	0	Jun-23		0	May-23	P

Statistical Process Control - Assurance & Variation

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55	55. Super Stranded Patients	Trajectory	117	Jun-23		144	May-23	No SPC
56	56. Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
57	57. Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
58	58. Elective Outpatient Activity	104%	85%	Jun-23	No SPC	82%	May-23	F
59	59. Patients seen in the Fracture Clinic within 72 hours	95%	#N/A	Jun-23	H	#N/A	May-23	?
60	60. % patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Jun-23	No SPC	0	May-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	88%	Jun-23	H	87%	May-23	No SPC
62	62. Reduction in Outpatient Follow Ups compared to 19/20 activity	75% or less based on 2019/20 activity	85%	Jun-23		82%	May-23	?
64	64. % Patients discharged to their usual place of residence	No Current Threshold	95%	Jun-23		94%	May-23	No SPC
65	65. Theatre Utilisation (measured as productive operating time only)	85%	86.40%	Jun-23	H	88%	May-23	?
66	66. Day case (measured as an aggregate of total cases)	85%	89.89%	Jun-23	H	87%	May-23	P
67	67. RTT - Number of patients waiting 65+ weeks	0	469	Jun-23	L	477	May-23	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
68	68. Supporting Attendance	4.20%	5.90%	Jun-23	L	6.00%	May-23	F
69	69. Retention	86.00%	85.25%	Jun-23	H	84.94%	May-23	F
70	70. Turnover	Below 13%	14%	Jun-23	L	14%	May-23	F
71	71. Bank and Agency Reliance	9% or Below	16.59%	Jun-23	H	16.32%	May-23	F
72	72.Core/Mandatory Training	85.00%	88.81%	Jun-23	H	88.70%	May-23	P
73	73. Safeguarding Training	Trajectory	82.32%	Jun-23	H	82.26%	May-23	F
74	74. PDR	85.00%	71.95%	Jun-23	H	72.68%	May-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)	-£2.10	-£2.36	Jun-23	No SPC	-3.08	May-23	No SPC
76	76. Cash Balance (£m)	£24.59	£30.39	Jun-23	L	28.76	May-23	P
77	77. Capital Programme (£m)	£6.34	£2.31	Jun-23	L	£1.22	May-23	F
78	78. Better Payment Practice Code	95%	92%	Jun-23		92%	May-23	F
79	79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£1.80	£1.80	Jun-23	No SPC	1.20	May-23	P
80	80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m)	£0.90	£1.80	Jun-23	No SPC	1.20	May-23	F
81	81. Agency Ceiling	Less than 3.7%	4.6%	Jun-23	No SPC	6%	May-23	F

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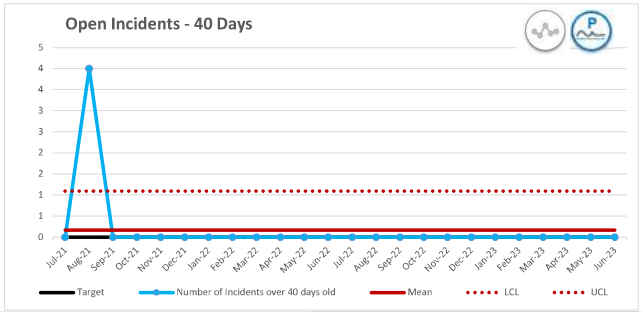
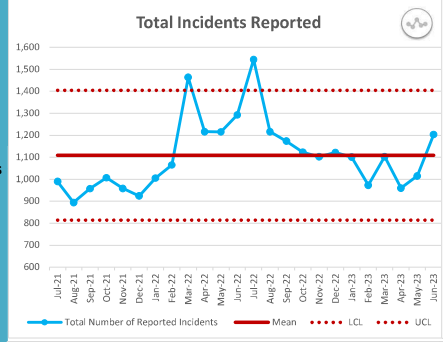
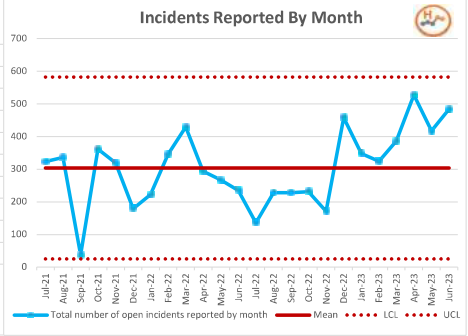
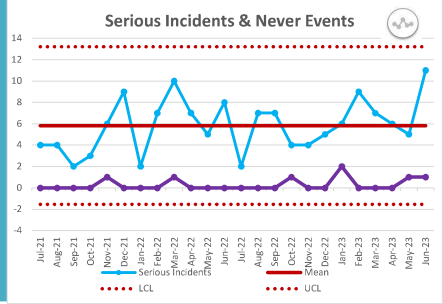
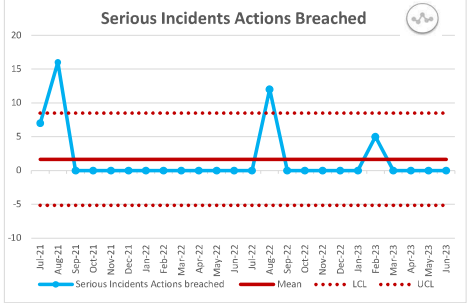
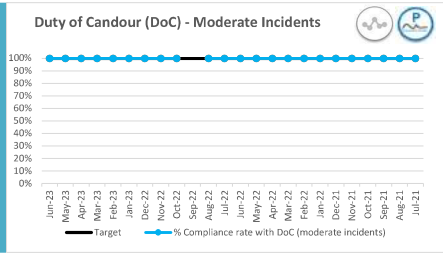
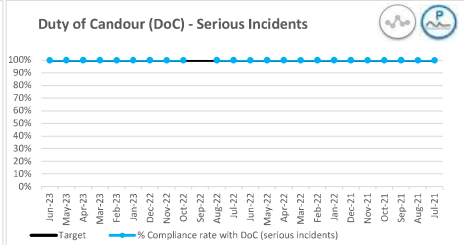
Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	    	**There were 0 incidents over 40 days old.**	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**Incident reporting remains within range with little variance across the Trust.** **There are 0 overdue 40-day incidents.** **There were 11 Serious Incidents reported in June 2023. An increase of 6 when compared to May 2023 - no themes identified.** **There were 0 breached serious incident actions in June 2023, over 40 days.**	**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. This is overseen by the Patient Safety Manager.** **WHH continue to work under the SI framework during the transition to PSIRF, to go live in September. PSIRF methodologies are being utilised.**
2. Duty of Candour (serious incidents) **Target: 100%**	 	**The Trust achieved 100% for Duty of Candour in month.**	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**There is no variance, the Trust remains 100% compliant.**	**Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.**

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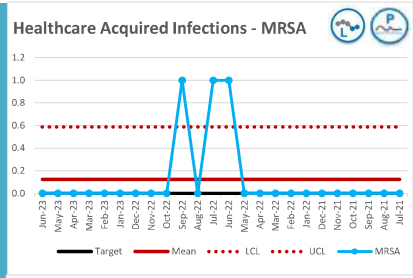
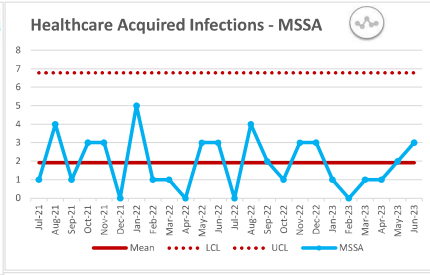
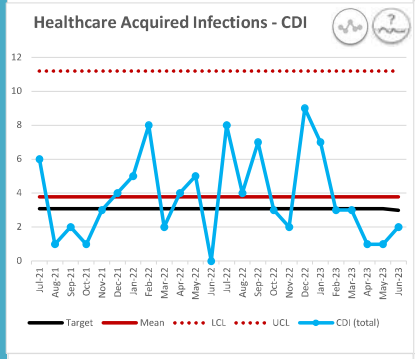
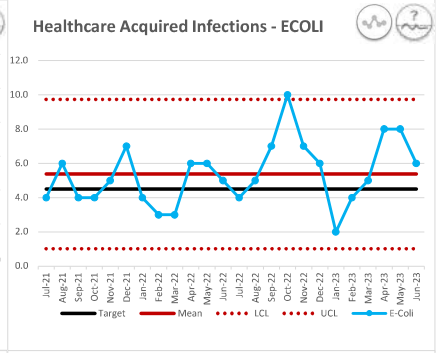
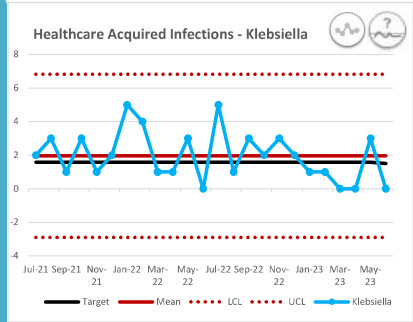
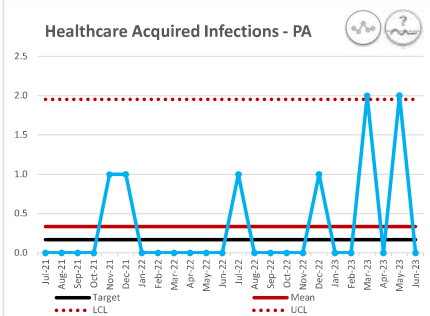
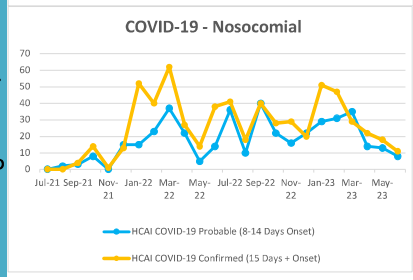
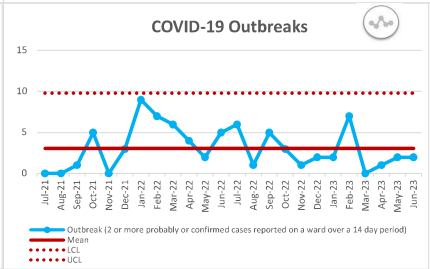
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO		(MRSA) Assurance: The Trust consistently passes the target. (MRSA) Variation: Special Cause Variation of an improving nature.	MRSA: Nil return for MRSA bacteraemia in Q1 MSSA: 2 Hospital onset case: 1 endocarditis - deep seated infection. CDI: 1 hospital onset/healthcare associated case in May 23 - within annual trajectory ECOLI: Klebsiella: Mainly UTI associated, followed by hepatobiliary source cases for all GNBSI cases. Pseudomonas aeruginosa: 2 Trust apportioned cases in May 23 - annual threshold reached. Covid-19: Revised national approach to testing. Winter season with increase in respiratory infections.P32	MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise investigation template to align with PSIRF. CDI: CDI prevention action plan in place. RCA investigations & review meetings will continue, approach will be aligned to PSIRF, SIGHT mnemonic education will continue, review of approach to auditing hand hygiene with NHSE, C. difficile study days in September. ECOLI: Klebsiella: Pseudomonas aeruginosa:Audit of hepatobiliary cases has commenced, revise GNBSI RCA template and re-introduce RCA investigation of hospital onset cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse led removal, focus support on wards with higher UTI associated cases. Reconvene the GNBSI Prevention Group. Covid-19: Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients, staff and visitors. The national requirements to report Covid-19 outbreaks remains in place.
4. Healthcare Acquired Infections (MSSA) Target: No set Target				
MRSA 0 cases over threshold MSSA 6 cases YTD - no threshold set				
5. Healthcare Acquired Infections (CDI) Target: Less than 36 -annual		(CDI) Assurance: N/A Annual Target (CDI) Variation: Common Cause (Normal) variation.		
CDI 4 cases YTD, annual threshold exceeded by 0 cases				
6. Healthcare Acquired Infections (Ecoli) Target: less than 54 - annual		(ECOLI) Assurance: N/A Annual Target (ECOLI) Variation: Common Cause (Normal) variation.		
E. coli 22 cases YTD (0 case(s) over the annual threshold)				
7. Healthcare Acquired Infections (Klebsiella) Target: Less than 18 - annual		(K) Assurance: N/A Annual Target (K) Variation: Common Cause (Normal) variation.		
Klebsiella spp. 3 cases YTD (0 cases over the annual threshold)				
8. Healthcare Acquired Infections (PA) Target: Less than 2 - annual		(PA) Assurance: N/A Annual Target (PA) Variation: Common Cause (Normal) variation.		
P. aeruginosa 2 cases YTD (0 cases over the annual threshold)				
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No		Assurance: N/A - No target. Variation: Common Cause (Normal) variation.		
2 in month COVID-19 outbreak. Covid-19: 8 day 8-14 cases probable healthcare associated cases YTD 11 day 15+ cases definite healthcare associated YTD				

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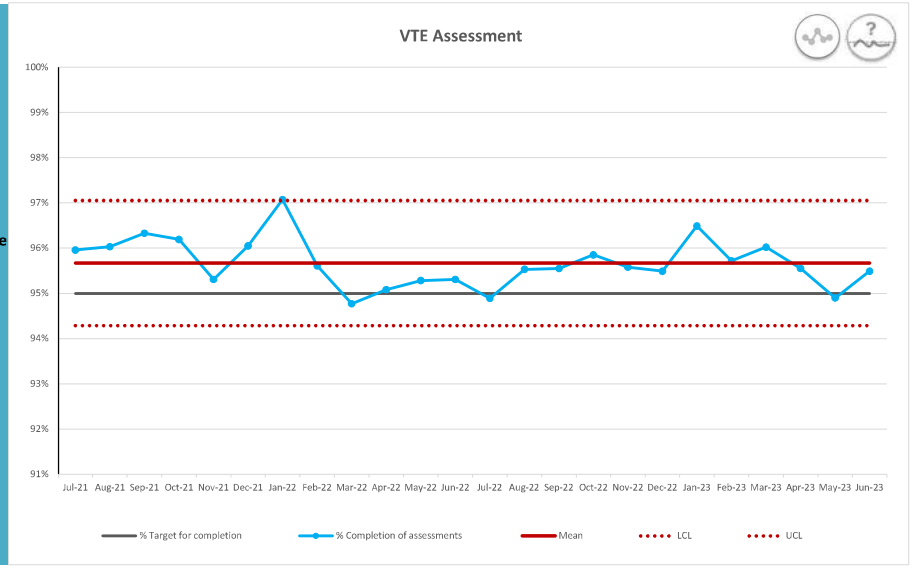
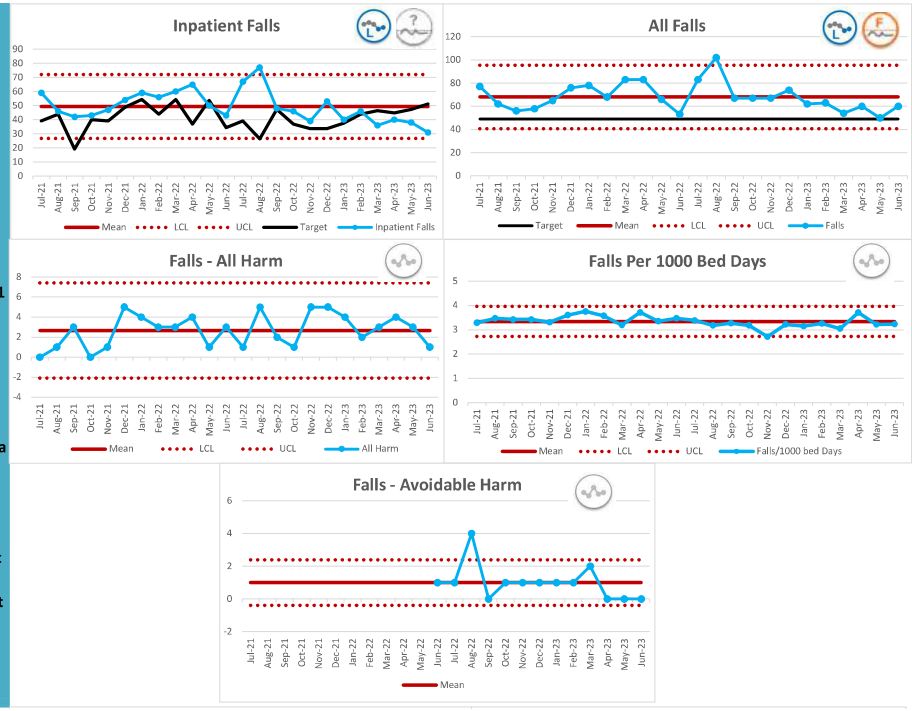
10. VTE Assessment Target: 95% (quarterly position)		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Performance target threshold for June 2023 is on track at 95.49%.	VTE RA Data sharing Further work with corporate information team to develop a BI dashboard of VTE RA data at every ward level to improve overall compliance. This was endorsed by PSCESC as an one of the improvement plans based on VTE report. Education and training To continue to raise awareness of the need for VTE completion at new August intake induction and with the every changeover of junior doctors 4 months placement. Improvement plan To gather feedback from all CBUs on how to improve future CBU VTE risk assessment compliance.
The Trust achieved the required target at 95.49% for VTE assessments in month.				
11. Inpatient Falls & harm levels Target: 20% or more decrease from 21/22 (590 Inpatient Falls in 2021/22)		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	A theme identified from review is no reassessment completed when patient condition changes. 1 fall with harm reported in June within the Emergency Department, undergoing investigation.	Fall risk alerts have been added to Lorenzo following an inpatient fall which supports the subsequent recognition of risk. A "quick glance" guide has been developed to highlight immediate falls risk and falls prevention measures in the timeframe before risk assessments and care plans are completed. The updated Enhanced Care Policy includes a new assessment tool to support prevention of deconditioning during enhanced care observations.
60 total falls were reported in month. 31 of these were inpatient falls. There has been a 16.67% increase in Trust falls from the previous month, and a 22.58% decrease inpatient falls. There has been an increase of 7 of Trust wide falls compared with same period last year. There was 1 falls in month with harm.				

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12. Pressure Ulcers **Target: 10% reduction based on 91 in 2021/22**	Pressure Ulcers - Category 2; Pressure Ulcers - Category 3; Pressure Ulcers - Category 4; Community Acquired Pressure Ulcers	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	A delay in upgrading to pressure relieving mattress, incorrect risk assessment, prolonged time on trolley in ED and inadequate repositioning have been identified as contributary factors to pressure ulcer development in June. The category 3 pressure ulcer developed under skin traction, actions in place.	Actions to improve the position include: 1.The application of heel film dressings for all patients in the Emergency Department (ED), in addition to regular pressure ulcer prevention measures. 2. The QI Team support the Matrons to monitor the sustainability of the change package. 3. Areas of higher incidence identified, ED, A6, B18, A1, A2. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses. 4. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management. 5. A workshop for pressure ulcer prevention was held in May and June, information has been collated and areas for improvement/training identified. 6. New PSIRF methodology to be applied to harms as a result of pressure ulcers going forward. 7. Display posters circulated for prevention of damage to heels. 9. New kit for use of prevention of heel pressure ulcers to be trialled across A7/A8 wk beginning 24th July
There were 11 hospital acquired category 2 pressure ulcers and 1 Category 3 pressure ulcer in month. There were 58 community aquired pressure ulcers in month.				
13. Medication Safety **Reconciliation within 24 hours Target: 80%**	Medication Safety - Reconciliation - 24 hours; Medication Safety - Reconciliation - Overall; Medication Safety - Controlled Drug Incidents; Medication Safety - Incidents with Harm	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Medicines Reconciliation: performance has improved against this metric following a change in the deployment of pharmacy staff to ward areas. The metric remains below target and this is linked to the current 40% vacancy rate in pharmacist posts. Controlled drug incidents: there is no target for this metric. 14 controlled drug incidents were reported in June - balance discrepancies (most commonly with liquid prepations) and issues with documentation around patient's own controlled drugs were the most commonly reported incidents. Incidents causing harm: there is no target for this metric. One incident causing harm, relating to poor communication, was reported in June.	Medicines reconciliation: 1. Ongoing recruitment plan in place - 4wte band 6 recruited with start dates in Sept 23 and Jan 24. 2. Continued use of bank and agency pharmacists to support gaps in establishment. 3. Pharmacist deployed to ED 5 days per week to support upstream completion of medicines reconciliaiton. Additional pharmacist and technician posts to support ED out to advert. 4. Implementation of team based ward pharmacy provision to reduce areas with no cover. 5. Risk stratified approach to pharmacist deployment to ensure higher acuity/polypharmacy patients prioritised. 6. Meeting planned between Chief Pharmacist, Pharmacy Clinical Services Manager and Director of Governance to identify additional improvement actions. Controlled drug incidents: Monthly self-assessments and quarterly CD audits are undertaken. Themes identified and addressed with specific action plans. Support given to areas with poor compliance. Incidents with harm: All medication incidents reviewed by pharmacy, clinical and governance teams and lessons learned shared.
Medicines reconciliation was completed within 24 hours of admission for 50% of patients. 78% of patients had MR completed during inpatient stay. There were 18 controlled drug incidents. There was 1 medication harm incident reported in month.				

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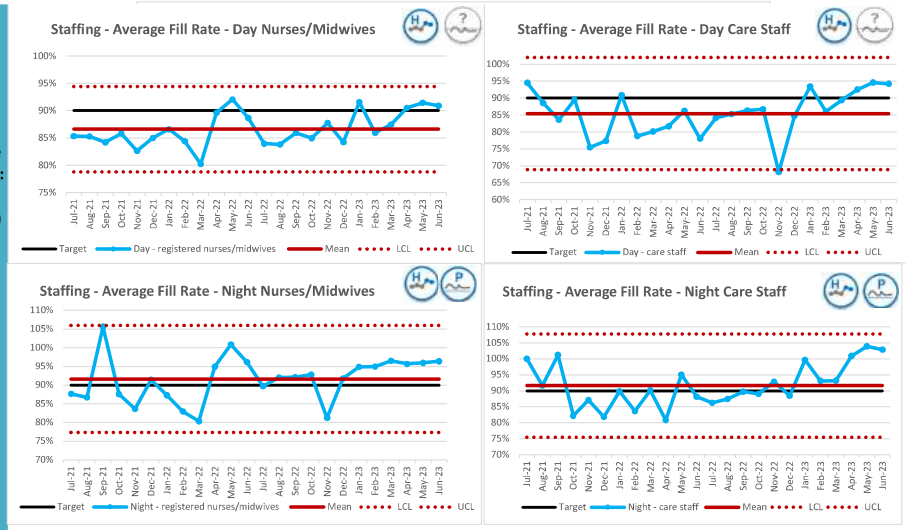
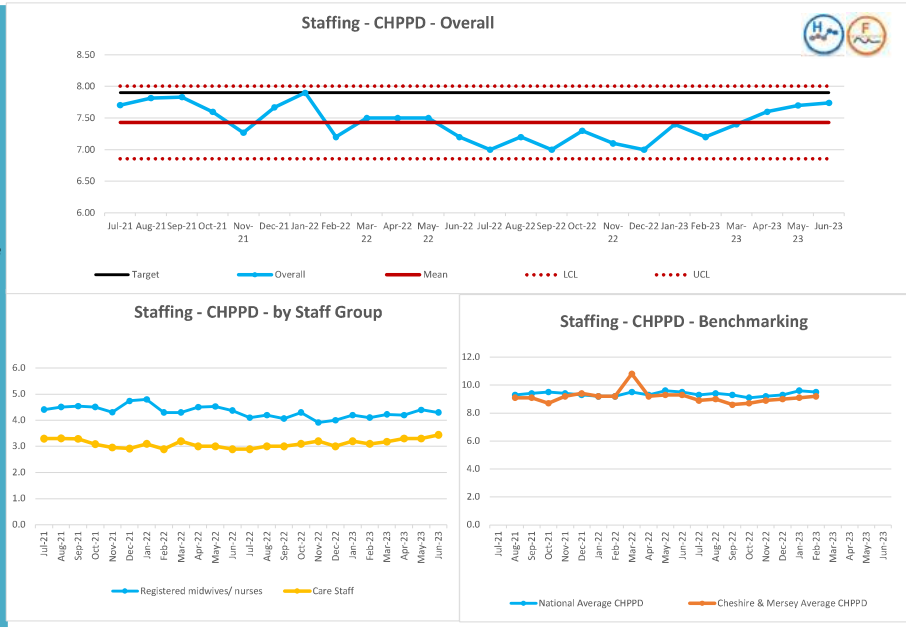
14. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 90.91% Day (Care Staff) 94.22% Night (Nurses/Midwife) 96.38% Night (Care Staff) 102.85%		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	A slight reduction in fill rates for 3 of 4 indicators is recorded in June, extra staff requested in areas as a result of additional beds (up to 24) in use across the Trust due to increased demand in ED	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 143.77 with 155 in pipeline including 83 students qualifying this summer and next and a further 38 international nurses commencing this year. HCSW vacancy is currently 43 with 40 in pipeline with more interviews arranged. The next recruitment event taking place in September 2023. Over recruitment process in place. Revenue requests in progress for the Emergency Department and A7/8/9. Agency reduction action plan in place with a £430k cost saving for Q1 23/24 compared to Q1 22/23. Work underway with Chester University to increase student placement capacity fill, Task and Finish Group in place.
15. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In month, the average CHPPD were: Nurse/Midwife: 4.3 hours Care Staff: 3.4 hours Overall: 7.7 hours		Assurance: The Trust consistently fails to hit the target. Variation: Common Cause (Normal) variation.	The CHPPD for June is 7.7 overall, slightly under a target of 7.9. Continued work on recruiting to vacancies, increased NHSP shift fill and the reduction of agency usage through the NHSP Agency Managed Service project.	Extra staff are requested for areas of higher dependency and acuity, with increased requests for staff to provide enhanced care across the Trust to support the care of patients with additional mental health needs. 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 to support the use of high quality temporary staffing.

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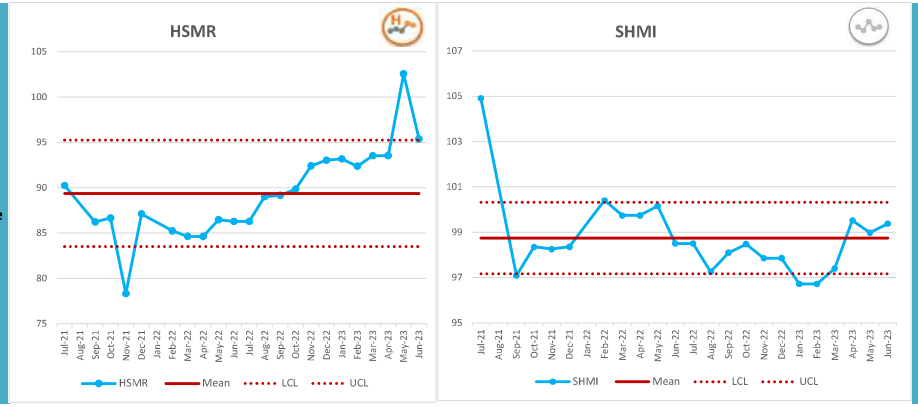
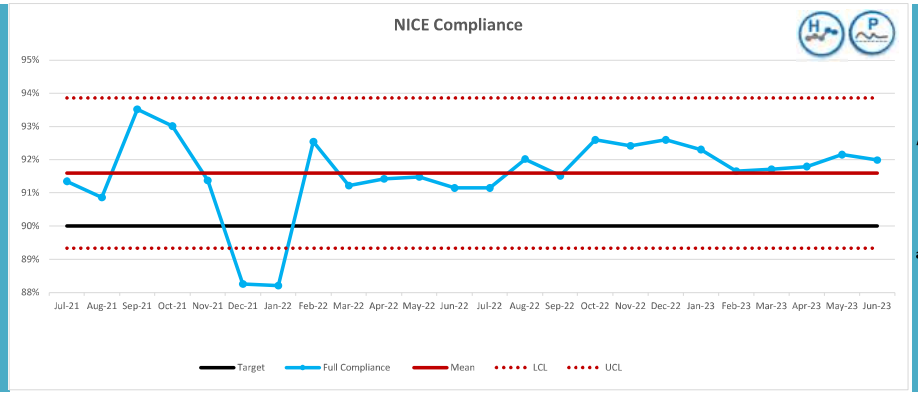
16. Mortality ratio - HSMR **Target: Plan** **17. Mortality ratio - SHMI** **Target: Plan** **SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 95.39. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 99.38.**	 	**N/A - No SPC/Target**	**SHMI remains cinsistently within the expected range.** **HSMR has increased but remains a low outlier.** **SHMI for Warrington is noted to be lower than for peer orgainisations.**	**Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. With 100% Medical Exainer scrutiny adding an additional layer of assurance.** **A UTI HSMR spike has been identified and will be monitored. If a trend continues, a focussed review into UTI mortality will be undertaken.**
18. NICE Compliance **Target: 90%** **The Trust achieved 91.99% 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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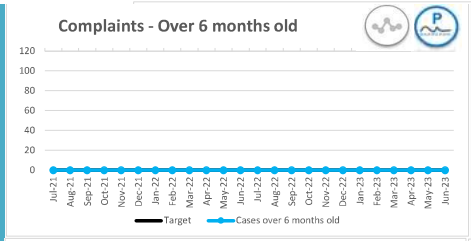
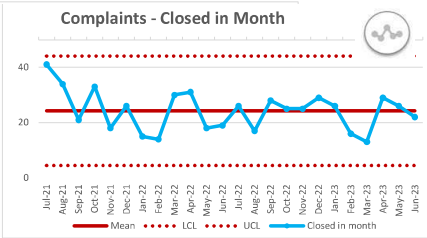
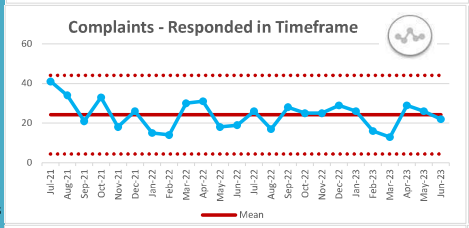
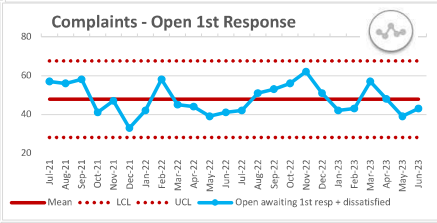
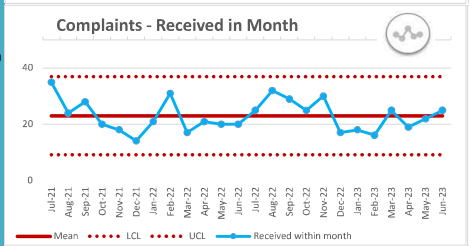
16. Complaints Target: Zero complaints open over 6 months old/in the backlog.	Complaints - Over 6 months old; Complaints - Closed in Month; Complaints - Responded in Timeframe; Complaints - Open 1st Response; Complaints - Received in Month; Complaints - PHSO; Complaints - PALS concern	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues to sustain performance in the timely completion of complaints. There continues to be no complaints over 6 months old. The complaints team and wider Trust are working hard to sustain this position.	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. Access line work is underway has part of Trust Quality Priorities.
In month, 25 new complaints were received to the Trust which was an increase of 3 from the previous month. There were 1 dissatisfied complaints received in month, which is a decrease from the previous month.				

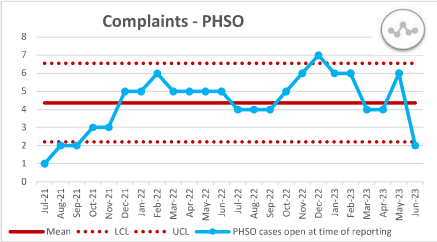


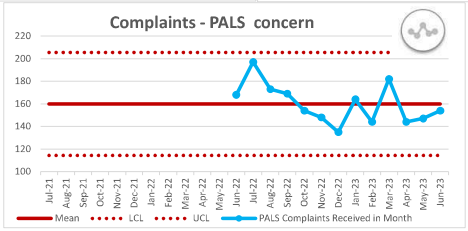












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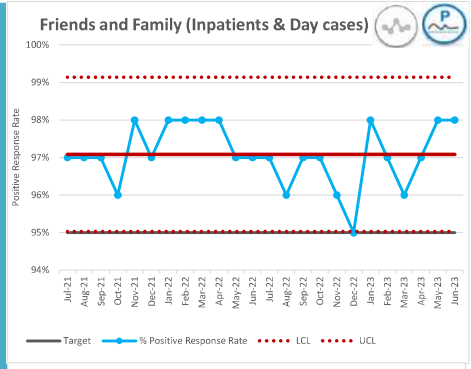
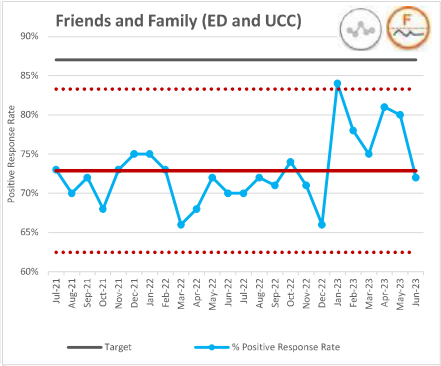
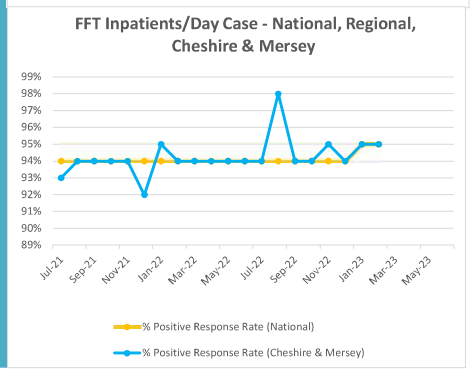
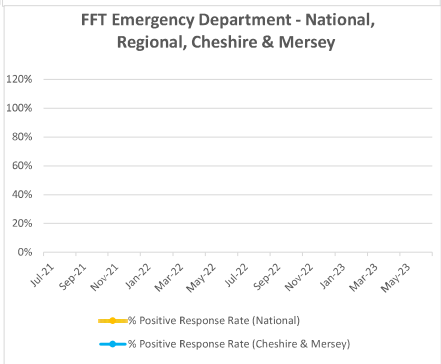
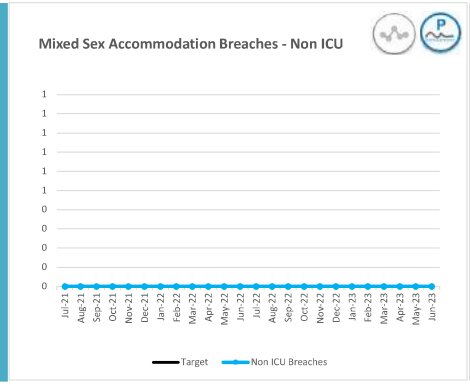
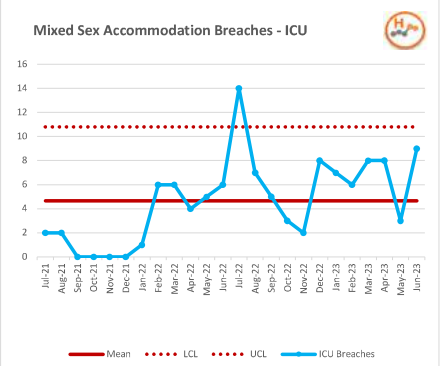
20. Friends and Family (Inpatients & Day cases) Target: 95% **21. Friends and Family (ED and UCC)** Target: 87% The Trust achieved 98% in month for Inpatient & Day case FFT and 72% for ED/UCC FFT. The most recent National average for FFT was NA% and for C&M was NA%.	   	(IP/DC) Assurance: The Trust consistently 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 98.00% positive recommendation rate in June 2023. ED/UCC - The Trust achieved 72.00% positive feedback in Friends and Family Test results in June 2023. The Patient Experience and Inclusion team and the senior nursing in the emergency team are continuing to focus on communication, both written and verbal. The team will also focus on actions based on the recent Mock CQC inspection.	Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients. Working with the Catering Department to ensure all wards fully aware of meal schedules in place. Experts by experience programme is embedded into the Quality Improvement Programme with patients representing key projects within the Trust: Patientt entertainment/Patient Engagement Portal/Phlebotomy booking service. ED/UCC - Key themes for improvement in relation to positive recommendation rates continue with communication, wait times and the environment. This is perpetuated by the super stranded position within the Trust and the increased attendees. Measures taken to improve patient experience within the Emergency Department include but are not limited to: -Addressing the actions from the Mock CQC inspection with a focus on patient care and comfort rounding -In conjunction with the ED senior team the Patient Experience and Inclusion Team and Communications team have commenced a review of the environment and visual displays within the department.
NO Data for December				
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 9 MSA incidents within the ITU.	 	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There were 9 mixed sex accommodation breach reported in June 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.	The priority to step down patients from ITU is part of the daily bed meetings to ensure prolonged delays are minimised, this remains a standing agenda item as part of efficient patient flow. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.

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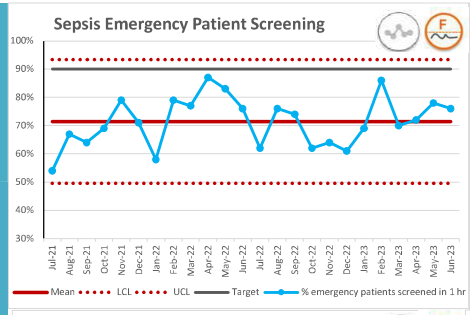
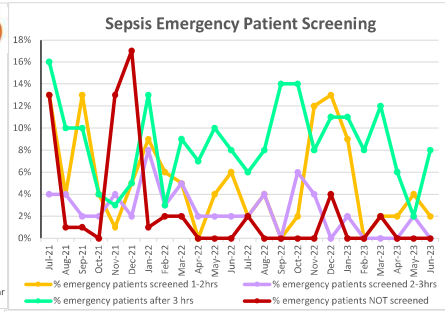
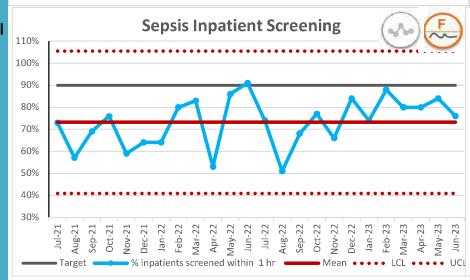
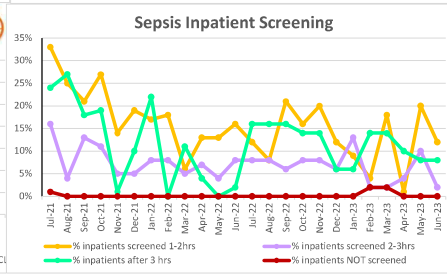
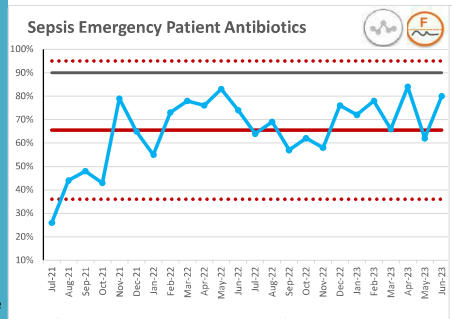
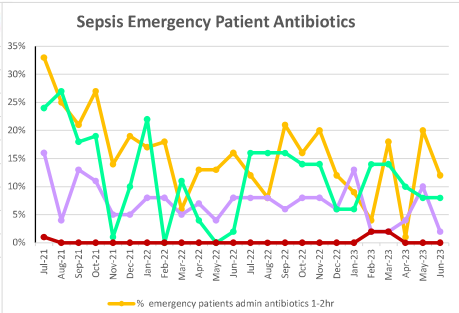
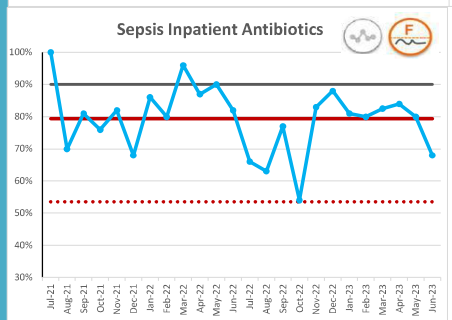
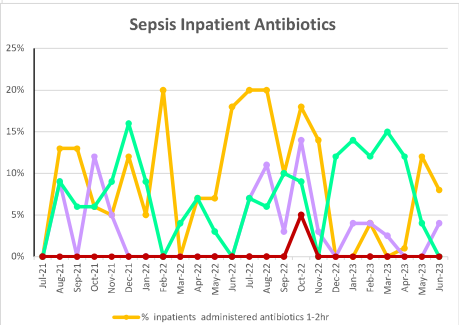
23. Sepsis - % screening for all emergency patients. **Target: 90%** **24. Sepsis - % screening for all inpatients** **Target: 90%** The Trust achieved: • 76% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 76% screening for all inpatients with suspected sepsis within 1 hour.	   	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	A decrease in both ED and inpatient areas for screening within an hour are reported for June. The increased attendances in the Emergency Department continue to be a contributory factor to the inability to achieve the 90% Trust target.	Quality Improvement support is in place to drive improvements across the Trust. Response to compliance to NEWS 2 sepsis triggers on inpatient wards is monitored by the Patient Safety Improvement Team with an improving position reported. A review of AQuA sepsis target measures will now take place in October as a result of the of the Academy of Medical Royal Colleges statement in relation to potential changes in the timeframe for assessment and treatment of patients with suspected sepsis. Improvement work across the Trust for the management of sepsis is led by the Deputy Chief Nurse and Sepsis Medical Lead. All patients who do not receive assessment and treatment within the 1 hour timeframe are reviewed with no harm recorded.
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: • 80% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. • 68% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.	   	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Improvements in the administration of antibiotics for ED has been noted in June, with 100% of patients having received their treatment within 6 hours. A reduction in inpatient areas within the 1 hour standard is reported as a result of the delay in the prescrition of antiobiotics, 100% were administered with 6 hours. A theme identified is the absence of STAT doses not prescribed.	The importance of prescribing antibiotics in a timely manner continues to be a focus for improvement. A comprehensive review of the prescribing process for antibiotics will be undertaken with the Chief Pharmacist, Medical Director, Trust Medical Lead for Sepsis and Emergency Department staff, to determine whether a more efficient solution can be introduced. A Sepsis Network Group Group has been developed, with WHH as lead, to learn and share best practice with Sepsis Nurses from other Trusts. The first meeting held in June. The team distribute themes each months for all areas to ensure learning is shared.

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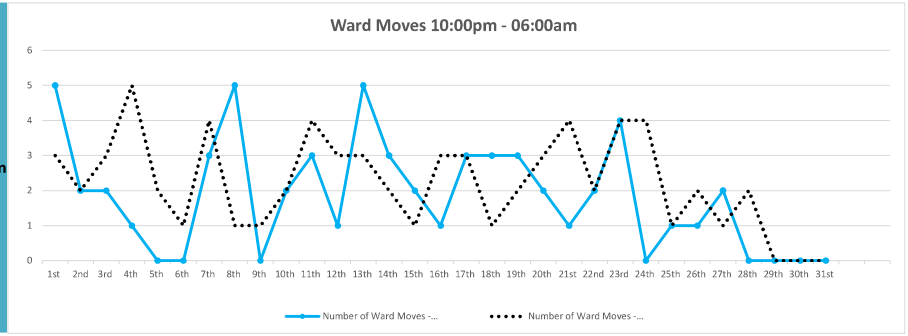
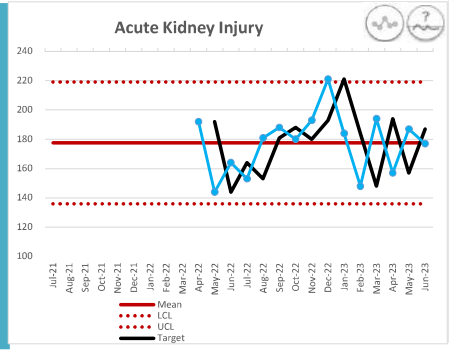
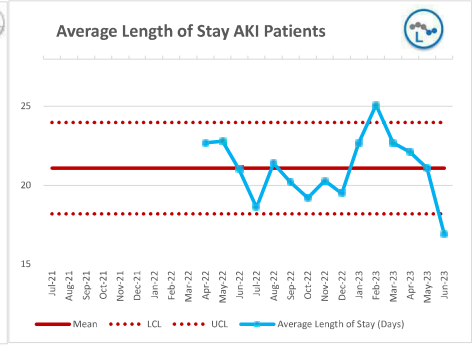
27. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 57 ward moves between 10pm-6am in month, compared to 69 in 2022.		N/A - Monthly/ Annual Comparison.	A 20% reduction in ward moves is reported since last month with an overall reduction when compared to the same reporting period last year. The reason for the reduction in ward moves after 10pm 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 177 acute kidney injuries reported in month.	 	Variation: Common Cause (Normal) variation.	There has been a decrease in the number of Hospital Acquired AKI's. The work to improve recognition and treatment of AKI has reduced ITU admissions with AKI by 82%. WHH transferring 30% less patients to tertiary units.	Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient . Staff survey currently in progress on 'barriers to completion' and suggested E-learning / ward-based teaching package to be developed required. 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.

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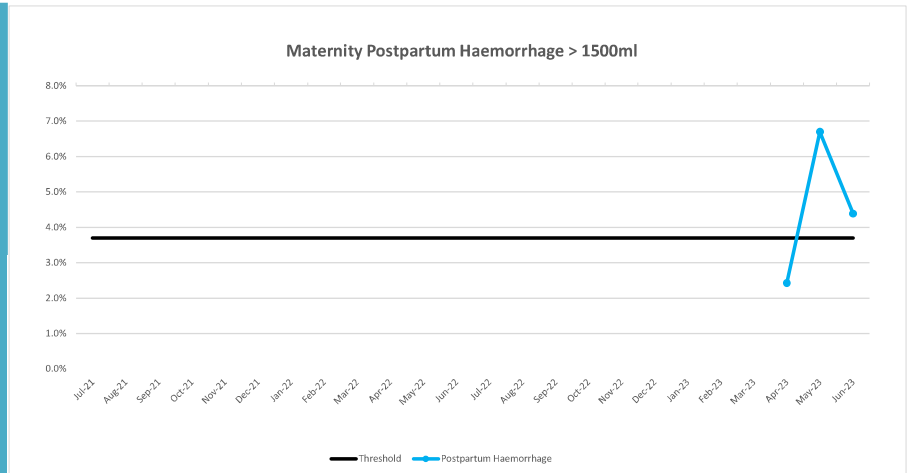
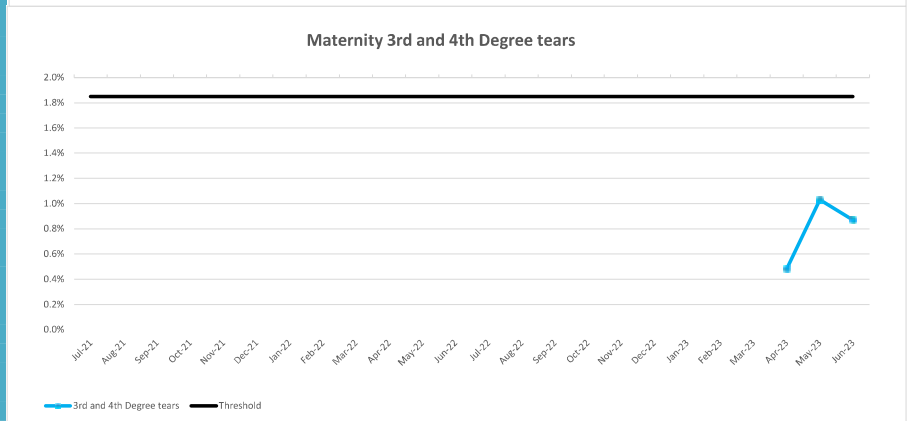
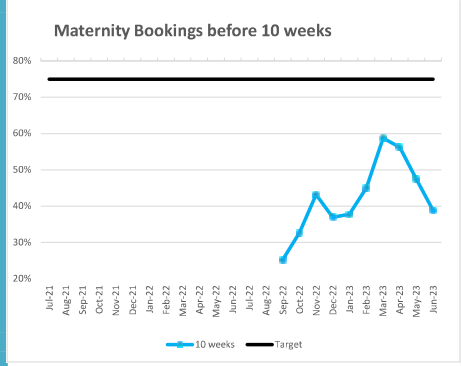
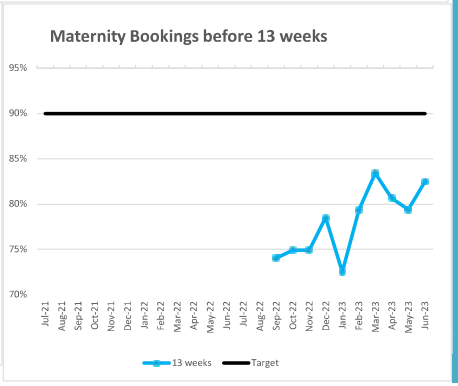
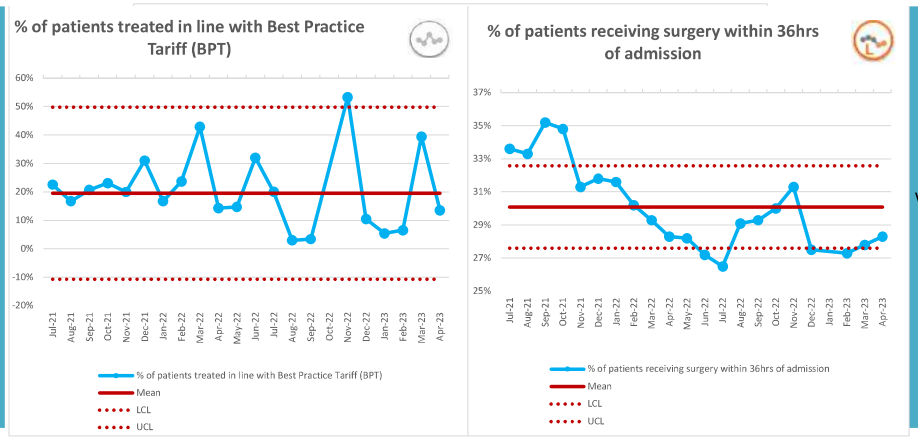
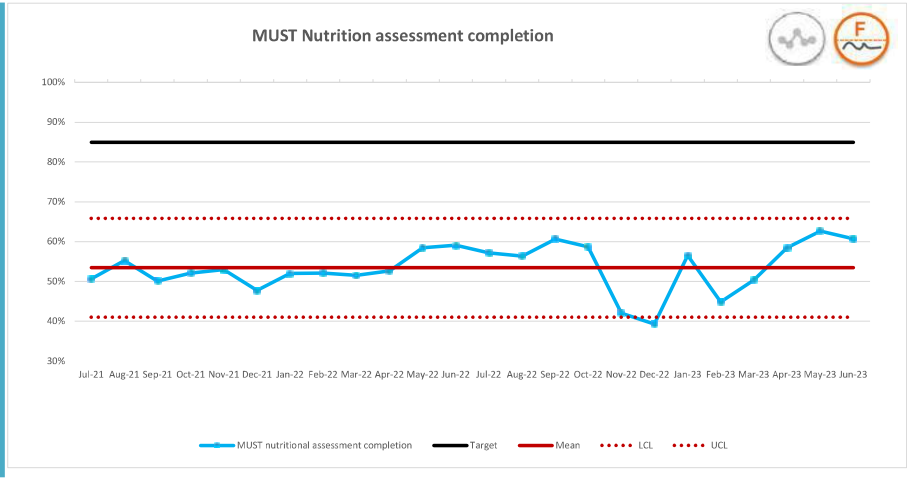
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml Threshold: < 3.7%	There were 4.39% Postpartum Haemorrhages >1500ml in month.		N/A - Not enough datapoints.	Rates for June are above the benchmark however there is an improvement from May. A deep dive was presented to QAC in May and learning has been captured in an action plan which is underway. This includes the introduction of an new medication regime for those undergoing elective caesarean section and further simulation training to support management of cases. PPH >1500mls will continue to be reviewed on an individual basis via governance processes 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. Rates of PPH >1500mls are also reported via the Maternity dashboard to CBU Governance meetings.	A deep dive was presented to QAC in May and learning has been captured in an action plan which is underway. All PPH >1500mls continue to be reviewed via governance processes.
30. Maternity 3rd and 4th Degree tears Threshold: <1.85%	There were 0.87% 3rd and 4th Degree tears in month.		N/A - Not enough datapoints.	Incidence of 3rd & 4th degree tears remain below benchmark data. All 3rd & 4th degree tears continue to be reviewed via governance processes and the learning from these reviews is then shared. Rates of 3rd & 4th degree tear are reported via the Maternity dashboard to CBU Governance meetings.	Incidence of 3rd & 4th degree tears remain below benchmark data. All 3rd & 4th degree tears continue to be reviewed via governance processes and the learning from these reviews is then shared. Rates of 3rd & 4th degree tear are reported via the Maternity dashboard to CBU Governance meetings.
31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks 10-week Target: >75% 13-week Target: >90%	38.8% bookings before 10 weeks and 82.5% bookings before 13 weeks.	 	N/A - Not enough datapoints.	An action plan is in place to improve timeliness of bookings and there had been significant improvement from 25% in September 2022 to 59% in March 2023 (for bookings before 10 weeks) and 72% in January 2023 to 83% in March 2023 (for bookings before 13 weeks). However, more recently there has been a deterioration in performance. As a result the action plan has been reviewed and further measures implemented. This has supported improvement in bookings <13 weeks which has improved in June 2023. Bookings <10 weeks remain a challenge. There are numerous reasons for this. Further process engineering has been completed including system changes to the BadgerNet EPR. It is anticipated these will improve performance alongside the introduction of an additional failsafe system.	An action plan is in place to improve timeliness of bookings and there had been significant improvement following implementation of an action plan within the Community and Antenatal Services. As there is a deterioration in performance in May 2023, the action plan has been reviewed and further measures implemented.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

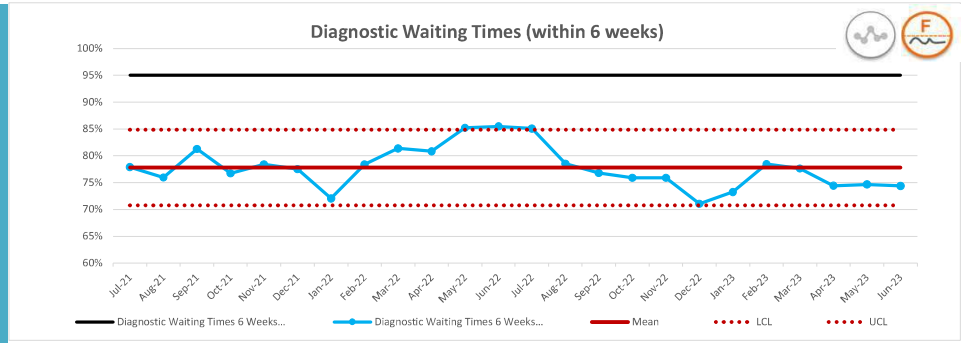
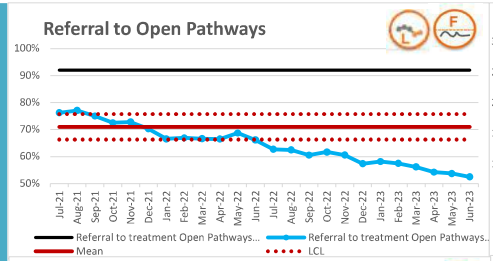
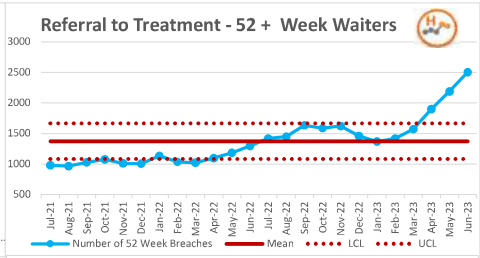
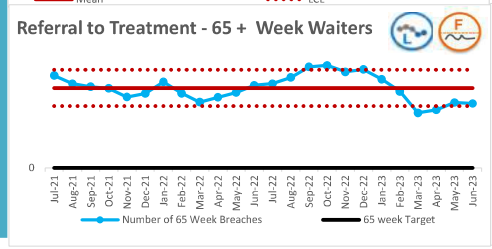
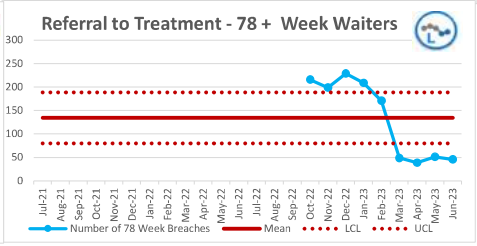
Appendix 2

	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**	**13.5% of patients were treated in line with Best Practice Tariff (BPT) in Apr-23.**		**Variation: Common Cause (Normal) variation.**	**There continues to be variation in achievement of KPI's for NHFD, with a below average compliance. The KPI's that are affecting achievement of BPT and continue to show below average compliance are 'Prompt Orthogeriatric Review' and 'Prompt Surgery'. With the increase in the Orthogeriatric service from May 2023, although still provided via 'in reach', there should be an improvement in KPI's, which are delivered by the Orthogeriatric team.**	**Work continues with regards to improving capacity to aid performance of 'Prompt surgery', this includes a review of theatre availability for trauma, scheduling of an additional list, as is possible, productivity monitoring and a review of the delivery of the Trauma Consultant on Call rota.**
33. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 60.72% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Data is available to measure MUST compliance on Lorenzo regarding 6 hour, 24 hour and 7 day compliance. A slight reduction is noted in June 2023 for completion of MUST, challenges are noted with the completion of the 7 day assessment which reduces the overall compliance.**	**All ward managers, matrons & lead nurses have access to the newly developed MUST compliance dashboard with a plan to develop local QI projects with the use of SPC charts in July 2023.** **Ward-based interventions have been relaunched with wards provided with posters detailing the ward based interventions recommended for MUST Score , 0, 1 & 2+. Audit of ward based interventions being designed with plans to audit by end of July. Collaboration with QI team to analyse audit data and formulate Trust wide quality improvement project by the end of August. Compliance is monitored by monthly Nutrition, Food & Hydration Steering Group.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: Risk Register | System Oversight Framework | Care Quality Commission

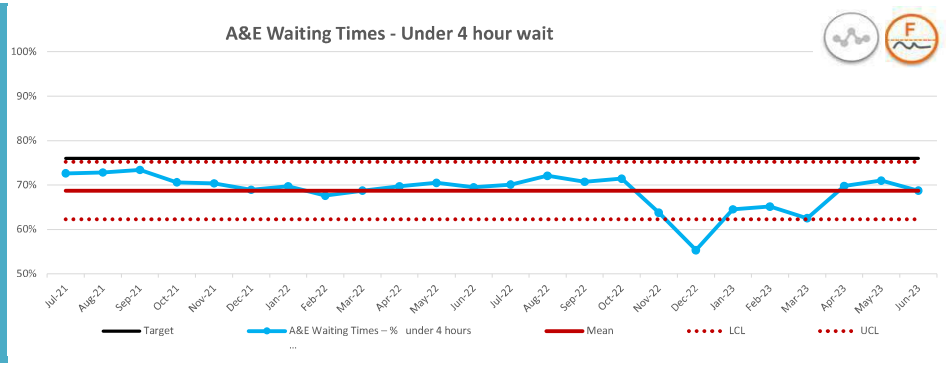
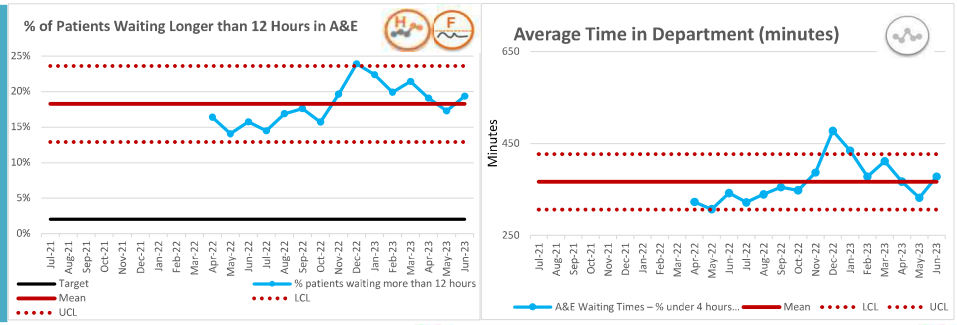
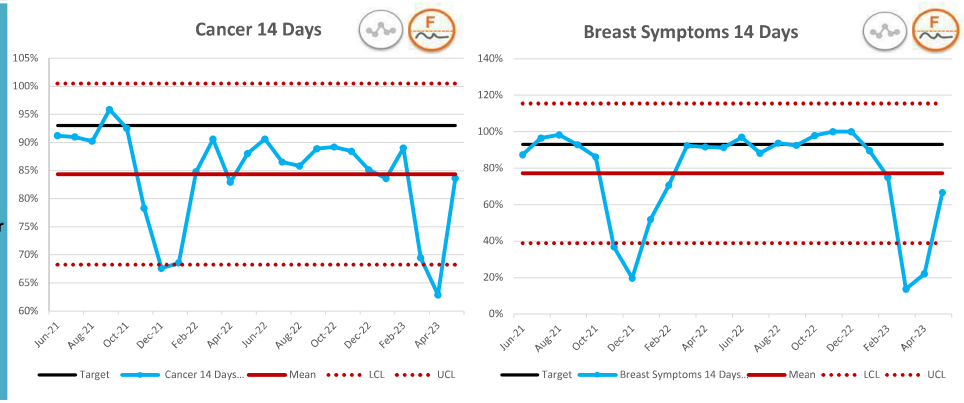
Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
34. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 74.38% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	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.
35. Referral to treatment Open Pathways Target: 92% 67. RTT - Number of patients waiting 65+ weeks Target: 0	The Trust achieved 52.53% in month. There were 2505, 52 week breaches, 46, 78 week breaches and 469, 104 week breaches in .	   	Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature. Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	RTT performance - 52, 65, 78 week wait performance in the reporting period was worse than the operational as a result of cancellations due to industrial action.	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre. • Restoration and recovery plans for 2023/24 have been drawn up in line with Operational Planning Guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

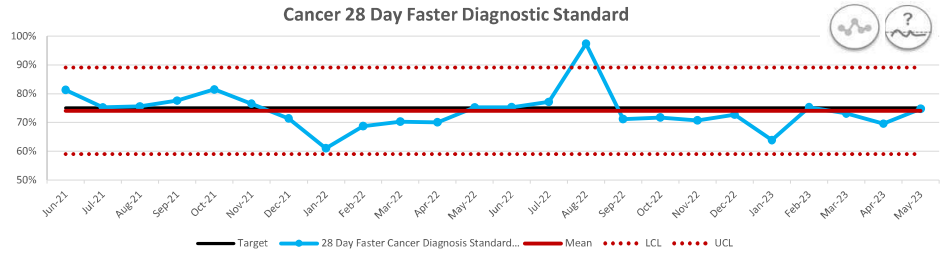
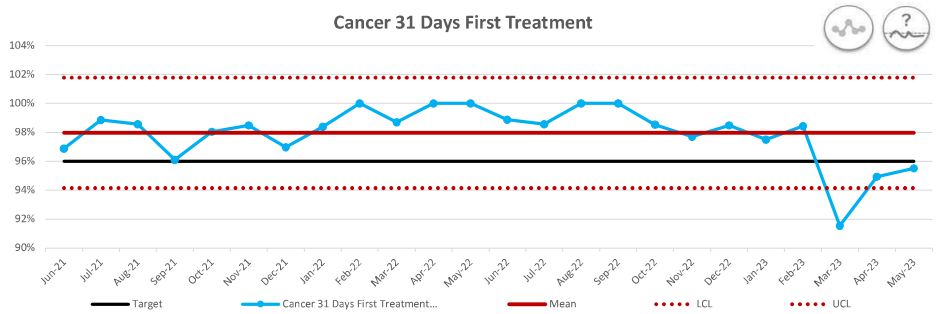
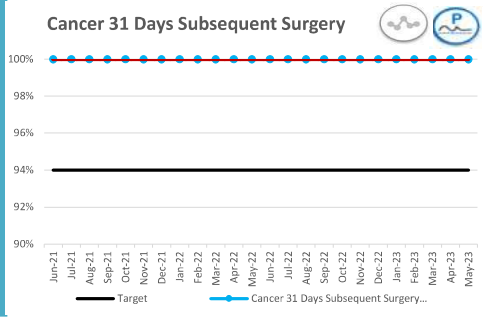
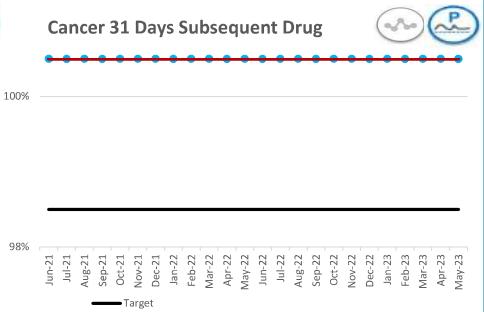
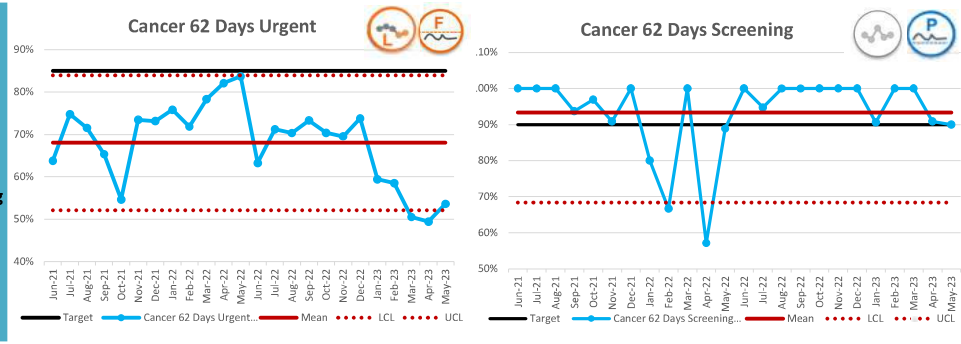
Key: Risk Register | System Oversight Framework | Care Quality Commission

	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% 37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	The Trust achieved 68.74% excluding Widnes walk ins in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Performance continues to be negatively impacted by high attends, and long length of stay as a result of community discharge delays.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • System resource investment in order to support Pathway 1 discharges. • Additional beds remain open on the Halton site to support bed capacity and flow. • Ward A10 opened in October (14 Beds) to support performance.
38. Average time in department ED No Target	19.34% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 378 minutes.		N/A - Not enough datapoints.	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 to be set up to support improvement.
39. Cancer 14 Days Target: 93% 40. Breast Symptoms 14 Days Target: 93%	The Trust achieved 83.62% in November 2022 for Cancer 14 days and 66.67% in month for Breast Symptomatic.		(C14) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation. (Breast) Assurance: The Trust inconsistently fails the target. Variation: Common Cause (normal) variation.	The 2ww standard and Breast Symptoms have seen a drop in performance through March and April due to the continued high levels of referrals coupled with reduced staffing within radiology to support the new patient clinics. There has also been some disruption caused by IA. The Breast service has taken corrective action which has seen performance improve in May.	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

Key: Risk Register | System Oversight Framework | Care Quality Commission

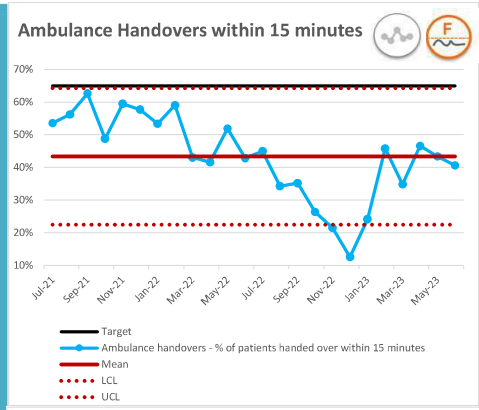
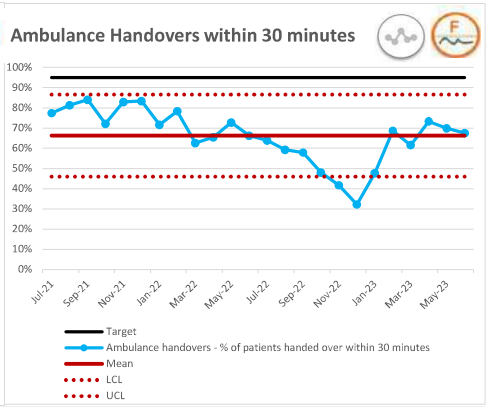
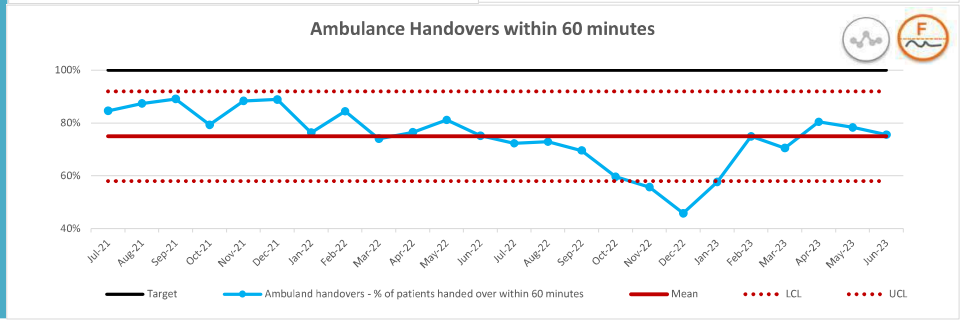
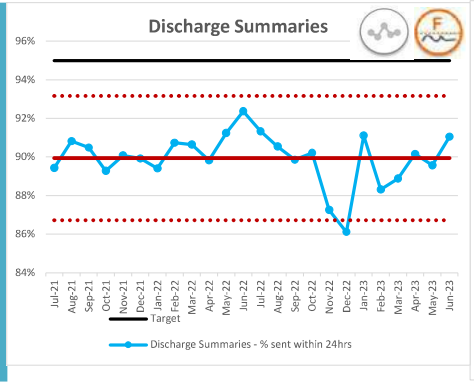
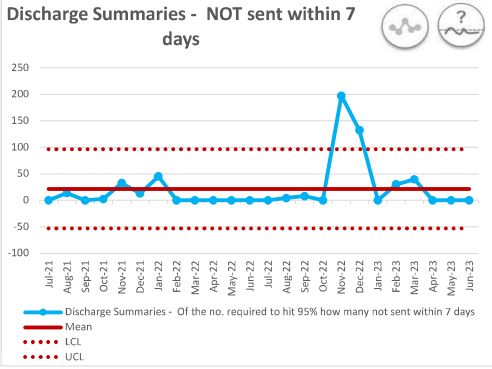
Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
41. 28 Day Faster Cancer Diagnosis Standard Target: 75%	The Trust achieved 74.72% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	This indicator is impacted by continued high volumes of referalls into General Surgery creating pressures on 2 week wait capacity. Short term additional capacity continues to be put in place.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG)
42. Cancer 31 Days First Treatment Target: 96% 43. Cancer 31 Days Subsequent Surgery Target: 94% 44. Cancer 31 Days Subsequent Drug Target: 98%	The Trust achieved 95.52% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in month.	  	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation. (Surgery) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation. (Drugs) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The 62 day and 31 day targets have both been affected by a number of longer waiting kidney patients and some breast breaches due to the 2ww issues causing overall longer pathways in this group who do not normally breach. This has remained an issue for April but is now resolving and will be reflected in May's performance.	Capacity is being reviewed in line with clinical service restoration plans.
45. Cancer 62 Days Urgent Target: 85% 46. Cancer 62 Days Screening Target: 90%	The Trust achieved 53.62% for Cancer 62 Day Urgent and 90% for Cancer 62 Day Screening in month.		(Urgent) Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature (Screening) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	The 62 day urgent target was not achieved in this reporting period, this was decrease on the months previous level, the key factors driving this drop are the Urology and CR pathways which have capacity constrains due to workforce pressures, a recovery plan is in place. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: Risk Register | System Oversight Framework | Care Quality Commission

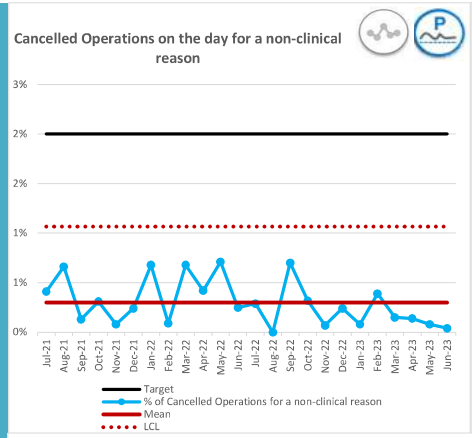
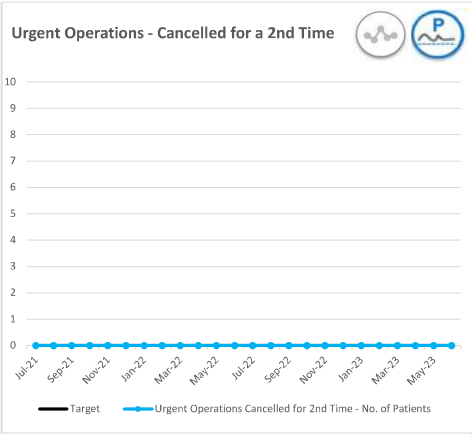
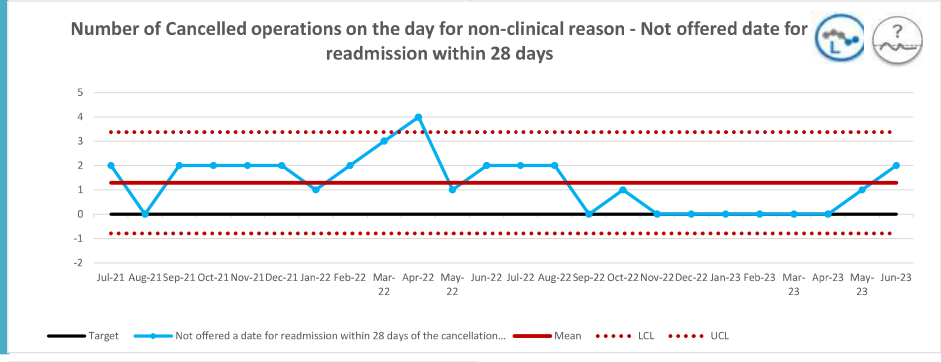
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 40.62% of patients were handed over within 15 minutes, 67.48% were handed over within 30 minutes and 75.64% were handed over within 60 minutes.**	  	**(15) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(30) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(60) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Handover performance has improved as a result of modest improvement in No Criteria to Reside patients and the reduction in the impact of winter. Additonal staffing to support the offloading of Ambulances has also been used in this period.**	**The Trust will continue to work in partnership with NWAS to identify and implement improvements.**
50. Discharge Summaries - % sent within 24hrs Target: 95% 51. Discharge Summaries - Number NOT sent within 7 days Target: ZERO **The Trust achieved 89.97% in month. There was 1 discharge summary not sent within 23 days required to meet the 95.00% threshold.**	 	**(24 hrs) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(7 Days) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: Risk Register | System Oversight Framework | Care Quality Commission

Access & Performance - Trust Position

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

Cancelled operations data validation for month is in progress.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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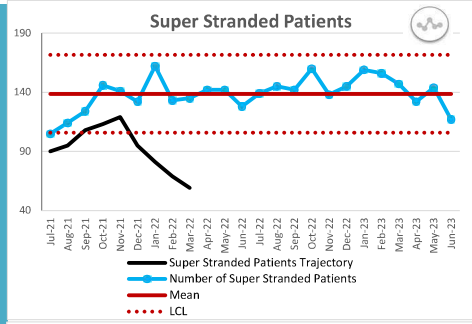
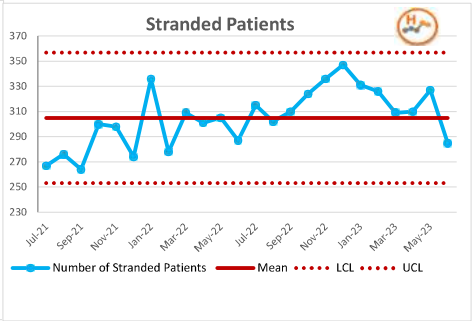
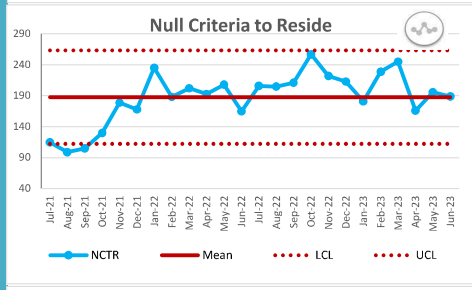
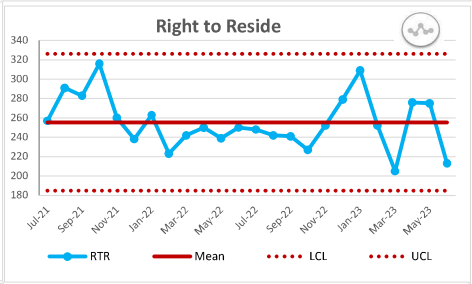
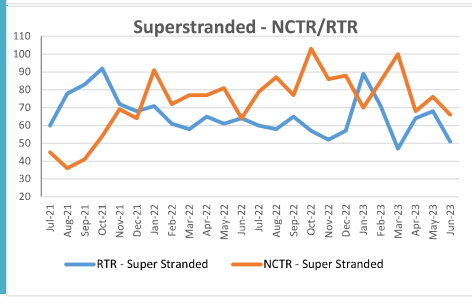
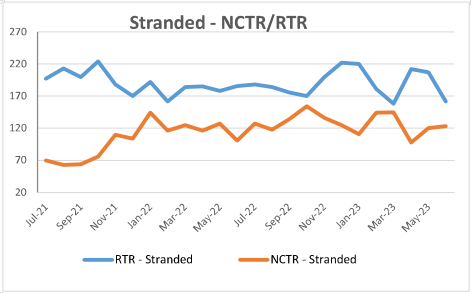
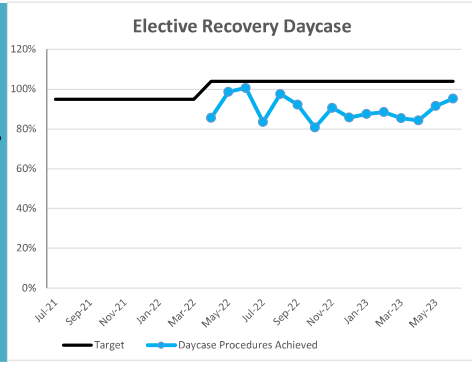
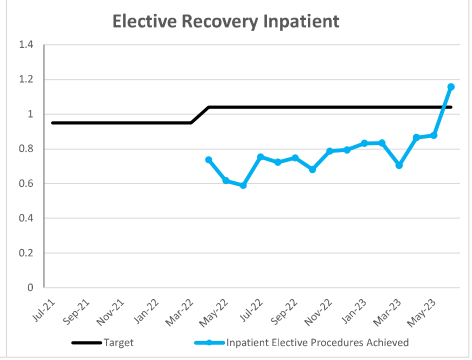
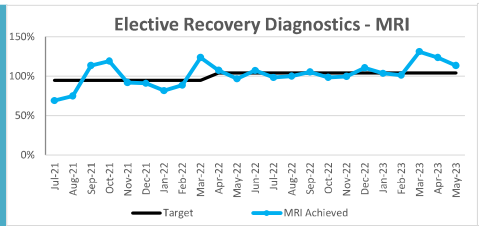
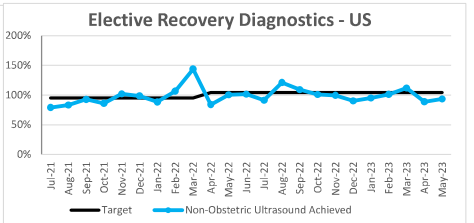
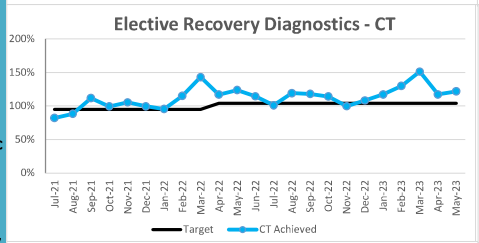
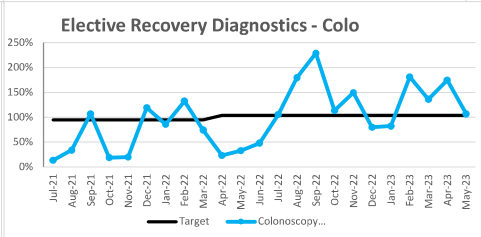
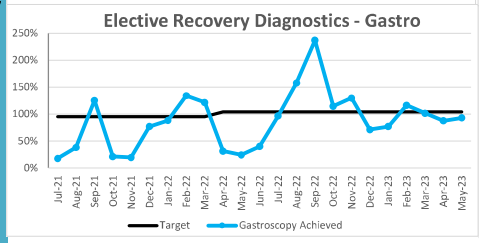
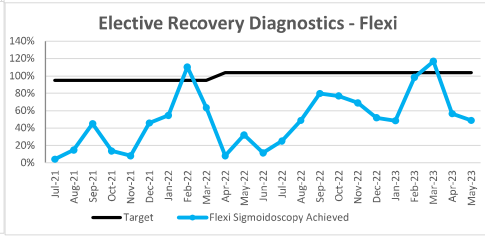
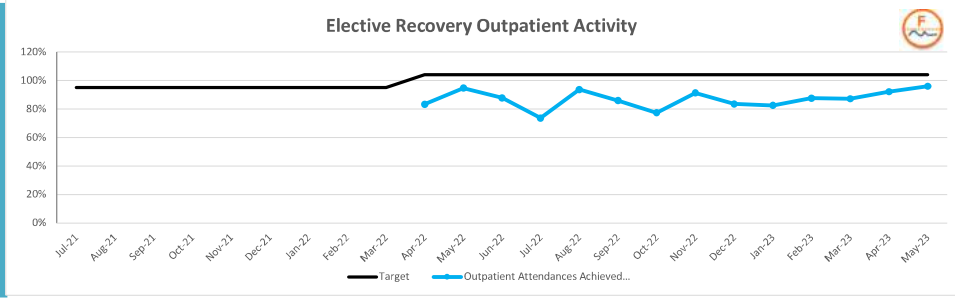
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Super Stranded Patients Target: Trajectory	     	There were 285 stranded and 117 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	(SS) Assurance: N/A Trajectory Not Agreed Variation: Common Cause (normal) variation. (SS) Assurance: N/A Trajectory Not Agreed Variation: There is special cause variation of a concerning nature. (NCTR) Assurance: N/A Trajectory Not Agreed Variation: Common Cause (normal) variation. (RTR) Assurance: N/A Trajectory Not Agreed Variation: Common Cause (normal) variation.	The number of Super Stranded patients continues to remain higher than trajectory as a result of the community and Local Authority discharge delays.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.
56. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	 	In month, the Trust achieved the following % of activity against 2019. This included 116% of Daycase Procedures and 95.3% of Inpatient Elective Procedures.	N/A - Grouped indicator.	Inpatient activity for the reporting period is below the Trajectory but is inline with the Month 1 plan when the cancellations for Industrial Action is taken into account.	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiatvie and Insourcing methods to undertake additional activity is being undertaken.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: Risk Register | System Oversight Framework | Care Quality Commission

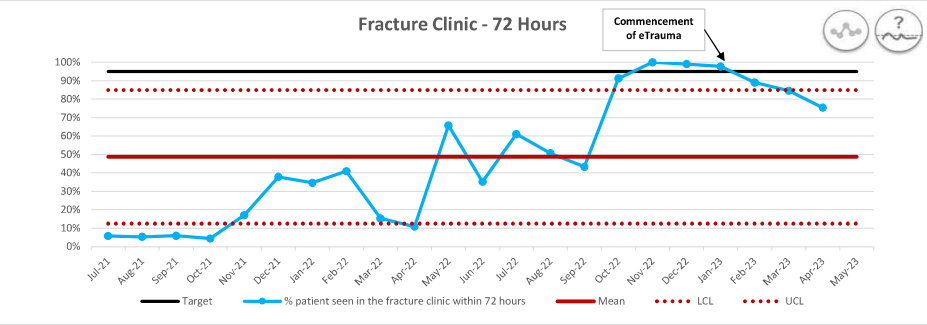
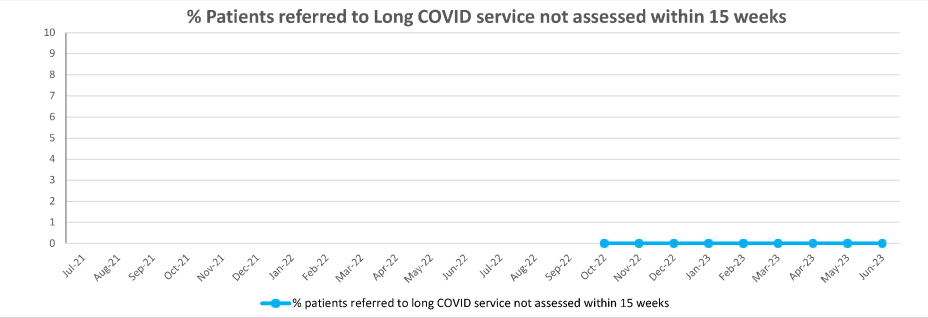
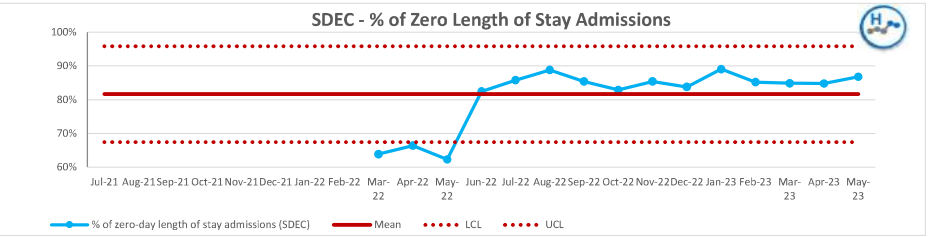
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
57. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
In month, the Trust achieved the following % of activity against 2019. This included: **113.55% of MRI** **122.07% of CT** **93.18% of Non-Obstetric Ultrasound** **48.81% of Flexi Sigmoidoscopy** **106.58% of Colonoscopy** **93.04% of Gastroscopy**	     	**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.**
58. Elective Recovery Outpatient Activity Aggregate Target: 104%				
In month, the Trust achieved 95.89% of Outpatient activity against 2019.		**Assurance: The Trust consistently fails the target.**	**The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative servcies such as patient initiated follow up. April 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

Key:
Risk Register
System Oversight Framework
Care Quality Commission

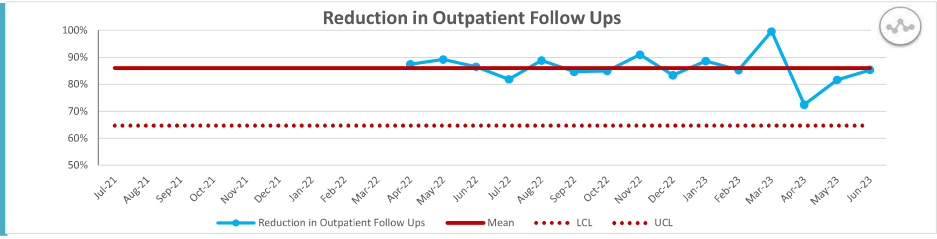
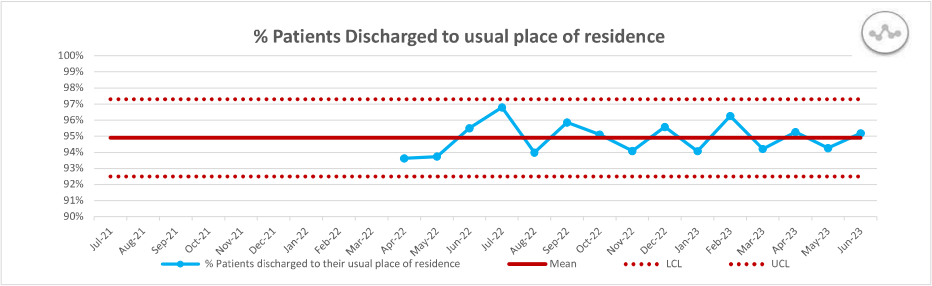
Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
59. Patients seen in the Fracture Clinic within 72 hours Target: 95%	The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	Issue of non-compliance addressed in-month.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
60. % patients referred to long COVID service not assessed within 15 weeks	The Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks for .		N/A - Not enough datapoints.		
61. 59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	88.19% of SDEC Emergency Admissions had a zero day length of stay.		Variation: Special Cause Variation of an improving nature		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
System Oversight Framework
Care Quality Commission

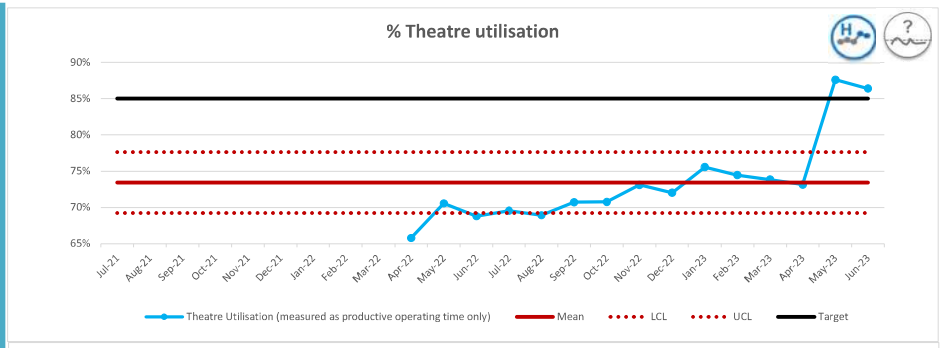
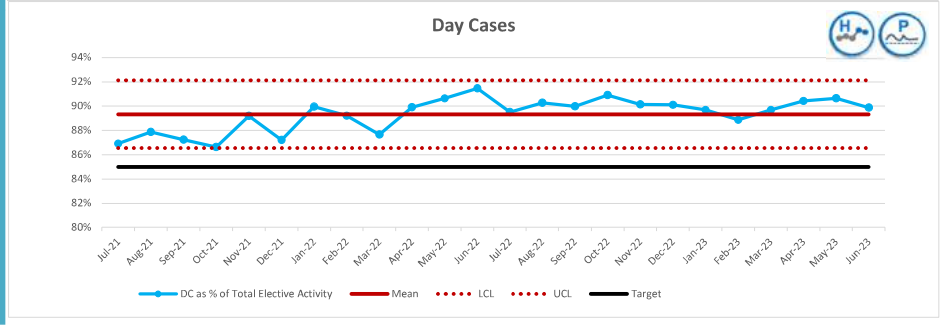
Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 85.35% of 19/20 activity in month.**		**Variation: Common Cause (Normal) variation.**		
64. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.19% patients in month who were discharged to their usual place of residence.**		**Variation: Common Cause (Normal) variation.**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
System Oversight Framework
Care Quality Commission

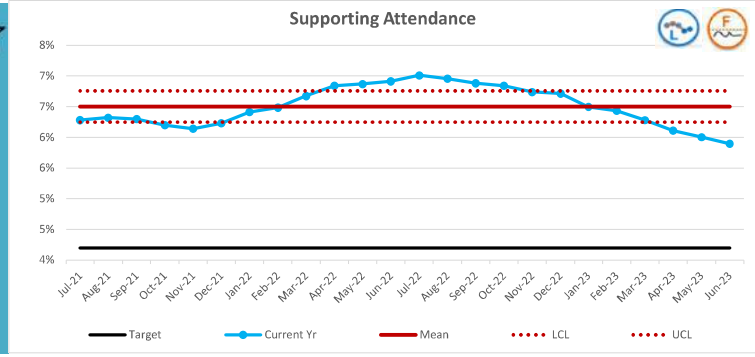
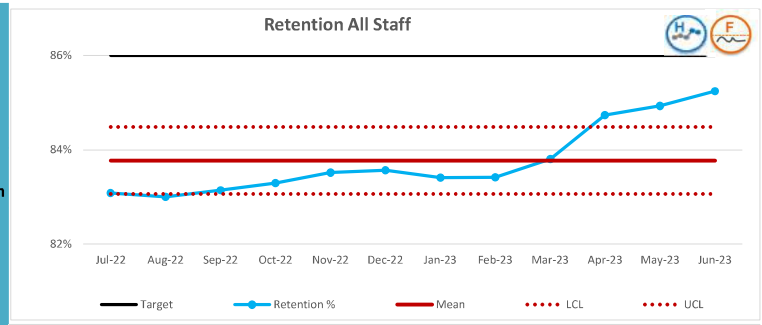
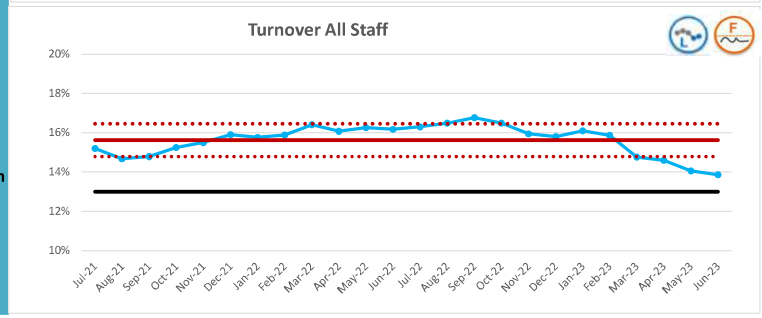
Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
65. Theatre Utilisation (measured as productive operating time only Target: 85%	86.4% Theatre utilisation in month (measured as productive operating time only). There were 89.89% Day cases, of total activity in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	Theatre Utilisation has improved in May 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 inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	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

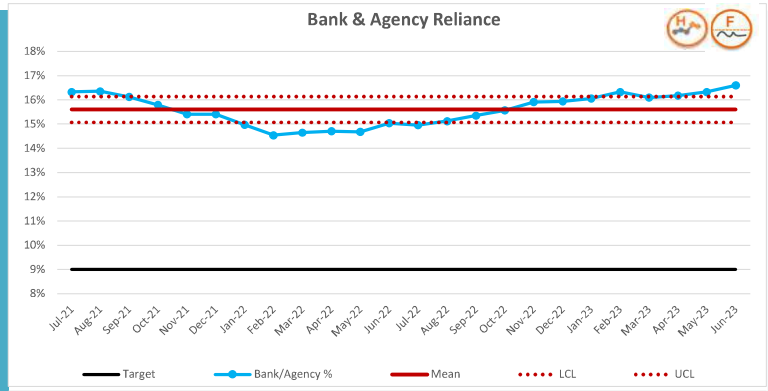
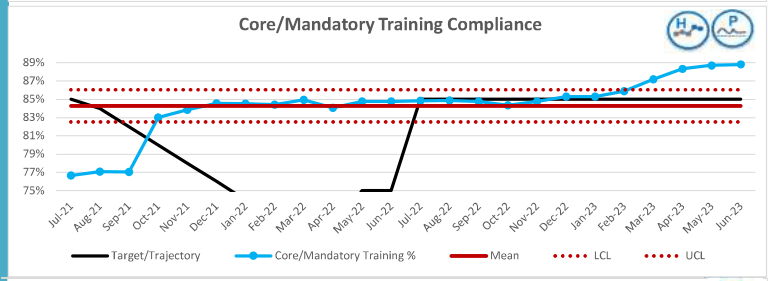
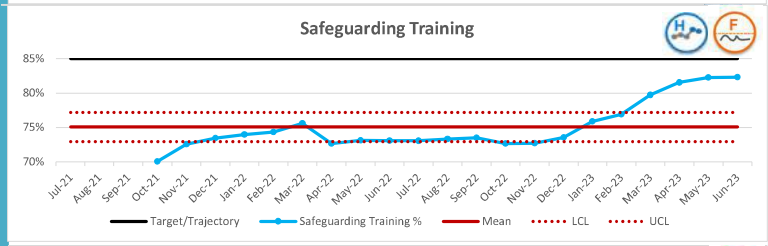
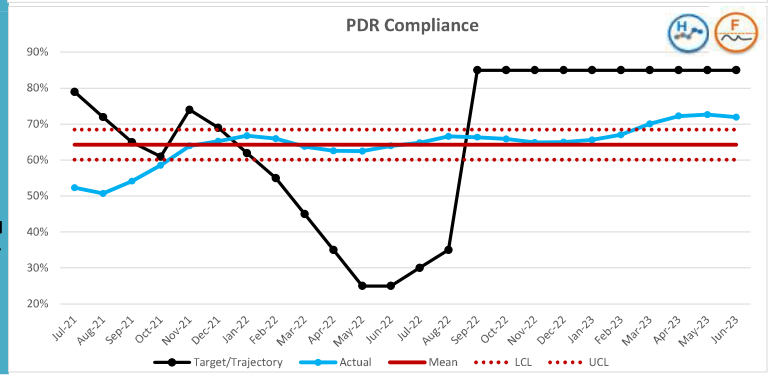
KEY:
- SOF: System Oversight Framework
- UoR: Use of Resources Assessment
- CQC: Care Quality Commission
- Trust Strategy
- Risk Register

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%** The Trust's sickness absence rate was 5.9% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence showing an Improving Variation. The annualised sickness absence percentage in June 2023 was 5.9%, a decrease from 6.1% in April 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.	The Trust implemented an updated Supporting Attendance policy in February 2022. Consequently, the Trust continues to see a significant improvement in long term sickness absence rates reducing from 4.4% in August 2022 to 3.6% in June 2023. The Occupational Health and Wellbeing, Mental Wellbeing Hub and HR Business Partnering team continue to meet on a regular basis to triangulate data relating to sickness absence to support bespoke interventions, such as the implementation of stress and resilience workshops for international recruits, directly responding to feedback received within the Staff Survey. In addition, the People Health and Wellbeing group meets regularly with line managers and leads from Care Groups to identify areas of best practice and facilitate shared learning on supporting the wellbeing of the workforce.
69. Retention **Target: 86%** Retention of all staff was 85.25% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Retention showing an Improving Variation. Retention of all staff in June 2023 was slightly below target at 85.25%, an increase from 84.7% in April 2023. Retention for permanent staff remains above Trust target in June 2023 at 89.62%.	Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving. 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 reviewind to inform future actions. 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.
70. Turnover **Target: Below 13%** Turnover of all staff was 13.86% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Turnover showing an Improving Variation. Turnover in June 2023 was 13.86%, a decrease from April 2023 which was 14.7%. Turnover of permanent staff in June 2023 was 12.85% which is below Trust target.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

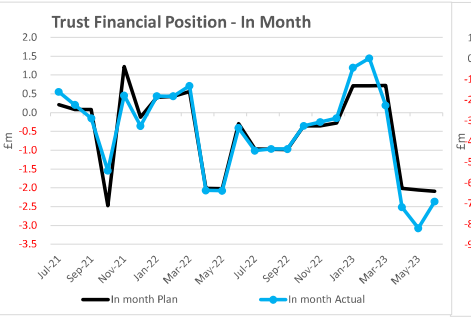
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
71. Bank and Agency Reliance Target: 9% or Below	Bank and Agency Reliance was 16.59% in month.		Assurance: The Trust consistently 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 June 2023 was 16.59% in June 2023 compared to 16.13% in April 2023. Reasons for the variation can be attributed to industrial action as well as continuing sickness absence, turnover and additional capacity.	The Resourcing Task and Finish group are developing robust processes to support compliance with national guidelines/standards for using temporary workers. All staff groups/CBUs will be monitored against these standards. Compliance is to be reported within the Medical and Nursing/AHP Workforce Groups and to FSC. A dashboard is being developed that will summarise workforce related intelligence to inform decision making regarding vacancies and temporary staffing. This will evolve to support the CBUs/staff groups to understand compliance gaps with national standards.
72.Core/Mandatory Training Target: 85%	Core/Mandatory training compliance was 88.81% 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 June 2023, CSTF Mandatory Training compliance was 88.81%, excluding Safeguarding Training (Children's and Adults); Safeguarding (Children's and Adults) compliance was 82.36%.	A Mandatory and Role Specific multi-disciplinary training panel continues to take place supporting SMEs to review and identify mandatory status. Changes have been made in terms of accessibility which has resulted in a slight increase in compliance. In order to respond to staff feedback regarding access to training, Learning and Development days have been established delivering training face to face and supporting staff to complete e-learning. Feedback is currently being evaluated in order to make further improvements. Further Learning and Development days are scheduled on a monthly basis until the end of the financial year.
73. Safeguarding Training Target: Trajectory	Safeguarding Training compliance was 82.32% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.		
74. PDR Target: 85%	PDR compliance was 71.95% in month. SPC - there is evidence of special cause variation for PDR compliance.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In June 2023, Appraisal compliance was 71.95%. In April 2023, Appraisal compliance was 72.26%. Currently Appraisal rates are below the trajectories but higher than 2022.	CBUs and Corporate Areas have been supported to develop trajectories and associated actions to improve PDR compliance, these continue to be monitored through the workforce governance structures and QPS. As a result of feedback from the Operational People Committee of improving appraisal compliance, updated paperwork to support career and PDR conversations is being developed aligned to the check-in conversation that was utilised during the pandemic and also the principles of the NHS Leadership Academy's Scope for Growth talent management tool. Pay progression has been implemented from 1st April 202 with one of the criteria for pay-affecting progression being an in-date appraisal which will continue to have an impact on compliance and meeting trajectories set within departments and teams.

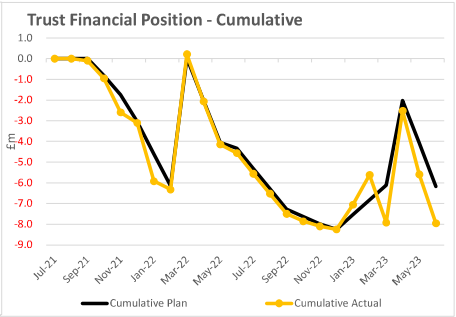
Warrington and Halton Teaching Hospitals NHS Foundation Trust

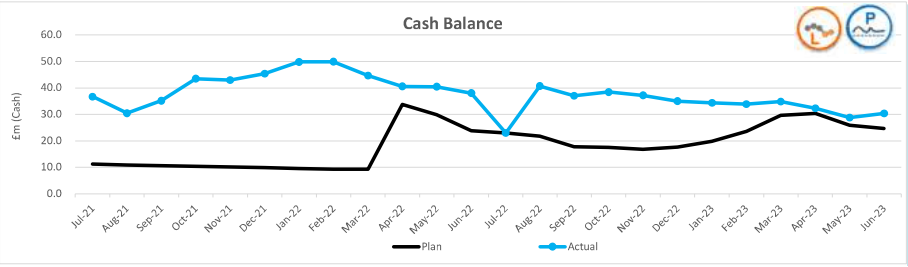
Finance and Sustainability - Trust Position

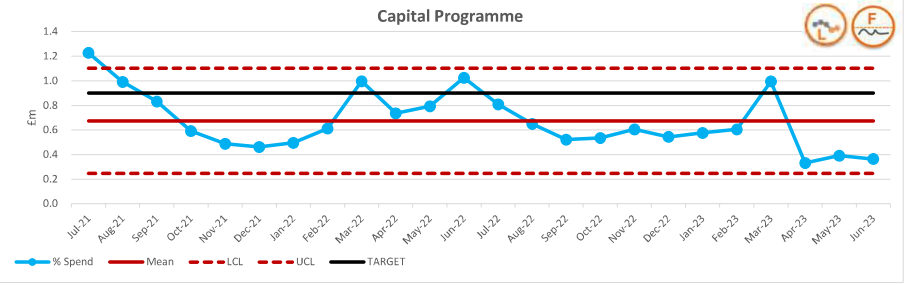
Key:
- SOF: System Oversight Framework
- UoR: Use of Resources Assessment
- RR116: Risk Register
- CQC: Care Quality Commission
- Trust Strategy

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 £7.95m at 30 June against a plan of £6.2m. The position includes ERF and £0.6m of assumed income to compensate for the impact of Industrial Action as advised by C&M ICS.**	**Assurance: The Trust inconsistently passes/fails the target.**	**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.**
76. Cash Balance **Target: On or better than plan**	**The cash balance as at 30 June 2023 is £30.39m.**	**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a concerning nature.**	**The current cash balance is £30.39m which is £5.8m better than the cash plan.**	**Payment of the creditors on receipt of invoices will get the cash back to plan.**
77. Capital Programme **Target: On plan 90%-100%**	**Capital expenditureat the end of month 3 is £2.31m against a plan of £6.34m.**	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**The underspend year to date of £4m is mainly due to the phasing of the capital plan.** **Medical equipment was expected to be delivered in the first quarter, due to supplier delays.** **Externally funded schemes are also behind plan at M3, in particular CDC which was profiled in 12ths whilst waiting for a detailed plan from cost advisors along with a subsequent delay due to an additional funding request.** **The monthly profile of the Trust plan has been updated to be more reflective of the expected position. With the updated profile, £3.66m was expected to be spent by 30 June 2023 giving a variance of £1.35m.**	**Medical equipment that was expected to be delivered in the first quarter is now expected in the second quarter. Following the delay due to an additional funding request, work with the contractors has now commenced and the majority of CDC expenditure is now expected in months 7 to 12.**





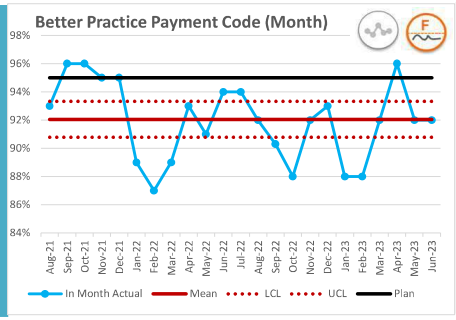
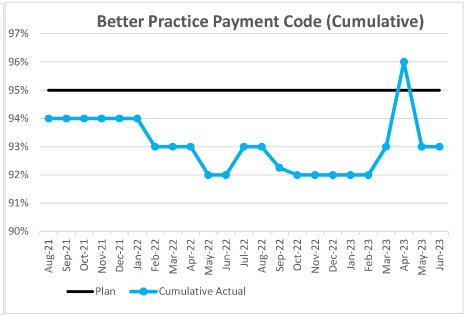
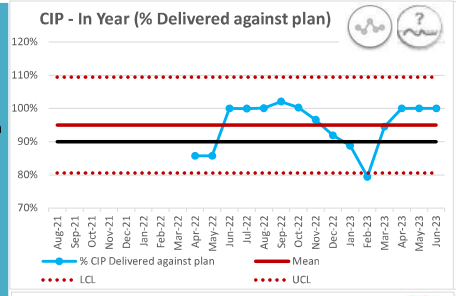
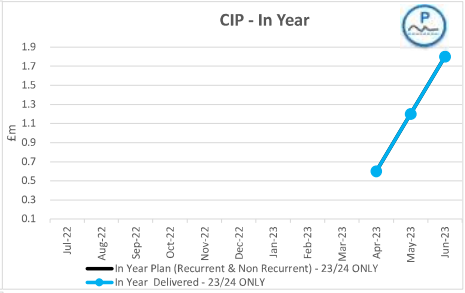
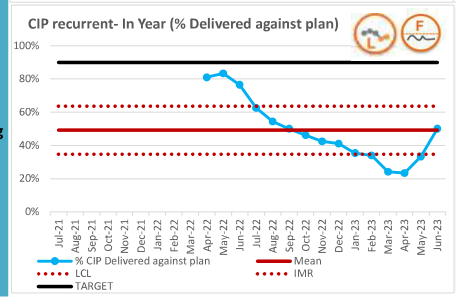
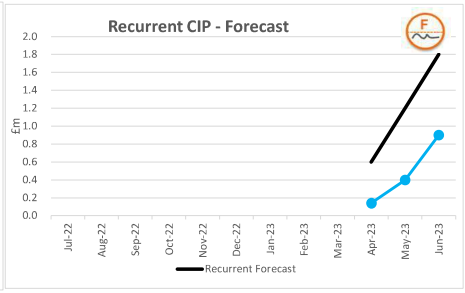
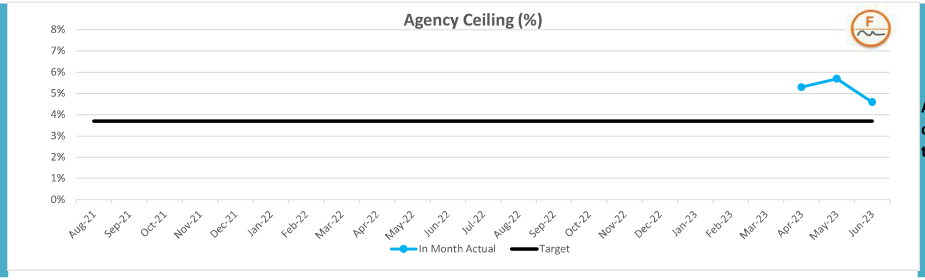




Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
- SOF System Oversight Framework
- UoR Use of Resources Assessment
- PR116 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%	UoR The Better Payment Practice Code performance based on volume for NHS is 83% and non-NHS is 93%. The Better Payment Practice Code performance based on value for NHS is 89% and non-NHS is 92%.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	Cumulative performance is 93.00% which is below the national target of 95.00%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.
79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date Target: >90% plan delivered YTD	UoR The month 3 CIP plan is £1.8m and £1.8m has been delivered.	 	Assurance: The Trust consistently passes the target.	78% of savings have been identified for 2023/24 which is £14m of the £17.9m target.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT programme with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust. The plan for 2023/24 continues to be developed for the £17.9m target.
80. Cost Improvement Programme (recurrent forecast) – In year performance to date Target: Recurrent Forecast is more than 90% of annual target	The Trust is in the process of identifying additional recurrent CIP schemes for 2023/24.	 	Assurance: The Trust consistently fails the target.	The Trust is working to identify additionall recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust. Of the £13.8m identified £5.6m is recurrent.	To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.
81. Agency Ceiling Target: Agency spend should not exceed 3.7% of total pay (ICS target)	UoR The Trust Agency spend in month is 4.6% against a target of 3.7%		Assurance: The Trust consistently fails the target.	The Trust Agency spend is above the agency ceiling due to industrial action open escalation areas and vacancies.	The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: - Agency controls best practice - Rostering compliance - Rate card compliance - Establishment Control compliance (or an alternative approach) - Unplanned absences - Recruitment activity

Appendix 3 – Trust IPR Indicator Overview

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

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

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

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

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

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

Appendix 4 - Statistical Process Control

1.0 What is SPC?

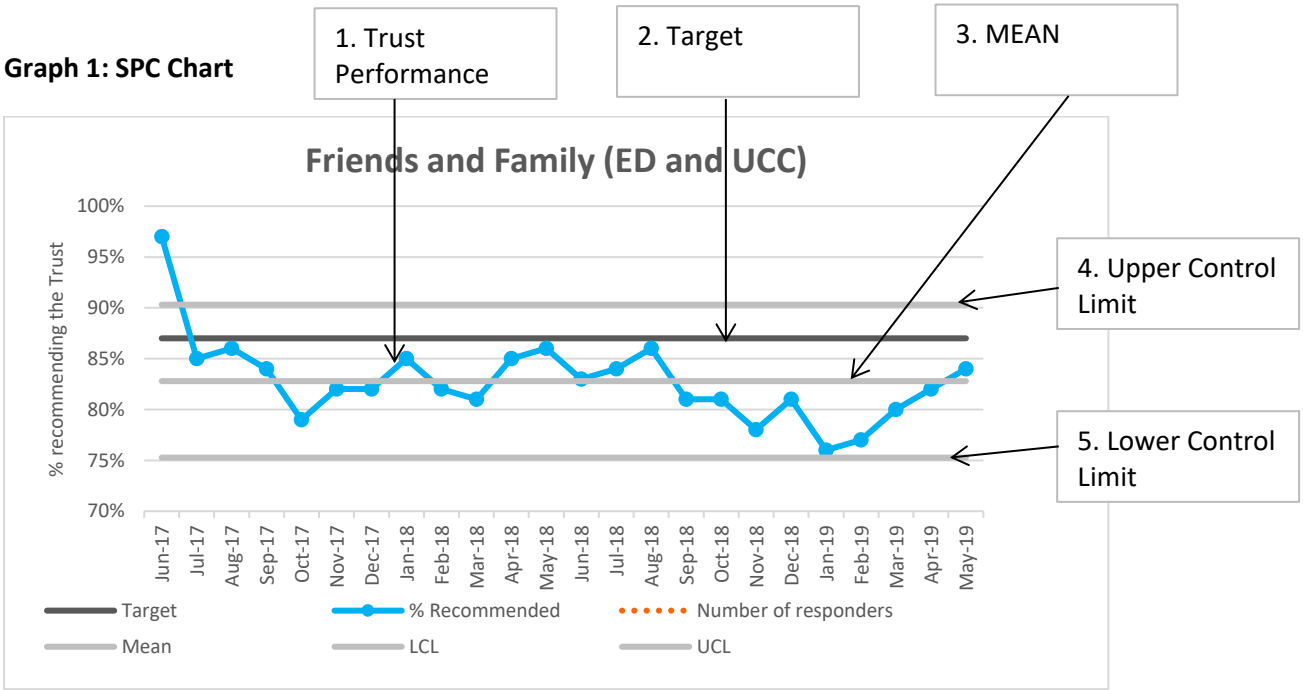
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

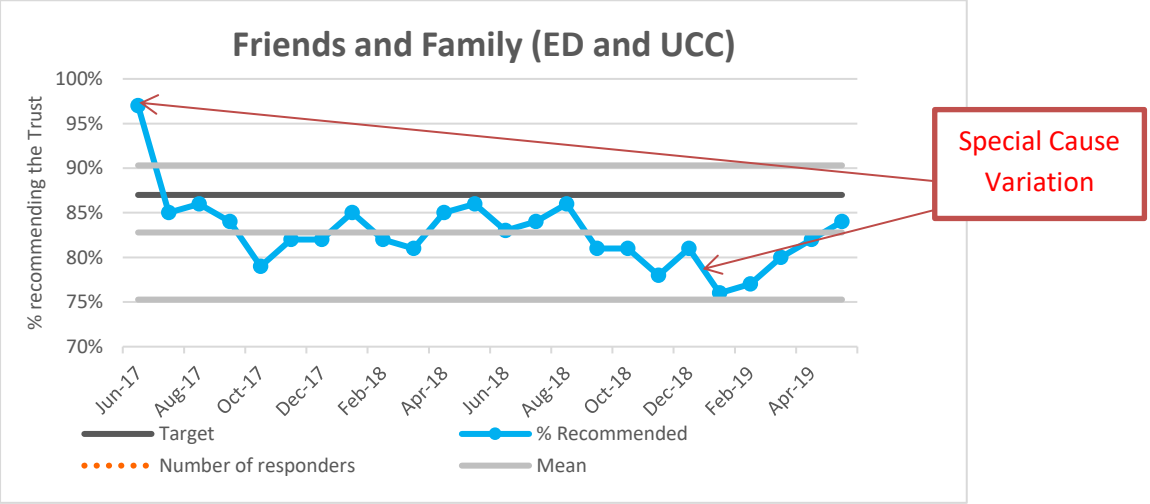


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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

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

Appendix 5: Income Statement, Activity Summary and Use of Resources Ratings as at 30 June 2023

Warrington & Halton Teaching Hospitals NHS Foundation Trust

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	**306,530**	**25,395**	**25,859**	**464**	**76,132**	**75,662**	**-470**
Non NHS Clinical Income							
Private Patients	8	1	1	0	2	3	1
Non NHS Overseas Patients	60	5	0	-5	15	10	-5
Other non protected	728	61	56	-5	182	146	-36
Sub total	**796**	**66**	**57**	**-10**	**199**	**159**	**-40**
Other Operating Income							
Training & Education	9,093	758	758	0	2,273	2,273	0
Donations and Grants	2,095	349	220	-129	1,048	455	-593
Miscellaneous Income	14,620	1,217	1,537	320	3,651	4,234	583
Sub total	**25,808**	**2,324**	**2,515**	**191**	**6,972**	**6,962**	**-10**
Total Operating Income	**333,134**	**27,785**	**28,431**	**646**	**83,303**	**82,783**	**-520**
Operating Expenses							
Employee Benefit Expenses	-246,746	-21,088	-21,472	-384	-63,217	-64,531	-1,315
Drugs	-20,191	-1,711	-1,839	-128	-5,133	-4,767	366
Clinical Supplies and Services	-22,298	-1,959	-2,259	-300	-5,851	-6,190	-339
Non Clinical Supplies	-38,134	-3,291	-3,608	-317	-9,734	-10,555	-822
Depreciation and Amortisation	-14,542	-1,119	-1,129	-10	-3,471	-3,377	94
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	**-341,911**	**-29,168**	**-30,306**	**-1,138**	**-87,406**	**-89,421**	**-2,015**
Operating Surplus / (Deficit)	**-8,777**	**-1,383**	**-1,875**	**-493**	**-4,103**	**-6,638**	**-2,535**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	25	25	0	30	30
Interest Income	518	86	153	67	333	446	113
Interest Expenses	-191	-16	-9	7	-48	-28	20
PDC Dividends	-5,679	-473	-473	0	-1,419	-1,419	0
Total Non Operating Income and Expenses	**-5,352**	**-403**	**-305**	**98**	**-1,134**	**-971**	**163**
Surplus / (Deficit) - as per Accounts	**-14,129**	**-1,786**	**-2,180**	**-394**	**-5,237**	**-7,609**	**-2,372**
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	-349	-220	129	-1,048	-455	593
Add Depreciation on Donated & Granted Assets	475	40	37	-3	119	111	-8
Total Adjustments to Financial Performance	**-1,620**	**-310**	**-183**	**126**	**-929**	**-344**	**584**
Adjusted Surplus / (Deficit) as per NHSI Return	**-15,748**	**-2,095**	**-2,363**	**-268**	**-6,165**	**-7,953**	**-1,788**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85a (i)		Trust Board	**DATE OF MEETING**	2nd August 2023

Date of Meeting	13 June 2023
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Ref	Agenda Item	Issue And Lead Officer	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/06/118	Hot Topic – GI Bleed & 7 Day Working in Gastroenterology	The Committee received a presentation which provided background on the position noting, the following key points: • JAG compliance requires 75%, WHH was sitting at 65% • Increasing the service to a 6/7 day service, to provide scoping at the weekends • a potential capital bid for transformation of endoscopy services • Capacity issues due to consultant establishment The Committee took some assurance on the actions in place and next steps to improve the position, including a Business Case for an additional Consultant which was awaiting approval and a longer-term plan for another Consultant. Both would support a move to a 7-day service.	The Committee received moderate assurance noting the actions in place and next steps	The business case for an additional consultant to be approved by the Executive Team.
QAC/23/06/119	Deep Dive – Ophthalmic	The Committee received the presentation in relation to an Ophthalmic Never Event that had happened during a glaucoma	The Committee received moderate assurance	SOP to be reviewed

	Never Event	surgery. Details were provided detailing the background, actions and recommendations. The Committee received assurance on the improvements to processes including the development of a Standard Operation Proceedure to mitigate any future Never Events of this nature. Further assurance was provided confirming the lessons learnt would be shared at the Clinical Network to encourage a system-wide approach.	noting the development of a SOP to mitigate future Never Events of this nature.	and approved
QAC/23/06/128	**Paediatric Audiology Incident Update**	The Committee received an update which included a summary of the current position and details on the actions for the remaining cohorts. The Committee received assurance on the progress against the actions identified and agreed the incident continued to be managed both robustly and compassionately. The Committee had sought and received assurance on levels of harm to date and noted that the outcomes of the remaining cohorts would be reported into the committee in due course. It was agreed that the updates to the Committee could move to bi-monthly.	**The Committee discussed the update and received moderate assurance on the progress to date.**	Reporting to move to bi-monthly QAC until sufficient assurance was received and reviews concluded.
QAC/23/06/133	**Patient Safety & Clinical Effectiveness Sub Committee**	The following item was discussed by the committee and highlighted as a risk. - National Hip Fracture Database Performance The Committee noted that the Trust was underperforming on the Best Practice Tariff Indicators for National Hip Fracture. The Committee were reassured of the ongoing monthly oversight of performance and delivery of plans as part of the Fragile Services agenda item in the Patient Safety and Clinical Effectiveness Subcommittee. However, a further Deep Dive was requested by	**The Committee discussed the fragility of the service agreeing a Deep Dive was required to provide sufficient assurance on measures to improve.**	Fractured Neck of Femur Deep Dive to be presented to the Committee in July

		the Committee to include details of the challenges, actions in place to improve and progress to date.		

The Committee also received the following items:

QAC/23/06/120 - Board Assurance Framework & Risk Register
QAC/23/06/121 - Committee Terms of Reference *(def from Apr)*
QAC/23/06/122 - Palliative Care & End of Life Bi-Annual Report
QAC/23/06/123 - Quality IPR Metrics
QAC/23/06/124 - Maternity Update

I. Ockenden Review Update
II. ATAIN Q4
III. Quarterly Transitional Care Audit

QAC/23/06/125 - Quarterly Maternity Safety & Experience
QAC/23/06/126 - Medicines Management Annual Report
QAC/23/06/127 - Controlled Drugs Annual Report
QAC/23/06/129 - Complaints Annual Report
QAC/23/06/130 - Quality Strategy Annual Report
QAC/23/06/131 - Quarterly Priorities Report Q4
QAC/23/06/132 - In-Patient Survey & Action Plan
QAC/23/06/133 - Patient Safety & Clinical Effectiveness Sub Committee Exception Report
QAC/23/06/134 - High level enquiries & External Assessment / Inspections (when notified)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85a (ii)		Trust Board	**DATE OF MEETING**	2nd August 2023

Date of Meeting	11 July 2023
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Ref	Agenda Item	Issue And Lead Officer	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/07/142	**Hot Topic – Fragile Services**	The Committee received a presentation which provided background and explained the need for a systematic oversight mechanism for Fragile Services, criteria and features, governance and reporting routes and recommendations to drive robust oversight. The areas covered included; • Paediatric Ophthalmology • Urology (Renal/Ureteric Stones) • Histopathology The Committee received a moderate level of assurance on actions, it was agreed that Deep Dives would be presented relating to Urology and Gynaecological Surgery in August and September.	**The Committee received moderate assurance noting the actions in place and next steps**	Deep Dives to be presented in relation to Urology and Gynaecological Surgery.

QAC/23/07/143	**Deep Dive – Fracture Neck of Femur (#NOF)**	The Committee received the presentation in relation to Fracture #NOF which provided background to the deterioration in a number of key performance metrics, and incidents in relation to pre and particularly post operative care of patients. The Committee received details around the challenges faced. The Committee received assurance on the recent progress made in regards to Orthogeriatric provision and also the plans and actions required around timely access to ward and theatre. The Committee were reassured of the governance and reporting mechanisms to ensure oversight of fragile services through PSCESC.	**The Committee received moderate assurance noting the action plans in place.**	A further update be provided to the meeting in October.
QAC/23/07/145	**Patient Safety & Clinical Effectiveness Sub-Committee (PSCESC)**	The following items were highlighted for escalation and were discussed by the Committee: I. Fragile Services Update – was provided in Hot Topic item QAC/23/07/142, in addition the committee discussed: • De-escalation of Diabetic Foot Clinic as a Fragile Service • Updated PSCESC Terms of Reference to include new Fragile Services section including monthly updates. II. CQUiN relating to Cancer Diagnosis - reflected several issues with other pathways III. Safety Profile in Operating Theatres – further focus on robustness of auditing IV. The Trust annual Pseudomonas aeruginosa threshold reached in month two V. NEWS2 performance in the Emergency Department	**The Committee received moderate assurance in relation to the areas highlighted.** **The Committee approved the revised PSCESC Terms of Reference.**	
QAC/23/07/146	**Patient Safety Incident Response**	The Committee received a report which set out the policy plan and update in relation to PSIRF, it was noted PSIRF would replace the Serious Incident Framework (SIF).	**The Committee noted the progress against the project plan and the clear timeline set**	Details of further PSIRF training to be circulated to

	Framework (PSIRF)	The Committee took assurance that the Trust was progressing through the final stages of implementation of the framework and also the development of the policies and plan. The Committee approved the Patient safety incident response policy, Patient Safety Partner Involvement Policy and the Patient Safety Incident Response Plan.	**by the ICB for implementation.**	Committee members.
QAC/23/07/157	**Arbury Court**	The Committee received a verbal update in the continued work with Arbury Court noting the progress on actions. The committee received reassurance that good working relationships had been forged and meetings would continue on a quarterly basis.	**The Committee received assurance on the progress to date and continuation of meetings with Arbury Court to improve quality and safety .**	Future updates be presented to the Committee on a quarterly basis.

The Committee also received the following items:

QAC/23/07/144 – Committee Chairs Annual Report
QAC/23/07/147 – Maternity Update
i Ockenden Review Update
ii Maternity Incentive Scheme Year 5 – Overview of Requirements
QAC/23/07/148 – Saving Babies Lives (SBLCB)
QAC/23/07/149 – Learning from Deaths Q4
QAC/23/07/150 – Nursing & Midwifery Strategy
QAC/23/07/151 – Safeguarding Annual Report (***Hot Topic – Mental Health to be presented to August Committee***)
QAC/23/07/152 - Director of Infection Prevention and Control (DIPC) Annual Report
QAC/23/07/153 - Infection Prevention Control BAF – Bi-Annual Update
QAC/23/07/154 - Health & Safety Annual Report
QAC/23/07/155 – Clinical Audit Annual Report
QAC/23/07/156 – Risk Management Annual Report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85b(ii)	MEETING:	Trust Board	DATE OF MEETING	2nd August 2023

Date of Meeting	21st June 2023
Name of Meeting & Chair	Julie Jarman, Strategic People Committee,
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/06/77	**Hot Topic – Band 2 to Band 3 Consultation Update**	The Committee received a presentation on the current position and the impact on the Trust. The next steps were noted: • Continue with planned consultation – back pay to be considered under separate process. • Consultation closed and now considering expressions of interest and feedback. • Continue support for HCSW staff. • Continue ongoing offer to meet with Unison staff.	**The Strategic People Committee noted and discussed the presentation and received a good level of assurance.**	**As requested.**
SPC/23/06/78	**Deep Dive – Mandatory Training**	The Committee received a presentation on the latest position for the Trusts mandatory training which concluded: • Compliance with mandatory training is improving month on month. • Mandatory training is not a 'nice to do', it all has legislative requirements.	**The Strategic People Committee noted the presentation and received a good level of assurance.**	**As requested.**

		• The Trust is listening to staff and their requirements. • Huge amount of intelligence available for leaders, individuals and Subject Matter Experts via the Trust's compliance dashboard. • Subject Matter Experts specific dashboard used to target areas of low compliance. • Increasing ask of staff with regards to Mandatory Training and therefore need to be mindful about future requests.		
SPC/23/06/80	**Chief People Officer Report**	The Committee received a report providing an update on the following key areas: • Update on Industrial Action • Celebrating Success • Cheshire and Merseyside Resilience Hub • AfC Pay Award and NHS Pension Thresholds The Committee noted the Industrial Action by Junior Doctors and plans being led by the Medical Director.	**The Strategic People Committee noted the report and the actions being taken to mitigate the risks arising from Industrial Action**	**As requested.**
SPC/23/06/81	**Workforce Equality, Diversity and Inclusion Strategy Update**	The Committee received the report which provided an update and assurance on the progress made in the delivery of the Workforce Equality, Diversity and Inclusion Strategy 2022-2025. In addition, the paper provided an overview of the NHS Equality, Diversity and Inclusion Improvement Plan published in June 2023. The Committee approved the recommendation to align reporting of the NHS Equality, Diversity and Inclusion Improvement Plan to SPC via the bi-annual Workforce Equality, Diversity and Inclusion (EDI) Strategy update, with oversight of delivery of the plan by the Workforce EDI Sub-Committee.	**The Strategic People Committee received and noted the assurance provided and the number of actions required regarding workforce EDI.**	**December 2023**

SPC/23/06/83	**Facilities Time Off – Annual report**	The Committee received the report with the data to be published relating to time spent on Trade Union facility time and activity for 2022-2023. The report outlined the activity and expenditure summaries, and the Trust is compliant and within set targets for these.	**The Strategic People Committee noted the contents of the report and approved the report to be published.**	**Annual.**
SPC/23/06/84	**Staff Opinion Survey – Summary of Care Groups and CBUs**	The Committee received the detailed report which provided an overview of the Staff Survey results by Care Group and CBU where available. The paper outlined the key priorities for each Care Group or department, where finalised, to respond to staff feedback.	**The Strategic People Committee members noted the contents of the report and the progress being made to support priority setting in response to staff feedback.**	**Annual.**

The Committee also received the following items:

Matters to Note for Assurance:
SPC/23/06/76 – Board Assurance Framework and Corporate Risk register
SPC/23/06/79 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
SPC/23/06/82 – Trust Board Monthly Staffing Report
SPC/23/05/68 – Guardian of Safe Working Hours Report – Q4

Sub-Committee Chairs Logs:
SPC/23/06/85 – Nursing and AHP Workforce Resourcing Group (01.06.2023)
SPC/23/06/86 – Operational People Committee (12.06.2023)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85b (i)	MEETING:	Trust Board	DATE OF MEETING	2nd August 2023

Date of Meeting	19th July 2023
Name of Meeting & Chair	Strategic People Committee, Julie Jarman
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/07/92	**Staff Story – Your Future, Your Way**	The Committee received a presentation relating to 'Your Future, Your Way', a programme that had been developed to support the career development of our global majority Nurses, Midwives and Allied Health Professionals. Staff also attended to tell their story. Further discussion took place in relation to recruitment and the difficulties that people may face when completing applications and during interviews, and that this needed to be reviewed in order to ensure there was equity when applying for promotions and that staff were not disadvantaged at any stage of the process.	**The Strategic People Committee noted the Staff Story and discussed and provided feedback in relation to the recruitment process needing review.**	**As requested.**
SPC/23/07/93	**Deep Dive – E-Rostering**	The Committee received a presentation which provided the background and context to E-Rostering. Members were then set up in groups for breakout discussions relating to feedback on E-Rostering. All feedback was presented by a member from each group, and this was captured to be fed into the agile / flexible working programme of work.	**The Strategic People Committee noted the presentation and discussion and further work required to support**	**As requested.**

			agile / flexible working.	
SPC/23/07/94	**Chief People Officer Report**	The report provided an update relating to the following key areas: · Update on Industrial Action · NHS 75th Birthday · National Pay Award and Bank Staff · National Workforce Plan Summary The Committee noted the industrial action that was taking place and that Consultants would be striking 20th – 21st July with Trust plans being led by the Medical Director.	**The Strategic People Committee noted the report and the actions being taken to mitigate the risks arising from Industrial Action**	**As requested.**
SPC/23/07/95	**Guardian of Safe Working Annual report**	The Committee received the report which details exception reporting activity and financial implications. The overall number of exception reports has increased compared to previous years as we are seeing the result of increased Junior Doctor engagement and education with regards to the exception reporting process. Exception reporting reduced significantly during the pandemic and therefore, we are now beginning to see true post pandemic levels of exception reporting.	**The Strategic People Committee noted the contents of the report and approved the Annual Report.**	**Annual.**
SPC/23/07/97	**Gender Pay Gap Report**	The Committee received the report which includes the Gender Pay Gap for 2022/23 with data effective as of 31st March 2023, and also a revised action plan for addressing the gender pay gap at WHH following the approval of the 2021/22 action plan in February 2023.	**The Strategic People Committee approved the Annual Report and noted the actions required to address the gender pay gap.**	**Annual.**

The Committee also received the following items:

Matters to Note for Assurance:
SPC/23/07/96 – Workforce IPR
SPC/23/07/98 – Trust Board Monthly Staffing Report
SPC/23/07/99 – People Policies and Procedures Overview Report Q4

Sub-Committee Chairs Logs:
SPC/23/06/85 – Nursing and AHP Workforce Resourcing Group (21.06.2023)
SPC/23/06/86 – Workforce Equality, Diversity and Inclusion Sub-Committee (04.07.2023)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85c (i)		Trust Board	**DATE OF MEETING**	2 August 2023

Date of Meeting	28 June 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/06/46	**Hot Topic - Discharge**	The Committee received the presentation noting:- • The impact on NCTR today and plan to further reduce. • The 2022/23 internal and external schemes partly funded by the £2.5m contributed to the Adaptive Reserves. • Discharge facilitators role (Also known as Transfer of care) • Transfer of Care hub is moving towards 7 day working • Differences between Halton and Warrington systems were discussed	The Committee **noted** the presentation receiving **good** assurance	
FSC/23/06/47	**Deep Dive – Surgical Specialties**	The Committee received the presentation noting:- • GIRFT efficiencies supporting the delivery of the activity target • Theatre efficiency 87.7% working to increase to 90% • The risk to achieving the planned activity target • Challenge across the NHS in relation to productivity post pandemic Considering the realignment of resources to support achieving the activity target	The Committee **noted** the presentation receiving **moderate** assurance	

FSC/23/06/49	**Corporate Performance Report**	The Committee received the presentation noting:- • ED performance is at 70.98% which is a slight increase on last month. • Extra bank holiday in May had an impact and A10 and B4 were open in May • Staffing corridors improve Ambulance turnaround but at a cost to the Trust (performing well on 15 minute and 30 minute ambulance handover) • Waiting List at 459 patients continues to grow linked to cancellation due to Industrial Action • 65 week trajectory is 51 worse than plan • Cancer expect to be compliant for June 2023 • Quality aspects are discussed in Quality Committee	The Committee **noted** the presentation receiving **good** assurance	**FSC July 2023**
FSC/23/06/50	**Pay Assurance Report**	The Committee received the report noting • Agency – continues to be managed and processes are being reviewed. The climate of industrial action is driving the usage of agency along with the acuity of patients • A benchmarking review and deep dive is underway to minimise nursing agency usage. This is owned locally in the Care Groups and is reporting through FRG • Two types of agency - NHSP controlled agency is driving down the costs and PLUS US / Patchwork contract for medical agency which will be reporting primarily to FSC • Off Framework agency requirements are being managed and usage has been limited over recent months • At the last FRG meeting the Care Groups shared their agency usage and plans to reduce it. It was highlighted that Unplanned Care Group is the main user of agency and they explained the deep dive they are undertaking. In addition Planned Care who are low user have been asked to turn off agency completely	The Committee **noted** and discussed the report, receiving **good** assurance	**FSC July 2023**

FSC/23/06/51	**Monthly CIP report**	The Committee received the report noting:- • CIP overview at month 2 the £1.2m target was achieved • Highlighted next steps for monitoring of the schemes • Discussed the ICS expectations of controlling expenditure • An update on the GIRFT Schemes • The impact of industrial action on the GIRFT progress as the planning for AI utilises significant capacity to plan for the IA as well as the days lost	The Committee discussed and **noted** the report and presentation receiving **moderate** assurance.	**FSC July 2023**
FSC/23/06/52	**Cost Pressures**	The Committee received the report noting:- • The risk of overspending on cost pressures and development on the Trust financial plan • The Executives and Deputies are undertaking a review on 30 June 2023	The Committee discussed and **noted** the report and presentation receiving **moderate** assurance.	**FSC July 2023**
FSC/23/06/54	**Mortuary update**	The Committee received the report noting:- • MIAA findings highlighted that the scheme exceeded budget • MIAA believes the updated processes if followed would have prevented this • Project risk registers to be implemented • The annual audit plan will be amended to incorporate to verify the adoption of the updated processes	The Committee discussed and **noted** the report receiving **moderate** assurance.	**Audit Committee will receive update following future audit of processes**
FSC/23/06/56	**Finance Report**	The Committee received a report noting:- • The month 2 position is off plan by £1.5m with deficit £5.6m • Two main drivers of the position - £0.7m Industrial Action expenditure and PBR income reduction relating to activity below plan, this assumes catch up on coding • Pay in particular ED staffing is a challenge. A review is being undertaken to ensure additional staffing costs are minimised • Revenue requests supported by the Executive Team are highlighted in the report	The Committee discussed the paper **noting** the emergency capital requests.	**FSC July 2023**

		• Risks include CIP in particular proportion of non recurrent, the pace of unplanned care CIP schemes and the impact of industrial action on CIP/GIRFT scheme planning and delivery. Cost Pressures and income linked to activity are also a concern. Risk of escalation areas being reopened and a corresponding increase in agency costs		
FSC/23/06/57	**Capital Position**	The Committee received a presentation noting:- • Schemes over £500k reviewed Catering, ED CT Scanner, Pharmacy Robot, Network IT scheme split over 2 years, Warrington Town Deal monies will be drawn down as required • Catering is now out to tender and 3 site visits have taken place, tender responses are due in mid July followed by 2 week review. The scheme is on track. • CDC phase 2 has experienced a cost increase, and funds previously ring fenced for this scheme have been requested and supported, therefore the scheme is no longer on pause. Risks to the whole project were discussed. • TIF - highlighted the increase in square meter and estimated worst case cost per square meter which present a risk to delivery. A number of mitigations are being explored ahead of the detailed costs being provided next month	The Committee **noted** the update and the risks.	**FSC July 2023**

Papers for Approval
N/A

Papers to Discuss and Note for Assurance
FSC/23/06/48 Board Assurance Framework
FSC/23/06/52 capital group annual report
FSC/23/06/53 annual capital report
FSC/23/06/55 Benefits realisation

FSC/23/06/33 Committee Chair’s Annual Report to Board
FSC/23/06/58 Costing / SLR
FSC/23/06/59 Digital Strategy Group

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85c (ii)		Trust Board	**DATE OF MEETING**	2 August 2023

Date of Meeting	26 July 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/07/66	**Hot Topic – Richard Barker Letter**	The Committee received the presentation noting:- • The request from the Richard Barker / Graham Urwin Letters • The key metrics in the letter link to performance, workforce, and finance and the presentation set out the Committee or the meetings where oversight and scrutiny takes place to an appropriate level of detail. The updated FSC performance report is under revision and will clearly demonstrate the requirements set out in the letter. • The response letter will be submitted by 31 August after review by Board and Committee. • All teams felt it was a useful check and were satisfied most areas are covered with some minor areas to follow up which are in train and will be completed by 31 August 2023. • Concerns if decisions taken out of the Trust it would be difficult to manage risks due to delays.	The Committee **noted** the presentation receiving **moderate** assurance	

		• First draft of a 3-5 year recovery plan was presented and discussed		
FSC/23/07/67	**Deep Dive – Agency**	The Committee received the presentation noting:- • NHSP is prioritised over agency • Reduction in agency for AHPs and midwives for Q1 • Comprehensive Agency Managed Services (CAMS) has reduced the cost per hour • Improved recruitment drive and over recruitment to reduce agency costs further • Working to move regular staff from agency to NHSP (bank) – in particular A&E, Theatres and ICU • All the schemes are monitored through an agency reduction action plan • Risk based approach and senior oversight of agency booking	The Committee **noted** the presentation receiving **moderate** assurance	
FSC/23/07/69	**Corporate Performance Report**	The Committee received the presentation noting:- • ED performance is at 68.74% which is a slight decrease on last month. • Working with NWAS on ambulance turnaround • ED is in Tier one resulting in Esist and GIRFT urgent care programme team visits in August • Utilisation of SDEC discussed, the Trust percentage of admissions from SDEC is similar to the national average • The DNA rate has increased and work is underway to review the reasons • Clinic utilisation is improving • Cancer (May 23) 62 day continues to improve • Waiting list growth continues and is linked to the impact of IA • The impact on patient care waiting longer is captured at Quality Assurance Committee. Patient safety and clinical effectiveness meeting looks at significant risk areas.	The Committee **noted** the presentation receiving **good** assurance	**FSC August 2023**

FSC/23/07/70	**Pay Assurance Report**	The Committee received the report noting:- • Controls are in place for bank and agency for vacancies and sickness • Off Framework agency requirements are being managed and usage has been limited over recent months – ICU and ED • In the FRG meeting the Care Groups review their agency usage and highlight plans to reduce it • More work to be done using existing resourcing groups to ensure controls are robust	The Committee **noted** and discussed the report, receiving **good** assurance	**FSC August 2023**
FSC/23/07/71	**Monthly CIP report**	The Committee received the report noting:- • CIP overview at month 3, the £1.8m target year to date was achieved • Highlighted the next steps for monitoring of the schemes • An update on the GIRFT Schemes • Good progress on identifying recurrent CIP however more to do or this will present a challenge to delivery in this year and impact on financial recovery	The Committee discussed and **noted** the report and presentation receiving **moderate** assurance.	**FSC August 2023**
FSC/23/07/73	**Cost Pressures**	The Committee received the report noting:- • The risk of overspending on cost pressures and development on the Trust financial plan • The Executives and Deputies continue to review the pressures and mitigations with further discussions on the 28 July 2023	The Committee discussed and **noted** the report and presentation receiving **moderate** assurance.	**FSC August 2023**
FSC/23/07/74	**EPCMS OBC**	The Committee received the OBC for EPCMS noting:- • Changes to the procurement route • Changes to the benefits highlighted, along with profile of funding and timescales • Discussed the potential risks • Discussed the expected go live date enabling full use of funding	The Committee discussed and **supported** the OBC receiving **good** assurance.	**Trust Board August 2023**
FSC/23/07/75	**Finance Report**	The Committee received a report noting:- • The month 3 position is off plan by £1.8m with deficit £7.95m • Two main drivers of the position - £0.9m Industrial Action expenditure and ED nursing pressures	The Committee discussed the paper **approving** the capital request.	**FSC August 2023**

		• ICS position £75m deficit against £55m plan, forecast deficit plan of £51m • ED capacity and staffing is a challenge, a further paper on the agenda • Revenue requests supported by the Executive Team are highlighted in the report • Capital is behind plan, the majority is on external schemes. • Approval of capital funding for a scope requested from the Committee.		
FSC/23/07/76	**Medical Staffing Review**	The Committee received a presentation noting:- • Significant work undertaken to provide high level information on a monthly basis • Full e-rostering from August will enable productivity to be added to the reports • High cost agency in planned care will be looked at – Care Group have been asked to look at their top 3 issues	The Committee approved the Terms of Reference and **noted** the content of the paper.	
FSC/23/07/77	**Revenue Requests – ED Nursing**	The Committee received a presentation noting:- • Approval by the Executive Team of a first phase of ED nursing staff to release the £450k ring fenced during budget setting • This supports reduction in agency and improvement in patient care in an escalated ED	The Committee **noted** the revenue request	**Trust Board August 2023**
FSC/23/07/78	**Capital Position**	The Committee received a presentation noting:- • Additional capital secured in May for enabling works 4 NOUS rooms and in June for CDC • Under spend on capital year to date, changes to profile for CDC are one of the reasons for this • Digital capital ringfencing to support the profiling of the EPCMS scheme was supported • Schemes over £500k reviewed Catering, MRI, CT Scanner, ED CT Scanner, Ultrasound extension, Induction of Labour, Pharmacy Robot, Network IT	The Committee **noted** the update and the risks, **approved** the changes to the capital contingency and **supported** the proposal to manage the Trust's phasing of IT capital to support the EPCMS project.	**FSC August 2023** **Trust Board August 2023**

		• Warrington Town Deal due for completion November • CDC funding request and phasing supported, MOU signed • TIF - final costs in the next week, will report to next FSC • The Trust has expressed an interest to be a Cheshire Endoscopy hub, no commitment at this stage, awaiting decision from CMAST for 2 shortlisted organisations to go to full business case		

Papers for Approval
FSC/23/07/74 EPCMS update

Papers to Discuss and Note for Assurance
FSC/23/07/68 Board Assurance Framework
FSC/23/07/72 Emergency Preparedness Annual Report
FSC/23/07/79 Digital Strategy Group

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/08/85 (d)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	02 August 2023

Date of Meeting	21 June 2023
Name of Meeting & Chair	Audit Committee Year End, Chaired by Michael O' Connor
Was the meeting quorate?	Yes

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

Agenda Reference	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/mandate to receiving body	Follow up/ Review date
AC/23/06/42	**External Auditors Findings Report on 2022-23 Accounts IAS 260 Memorandum including. Management Letter of Representation to Grant Thornton (Head of External Audit Opinion Statement)**	The Committee received the report, which summarised the key findings and other matters arising from the statutory audit of the Trust and the preparation of the Trust's financial statements for the year ended 31 March 2023 for those charged with governance. The outstanding areas were listed within the report. It was noted that auditing work was ongoing but close to finalising within the coming week, following a few areas of final testing, it was anticipated that the audit report opinion would be unmodified. Auditor's Annual Report for the year ended 31st March 2023 - The Committee received and discussed the report which highlighted 6 recommendations.	**The Committee noted the updates and approved the contents of reports subject to minor amendments**	receipt of the Auditors final opinion, for inclusion in the 2022/23 Annual Report submission**.**

AC/23/06/43	**Presentation of the Draft 2022-23 Annual Report**	The Committee noted the updates and approved the Annual Report 2022/23 for submission to NHSE following some minor amendments.	**The Committee approved the Annual Report 2022/23 for submission to NHSE**	n/a
AC/23/06/44	**Final Accounts**	The Committee received the which detailed the amendments that had been made since draft unaudited accounts 2022/23 were presented to the Audit Committee on 27 April 2023. The Committee agreed that that should there be any additional changes that do not impact on the draft audit opinion, the Audit Committee would be asked to support approval of any further amendments on the committee's behalf by the Chair of the Audit Committee and disclosed to the committee by email.	**The Audit Committee reviewed and supported the draft 2022/23 Annual Accounts**	n/a
AC/23/06/46	**Quality Account**	The Committee received report, it was explained that In line with legal requirements, Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce and publish their Quality Accounts for the 2022-2023 financial year by 30 June 2023. It was noted that NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report, instead a separate Quality Account is produced.	**The Audit Committee reviewed and approved the Quality Account on behalf of the Trust Board.**	n/a
AC/23/06/47	**Code of Governance Compliance**	The Committee received the report which provided assurance that as 31st March 2023, the Trust was able to evidence its compliance with all principles of the NHS Foundation Trust Code of Governance.	**Approved the declaration of compliance with the provisions of the Code in the Annual Report 2022-23**	n/a

AC/23/06/48	**Compliance with Licence Annual Return - completion of FT4 Declaration**	The Committee received the report which detailed the requirements of NHS FTs to self-certify whether or not they have complied with the conditions of the NHS provider licence. It was noted that now that the FT4 declaration was approved it would be published on the Trust website and shared with the Council of Governors.	**The Audit Committee approve the confirmed declarations and confirmed that no material risks had been identified as described.**	n/a

Other items included on the agenda were:
AC/23/06/45 - Trust Accounts Consolidation Certificate & TAC Confirmation Schedules

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/86i**	
SUBJECT:	**Maternity Update Ockenden Report**	
DATE OF MEETING:	2nd August 2023	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
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..	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates. In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 31st May 2023 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 95.76% compliant and is on trajectory to be 100% compliant by 31st December 2023. • **Ockenden 2**: WHH is 73.97% compliant (previously 69.86% at the end of April 2023) and is on trajectory to be 100% compliant by 30th November 2023. This trajectory was impacted by the cancellation of a 6-month High Dependency Training Programme scheduled to start in October 2022 for Band 7 staff. Training has now commenced on 5 June 2023 for 6 months to end November 2023. • Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023.	
PURPOSE: *(please select as appropriate)*	Information ✓ | Approval | To note ✓ | Decision	
RECOMMENDATION:	The Trust Board is requested to note the findings of this paper for information.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee

	Agenda Ref.	QAC/23/07/147
	Date of meeting	11th July 2023
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/23/08/86

1. BACKGROUND/CONTEXT

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

RAG

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring
LMNS	LMNS action
Duplicate	Action duplicated/combined with another action
BN Issue Log	Transferred to BN Issues Log

2. KEY ELEMENTS

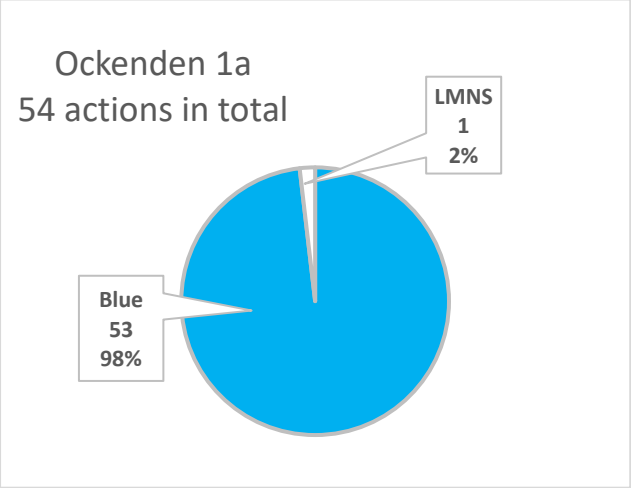
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

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

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

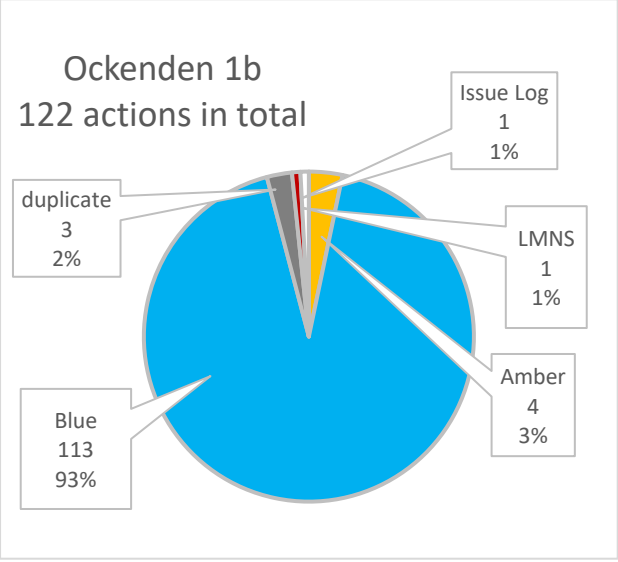
No change from previous month.

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



Update

4 Amber (previously 1): -
On track to move to green by end Dec 2023

0 Green (no change)

113 Blue (no change)

1 – Action not for WHH

3 Duplicate – actions combined as refer to appointment of 11th Consultant who will take on the role of Lead Obstetrician in Fetal Surveillance

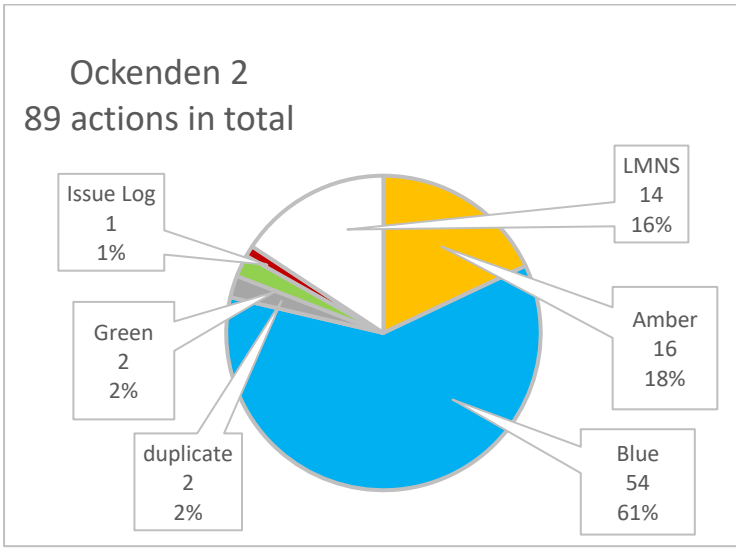
1 Action has been transferred to a BadgerNet Specific Issue Log (previously 4 – 3 technical issues have been resolved and now moved to Amber).

Excluding the 1 LMNS and 3 duplicate actions, Ockenden Part 1b action plan is currently 95.76% compliant (no change from previous month), with a trajectory to be 100% compliant by 30th December 2023.

2.1.4 WHH Compliance with Ockenden 2 Report

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

Chart 3: WHH Ockenden 2 Compliance



Update

0 Red (previously 1)

16 Amber (previously 16)

On track to move to green by end September 2023

2 Green (previously 4)
On track to move to blue by end July 2023

54 Blue (previously 51)

14 – Actions not for WHH (no change)

2 – Actions duplicated (combined) as refer to appointment of 11th Consultant who will take on the role of Lead Obstetrician in Fetal Surveillance

Previously one red action relating to the cancellation of training for High Dependency care skills by the University of Salford. This action has now moved to Amber as the course has now commenced as planned, and the three members of staff have completed their theory training and the practical training is scheduled and on track. Excluding the 14 LMNS and 2 duplicate actions, Ockenden 2 action plan is 73.97% compliant (previously 69.86%).

Trajectory for completion of this action plan is 30th November 2023.

2.2 WHH Risks for Escalation

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

- The Ockenden Insight visit in July 2022 identified the need for a 'Failsafe Clerk' to support screening compliance. Recruitment to the post has been completed with HR processes underway. Timeline for the postholder to be in place is August 2023
- The Lead Obstetrician in Fetal Surveillance role will be included in a new Consultant post. Funding has been identified for this new post and recruitment will commence. Meeting this recommendation will be dependent upon successful recruitment and anticipated recruitment is six months.
- An Education Midwife and additional supernumerary clinical skills facilitators is required. The Practice Development Midwife role has been reviewed following the retirement of the previous postholder. Following the review and funded via reallocation of funds from a vacant post, the role has been increased from 0.8fte to 1.0fte. The review of the job description has also taken account of the need for additional clinical visibility. This amended post has now been recruited to.
- It had been planned to utilise funding from a temporarily vacant post to fund additional hours for existing, experienced, clinically expert staff to work ad-hoc extra hours as part of a rota of clinical skills facilitators will commence in July. This would provide the supernumerary aspect of the requirement whilst also providing a development opportunity for midwifery colleagues. This plan has been paused whilst the additionality required following the publication of Saving Babies Lives Care Bundle version 3 is considered. An updated plan will be provided to a future Quality Assurance Committee.

2.3 Ockenden Summary

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

- Ockenden 1a is 100% compliant.
- Ockenden 1b is 95.76% compliant with a trajectory to be 100% compliant by 31st December 2023.
- Ockenden 2 action plan is 73.97% compliant (previously 69.86%). Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023.

3. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting will be shared at the Women's and Children's Clinical Business Unit Governance Meeting on 28 July 2023.

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 13th June 2023.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/86ii**	
SUBJECT:	**Maternity Incentive Scheme Year 5 Overview of Requirements**	
DATE OF MEETING:	2nd August 2023	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF*)*	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Resolution (NHSR) is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards. Year 5 specifications and timelines were released on 31 May 2023 and advised Trusts must submit the completed Board declaration form to NHS Resolution by 12 noon on 1 February 2024. There are no new safety actions withing the year 5 scheme. A full analysis of current position is being collated and will be shared at the next Quality Assurance Committee and Trust Board. Within the Year 5 specification there is significant additional reporting to provide assurance to the Board (Safety Action 9) on maternity and quality issues. This includes the requirement for a monthly review of feedback, staffing in maternity services and training compliance. Reporting to meet this requirement will commence with effect from August 2023 Quality Assurance Committee. There is also the requirement *"that a review of the Trust's claims scorecard is undertaken should be discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023."* For year 2021/22 there are no new open claims within Obstetrics. This was reported and discussed at Quality Assurance Committee on the 11th July 2023. The year 5 recommendations require at least one additional meeting to take place before the end of the year 5 scheme	

	demonstrating oversight of progress with any identified actions from the first review of the claims scorecard as part of the PSIRF plan. This action will be completed at October Quality Assurance Committee when the 2022/23 claims scorecard will be presented with action plan as per the guidance			
PURPOSE: ***(please select as appropriate)***	Information ✓	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/23/07/147**		
	Date of meeting	11/7/2023		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Incentive Scheme Year 5	AGENDA REF:	BM/23/08/86ii

1. BACKGROUND/CONTEXT

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

Year 5 specifications and timelines were released on 31 May 2023 and advised Trusts must submit the completed Board declaration form to NHS Resolution by 12 noon on 1 February 2024.

This paper will update the Board of the with the key aspects of the year 5 specification and next steps.

2. KEY ELEMENTS

The 10 Maternity Safety Actions

- Safety Action 1: Use of the National Perinatal Mortality Review Tool
- Safety Action 2: Submitting data to the Maternity Services Data Set
- Safety Action 3: Transitional care services to support Avoiding Term Admissions into Neonatal Units
- Safety Action 4: Effective systems of clinical workforce planning
- Safety Action 5: Effective system of midwifery workforce planning
- Safety Action 6: Demonstrating compliance with Saving Babies Lives Care Bundle v3
- Safety Action 7: Gathering service user feedback and working with Maternity Voices Partnership to coproduce local maternity services.
- Safety Action 8: Multi professional maternity Core Competency Framework training
- Safety Action 9: Board Assurance for maternity and neonatal safety and quality issues.
- Safety Action 10: Reporting of qualifying cases to HSIB and NHS Resolution Early Notification Scheme

Overview

- No new safety actions.
- Some minor amendments to data to be reported to reflect changes in national direction e.g Maternity Continuity of Carer.
- Some amendment to target measures.
- New focus on locum workforce and rest periods for doctors working non-resident on-call out of hours.
- Additional requirement regards service user involvement in developing and delivering training and the provision of training based on learning from local findings and incidents.

- Significant additional reporting to provide assurance to the Board (Safety Action 9) on maternity and quality issues to include a monthly review of feedback, staffing in maternity services and training compliance.

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?

	Required Standard	Evidence	Comments
a	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.	Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues.	In place
		Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).	To commence wef August Quality Assurance Committee and October Board reporting
b		To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Not yet in place, to commence following discussion with LMNS re system/governance process
	Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement	Evidence that in addition to the monthly Board review of maternity and neonatal quality as described in (a), the Trust's claims scorecard is reviewed alongside incident and complaint data.	2022/23 Scorecard data reported to QAC July 2023 Trust level (Board or directorate) quality meeting by 17th July 2023.

	plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Not yet in place in this form, reporting timeline and plan to be shared at August Quality Assurance Committee
	Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.	Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented.	Complete WHH 'Quad' commenced Perinatal Culture and Leadership Programme June 2023. Learning and feedback from this work will feed into future Quality Assurance Committee and Board reporting.

Safety Action 9 – scorecard data

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

For year 2021/22 there are no new open claims within Obstetrics.

Volume of claims by Incident Year

Year	Open	Closed	Periodical Payments
2012/13	1	3	0
2013/14	1	8	0
2014/15	0	1	0
2015/16	2	2	0
2016/17	1	1	0
2017/18	4	3	0
2018/19	1	2	0
2019/20	0	0	0
2020/21	2	1	0
2021/22	0	0	0
Total	**12**	**21**	**0**

Taken from WHH Trust Claims Scorecard, previously discussed at Quarterly Clinical Claims Review Group and Quality Assurance Committee

The year 5 recommendations require at least one additional meeting to take place before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review of the claims scorecard as part of the PSIRF plan. This action will be completed at October Quality Assurance Committee when the 2022/23 claims scorecard will be presented with action plan as per the guidance.

Next Steps

- Monthly Maternity Incentive Scheme Year 5 reports to commence as part of monthly Maternity update to Quality Assurance Committee with effect from August 2023.
- Maternity MIS Year 5 update to include current position and monthly assurance of progress against targets.
- New reporting to meet requirements of Safety Action 9 be agreed and commence with effect from August 2023 Quality Assurance Committee and October Board reporting
- Ongoing review of updates to guidance, measures and time periods for compliance. Trusts were advised on 30/6/2023 NHS England will be issuing some additional clarification and guidance relating to safety actions 6 (SBL), 8 (Training) and 9 (Board Assurance).

3. MONITORING/REPORTING ROUTES

Compliance with MIS is reported at the monthly Women's Health Governance and Women's and Children's Clinical Business Unit Governance meetings. Compliance will also be reported monthly to Quality Assurance Committee.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on the 11th July 2023.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/08/86iii**	
SUBJECT:	**Annual Avoiding Term Admission into Neonatal Unit (ATAIN) Report 2022/2023 Quarter 4/**	
DATE OF MEETING:	2nd August 2023	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	• Q4 2022/23 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 6.77% which is the first time the service has failed to meet the national target since Q2 2021. • Although the ATAIN rate for Q4 has not met the national target on this occasion, the percentage of avoidable admissions has not risen, therefore is not suggestive of a deterioration in the standard of care. • To ensure the service maintains low avoidable rates, a monthly audit of all ATAIN elements (asphyxia, temperature control, jaundice, hypoglycaemia and respiration) is in progress. • The mean for the year is 5.4% which is below both the regional NWNODN (North West Neonatal Operational Delivery Network) and national targets of 5.6% and 6% respectively. • All term admissions in Q4 were reviewed and learning from these cases informs the ATAIN action plan. • The ATAIN action plan is monitored via WCH Governance.	
PURPOSE: *(please select as appropriate)*	Information ✓ / Approval / To note / Decision	
RECOMMENDATION:	The Trust Board is requested to note the findings of this paper for information and to share this with the Trust Board as per MIS Year 5 recommendations.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/23/06/124
	Date of meeting	13th June 2023
	Summary of Outcome	Submit to Trust Board

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	**2022/2023 Quarter 4/ Annual Avoiding Term Admission into Neonatal Unit (ATAIN) Report**	**AGENDA REF:**	**BM/23/08/86iii**

1. BACKGROUND/CONTEXT

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

This paper describes the current position of Warrington and Halton Teaching Hospital (WHH) against Safety Action 3 of MIS Year 4 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 4 specify the ATAIN action plan should be shared with Trust Board, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meetings. MIS Year 5 published on May 31st 2023 has maintained focus on this Safety Action.

2. KEY ELEMENTS

WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies that were admitted to the Neonatal Unit (NNU) during the Q4 reporting period from 1st January 2023 to 31st March 2023. This report also contains annual figures for year 2022-2023.

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

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

Summary of unexpected term admissions to NNU

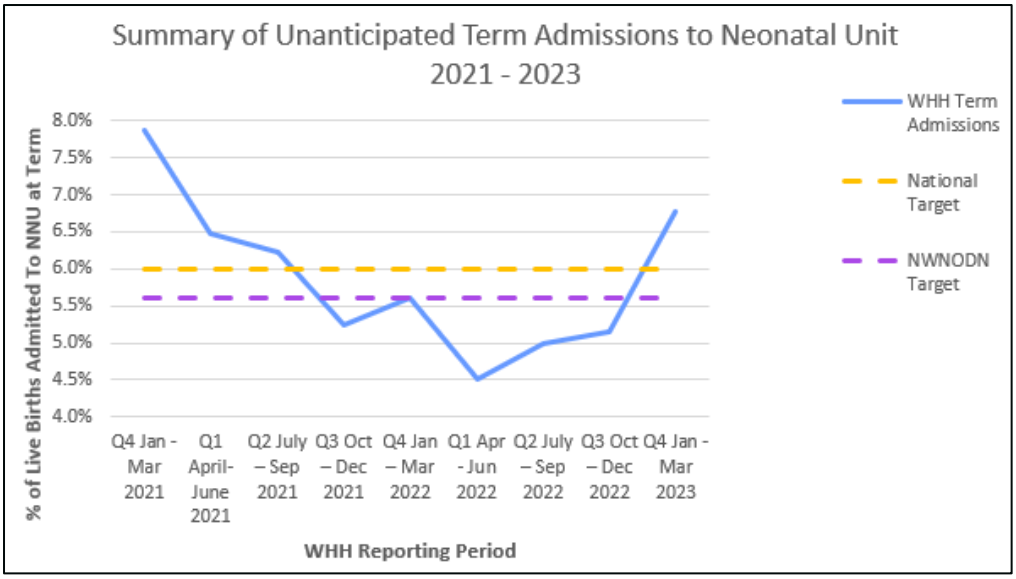
The Q4 ATAIN Rate was 6.77%. Out of 43 term admissions, four were not reviewed as part of the ATAIN process, due to the following:

- Two mothers were transferred to ICU (one following massive obstetric haemorrhage [MOH] and the other was peri-arrest), babies stayed on NNU whilst mothers on ICU but neither baby required any additional care.
- One mother was transferred to a medical ward due to maternal seizure; baby was on NNU during this stay but required no additional care.
- One baby remained on the postnatal ward to undergo testing for Congenital Adrenal Hyperplasia (CAH) due to the sibling having CAH. Baby was admitted for treatment once diagnosis confirmed – treatment needed to be administered by neonatal nursing staff with monitoring in place.

Although the ATAIN rate for Q4 has not met the national target on this occasion, the percentage of avoidable admissions has not risen, therefore is not suggestive of a deterioration in the standard of care. However, to ensure the service maintains low avoidable rates, a monthly audit of all ATAIN elements (asphyxia, temperature control, jaundice, hypoglycaemia and respiration) is in progress.

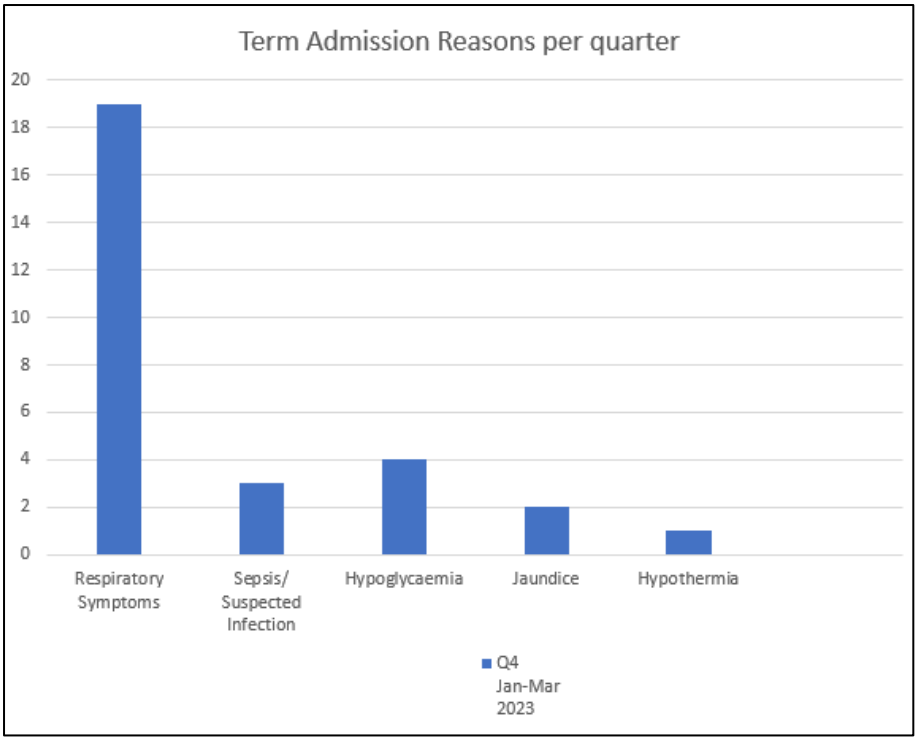
The mean ATAIN rate for the full year 2022-2023 is 5.44%, which is below both the regional NWNODN (North West Neonatal Operational Delivery Network) and national targets of 5.6% and 6% respectively.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	National target 6%	NWNODN Target 5.6%
Q1 Apr – Jun 2022	574	26	4.52%		
Q2 Jul – Sept 2022	682	34	4.98%		
Q3 Oct – Dec 2022	642	33	5.14%		
Q4 Jan – Mar 2023	635	43	6.77%		
Total	2533	138	5.44%		



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

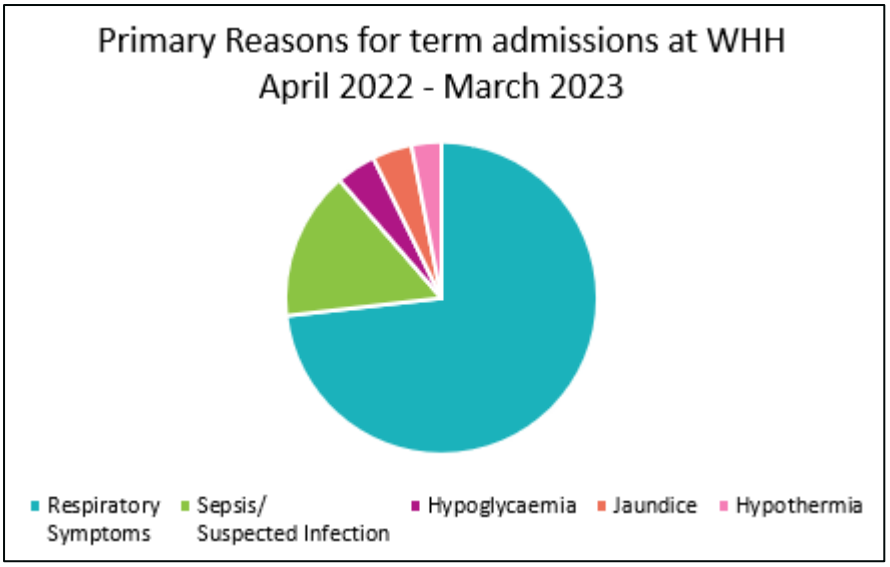
WHH Number Live Births 2021-2022		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissi	No of babies	% Term admissi	No of babies	% Term admissi	No of babies	% Term admissi	No of babies	% Term admissi
Q1 Apr-Jun 2022	574	26	4.52%	13	50.0%	4	15.4%	0	0%	2	7.7%	2	7.7%
Q2 Jul-Sep 2022	682	34	4.98%	21	61.8%	5	14.7%	0	0%	0	0%	0	0%
Q3 Oct-Dec 2022	642	33	5.14%	18	54.5%	3	9.1%	0	0%	0	0%	0	0%
Q4 Jan-Mar 2023	635	43	6.77%	19	47.5%	3	7.5%	4	10%	2	5%	1	2.5%



47.5% (19) of Term Admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Of these, 13 cases were diagnosed with Transient Tachypnoea of the Neonate (TTN). Of the babies with TTN, 1 was deemed an avoidable admission with MDT opinion that earlier recognition of hypoxic changes on CTG and ongoing hyperstimulation should have led to expedited delivery via instrumental delivery more than one hour earlier. The MatNeoSIP Innovation Coaching Project is currently underway within the service, which aims to improve the Transitional Care offering and reduce term admission.

Of the other respiratory-related admissions, one baby had Respiratory Distress Syndrome (RDS), one baby had a small pneumothorax, one baby had suspected sepsis, one baby was admitted due to poor feeding after a successfully managed low temperature, one baby had a very rare choanal atresia and one baby was born by emergency due to a fetomaternal haemorrhage. None of these babies were deemed avoidable admissions.

Below is a chart showing the primary reasons for term admissions at WHH for 2022-2023 as recorded on BadgerNet by ATAIN admission criteria. Respiratory symptoms remain the overarching reason for admission of term babies to the Neonatal Unit.



Themes and Learning: Outcomes of ATAIN review

WHH 2020/21 2021/2022	Number of Term Admissions	Outcome of ATAIN review	
		Avoidable Admissions	Unavoidable Admissions
Q1 Apr – Jun 2022	25	6	19
Q2 Jul – Sept 2022	34	13	21
Q3 Oct – Dec 2022	33	5	28
Q4 Jan – Mar 2023	43	7	32
TOTAL	131	31 24%	100 76%

Reasons for categorising term admissions as avoidable included one baby where a longer transition period on Birth Suite may have prevented the admission, one baby had an unintentional fall on the postnatal ward when the mother fell asleep after feeding and two babies were admitted by a locum Registrar doctor to the Neonatal Unit to receive phototherapy and septic screen. This could have taken place on the Postnatal Ward.

The table above also shows the outcome of ATAIN reviews for 2022-2023 and notes less than a quarter of all term admissions were deemed potentially avoidable.

Good Practice:

- Generally excellent neonatal care resulting in reduced separation of mother and baby noted
- Excellent antenatal care noted in several cases with appropriate birth plans, repeated scanning and liaison with tertiary hospital
- Excellent documentation noted in a number of cases

- Recognition of upper airway problem in a baby who went on to be diagnosed with a very rare choanal atresia

Learning Points/Themes/Actions:

- CTG learning – multidisciplinary
- All midwives require competency assessment for medicines management, including training on wristbands
- If a baby's sats are lower than expected, additional O2 should be applied during resuscitation
- Assist call bell used instead of emergency call bell during shoulder dystocia

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

Recommendations:

- Continuation of targeted support for staff as required from cases requiring individualised learning
- Regular ATAIN meetings to discuss cases and actions/progress
- Focussed learning from ATAIN to continue to be included on the lessons learned to be shared and discussed with all midwifery and obstetric staff
- Continued participation in Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) training with a focus on perinatal optimisation
- Regular review of ATAIN actions to ensure timely completion

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

This report has previously been noted and discussed at Quality Assurance Committee on the 13th June 2023.

5. RECOMMENDATIONS

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

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

ATAIN ACTION PLAN

No	Action	Owner	Review Date	Target Completion Date	RAG status
1	Induction of Labour (IOL) guideline to be reviewed in relation to timing of induction for Large for Gestational Age (LGA) and maternal request; no Propess to be given following Spontaneous Rupture of Membranes (SROM).	Associate Clinical Director	31/8/2023	31/01/23 – date extended to allow task & finish group meetings to take place. Will continue to be reviewed.	
2	Review of process of transferring women from the Nest for emergency delivery.	Nest Manager / Obstetric Governance Lead Consultant	31/05/2023	Target met – Nest simulation held November and December 2022. SOP to be reviewed, policy is clear. Policy ratified January 2023. Another drill planned for 09/08/23 Drills will be organised on a regular basis.	
3	Warm care bundle to be adapted for theatre environment. For consideration: facilitation of skin-to-skin in theatre, removal of weighing scales from theatre	Maternity Theatre Co-ordinator / Birth Suite Manager / Infant Feeding Co-ordinator	31/7/2023	Skin-to-skin in theatre has been facilitated and has been added to the theatre safety huddle. Weighing scales location is under review regarding appropriate place to site these. Wool blankets have been ordered.	
4	Appointment of fetal monitoring lead consultant as per Ockenden requirements. Associate Clinical Director currently fulfilling role.	Associate Clinical Director / CBU Manager	31/10/2023	Associate CD fulfilling this role still. Two new Consultant appointments have been made – job plans and start dates TBC. 11th Consultant to be advertised.	

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/87**			
SUBJECT:	**Quality Strategy Update – Annual Report**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**All**			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Annual Quality Strategy report sets out our key quality and priorities progress report for 2022-23. These are linked to our Quality Strategy 2021-2024. The report details key achievements over the past year that have impacted upon the quality of care and standard of services delivered at WHH. The report also details the quality priorities Q4 progress report 2022-23 which identifies areas of improvement in the quality of services provided. These are noted within the Annual Quality Account 2022/2023.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the update and progress made on the implementation of the key quality priorities for 2022-23.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/23/06/130**		
	Date of meeting	13th June 2023		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Quality

We will..... **Always put our patients first** through high quality, safe care and an excellent patient experience

WHH ANNUAL QUALITY STRATEGY REPORT 2022-23

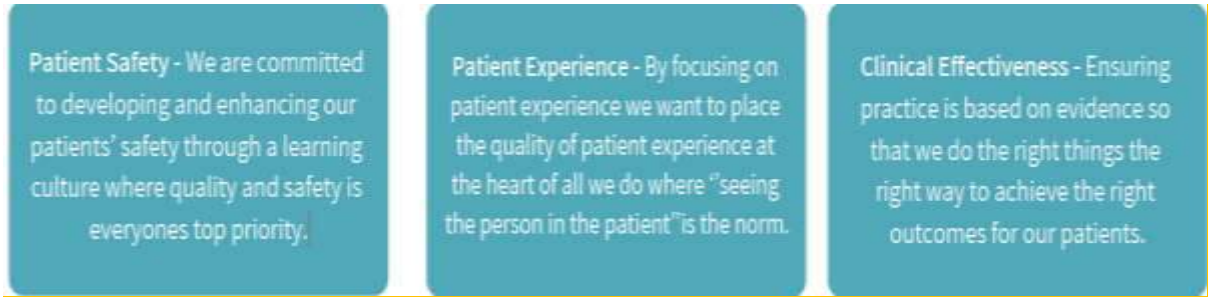
Our WHH Strategic Quality Objectives

At Warrington and Halton Teaching Hospital NHS Foundation Trust our strategic aim is to always put our patients first through high quality, safe care and an excellent patient experience. We will achieve this aim through our three strategic Quality objectives.

Our 3 strategic objectives under the Quality domain are:

WHH wants to ensure patients are safe in our care, to provide patients with the best possible clinical outcomes for their individual circumstances and to deliver an experience of hospital care which is as good as it possibly can be. With this care model in mind we use the following three priority domains:

- **Patient Safety Domain**
- **Patient Experience Domain**
- **Clinical Effectiveness Domain**



Performance against Quality Priorities for 2022-23

Performance against Quality Priorities for 2022-23

The following Quality Priorities were identified in 2022-23 and the information below contains an update on progress on each of the quality priorities. These are referenced in accordance with the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

Throughout the year the progress of each quality priority is reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee and to the Quality Assurance Committee.

Patient Safety

We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.

Quality Priority 1: Improve sepsis screening and timely management

Lead: Deputy Chief Nurse

What success will look like

1. Early recognition of deteriorating patients in ED and Inpatients

2. 90% of patients who meet criteria are screened for sepsis within 1 hour

3. 90% of patients receive IV antibiotics within 1 hour where red flag sepsis is diagnosed

Final Progress Summary

1. Early recognition of deteriorating patients in ED and Inpatients

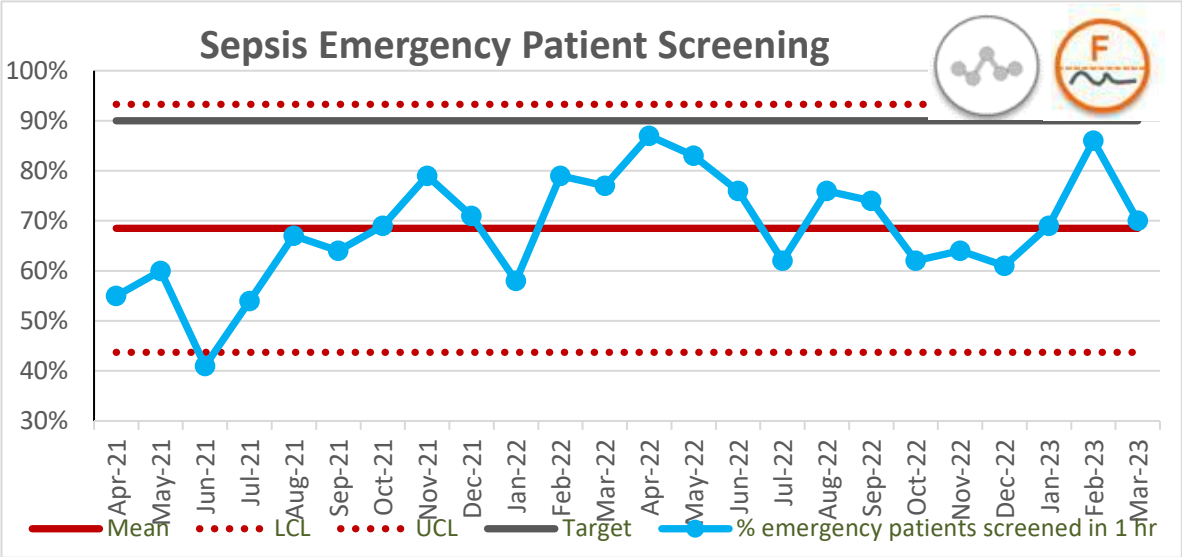
During 2022/2023 Sepsis management has shown improvement within both the Emergency Department and amongst inpatients, however operational challenges have to some degree limited performance for the following reasons:

- A higher number of patients presenting to the Emergency Department.
- Higher clinical acuity amongst patients.
- The number of patients considered to be stranded due to the absence of an appropriate place of discharge.

Warrington and Halton Teaching Hospitals NHS Foundation Trust is able to provide assurance that all patients have been clinically prioritised in order to deliver the right care at the right time in accordance with the statement produced by the Academy of Royal Medical College (AORMC). This considers the balance of risk in ensuring that patients receive urgent treatment with appropriate clinical prioritisation. It also considers the need for sufficient time in making informed decisions where it is safe to wait for results and clinical assessment. At Warrington and Halton Teaching Hospitals NHS Foundation Trust the care of patients who have received their screening and antibiotics outside of the 1-hour timeframe have been reviewed with no clinical harm concluded as a result. Recognising that further improvement is required Warrington and Halton Teaching Hospitals NHS Foundation Trust has agreed that this quality priority should continue in 2023/2024.

Assurance can be given in relation the recognition of inpatients who trigger for possible sepsis on their NEWS 2 score. A daily review of all inpatients physiological observations is completed to ensure that triggers have been responded to appropriately, and where required, the Patient Safety Team initiate a follow up. An improving picture can be seen for 22-23 as in Q1 the Patient Safety Team followed up 26% of 185 patients, Q4 position shows a follow up of 5% of 139 patients, thus evidencing appropriate use, recording, escalation and actioning of NEWS2.

2. 90% of patients who meet criteria are screened for sepsis within 1 hour

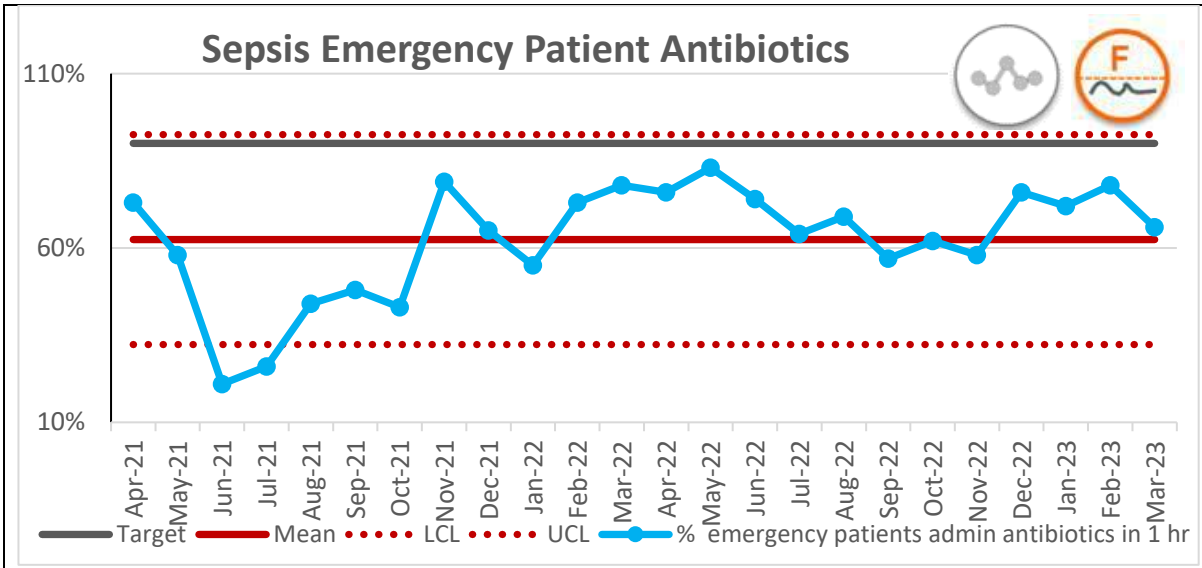


Overall, the linear performance for patients who meet the criteria, and are screened for sepsis within 1 hour is improving. An improvement of 21% for screening patients in the Emergency Department has been demonstrated and an 8% improvement for inpatients during Q4. To identify and action focused improvements an audit was undertaken by Mersey Internal Audit. Recommendations were identified and have been progressed:

- Completion of the Sepsis 6 pathway- ongoing work supported by a digital solution.
- Communication - Sepsis is included as a standard section on the ward Safety Huddles.
- Medical and Nursing Lead for Sepsis is in place.
- Training- 77% compliant - trajectories in place.

Progress for improvement is monitored via the Sepsis Improvement Group reporting to the Quality Assurance Committee. This is included on the Integrated Performance Report with updates provided to the Clinical Quality Focus Group.

3. 90% of patients receive IV antibiotics within 1 hour where red flag sepsis is diagnosed



Overall, the linear performance for patients who meet the criteria, and are screened for sepsis within 1 hour and receive antibiotics is improving, however Warrington and Halton Teaching Hospitals NHS Foundation Trust did not achieve the 90% internal target set. An improvement of 9% for patients receiving antibiotics within an hour in the Emergency Department has been demonstrated and 5% for inpatients for Q4. Delays in prescribing have been highlighted as an action for improvement impacted by the higher number of patient attends within ED.

How have we achieved this priority

Priority has not been fully achieved although improvement in performance is evidenced as described. However, Warrington and Halton Teaching Hospitals NHS Foundation Trust demonstrate an improving position in compliance for ED across Cheshire, Merseyside and Greater Manchester, in accordance with AQuA ED Sepsis compliance measurements. Warrington and Halton Teaching Hospitals NHS Foundation Trust are currently placed 3rd out of a group of 15 Trusts for 22/23. A Sepsis Improvement Group is in place which look at all aspects of the Sepsis pathway, additional training has been delivered to new starters, doctors and Trust staff, Sepsis Awareness Weeks have been held in the Emergency Department with continual updates provided within the Trust Wide Safety Brief.

Forward planning to continue to meet this priority

A full process review of the Sepsis Pathway has been completed with actions identified including:

- Digital support, to streamline the current paper and electronic Sepsis 6 pathway currently in use at Warrington and Halton Teaching Hospitals NHS Foundation Trust.
- Increased training provision in addition to the e-learning package.
- Review of transfer and communication of information.
- Continued work with AQuA.

The Executive Medical Director has requested to meet with the AQUA Clinical Lead for Sepsis to discuss whether a more proportionate response to sepsis performance reporting based on clinical need could be considered in parallel with the existing NICE standards. It would be likely that such an approach would support improvements working in the best interest of all patients

Quality Priority 2: Continue to develop models of waiting list management in line with national guidance ensuring appropriate clinical prioritisation
Lead: Associate Director Planned Care
What success will look like

1. Continue to undertake clinical triage process

2. Continue to undertake harm review process (in partnership with Primary Care Colleagues)

3. Continue to report for assurance via Clinical Safety Oversight Group, Quality Assurance Committee and Strategic Oversight Group

Final Progress Summary

1. Continue to undertake clinical triage process

Throughout 2022/2023 all patients have continued to be prioritised using the national Priority Code system. Patients are continually reviewed utilising a process of clinical triage across all specialties. This will continue in accordance with national requirements. This process has been further supported as referenced within the second identified parameter, relating to the identification of potential harm.

2. Continue to undertake harm review process

The harm profile has remained static at 12 harms identified since 24/03/2021. Harm reviews are conducted on patients who breach 52 weeks and any patient who has an expired Priority Code. In recent months this as altered to 52 week harm reviews continuing with a random 10% sample of patients who have an expired priority code. This alteration was based upon assurance of the harm profile. This process has been underpinned by the Trust's existing governance processes. This process is also supported by Primary Care colleagues who form part of the review panel. The target to deliver the 104 week wait target by the end of June 2022 was achieved, discounting those patients who were on a P6 code where delay to surgery was at the request of the patient or where the patient was not considered to be fit for surgery.

3. Continue to report for assurance via Clinical Oversight Group and Quality Assurance Committee and Strategic Oversight Group

Throughout 2022/2023 bi-weekly presentations have been provided to the Clinical Oversight Group and the Clinical Recovery Oversight Committee with escalation to the Quality Assurance Committee as required. The data is also reviewed at the Performance Review Group and shared with the Integrated Care Board (PLACE) via the Clinical Quality Focus Group.

How have we achieved this priority

- A localised RAG rated outpatient's system was developed with the following parameters identified; high/medium/low risk with clinically agreed dates for follow ups.
- Electronic systems and processes in place to capture the initial priority code listing.
- Panel of appropriate clinicians established amongst Primary and Secondary Care colleagues to capture the patient's full journey when considering potential harm.
- Supported by existing governance processes where harm may have been identified.

Forward planning to continue to meet this priority

All services that list patients for a procedure are using ICE electronic listing. The systems and processes implemented in 2022/2023 will continue.

Quality Priority 3: Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework

Lead: Associate Director of Governance, and Patient Safety Project Director
What success will look like
1. Ensure a patient safety culture continues to be embedded across the organisation in accordance with the requirements of the patient safety strategy and alterations to the investigation process utilising new methodologies (Patient Safety Incident Response Framework – PSIRF) **2. Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance** **3. Evidenced through implementation of a learning framework**

Final Progress Summary

1. Ensure a patient safety culture continues to be embedded across the organisation in accordance with the requirements of the patient safety strategy and alterations to the investigation process utilising new methodologies

Implementation of PSIRF milestones continue to be embedded, in line with the PSIRF implementation plan. New investigation methodologies are being piloted and different forms of learning responses being used to feedback to patients and families. Evaluation of these is underway to inform future interventions.

In accordance with the PSIRF recommendations two patient safety partners have been recruited to support the ongoing patient safety improvement work.

2. Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance

Datix is being used to facilitate incident reporting and emphasis is being placed on feeding back from incidents to reporters. Strengthening incident investigation action plans is a focus for the governance team to support improvements in learning.

Thematic analysis of incidents from across specialties is supporting deeper understanding of clinical issues and this information is being used to inform risks on the risk registers where appropriate.

Analysis of all incidents, complaints, claims and other information has commenced to help to support the development of our PSIRF local priorities. A potential new electronic system is being scoped to support the implementation of PSIRF offering greater triangulation of data to support learning and improvement.

3. Evidenced through implementation of a Learning Framework

The Draft Learning Systems Framework has been developed and is awaiting final ratification at the Education Governance Group. This will be approved and presented to the Patient Safety & Clinical Effectiveness Meeting (PSCESC) and Quality Assurance Committee. An initial introductory meeting was held with other Trusts (Lancashire and South Cumbria) who had implemented a similar framework to learn from their implementation of PSIRF and staff engagement activities.

How have we achieved this priority

The focus on this priority remains as per the national requirement and implementation is on track to deliver the agreed milestones.

Forward planning to continue to meet this priority

The PSIRF implementation plan is evidence of continuous progress being made against the described objectives. Further work with regard to embedding a culture change programme is underway to support the requirements of PSIRF.

Clinical Effectiveness

Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.

Quality Priority 4: To evidence a culture of quality, safety and learning across clinical services

Lead: Associate Medical Director for Clinical Effectiveness

What success will look like

1. Implementation and Audit of Locally Derived Safety Standards which apply to Invasive Procedures 'LocSSIP'

2. Audit of WHO surgical safety checklist to determine effectiveness, with evidence of effective operative debriefs delivering effective learning, team culture and improvement

3. Improve patient safety through the delivery and evaluation of human factors training

Final Progress Summary

1. Implementation and Audit of Locally Derived Safety Standards which apply to Invasive Procedures 'LocSSIP'

Mersey Internal Audit Agency (MIAA) LocSSIP audit was undertaken with recommendations identified and completed. Oversight of LocSSIP interventions has been monitored via the LocSSIP Task and Finish Group, led by the Associate medical Director for Clinical Effectiveness reporting to the Patient Safety and Clinical Effectiveness Sub Committee (PSCESC).

LocSSIP documentation audits provided **significant assurance** with greater than 90% data entry completion. Clinical areas performing a high volume of procedures audited in this year's cycle include:

- Endoscopy
- Cardiac Catheter Lab
- Ophthalmology
- Paediatrics
- Gynaecology

The Deputy Chief Nurse is coordinating audit of Ward areas with infrequent LocSSIPs that were not represented in this years documentation audit.

Observation audits: Three LocSSIP observational audits have been undertaken in Clinical areas performing a high volume of procedures, these delivered **significant assurance** in:

- Ophthalmology
- Catheter Lab
- ITU

The Deputy Chief Nurse is coordinating audit of Ward areas with infrequent LocSSIPs that were not represented in the 2021-22 documentation audit.

Observation audits: Three have been completed with positive feedback of processes used.

2. Audit of WHO surgical safety checklist to determine effectiveness, with evidence of effective operative debriefs delivering effective learning, team culture and improvement

Theatre teams have undertaken a programme of work on the five steps of safe surgery. This has been supported by observation visits at other Trusts to share learning and experience. This has been supported by a revised Standard Operating Procedure and a test of change utilising quality improvement methodologies. Evaluation of the test of change was completed with findings informing the five steps of safer surgery. The changes implemented were derived from reducing human factor questions and not repeating the same questions in the sign in, time out and sign out process. This reduces the repetitive question down from 39 to 16 creating greater efficiency. This was further supported by an improved huddle document and debrief in order to conclude the five steps. The team presented theses changes in a national theatre managers conference, and it was well received. A safe surgery dashboard to monitor quality was also formulated and a balanced score card used as an audit tool. This programme of work is being further expanded to eight steps of safer surgery with proposed changes to National Safety Standards for Invasive Procedures documentation, as advised by the Centre for Perioperative Care. The team will be working alongside AQUA in 2023/2024 on the safe surgery programme to further evidence quality improvement.

3. Improve patient safety through the delivery and evaluation of human factors training

The LocSSIP Awareness e-learning (ESR) has been effectively implemented. Compliance with this training remains high at 87.94%.

Human factors training is provided for individuals responsible for developing and updating LocSSIPs. Focused training has also been provided to areas identified as requiring further support. Simulation training is also considered during the design of checklists and incidents with favourable feedback relating to this form of training.

Quality Priority 5: 'Get It Right First Time' Clinical Productivity programme to be implemented across all specialities to deliver enhanced quality and productivity.

Lead: Head of Finance GIRFT (Getting it Right First Time)

What success will look like

1. Each speciality to identify and commit to deliver 2 Clinical Productivity priorities as agreed with an Executive led GIRFT Steering Group

2. Improvement to be measured with agreed productivity metrics utilising internal data for assurance

3. To be monitored by GIRFT Steering Group reporting to the Patient Safety and Clinical Effectiveness Sub Committee

Final Progress Summary

1. Each speciality to identify and commit to deliver 2 Clinical Productivity priorities as agreed with an Executive led GIRFT Steering Group.

Warrington and Halton Teaching Hospitals NHS Foundation Trust created a dedicated GIRFT team consisting of an Associate Medical Director, Head of Finance, Clinical Lead for Medicine (Unplanned Care), Clinical Lead for Trauma and Orthopaedics (Planned Care) and Clinical Lead for Anaesthetics/Day case (Planned Care). Areas for improvement were agreed with each speciality with the focus to improve efficiency, productivity and quality. Progress is reported bi-weekly through the Care Group Transformation Boards and monthly to the Executive team and to Finance and Sustainability Committee.

2023/24 Priorities have been agreed with each Care Group and detailed workplans with timescales and metrics are being finalised.

2. Improvement to be measured with agreed productivity metrics utilising internal data for assurance.

- Each Care Group has GIRFT priorities/workstreams in place for 2022/23 which have been monitored and supported via the established reporting structure. This will continue in 2023/24 for on-going and new priorities.
- All national GIRFT communications relevant to the Trust are forwarded to the appropriate specialties, including national reports, action plan updates, and webinars.
- Agreed action plan for Lung Cancer now agreed with the National team following Deep dive.
- Gynae and Medicine Deep Dives arranged for Q1 and Q2 of 2023/24.

3. To be monitored by GIRFT Steering Group reporting to the Patient Safety and Clinical Effectiveness Sub Committee

Established reporting structure: GIRFT and Transformation work is reported into the bi-weekly Planned/Unplanned/Outpatient Transformation Meeting, this then reports into the GIRFT Steering Group which then reports to the Executive Team, Finance and Sustainability Committee, Patient Safety and the Quality Assurance Committee.

Quality Priority 6: Discharge processes will be strengthened to improve the quality of discharge to home and community providers

Lead: Director of Operations, Deputy Medical Director and Deputy Chief Nurse

What success will look like

1. Ensuring early measures are in place to facilitate timely discharge, improving length of stay, with data presented by each ward

2. Patients will be partners in their care through communication and information sharing, measured through survey feedback

3. Plan for discharge from the point of admission with effective management of Estimated Dates of Discharge, identified at Board rounds and through high-quality discharge summaries

Final Progress Summary

1. Ensuring early measures are in place to facilitate timely discharge, improving length of stay, with data presented by each ward

During the reporting period Warrington and Halton Teaching Hospitals NHS Foundation Trust has implemented a number of actions to facilitate timely, safe discharge and length of stay. This has been challenging in part due to the continued high number of increased attends and the number of patients considered to be stranded with no onward appropriate care provider identified. Warrington and Halton Teaching Hospitals NHS Foundation Trust have continued to work closely with system partners throughout 2022/2023.

Measures in place to support have included:

- A dedicated discharge area has been added to Lorenzo (the digital platform utilised at the Trust), thus enabling ease of access to all discharge documentation.
- Discharge information packs have been implemented across the organisation containing key information to support timely and safe discharge including information about community support packages such as 'Healthy and Home'.
- Urgent Care Response (UCR) and Warrington Wellbeing team have provided an in reach service to the Emergency Department and Acute Medical Unit (AMU) to support with early discharge and ongoing support packages.
- Semi-automation of D2A forms and Transfer of Care forms to enable timely completion of community provisions.
- Ongoing work with Criteria Led Discharge. NHSE supporting with plan to implement across all suitable wards.
- Ongoing work with the digital team reviewing bed management system including weekend discharge lists.
- Multi-disciplinary Team safari ward rounds implemented for long length of stay patients with a right to reside led by the Medical Director.
- Virtual wards to support early supported discharge.
- Therapy teams continue to lead on work around deconditioning to support ongoing improvements with discharge and patient care. Initiatives introduced to prevent deconditioning include educating patients and staff via training and providing patient leaflets. Introducing individual care plans for activity example chair-based exercises programmes and cognitive stimulation. Embedding mobility and functional decline discussions into board rounds. Encouraging fit to sit and adopting the home first approach.
- Average length of stay is 6.89 days with areas evidencing a longer length of stay including areas such as elderly care.

2. Patients will be partners in their care through communication and information sharing, measured through survey feedback

- Friends and Family survey in place to facilitate feedback. Key trends and themes are reviewed at CBU governance meetings with completion data monitored through the Trust Integrated Performance Dashboard.
- Social media campaign and re-launch of 'Where Best Next?' and to promote a 'home first' approach, wherever possible. This required full involvement from patients, their loved ones, and carers in discussions about discharge from the earliest opportunity.
- Discharge letter to be given to patient upon admission outlining what will happen during their stay including prompts to ask questions around their care, again supporting the early discharge process.

3. Plan for discharge from the point of admission with effective management of Estimated Date of Discharge identified at Board rounds and high-quality discharge summaries

- A review of the discharge pathway terminology and functionality on whiteboards and Lorenzo was undertaken to ensure that processes were effective and efficient.
- A discharge improvement task and finish group was established to review Board Round Standards. Ongoing project to support wards.
- 'Home for' campaigns throughout the reporting period have been implemented.
- Work has been undertaken with regard to the quality of discharge summaries which provided significant assurance of appropriate completion.
- Auto-population of the discharge summary has improved the information provided in support of information required by General Practitioners.

How have we achieved this priority

- The discharge tab on Lorenzo remains in place.
- Use of automated forms for ease and high quality information.
- Discharge information packs.
- The Friends and Family feedback to ensure efforts remained focused.
- Meeting with NHSE to discuss Criteria Led Discharge plans.

Forward planning to continue to meet this priority.

- Ongoing work to embed criteria led discharge across all wards.
- GIRFT priority of reducing LOS (length of stay) including review of pathways required.
- Implementation of clearer discharge pathways and terminology once agreed -including criteria led discharge (NHSE/I).
- Further work on Board Round Standards with support from Quality Improvement and digital colleagues.
- Further work needed with digital team reviewing bed management system including weekend discharge lists.

Patient Experience

By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

Quality Priority 7: Nutrition and Hydration - ensuring patients receive and are supported to optimise dietary and hydration needs.
Leads: Head of Patient Experience and Head of Facilities
What success will look like
1. Implement and monitor the action plan to deliver the outlined recommendations of the 2020 'Independent Review of NHS Hospital Food' report ensuring access to high quality food and choice supported by an independent industry expert **2. Refresh and implement the Nutritional Care Strategy in collaboration with patients** **3. To ensure all patients hydration needs are met and monitored in accordance with their health needs, utilising ward-based quality metrics**

Final Progress Summary

1. Implement and monitor the action plan to deliver the outlined recommendations of the 2020 'Independent Review of NHS Hospital Food' report ensuring access to high quality food and choice supported by an independent industry expert

Warrington and Halton Teaching Hospitals NHS Foundation Trust developed a Food and Drink Strategy alongside a workplan to deliver recommendations contained within the 'Independent Review of NHS Hospital Food' (2020). This was approved at the Quality Assurance Committee. The workplan has been monitored during the reporting period at the Nutrition and Hydration Steering Group.

Delivered recommendations set out in the NHS Hospital Food Report which have included.

- Catering have received a £1.8 million capital bid for equipment which was approved at Trust Board in May 2022. There is now a full design programme for the project with construction in progress.
- New crockery for patients living with dementia.
- Catering questionnaires for patients are carried out on a bimonthly basis with results monitored at the Patient Experience Sub Committee
- Ensuring a wide range of snacks are available for patients.
- Hot finger food now in place for patients living with dementia.
- Continue to maintain a 5* hygiene rating.
- Ensure a wide range of drinks are on offer on wards and departments.
- Procure a digital meal ordering system to support patients to have a full understanding of the meals they are choosing to include what the meals will look like, nutritional value, allergy information.

2. Refresh and implement the Nutritional Care Strategy in collaboration with patients

Implementation of the Trust Food and Drink Strategy 2022-2025 with objectives set out that are cognisant of local and national guidance. The strategy sets out to:

1. Improving the individual nutrition and hydrational needs of our patients.
2. Integrating multi-disciplinary working; bringing together all teams to improve nutrition and hydrational outcomes.
3. Improving the quality and choice of food offers available to patients.
4. Improving the quality and choice of food offers available to our workforce 5. Sustainability and procurement of patient, workforce and visitor catering services.

3. To ensure all patients hydration needs are met and monitored in accordance with their health needs, utilising ward-based quality metrics

- Senior Nurse Workshops held to discuss the Trust Food and Drink Strategy and forward plans.
- Performance with specific metrics monitored by the Nutrition and Hydration Steering Group, including assessment that impact nutritional status.
- Monitored via observation walk rounds; Board walk rounds, Governor walk rounds, Mock Inspections, Ward Accreditation.

- Food tasting events undertaken by Executive team and Governors.
- The catering team have and continue to support a number of religious and celebratory events with food and drink for our patients. Examples of this have included but are not limited to.
    - Diwali - a range of Indian savoury and sweet snacks.
    - Chinese New Year.
    - Mother's Day.
    - Childrens Ward – Pizza Takeaway Nights every Saturday night.
    - Queens Jubilee – Afternoon Tea.
    - Provision of mocktails for celebratory occasions.

Forward planning to continue to meet this priority

- The recommendations from the 2020 'Independent Review of NHS Hospital Food' report have been included in the Trust Food and Drink Strategy 2022 – 2025 for continuous monitoring within the Nutrition and Hydration steering group.
- The digital meal ordering system will be procured by June 2023.
- Vending machines that serve microwave healthy meals has been scoped for procurement with an order raised to trial.
- Patient feedback in relation to food and drink will continue to be monitored bimonthly at the Patient Experience Sub Committee with questions also included in the national annual inpatient survey for continuous review.
- PLACE assessments will continue on an annual basis.
- Walk rounds to intermittently focus upon Nutrition and Hydration with feedback progressed through the steering group.

Quality Priority 8: Ensure the Mental Health and Learning Disability Strategies are implemented Trust wide.

Leads: Director of Governance, Lead Nurse Adult Safeguarding, Lead Nurse Child Safeguarding, Associate Chief of Nursing Unplanned Care and Associate Chief Nurse Planned Care

What success will look like

1. Audit the use of patient's passports by Care Group via the Learning Disability and Mental Health Steering Groups

2. Evidence effective and robust alert processes for the Trust EPR system

3. Competency based training for Learning Disability, Autism and Mental Health available for all staff groups in the Trust

Final Progress Summary

1. Audit the use of patient's passports by Care Group via the Learning Disability and Mental Health Steering Groups

The audit of patient passports has identified that there remains opportunity to work with system partners to ensure that patient passports are provided at the point of admission and updated

accordingly. Of the cases reviewed 16% of patients did not attend the Trust with a passport in place. Workstreams are in place to support and improve communication between health providers with regard to vulnerable patient groups. One example of this during the reporting period is Arbury Court with positive progress being made. It is recognised within the Acute Trust and from within the Integrated Care Board that there is further opportunity to enhance care provision with regard to patients with Learning Disabilities and Mental Health complexities for which discussions are underway. This will also be fundamental to the implementation of Liberty Protection Safeguards in the future.

Warrington and Halton Teaching Hospitals, NHS Foundation Trust continue to house and work alongside CORE24 based within the Emergency Department to review and support patients with mental health diagnosis. Discussions are underway to determine whether this service provision could be further enhanced recognising the significant increase in patients requiring care at the Trust.

2. Evidence effective and robust alert processes for the Trust EPR system

Alert systems and processes are in place with the support of the EPR and Safeguarding Team. This is also supported by the Learning Disability Specialist Nurse. The alert is placed on the patients Lorenzo record.

3. Competency based training for Learning Disability, Autism and Mental Health available for all staff groups in the Trust

An established training program that is competency based and reflects the Oliver McGowan training program have been in place for almost 2 years. Further work has been supported by a Mental Capacity Act Assessor/ trainer agreed through secondment which has been a very positive measure. Access of Local Authority training provision has also been provided. Work is currently underway to develop a Mental Health Acute Provider training package and has been agreed as a quality priority for 2023/2024.

As part of the LD strategy, 20 LD champions are now in place across the Trust and support for staff to ensure that the highest standard of care is delivered has included:

- Reasonable adjustment care plan and Standard Operating Procedure.
- Monday Makaton training sessions 'Makaton Mondays' to support staff in communicating with patients and their relatives.

How have we achieved this priority

- Training.
- Appointment of the LD Nurse Specialist.
- Secondment for Mental Health staff member.
- Working collaboratively with system partners.
- Alert system.
- LD Champions.

Forward planning to continue to meet this priority.

To continue with actions undertaken and to work alongside system partners to determine next steps relating to service need. Further work with specific reference to Mental Health has been agreed as

a quality priority for 2023/2024. This will include a specifically designed training programme for acute providers.

Quality Priority 9: Through patient centred communication and service development address inequalities for access to health.

Leads: Head of Strategy, Equality, Diversity and Inclusion Lead, Deputy Chief Nurse and Head of Patient Experience.

What success will look like

1. Work with partners to support our population to access preventative and early intervention services specific to the needs of each person through the co-design of digitally enabled services

2. Deploy and audit the accessible information standards policy across Warrington and Halton Teaching Hospitals, NHS Foundation Trust

3. Monitor and deliver against the First Impressions project – listening and improving the experience for patients, service users, their families, carers and our workforce

Final Progress Summary

1. Work with partners to support our population to access preventative and early intervention services specific to the needs of each person through the co-design of digitally enabled services

During the reporting period the Halton Health Hub was opened. This is situated within Shopping City in Runcorn, providing Optometry, Orthoptics, Audiology and Dietetic Outpatients services. It has been designed to provide an improved patient experience, allowing patients easier access to their appointments, as well as assisting the Trust in furthering our ambitions in improving the health, wealth and prosperity of our boroughs by encouraging use of other facilities within Shopping City and boosting the local economy.

To further enhance partnership working and access to preventative and early intervention services, a service level agreement was put in place to enable Halton Borough Council's Public Health team to utilise the Halton Health Hub to provide a drop-in vaccine outreach service for COVID-19 and flu vaccinations. A further service level agreement has been put in place for Halton General Practice Health Connect to utilise the Hub to provide a Primary Care Acute Respiratory hub 3 days a week. This will be expanding to an extended access primary care service from Spring 2023.

Work continues on the development of the Living Well Hub in Warrington town centre. The Hub will target and address health inequalities in Warrington by providing a range of services focused on prevention and early intervention in a town centre location with close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a flagship project for the local health and care system to work collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project represents an investment of £3.1m, has been co-designed with patients and system partners through extensive engagement and is on-track to be operational by Autumn 2023.

£2.9M of funding has been successfully secured as part of the Runcorn Town Deal plan to create a health and education hub in Runcorn. The hub is planned to deliver services focussed on prevention, women and children and long-term conditions, from a central location in Runcorn. Being developed in partnership with a range of health and care providers across Runcorn, the scheme includes a flexible education element designed in partnership with Riverside College and the Health and Social Care Academy. This will support growth of our future workforce through grass-roots investment in academies.

The Trust has been successful in bidding for new capital and revenue funding from NHS England to develop a Community Diagnostic Centre (CDC) for Warrington and Halton at the Halton site, which will deliver diagnostic capacity for an additional c140,000 diagnostic tests by the end of 2024, supporting easier access to diagnostic services and earlier diagnosis of disease for patients.

2. Deploy and audit the accessible information standards policy across Warrington and Halton Teaching Hospitals, NHS Foundation Trust

The policy is accessible and has been deployed across the Trust. There is further work required to be supported with digital systems.

3. Monitor and deliver against the First Impressions project – listening and improving the experience for patients, service users, their families, carers and our workforce

First impressions are the lasting impressions, which inspire confidence in the safe care and experience that our patients receive. First impressions are formed within 15 steps of entering the hospital and can influence the way patients, service users, their families and carers perceive their whole experience. The first impressions programme ensures that the Trust advances equality of opportunity between people who share a protected characteristic and those who do not.

Achievements to date include:

- Implementation of a fully staffed welcome desk on the Warrington site providing a range of support including.
- Access to interpreters including Basic Sign Language via 'language line' at first point of entry.
- Support with wayfinding.
- Support with wheelchairs and assistance getting to required departments.
- Support with car parking.

Text a task initiative embedded into the Trust supporting staff to take pride in the hospital environment, more notably in communal areas thus ensuring a welcoming, accessible and positive experience for our patients and visitors. This initiative enabled staff to report estate concerns via a text sending a picture and a brief description of the issue instantly. Concerns raised are addressed by the Trust Estates team within 24 hours.

Regular 15 steps challenges carried out in the Trust by both Estates and Facilities and Patient Experience and Inclusion Team to mitigate any concerns highlighted in the moment.

15 steps challenge utilised for all mock inspections.

First and lasting impressions embedded into a plethora of observations and assessments within the Trust including but not limited to:

- Governors observations.
- Ward accreditation.
- CQC mock inspections.
- Leadership observations.
- Patient Led Assessments of the Care Environment (PLACE).

The Head of Patient Experience and Inclusion is a member of a national group who are tasked with the review and refresh the 15 steps challenge toolkit.

Forward planning to continue to meet this priority

Cheshire and Wirral Partnership NHS Foundation Trust's Living Well Bus will return to Halton Hospital in May to deliver additional drop-in clinics.

An SLA is in development for Halton GP Health Connect to provide extended access GP services from the Hub, commencing May 2023.

Work continues on development of the Living Well Hub in Warrington town centre. The Hub will target and address health inequalities in Warrington by providing a range of services focused on prevention and early intervention in a town centre location with close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a flagship project for the local health and care system to work collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project represents an investment of £3.1m, has been co-designed with patients and system partners through extensive engagement and is on-track to be operational by Autumn 2023.

£2.9M of funding has been successfully secured as part of the Runcorn Town Deal plan to create a health and education hub in Runcorn. Due to be operational in late 2024, the hub is planned to deliver services focussed on prevention, women and children and long-term conditions, from a central location in Runcorn. Being developed in partnership with a range of health and care providers across Runcorn, the scheme includes a flexible education element designed in partnership with Riverside College and the Health and Social Care Academy. This will support growth of our future workforce through grass-roots investment in academies.

Warrington and Halton Teaching Hospitals, NHS Foundation Trust was successful in bidding for new capital and revenue funding from NHS England to develop a Community Diagnostic Centre (CDC). This will be based at the Halton site. It will deliver additional diagnostic capacity, supporting easier access to diagnostic services and earlier diagnosis of disease for patients.

Quality Strategy: Quality and Safety Priorities 2022-23

Key Quality & Safety Priorities for 2022-23 detailed in the Quality Strategy

In addition to the agreed quality priorities 2022-23 which are linked to the Annual Quality Accounts, Warrington and Halton Teaching Hospitals, NHS Foundation Trust has also delivered on a number of key quality and patient safety priorities for 2022-23 which are linked to our Quality Strategy2021-2024. The report details the key achievements made over the past year that have impacted upon the quality of care and standard of services delivered at WHH.

These key quality and safety priorities have an overarching impact across the organisation and evidence demonstrates a strong commitment of continuous improvement across all three domains of quality. These include:

Patient Safety Domain

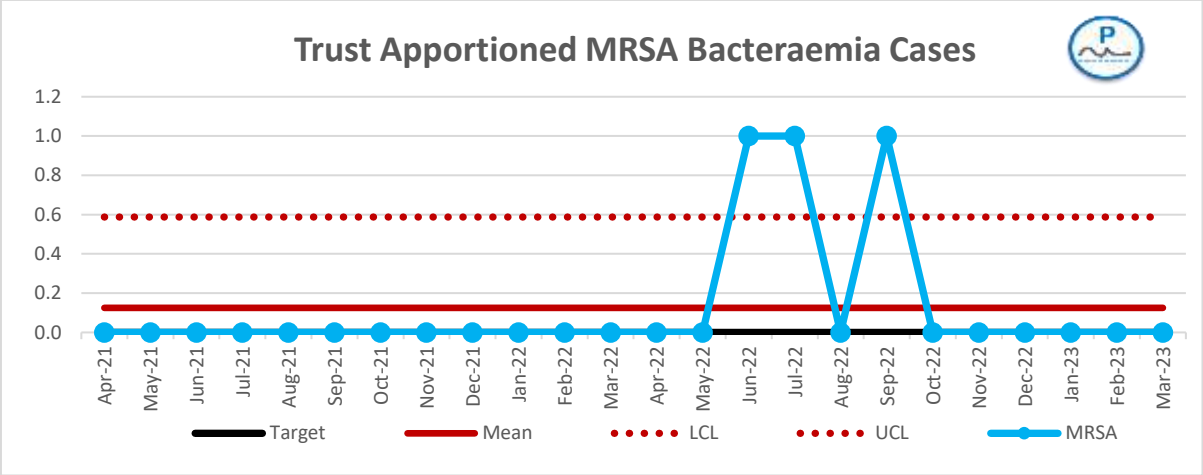
Reducing avoidable harm and deterioration - Reducing healthcare Associated Infections

An overall summary of Gram Negative Bloodstream Infections (GNBSI) and Healthcare Associated Infections has been provided in the table below for 2022-23. The national and local data for the full financial reporting period has been included.

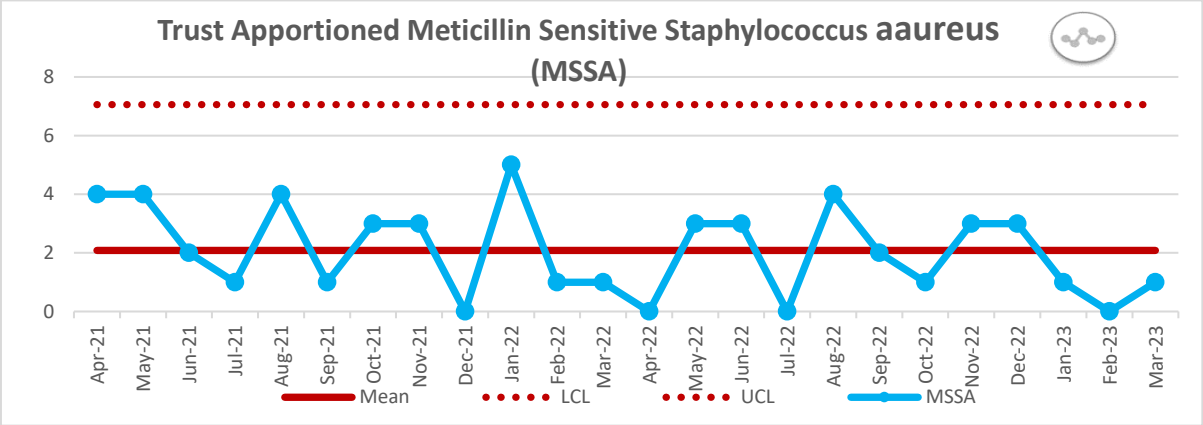
Number of Hospital Apportioned Cases Reported 2021-22	Number of Hospital Apportioned Cases Reported 2022-23	Mandatory Reportable Healthcare Associated Infections
1	3	Methicillin-Resistant Staphylococcus Aureus (MRSA) 1 case was considered unavoidable
29	21	Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA) *
46	55	Clostridioides Difficile (C. Difficile) cases. C. Difficile cases include community onset/healthcare associated and hospital onset/healthcare associated cases.
		Gram-negative bloodstream infections (GNBSI)
46	67	E. Coli Bacteraemia (Gram Negative)
26	22	Klebsiella Bacteraemia
3	4	Psudomonas Aeruginosa Bacteraemia
*There are no targets set nationally for MSSA bacteraemia cases.		

The graphs below are extracts from the Trust Integrated Performance Report.

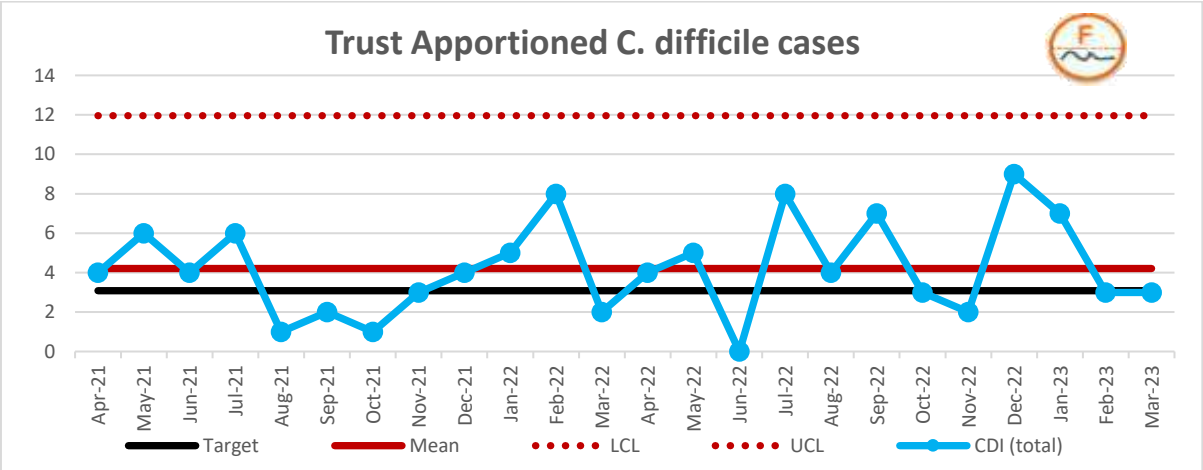
Graph 1 shows the results for MRSA bacteraemia cases in 2022-23.



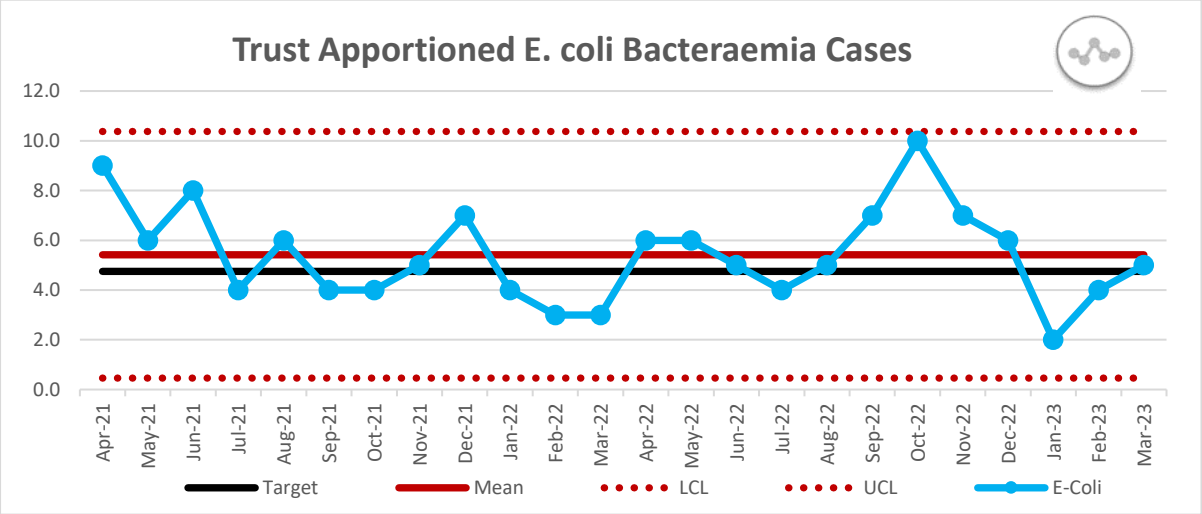
Graph 2 shows the results for MSSA bacteraemia cases in 2022-23.



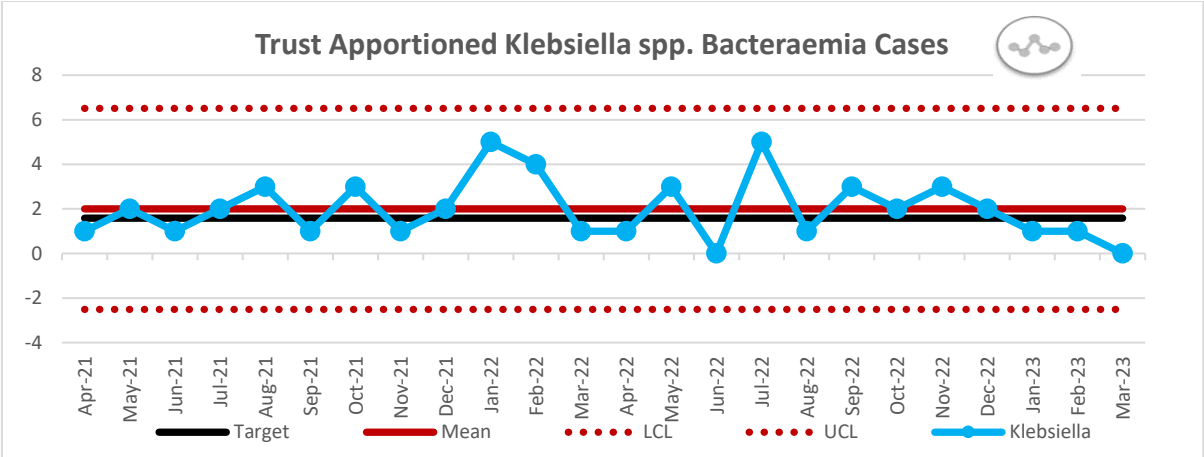
Graph 3 shows the results for Clostridium Difficile Infections (CDI) cases in 2022/23.



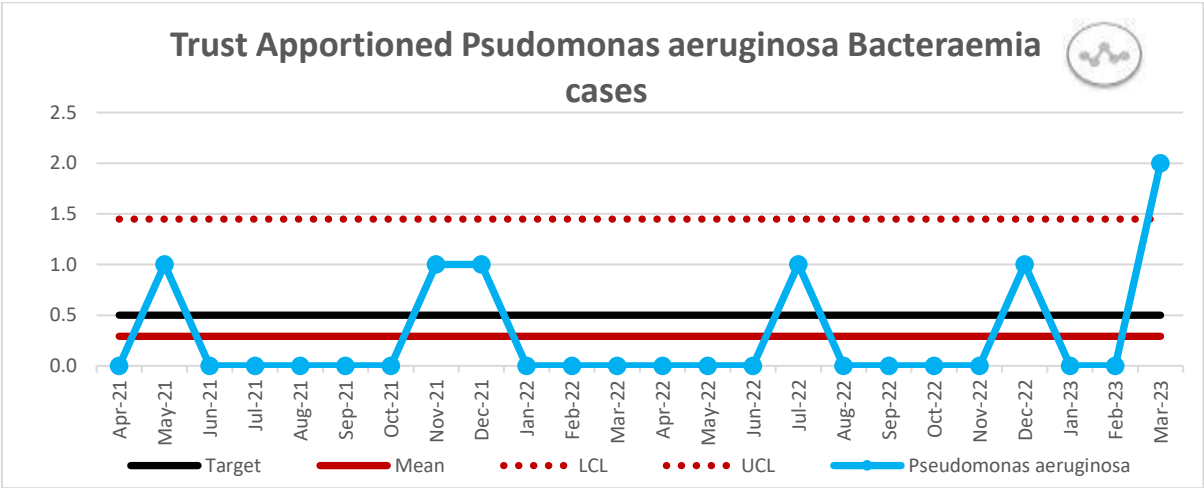
Graph 4 shows the results for E Coli Bacteraemia cases in 2022/23.



Graph 5 shows the results for Trust Apportioned Klebsiella spp. Bacteraemia Cases in 2022-23.



Graph 6 shows the results for Trust Apportioned Psudomonas Aeruginosa Bacteraemia cases in 2022-23.



Improving performance in relation to healthcare associated Infections remains a key priority for the Trust.

Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia

With regards to health care acquired infections (HCAI) during 2022/23, the Trust threshold was 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and despite the continued focus on managing HCAI; the Trust reported 3 cases of MRSA bacteraemia. 1 case was considered unavoidable.

Methicillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia

The Trust also carefully monitors Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia and E. coli bacteraemia. The Trust reported 21 hospital onset cases of MSSA bacteraemia during the financial year. This is an increase of 6 cases compared to the previous financial year. These cases are under review to identify any areas for care improvement.

Clostridium Difficile

In relation to Clostridium difficile the Trust reported 55 cases against the annual threshold of 27 hospital onset cases. Clostridium difficile cases include community onset/healthcare associated and hospital onset/healthcare associated cases. The ICB review panel (previously known as the CCG) consider the cases and have deemed that 18 of the 22 cases between Q1 and Q3 were not due to lapses in care. Cases from Q4 will be reviewed by 31 May 2023.

An overall summary of Gram Negative Bloodstream Infections (GNBSI) has been provided below for 2022-23. Gram Negative Bloodstream Infections include:

- E. coli bacteraemia.
- Klebsiella spp. Bacteraemia.
- Psudomonas Aeruginosa Bacteraemia.

Gram Negative Bloodstream Infections, the Trust had a target to achieve a 5% reduction in Gram Negative Bloodstream Infections (GNBSI)

Background to Gram Negative Bloodstream Infections

- The UKs 5-year national action plan (2019) details the ambition to halve healthcare associated Gram negative bloodstream infections delivering a 25% reduction by 2021-2022 with the full 50% by 2023-24. This priority links with our Quality Strategy to develop and enhance patient safety.

How progress will be monitored, measured and reported:

- Infection Prevention and Control Sub Committee monthly.
- Patient Safety and Clinical Effectiveness Sub-committee monthly.
- A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

Gram Negative Bloodstream Infections (GNBSI) and Healthcare Associated Infections - Implementation and Performance:

Despite every effort made, overall, the Trust did not achieve the 5% reduction in GNBSIs for the reporting financial year. The Trust had a total of 93 GNBSI cases compared to 75 GNBSI cases in 2021-22. A breakdown of each of the bacteraemia's is detailed below and includes a summary of actions taken.

- **E. coli bacteraemia**

The Trust reported 67 hospital onset cases of E. Coli bacteraemia during the financial year This is an increase of 21 hospital onset cases of E. Coli compared to the previous year.

- **Klebsiella spp. Bacteraemia**

The Trust reported 22 Trust Apportioned Klebsiella spp. Bacteraemia Cases during the financial year This is a decrease of 4 hospital cases of Trust Apportioned Klebsiella spp. Bacteraemia cases compared to the previous year.

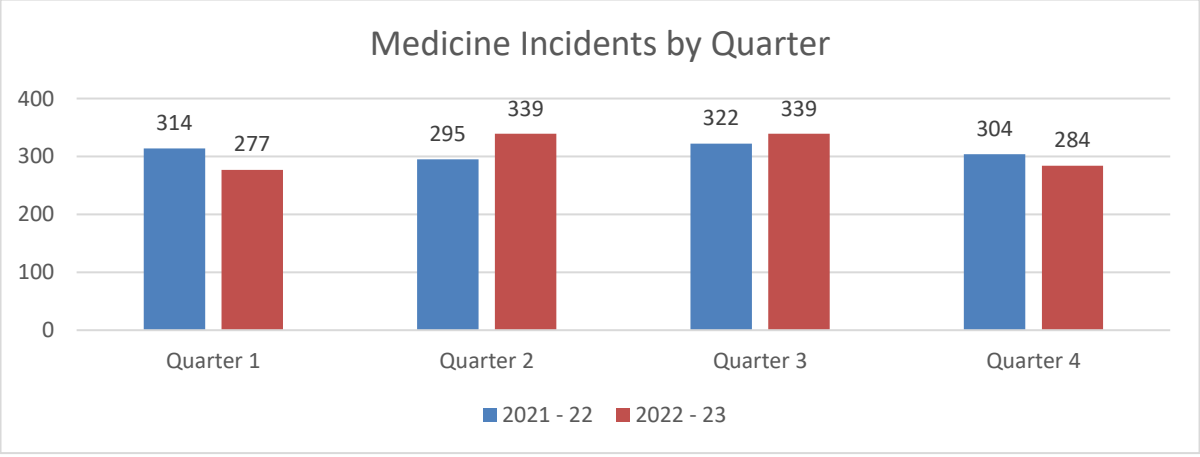
- **Psudomonas Aeruginosa Bacteraemia**

The Trust reported 4 Trust Apportioned Psudomonas Aeruginosa Bacteraemia cases during the financial year This is an increase of 1 Trust Apportioned Psudomonas Aeruginosa Bacteraemia case compared to the previous year.

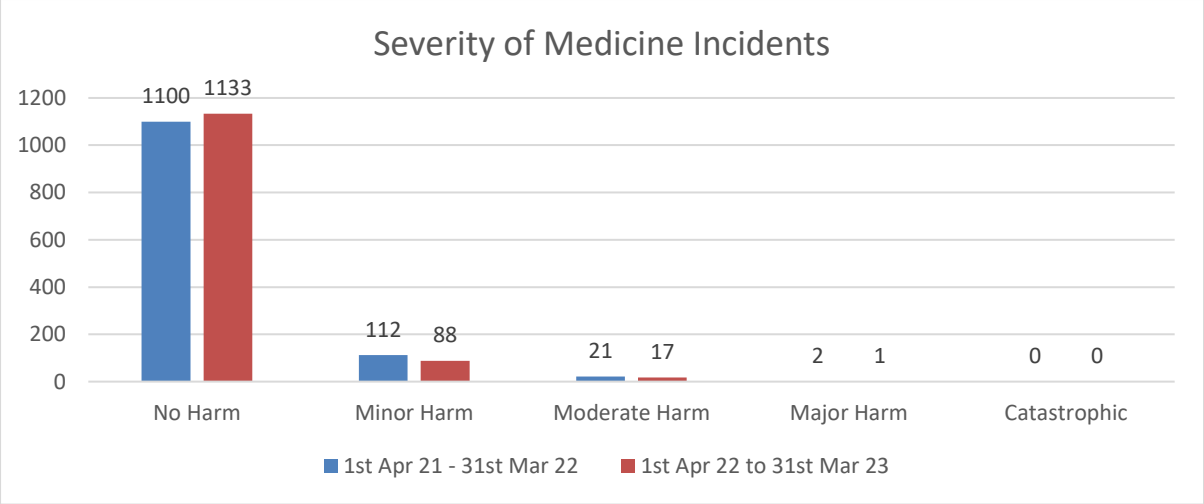
Partnership working is in place across the health economy and the Trust is working with community partners to progress the action plans. Work streams related to the reduction of healthcare acquired infections continue with oversight at the Patient Safety Sub Committee and the Quality Assurance Committee.

Reducing medication errors

Despite every effort made, overall, the Trust only just failed to meet a reduction on medication errors compared to the previous 12 month reporting period. The Trust had a total of 1239 total medication errors compared to a total of 1235 medication errors as shown in the graph below.



What is pleasing to note is that there has been a reduction in the severity of incidents in minor, moderate and major harm compared to 2021-22 data.



WHH has a medicine safety learning from incidents safety brief which is published on a monthly basis and is cascade Trustwide via email to all WHH staff

Some examples of the lessons learned end actions taken to improve medication errors is detailed below.

A patient was discharged with another patient's medication. The patient took the antibiotic ciprofloxacin intended for another patient, which resulted in her INR being raised as she was also taking warfarin.
Lessons Learnt:

The new electronic Adult Discharge Checklist MUST be completed to ensure a safe discharge for all adult inpatients.

At the time of discharge the patient's nurse must:

- Print the Discharge Summary after the discharge medicines have been received from pharmacy.
- Check the patient's discharge medication against the patient's Discharge Summary and discharge prescription.
- Contact pharmacy if there are any issues/discrepancies with the discharge medication.

If the patient needs a District Nurse to administer injections after discharge:

- A District Nurse Referral needs completing for the injections to be administered.
- A Community Prescription Advice and Administration Form needs to be completed for each medicine to be injected. This form can be printed from the Extranet.

The Community Prescription Advice and Administration Form is for short term use only (24-72 hrs) until the patient's GP is able to complete community prescription and authorisation sheets.

A patient's discharge was not communicated to the Anticoagulation Team for their warfarin to be dosed and followed up. The discharge prescription stated for the warfarin to be omitted over the weekend as the INR was raised. The patient's partner was not aware of the dosing information and gave him his usual dose on discharge.

Patients who are being discharged on a vitamin K antagonist (warfarin, acenocoumarol and phenindione):

- On the day of discharge, request an INR in the morning and inform the Anticoagulation Team of the discharge and give them the patient's yellow anticoagulation book for dosing.

- The Anticoagulation Team can be contacted Mon – Fri (9am to 5pm) on Bleep 095 (Outside of these working hours, the patient's medical team are responsible for dosing).

When the patient is discharged, refer to the yellow anticoagulation book and the patient's electronic record on Lorenzo, and ensure the patient/carer knows what dose of their vitamin K antagonist they are taking post discharge and when and where to return to have their INR rechecked.

A patient with epilepsy who took sodium valproate was prescribed meropenem which was administered for 5 days.

- If meropenem is given when valproate is used for the management of epilepsy there is a risk that the patient may suffer seizures and valproic acid is being used for the management of mood, then the patient's mental health may deteriorate.

- Meropenem should not be prescribed if a patient is taking valproate/valproic acid. An alternative antibiotic should be prescribed as per Antibiotic Formulary or discuss with Consultant Microbiologist for an alternative treatment.

Reducing Serious Harm Falls

Falls Collaborative: During the reporting period the Trust set to achieve a 10% reduction in falls by March 31st 2023. To meet this aim the Trust identified that the number of falls on average must reduce to 44.4 per month. It is evidenced that a reduction in falls was noted across 3 consecutive months. November data identifies the lowest number of inpatient falls in a 16-month period. A reduced number of falls was also achieved in March 2023. In January 2023 the Trust reported 36 falls, February 42 falls and March 34 falls - this was within normal variation. These continue to be reported and reviewed with learning shared at the Operational Patient Safety Group (OPSG). This is discussed at the weekly Harm Free Care Meetings. The Trust also launched falls champions across the organisation to support learning and improvement.

Reducing Hospital Acquired Pressure Ulcers

Pressure Ulcer Collaborative: The Trust's aim was to achieve a 14% reduction in hospital acquired pressure ulcers from the 2021-22, an average of 7.7 per month by March 31st 2023. This meant that the Trust must reduce the average number of pressure ulcers to an average of 6.6 per month. In September 2022 an increase in pressure ulcers was reported detailing 15 category 2 pressure ulcers and 1 category 3 pressure ulcer. This led to a thematic analysis being undertaken by the Expert Faculty. The analysis indicated greater focus on risk assessments and device related pressure ulcers. Pressure ulcers are also associated with length of stay due to system pressures and patient deconditioning. An improvement action plan is in place and work continues with system partners.

Safe staffing levels - Rota Gaps and Plan for Improvement for NHS Doctors in Training

We continue to recruit to doctors in training across the Unplanned Care Group which at the time of reporting has two gaps. These gaps consist of GPST/IMT and registrar posts.

In the short to medium term, rota gaps are covered through use of Trust Bank doctors and some agency doctors. We are in the process of advertising fixed term posts through NHS jobs.

The table below shows the Deanery Trainee gaps at 1st April 2023:

Care Group	Grade and Number of Deanery Trainee Vacancies
Planned Care	7 Speciality Training
Unplanned Care	7 GP Specialty Training (GPST)
Clinical Support Services	3 GP Specialty Training

The Trust plan to address rota gaps for NHS Doctors and Dentists in Training

Medical Rota Infrastructure:

- Early identification of gaps from deanery data.
- Implementation of e-rostering for junior doctors.
- Consolidation of speciality rotas into a single rota by grade/tier to allow an effective spread of available junior doctor resource.

Where Gaps remain these are mitigated for by the following measures:

- Where gaps occur with short notice, bank and agency junior doctor resource are utilised to maintain safe medical staffing – this remains an option of last choice, with the more sustainable options below being utilised whenever practical.

- Clinical Fellows (CFs) – We continue to recruit to these posts at speciality level, in order to continue to enhance the multi-disciplinary teams at ward level, offering specific experience and research opportunities via fixed term or substantive contracts.

- Trust Grades (TGs) - Recruiting to Trust Grade posts has allowed specialities to provide a senior level doctor in a non-training post within specialities and at Ward level. This has enabled us to create additional out of hours support, linked with our General Internal Medicine and surgical specialities rotas.

- International Fellows (ITFs) – The Trust actively participates in this scheme designed to allow doctors to enter the UK from overseas in order that they can benefit from training and development in NHS services before returning to their home countries. We continue to recruit through this programme where appropriate.

- Exploration of alterations to doctor in training on call rota's to maintain service requirement and reduce frequency of gaps:

  - Physician Associates (Pas) –The Trusts has a well-established a Physician Associate workforce and training program delivered through the University of Chester. This allowing alternative and sustainable skill mix within departments working alongside doctors in training on on-call rotas.

  - Advanced Clinical Practitioners (ACPs) and Trainee Advanced Clinical Practitioners (TACPs)

  - We have been successful in recruiting ACPs and TACPs across the organisation. Supporting these roles through gaining a masters degree in advanced clinical practice from a Higher Education Institute (HEI). Offering work based and academic learning. These roles work towards developing the clinical skills to provide care autonomously following completion of the trainee position. Allowing us to establish a workforce that can work alongside our doctors in training and further support out of hours working once qualified.

Focus on having no avoidable deaths by reducing clinical and operational risks

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 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.

All phases of care and documentation records including overall care had a majority of 'good' ratings as shown on the graph below.

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 Mortality Review Group (MRG) to highlight good care.

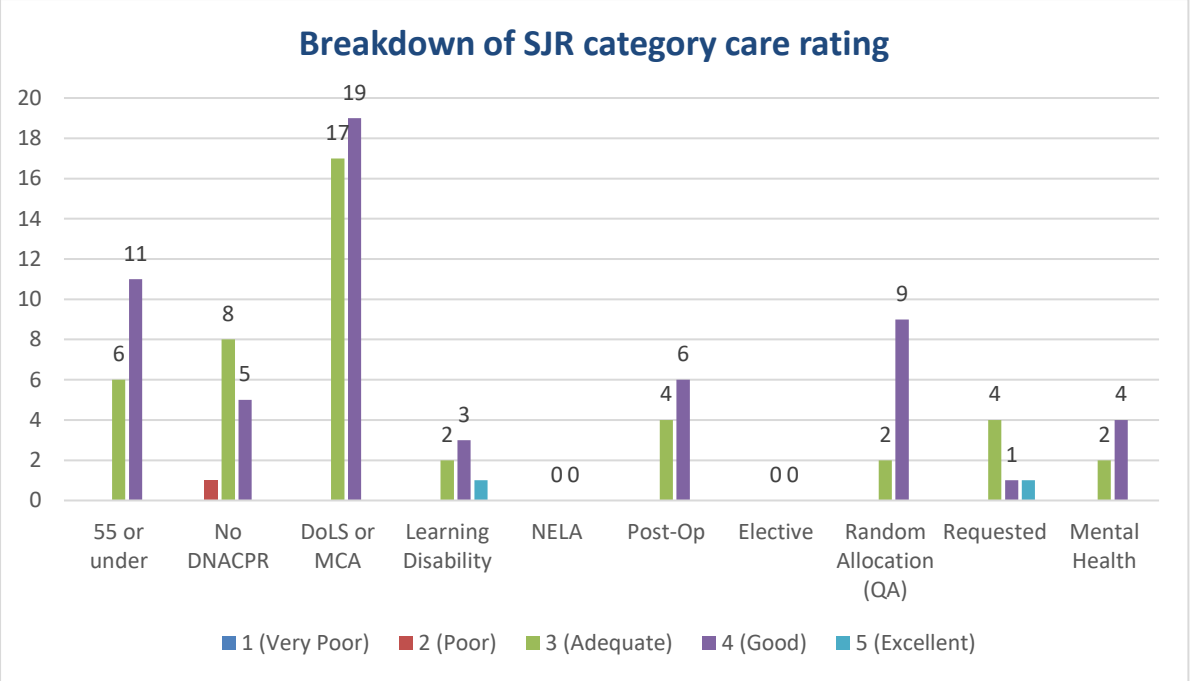
During 2021-22 there was a total of 5 SJRs that were noted as poor care. They are as follows:

- 1 became a Serious Incident
- 1 became a COVID Root Cause Analysis (RCA)
- 1 RIR which on review found appropriate care
- 2 were focused on Urinary Tract Infection (UTI) reviews.

In comparison to 2022-23 there was a total of 10 SJRs that were noted as poor care. They are as follows:

- 1 shared with PLACE colleagues.
- 1 escalated to the acute care governance meeting.
- 1 shared to ED governance meeting.
- 1 was raised as a Datix and fed back directly to the team involved.
- 1 was escalated to a RCA and learning and actions identified and implemented.
- 1 was reviewed and the learning was regarding the DNACPR and a new form had been implemented to help prevent this happening again in the future.
- 1 escalated to an incident and following the review no RIR or further review was needed.
- There are 2 incidents that are due to be discussed during June 2023 meeting (Following a review these incidents could possibly be upgraded from a poor rating to adequate).

All phases of care and documentation records including overall care had a majority of 'good' ratings as shown in the graph below.



- All categories except for ME Request and Random Allocation patients are predominantly receiving good care.
- ME Requested patients have received equal ratings of adequate and good care. This evidences that the ME service is working positively to identify and highlight to MRG patients with potential issues in care.
- Random Allocation patients received significantly more adequate than good care. 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.
- Patients who have died with a severe mental health disorder have received all good care ratings.

NB Some care ratings are duplicated on this graph as often a patient may die and more than one SJR category applies.

Clinical Effectiveness Domain

Ensuring mortality rates are at least within expected limits

The data made available to the Trust by NHS Digital is with regard to the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

Date Period	Trust	Banding	England Average	England Highest	England Lowest
November 2021 - October 2022	97.41	2	99.93	124.7	62.26
November 2020 - October 2021	98.3	2	100.0	118.6	71.9
November 2019- October 2020	106.9	2	100	117.75	67.82
November 2018 - October 2019	106.89	2	100	120.12	68.48
October 2018 – September 2019	105.93	2	100	118.77	69.79
October 2017 – September 2018	109.92	3	100	126.81	69.17
July 2016 – June 2017	112.32	2	100	122.77	72.61

NB COVID-19 has been excluded from the SHMI 2020-2021 at a national level by NHS Digital, this is to make the indicator values as consistent as possible with those from previous reporting periods. The most up to date data is displayed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher than expected number of deaths.

Trusts are banded 1-3 as follows:

1. The Trust's mortality rate is 'higher than expected'.
2. The Trust's mortality rate is 'as expected'.
3. Where the Trust's mortality rate is 'lower than expected'.

The Trust was categorised 'as expected' over the past 12 months.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

The Trust share learning from the Mortality Review group using the Mortality and Morbidity (M&M) meetings which are an opportunity for peer review, collective learning and quality improvement. These are held across all CBU's on their allocated audit days. Mortality and morbidity meetings are a professionally accountable forum based on sound educational principles. They encourage openness, honesty and transparency from participants. They focus upon learning and improvement of systems and processes of care and not on individual performance.

• Learning from deaths

In March 2017, The National Quality Board issued "National Guidance on Learning from Deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care". This guidance included the requirements that trusts must publish a Learning from Deaths policy, and that from December 2018 Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting. This data must include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.

Reducing mortality is a priority for the Trust and is focused through the Mortality Review Group (MRG). The Mortality Review Group performs in-depth investigations using the Structured Judgement Review methodology into groups of patients conforming to agreed criteria as defined within the Trust Learning from Deaths policy.

The Trust currently has 8 trained clinicians who are trained in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes. The Trust has developed an electronic system which logs Structured Judgement Reviews (SJR) electronically and triangulates findings with complaints, claims, inquests, Medical Examiners Office and clinical incidents. This facilitates richer learning across the Trust.

Mortality meetings focus upon process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. Any actions and improvements that have been made by the Mortality Review Group are reported to the Patient Safety & Clinical Effectiveness Sub-Committee monthly and the Quality Assurance Committee.

From 1st April 2022 to 31st March 2023, 431 SJRs were completed. 9 investigations (Serious Incidents) were carried out in relation to 1427 of the deaths. They occurred in each quarter of that reporting period as follows:

- Quarter 1 - 97 SJRs completed and 2 Serious Incidents.
- Quarter 2 – 100 SJRs completed and 3 Serious Incidents.
- Quarter 3 - 101 SJRs completed and 2 Serious Incidents.
- Quarter 4 – 133 SJRs completed and 2 Serious Incidents.

In order to support learning across the Trust human factors training has been undertaken in accordance with findings of Trust internal intelligence to continually drive the standard of care delivered to patients. The Mortality Review Group will also form part of the wider Patient Safety Incident Response Framework in 2023-24.

The Mortality Review Group alongside other modalities provides valuable feedback on all aspects of care and helps us to understand what we may need to improve upon. It also provides the opportunity to identify practice that has been effective and meaningful to our patients. In addition, quality improvement leads attend the Mortality Review Group to triangulate themes identified with quality improvement initiatives.

The Trust publishes their quarterly and annual Report on Mortality Reviews on the Trust's website: www.www,nhs.uk https://www.www.nhs.net_board-meetings-and-papers

Participation in National Clinical Audits 2022-23

Clinical audit forms an integral part of the clinical governance framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change(s): New Principles of Best Practice in Clinical Audit, Healthcare Quality Improvement Partnership, 2nd Edition, 2011.

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit. Clinical audit is the governance vehicle in relation to determining assurance within clinical practice and is integral to the core business of the Trust.

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust recognising the importance of the annual forward audit plan and its contribution to improving patient outcomes and experience. The Trust-wide Forward Audit Plan 2022-23 was implemented at the start of the financial year following approval by the Patient Safety and Clinical Effectiveness Committee and by the Quality Assurance Committee.

The Trust is also committed to undertaking local clinical audits many of which focus upon some of the greatest challenges experienced by the population that we serve. The information below provides an overview of all the national clinical audits, and local clinical audits undertaken during 2022-23. The table below details each of the national clinical audits and identified the actions the Trust will take to improve the quality of healthcare provided:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
1.	Myocardial Ischaemia National Audit Project (MINAP)	The Trust involvement in the national mandatory Myocardial Ischaemia National Audit Project (MINAP) show: Patient's undergoing angiography within 72hours of admission has decreased from 40.97% to 31.82%. Timely access to angiography for patients admitted to the trust is entirely dependent on capacity to undertake angiography at the local tertiary centre (Liverpool Heart and Chest Hospital). **Actions:** • Review angiography triage process to optimise efficiency of early referral. • Improve communication with Liverpool Heart and Chest to improve time to angiography (system partner pathway review). Escalate delays to angiography early. • Education and dissemination of referral criteria to cardiac rehabilitation.
2.	National Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	The Trust perinatal mortality for births within the Trust in is within the Standard Deviation. All stillbirths and neonatal deaths within 28 days have a review, which includes external representation from neonatal, obstetric and midwifery colleagues from the Cheshire and Merseyside Local Maternity System (LMS). Information is sent via the Perinatal Mortality Review Tool, which is nationally adopted and collects this data. In addition, Warrington and Halton are compliant with all elements of the NHSE Saving Babies Lives Care Bundle 2019.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		Further improvements will be enhanced by the following: • Implementation of Badger Notes with multiple language patient information leaflets (on reduced foetal movements) • Implementation of Birmingham Symptom-specific Obstetric Triage System (BSOTS) system
3.	National Hip Fracture Database: 1st April 2019 - 31st Jan 2023	• A series of action plans have been implemented via Theatres Improvement Group; additional support is required to establish Theatre 2 as a forward waiting area for the next fractured neck of femur patient but additional funding for staff/start time of clinics/escalation policy is needed. • The action plan will be monitored via a red flag report at the monthly Governance meeting, where this issue is a standing agenda item. • The Patient Safety and Clinical Effectiveness Committee has asked for quarterly updates on progress. Latest update (March 2023) included a summary of the following: – Standardisation in productivity by Consultant's – Extension of trauma theatre finish times – Additional weekly scheduling of trauma list Continued in reach frailty service model
4.	National Prostate Cancer (NPCA):	The NPCA reports on 14 performance indicators of which seven are applicable to the Specialist MDT which Warrington and Halton Hospital work with in collaboration. It is positive to note that out of the patients that completed a Patient Satisfaction Survey 92% rated their overall care as 8/10 or above.
5.	Breast Cancer Implant Registry (BCIR): 1st Jan 2021 - 31st Dec 2021	• The latest data was reviewed along with the previous 2 years. • It was agreed by Lead Clinician and Medical Director for Clinical Effectiveness that no further scrutiny from a cancer perspective is required. No action plan for improvement required.
6.	The British Association of Urological Surgeons (BAUS) Renal Colic: 1st - 30th Nov 2020	• This audit was highlighted an issue in the Trust does not have access to "hot lists" to deal with urgent stone cases by laser as per the NICE guidance and something that this audit was trying to capture nationally. • The service has a number of items on the Risk Register which have been monitored at the Patient Safety and Clinical Effectiveness Sub Committee.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		The Urology team are aware of service limitations and the response to address the concern is by participating in an improvement project
7.	Adult Asthma	Warrington and Halton Hospitals results are lower that the England national average for the Key Performance Indicators (KPI's) 1 (wheeze) and 3 (worsening symptoms). The Trust has a high compliance rate with the Discharge Bundle when compared to national data (83% versus 48%).
8.	National Ophthalmology Database (NOD) Cataract Surgery: 1st April 2020 - 31st Mar 2021	Most operations at Warrington and Halton Hospitals were conducted by consultant surgeons (77%), with a small proportion (22%) being undertaken by more experienced trainee surgeons, none by career grade non-consultant surgeons and limited numbers (0.9%) by less experienced trainee surgeons. No action plan for improvement required.
9.	Cardiac Rhythm Management (CRM): 1st April 2020 - 31st Mar 2021	Not many procedures performed locally at Warrington and Halton Hospitals, except simple permanent pacemakers for bradycardia. The relevant metrics of re-intervention are in keeping with national standards. No action plan for improvement required.
10.	National Audit of Smoking Cessation: 1st July - 31st Aug 2021	All patients in the audit were asked about their smoking status and this was documented in their medical notes. When compared to the national figures Warrington Hospital positively records this data. Just under half the sample (45.0%) were offered nicotine products to help them abstain. This is higher than the national figure at 32.4%. Although for 20.0% of the sample there were no follow up arrangements made this is better than the national figure (29.0%). Further improvements will be enhanced by the following action plan: • To ensure the 55% of the sample are offered nicotine products to help them abstain • Clear follow up arrangements in discharge plan • Assess numbers of patients abstinent after 4 weeks after discharge

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
11.	National Audit of Breast Cancer in Older Patients (NABCOP): 1st Jan 2014 - 31st Dec 2020	Warrington and Halton Hospitals have been testing the hormone receptor status on ALL invasive breast cancers for the 11 years and ALL invasive cancers are discussed in the breast Multi-Disciplinary Team (MDT) . NICE guidance id followed NG101 – Early and locally advanced breast cancer: diagnosis and management. Further improvements will be enhanced by the following action plan: • Undertake a clinical audit to ascertain why reoperation rate anecdotally from experience in the MDT is lower than the national stated average but has been reported as higher in certain age groups • Undertake a clinical audit of reoperation rates following breast conserving surgery
12.	Cardiac Rehabilitation: 1st Jan 2020 - 31st Dec 2020	Data from the Audit of Cardiac Rehabilitation (ACR) is used to quality assure services in the UK and in doing so creates an opportunity to support patient choice through sharing relevant data. Warrington and Halton were awarded with a green flag, showing no risk s to the Trust. No action plan for improvement required.
13.	Children and Young People Asthma – Clinical Data and Organisational Data: 1st Jan 2020 - 31st Dec 2020	The Warrington and Halton Hospitals results are only applicable in 3 out of the 5 Key Performance Indicators (KPI's) due to having no patients in the sample (patient smokers) or parent/carer who are smokers. • Steroids administered within 1 hr of arrival at hospital exceeded the national average 54% compared to 41%. • Inhaler technique checking was performed in 91% of cases audited compared to 63% nationally. • Further improvements will be enhanced by the following action plan: Include the Patient Asthma Plan (PAP) as part of discharge planning.
14.	Pulmonary Rehabilitation (PR) Regional Report: 1st April 2021 - 30 April 2021	The main are to be highlighted are the wait times which we know are prolonged due to backlog from the pandemic. Further improvements will be enhanced by the following action plan: • Suitable patients will have incremental shuttle walk test as outcome measure. • Moving forward aim to work with other Trusts to sign up to the Accreditation Process.
15.	National Diabetes Audit type 1 Report: 1st Jan 2020 - 31st Mar 2021	Adequate processes exist and are being followed in relation to managing Type 1 Diabetes Mellitus. Further improvements will be enhanced by the following action plan:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		• Mandatory insulin training to include: • E-learning at induction followed by a training update by the Diabetes Specialist Nurses • A mandatory insulin training update organised by Diabetes Specialist Nurses to be attended every two years. • The training to be included on Electronic Staff Record (ESR) and on training compliance reports. • Diabetes Specialist Nurses to provide teaching sessions for Emergency Department, and wards. • To include in the Guideline for the management of medicines errors specific insulin training to be completed by staff involved in insulin incidents. • Review of Emergency Department stock lists to ensure Intravenous fluids used in Diabetic ketoacidosis (DKA) are included. • ICE (The Sunquest ICE system links GP practice directly to our laboratories, meaning results can be requested electronically) Diabetes in-reach service pathway/referral form is being upgraded to gather information which will help triage new in-patient referrals optimally.
16.	National Neonatal Audit Programme (NNAP)	Specific quality improvement programmes have increased the rates of normothermia and breastfeeding on the neonatal unit significantly, improving outcomes for parents and babies. Parental presence on the neonatal unit was severely affected by the Covid-19 pandemic. This has now improved with a focus upon family integrated care. Action plan for Further Improvement: • Ensure staff training and parental support to express and deliver colostrum to baby within 24 hours of life. • Continue quality improvement project using temperature control measures on delivery suite and monitoring of temperature from birth. • Ensure Badger net is completed to record when parents have attended ward round. • Continue Family Integrated Care (FICare) to support families to be involved in everyday care.
17.	Paediatric Diabetes (NPDA):	The Clinical outcomes continue to be above the national average for:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		• Patients with poor control were consistently lower when compared to national average. • A greater number of patients with good control despite COVID pandemic pressures. • Lower than national average regarding patients with kidney disease. **Action for Further Improvement:** • Raise awareness among patients for regular annual eye checks (Digibete Application Communication). • Training plus raising awareness for junior doctors at induction to ensure completion of Thyroid and Coeliac screening completed and chased at diagnosis. • Ensure communication to regional eye screening team to obtain annual screen reports.
18.	National Joint Registry (NJR)	Warrington and Halton Hospitals and the Captain Sir Tom Moore Building (formerly known as Cheshire and Merseyside Treatment Centre) are performing within the 'expected' range for hip, knee, elbow, and shoulder replacement surgery. Performance is 'better than expected' in 4 out of the 5 quality measures.
19.	Chronic Obstructive Pulmonary Disease Audit (COPD)	Warrington and Halton Hospitals results were higher than national figures for 4 out of 6 Key Performance Indicators. For the KPI 1 Acute treatment with NIV within 2 hours of arrival and KPI 3 Spirometry results available statistics are below the national average. **Action for Further Improvement:** • Training to be rolled implemented regarding obtaining prompt arterial blood gases and venous blood gases (ABG/VBG) with appropriate and timely action.
20.	Stroke Sentinel National Audit Programme (SSNAP)	In the final two quarters of 2022/ 2023 Warrington and Halton Hospitals noted a declining position namely in the timely repatriation of patients. This has been impacted by a continued high number of attends and the high number of patients considered to be stranded.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2022/23**	**Quality Improvement Plan: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		Action for Further Improvement: Improve flow through stroke unit to support repatriation. Improvement evidenced to date. Review of stroke pathway through ED.
21.	British Thoracic services (BTS) Pleural Services Organisational Audit: April 2021 - snapshot	Warrington and Halton Hospitals provides an expanding pleural procedures service. Non general anaesthetic pleural procedures performed in last year were over 1200 which is in the top 5 nationally. However, a number if service limitations were noted. • A number of actions are in place to improve the service: • The appointment of trust pleural lead through recent consultant appointment. • Getting it Right First Time (GIRFT) action. • Dedicated pleural service with Outpatient clinics, data capture for Best Practice Tariff (BPT), pleural in-reach and dedicated referrals pathway. • Develop an indwelling pleural catheter service and medical thoracoscopy. • Continue with Pleural Local Safety Standards for Invasive Procedures (LocSSIPs) audits.

Local clinical audit is important in measuring and benchmarking clinical practice against agreed markers of good professional practice stimulating changes to improve practice and re-audit to determine that service improvements have been made and sustained.

The reports of 39 local clinical audits were reviewed by the Trust in 2022-23 with actions in progress to improve the quality of healthcare provided. The table below details a sample of local audits undertaken.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance to the Board of Directors 2022/23**	**Details of actions taken to improve the quality of local services and the outcomes of care**
Clinical Support Services		
	2022 Administration of Blood Audit- Bedside Practice	'Bloody Matters' newsletter produced and disseminated. The publication included a reminder to staff that blood transfusions must run through a pump using the correct administration set as outlined in the policy. Running blood through a pump reduces the risk of the under or over prescription of timed infusions. Training compliance can now be viewed through the LION Portal. At the 31 March 2023, compliance was 84.64%.

		The Trust has been piloting a traceability bedside digital app on the Programmed Investigation Unit at Halton. At present a web-based version of the app has been trialled. A Transfusion Link Nurses Group has been established.
2.	Investigation and initial management of Suspected Meningitis in Adults at Warrington Hospital	Creation of Standard Operating Procedure to support the overview of meningitis treatment and important considerations during investigation. To be added for completeness to meningitis guidelines on Micro guide.
3.	Radiographers Initial Image Interpretation	Image interpretation teaching sessions with dissemination of audit results. Discussion and learning to be shared at Governance meeting. Re-audit scheduled.
4.	Quality of Chest X-ray for Nasogastric Tube	Imaging protocol to be reviewed including post-processing algorithm. Re-audit scheduled.
5.	Audit of compliance of mismatch repair (MMR) / microsatellite instability testing (MSI) /Lynch Testing of Colorectal Specimens	All colorectal carcinoma biopsy specimens (if sufficient material) or resection specimens to be sent for MMR. Communicated throughout the department. Re-audit scheduled.
6.	Audit of the Ratio of Anterior-Posterior/Posterior- Anterior (PA/AP) Chest X-rays Performed in Emergency Department X-ray	Continue to promote the importance PA projection and remind clinical staff to ensure mobility on request is correct. Staff education on methods to facilitate PA projections in patients with poor mobility underway.
Corporate Services		
7.	National Early Warning Score (NEWS2)	Acute Care Team to review observations for patients and support identified training needs. All nurses to maintain attendance at Acute Illness Management (AIM) course every three years. Compliance with NEWS2 reported via PSCESC. Weekly and monthly local audits in place. Publish E-learning for NEWS2 and escalation, including Medical Emergency Team (MET) calls. 8-hourly setting to be removed, reducing risk of patients having this selected when NEWS 1-4.

		Fraxinus to remove the clinical parameters box from the screen completed by nurses on every observation set. To be accessed via computer/laptop via "observations settings" button.
8.	Trust Wide Discharge Summary Audit	Review discharge summary template miscellaneous section to improve completion of AKI section, falls and blood transfusion. Audit Function of E-outcomes to be explored to establish if Expected Date of Discharge (EDD) history with date and time can be reviewed for audit purposes. Digital compliance audit of completion of discharge checklist to be explored. Easily accessible information available on every inpatient area regarding Trust Discharge Planning Policy, to support non-Trust staff. Training and education to be provided at ward level on Discharge Planning Policy and Standard Operating Procedure, including use of Discharge Checklist. Further Trust Wide audit to be conducted – planned.
9.	Staffing Escalation Audit	Gold command status (red/amber/green) assurance of staffing position. Where red flags are identified the site manager and late Matron to visit the area to discuss risk assessment and actions to be taken. All staffing moves need to be recorded on gold command and staffing numbers to be reflective of this.
Digestive Diseases		
10.	Surgical Site Infection Post Elective Breast Surgery – a Retrospective Audit	Routine antibiotic prophylaxis should be considered / advised for high-risk surgical patients e.g., high Body Mass Index (BMI), diabetes and immuno-compromised) who are undergoing non implant, non-reconstructive and recurrent elective breast surgery.
11.	Incidence and Management of Deliberate Foreign Body Ingestion at Warrington and Halton NHS Trust	Monitored via Director of Governance. Escalated to PLACE / NHSE/ Elysium/ PROSPECT. Reported to Quality Assurance Committee. Reported to Adult Safeguarding Board. 3 pronged approach.

		Review of pathways. Education / training. Passports and appropriate documentation.
• Integrated Medicine & Community		
12.	Measurement of Lying and Standing Blood Pressure in Patients Above 65	Including Lying standing Blood Pressure record (paper)into Multifactorial fall risk assessment booklet. Modifying the lying standing BP recording form as per Royal College of Physicians (RCP) guidelines.
13.	Management of Acute subdural Haematoma in the Elderly	Develop Local guidelines on management of acute subdural hematoma. Re-audit after implementation of guidelines.
Medical Care		
14.	Osteoporosis in Rheumatoid Arthritis Patients	Education regarding the significance of bone health measurements in patients with inflammatory arthritis via sharing and highlighting research papers about. Bone health assessment proforma to be readily available. Re-audit scheduled.
15.	Re-audit to Assess the Recognition and Initial Management of Acute Kidney Injury Among Medical Admissions in Acute Medical Unit	Ensure AKI is on the trust mandatory training. Ensure AKI role is embedded within the Acute Care Team. Implementation of AKI care Bundle.
16.	Monitoring of blood glucose in Respiratory patients on Glucocorticoid therapy	Development of a local Guideline for monitoring and management of Steroid induced hyperglycaemia with input from Diabetes and Endocrine Team. To be supported by a quality Improvement project for improvement and sustainability.
Surgical Specialities		
17.	Orthoptic Investigation of Intermittent Distance Exotropia Guidelines Audit	To review the IDEX treatment guidelines and reflect accordingly. Embed a journal club to evaluate the need for minus lens treatment and far distance measurements. Liaise with Newcastle Orthoptic Department to establish the need for Newcastle Control Score.
18.	Audit to study new referrals to Diabetic Retinopathy service	Review appointment letters to ensure that appropriate level of importance is highlighted to influence attendance rate.

19.	Stroke Service Review	Maintain current standards of 100% compliance to the Royal College of Physicians clinical guidelines standards 1,2 ,4 and 6 by offering all patients an assessment.
20.	Surgical Outcomes – Strabismus Surgery	100% of patients to have a quantitative range for surgical aim in Medi sight rather than a definitive number.
21.	BOAST Fracture Clinic Service and Virtual Fracture Clinic Quality Improvement project	Introduce the E-Trauma system.
Urgent & Emergency		
22.	Renal Screen Ordering in Acute Kidney Injury (AKI) Stage 2/3 at Warrington Hospital	Create a renal Tab in ICE (Sunquest ICE system links GP practice's directly to the laboratories, allowing for electronic results request).
23.	Compliance with HEART score and RCEM Consultant Sign off for Cardiac Chest pain in the Emergency Department	Electrocardiogram (ECG) sign-off training for clinicians in the Emergency Department. Reiterate the HEART score (scoring system for major cardiac events) pathway in induction.
24.	Re-audit to Assess the Recognition and Initial Management of Acute Kidney Injury (AKI) among Medical Admissions in Acute Medical Unit	Ensure AKI is on the trust mandatory training. Ensure AKI role in the acute care team is implemented. Implementation of AKI care Bundle in the trust policy. Pharmacy to expedite AKI medication reviews as able.
25.	ECG Prioritisation in Patients Presenting to A&E with Chest Pain	Consider one designated area for triage solely for ECGs. Consider designated ECG technician.
26.	First Seizure Management in Emergency Department (ED)	Ensure provision driving and occupational advice to all relevant 1st seizure patients as per Royal College of Emergency Medicine (RCEM) standards. To make available printable advice leaflets in ED.
Women & Children		
27.	Evacuation of Retained Products of Conception - Current Practice	Training of staff to carry out procedure. Information leaflet for patients. Nurse and doctor training about procedure and how to counsel women. Place onto planned theatre lists to positively influence uptake.
28.	Readmissions with Caesarean Section wound infections	Raise staff awareness of the importance of reviewing swab results. Opportunity to share via 'Our wise learning'.

		Formulate a Standard Operating Procedure for women presenting with Caesarean section wound infection in the postnatal period.
29.	Transitional Care of the New-born	Improving Transitional Care Documentation. Review of the location/staffing model for Transitional Care/Additional Care. Discussion with the CBU. Education of midwifery staff.
30.	Use of Robson Classification to Assess Caesarean Section Rates in Warrington Hospital.	Establish designated Vaginal Birth after Caesarean (VBAC) clinic
31.	The Efficiency of the Elective Caesarean Section Theatre Lists at Warrington Hospital	A new local Warrington 'Elective Caesarean Section' guideline to be published. Designated team to oversee all cases.
32.	Chronic Hypertension in Pregnancy Audit	All women with hypertension or any maternal medical conditions should be booked by 10 weeks. Monitoring processes in place.
33.	7 Day Services Clinical Standard 2 Audit: Time to Consultant Review: 14 hours	Discussion with consultant team regarding weekend /evening to consider new eligible patients within specified time period. Model under review.
34.	Impact of Freestyle Libre on Type 1 Diabetes Mellitus	Baseline lab HbA1c (average blood glucose i.e., sugar levels for the last two to three months) to be recorded at commencement of Freestyle Libre. (FreeStyle Libre is a continuous glucose monitoring (CGM) system that doesn't require a blood sample from a finger stick). Input Libre Ambulatory Glucose Profile (AGP) data in clinic letters. Libre education to include all interested patients with an offering to all eligible patients at time of diagnosis. Involvement of Youth Workers to target postcode areas with low uptake.
35.	System-wide Paediatric Observations Tracking (SPOT) Re-Audit	Single Point lesson to be sent to staff raising awareness regarding importance of documentation and escalation of risk (PEWS).

- ## Improve outcomes, based on evidence: such as National Institute of Clinical Excellence (NICE)

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

The guidance takes many forms: NICE guidelines which can be clinical guidelines, social care, public health and medicines practice; technology appraisals; Interventional procedures; medical technologies; diagnostics and highly specialised technologies. The WHHFT Trust database identifies and documents NICE Clinical Guidelines, Technology Appraisals and Quality Standards.

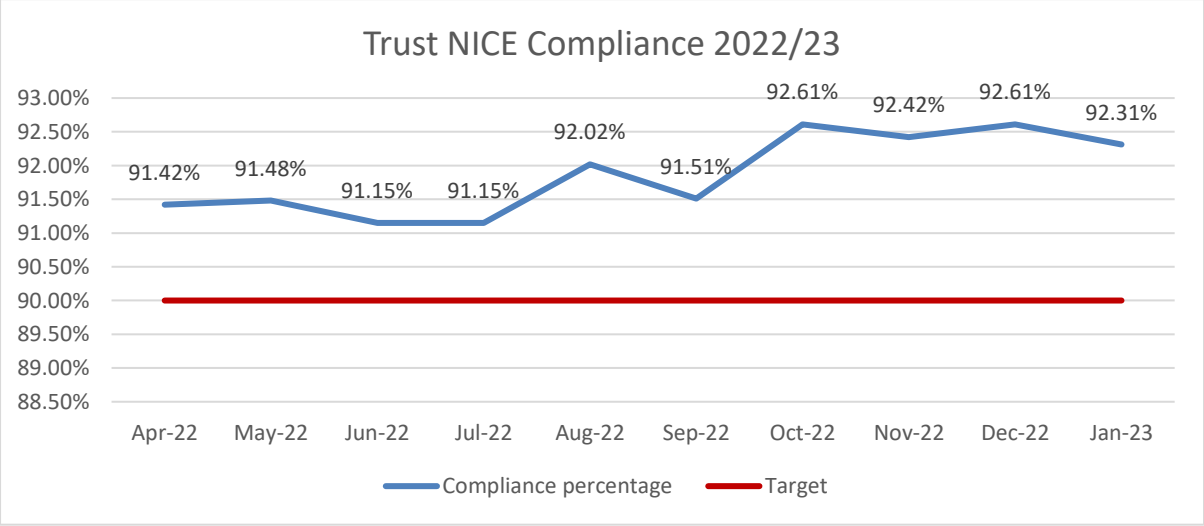
NICE publishes guidance monthly. The Trust is required to review the guidance and assess whether it is applicable to the services it provides and where relevant, conduct a baseline assessment to determine if the Trust is compliant with the guidance. Where the Trust is not compliant an action plan is developed and implemented.

Trust Position:

The Trust has 7 categories for applicable NICE guidance:

- Compliance under review (in date) –guidance has been sent to the lead and a response is awaited but is still within timeframe.
- Compliance under review (overdue) – guidance has been sent to the lead, but a response has not been received within timeframe.
- Non-Compliant - The Trust are not compliant with the guidance.
- Full Compliance – The Trust is compliant with the guidance and full evidence received.
- Partially Compliant- The Trust have partial compliance with the guidance as not all recommendations have been met.
- Agreed Partial Compliance – The Trust has received full evidence and has full compliance within its services, however, cannot be assessed as full compliance due to not offering all services within the guideline.
- For information purposes only

Graph 1 – An overview of the Trust's compliance with NICE in 2022/23



The Trust's current compliance with NICE Guidance is 91.65% which remains over the target of 90% compliance.

The table details – Each CBU's latest NICE compliance figures:

CBU	Number of Guidelines compliant	Number of partial compliance guidelines	Guidelines under review	Compliance
Clinical Support Services	217	1	0	**99.64%**
Digestive Diseases	43	2	2	**91.49%**
Integrated Medicine & Community	16	2	0	**88.89%**
Medical Care	53	9	2	**82.81%**
Surgery Specialties	39	4	1	**88.64%**
Urgent & Emergency Care	22	0	0	**100%**
W&C Health	81	4	1	**94.19%**

The table below details – Applicable NICE Guidance data:

Type of Guidance	*Full Compliance	Agreed Partial Compliance	Partial Compliance	Non-Compliant	For information purposes only	Under Review	Grand Total
CLINICAL GUIDELINE	136	14	29	0	20	7	**206**
QUALITY STANDARD	113	14	9	0	1	1	**138**
TECHNOLOGY APPRAISAL- *Technology appraisals are recommendations on the use of new and existing medicines and treatments within the NHS.*	228	0	0	0	1	0	**229**
Grand Total of those applicable)	**477**	**28**	**38**	**0**	**22**	**8**	**573**

573 pieces applicable NICE Guidelines are on the NICE database. Of these, 38 are partially compliant which is an increase of 2 from the last reporting period. This is an expected increase due to a stricter

approach when assessing overall compliance of a guideline. If one recommendation within the guideline is not met or is partially met, then the guideline will be assessed as partial compliance. This allows for more robust monitoring of actions and deadlines to progress the recommendation. Actions are monitored through action plans and the Clinical Effectiveness Managers attendance at monthly CBU and Specialty Governance meetings.

Under Review guidelines

- There are currently 8 guidelines that are "*Under Review"* to determine compliance. This is a reduction of 2 from the last reporting period.
- 4 guidelines are currently being evaluated within timeframe and 4 are overdue, with plans in place to reduce this.
- All 3 guidelines that were previously overdue on the last reporting period have now been completed.

The table details – Overdue NICE Guidelines:

NICE ID	NICE Title	Type of Guidance	CBU/Area
NG14	Melanoma@ assessment and management	NICE Clinical Guideline	Trust-wide
QS226	Osteoarthritis in over 16s: diagnosis and management	NICE Quality Standard	Surgical Specialities
NG225	Self Harm:assessment, management and preventing recurrence	NICE Clinical Guideline	Trust-wide
NG228	Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management	NICE Clinical Guideline	Digestive Diseases

Actions in place for overdue guidance:

NG14
This guideline was sent for clarification to ascertain a lead. It has been clarified that this guideline relates to Dermatology therefore has been sent to the Senior Manager of the Medical Care CBU for urgent review and completion of this guideline. Full support has been offered from the Clinical Effectiveness Manager to ensure the prompt completion of this guideline.

QS226
This guideline was allocated to the Trauma & Orthopaedic (T&O) Team on 24th November 2022. A deadline was given of 19th January 2023. Unfortunately, due to operational pressures this deadline was not met, however a meeting to progress the baseline has been arranged for 29th March 2023 and from there, the Clinical Effectiveness Manager will provide appropriate escalation to the CBU leads and offer support to ensure that the completion of the quality standard is prioritised.

NG225
This guideline was allocated to the Safeguarding Team for review. The Safeguarding Team suggested that this guideline be taken for discussion to the Mental Health Steering Group and to the Emergency

Department and the Paediatric Teams for input. The Clinical Effectiveness Manager is currently in discussion with all relevant departments to ensure this guideline is completed promptly.

NG228
This guideline was sent to the Associate Medical Director for Clinical Effectiveness's deputy for NICE to review and ascertain if this guideline is applicable to WHH. The Clinical Effectiveness Manager and the Associate Medical Director for Clinical Effectiveness's deputy for NICE is still waiting on clarification as to whether this guideline is applicable to WHH. This is being escalated at the Speciality Governance Meeting.

Workstreams currently being undertaken.

- The new Clinical Effectiveness Manager has now commenced in post.
- The Clinical Effectiveness Manager has continued providing monthly performance reports to monthly CBU and Specialty Governance meetings.
- Meetings with service leads are taking place to progress the guidelines 'under review'.
- The newly appointed Associate Medical Director for Clinical Effectiveness who oversees NICE has monthly meetings with the Clinical Effectiveness Manager to help establish leads for guidelines and ensure a triangulated approach to progressing the partially compliant guidelines.
- Action plans for all partial compliant guidelines have been sent to all relevant leads for review.
- WHH is in the process of preparing to transfer our NICE data onto the upgraded version of sharepoint.
- In preparation for this transition. WHH is working with coreshare to map out what is required from the upgraded sharepoint system. Initial migration is expected to take place by the end of Q1 2023/2024.

Workstreams planned for the next reporting period.

- The Clinical Effectiveness Manager to liaise closely with the relevant leads to ensure all 'under review' guidelines are promptly completed.
- The Clinical Effectiveness Manager to continue to review the remaining partially compliant guidelines to ensure actions plans, leads and deadlines are in place. These will then be circulated to the CBU's for discussion and escalation.
- The Clinical Effectiveness Manager and Associate Director of Governance are liaising with coreshare to ensure a smooth migration of NICE data onto the upgraded sharepoint online system (currently sharepoint 2010)

Patient Experience Domain:

Focus and acting on what patients tell us and co-creating solutions to challenges they face

The Trust is on journey 'Moving to Outstanding' and the examples of Patient Experience Improvements within the Care Groups is demonstrated below.

Virtual tours

A number of virtual tours have been created and published to support accessibility to services. These have included Main Outpatients, Children's Outpatients and Neonatal Services. Neonatal services have also included a flip book of information for parents detailing what to expect from the service and support available. Children's Outpatients services included children and young people as the guides for the video ensuring the tour is relatable to children and young people using the service.

Patient Activities

In support of the Trust Active Hospital campaign which aims to change the physical activity culture within WHH to encourage patients to move more and remain active during their hospital stay, activity timetables have increased on wards which has been particularly successful with patients living with dementia. As an example, ward A6 have commenced an activity timetable.

- **Involving patients in their care and embracing the 'no decision about me without me' philosophy.**

Clinical business units each share examples of lived experience of patients during their stay in hospital. There are many examples where the wards have demonstrated they are actively listening to their patients to support their wellbeing and holistic needs in addition to clinical needs.

- **Patient Story:** One example details support for a 25-year-old patient admitted to B18 who had a background of complex respiratory conditions and learning disabilities. Some of the ways the team supported this patient included hand massages, painting her nails, meeting mini mouse and Barney, carol singers and birthday presents from the team. These activities not only provided an outstanding patient experience but enhanced trust between the patient and the team caring for her ensuring she felt calm and safe whilst in their care.

Ockenden Report

All Trusts were asked to reassess their position in terms of the 15 Immediate and Essential safety actions recommended following the publication of the Ockenden Report Part 2 on 30 March 2022. The Women's and Children's CBU Governance meeting considered the Trust's position against these recommendations and a monthly update report is presented to the Quality Assurance Committee (QAC).

The Maternity Team have focused on implementing the actions from the Ockenden report with assurance of completion evidenced within three action plans:

- Ockenden Part 1a developed following release of the first report.
- Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence. submitted.
- Ockenden Part 2 following the launch of the second report.

Ockenden 1 actions are on schedule for completion by December 2023 (within timeframe). Ockenden 2 does not have any national timelines attached. The Trust have agreed internal deadlines for completion of 30th November 2023.

The final position at the close of 2022/2023 is as follows:

- Ockenden Part 1a: 100% compliant.
- Ockenden 1b: 94.91% compliant and on trajectory to achieve 100% compliance by 30th December 2023. There are no urgent actions.
-

- Ockenden 2: 68.53% compliant - on trajectory to achieve 100% compliance by 30th November 2023.

During 2023-24, the monthly Women's and Children's CBU Governance meetings and the monthly Quality Assurance Committee (QAC) will continue to monitor compliance.

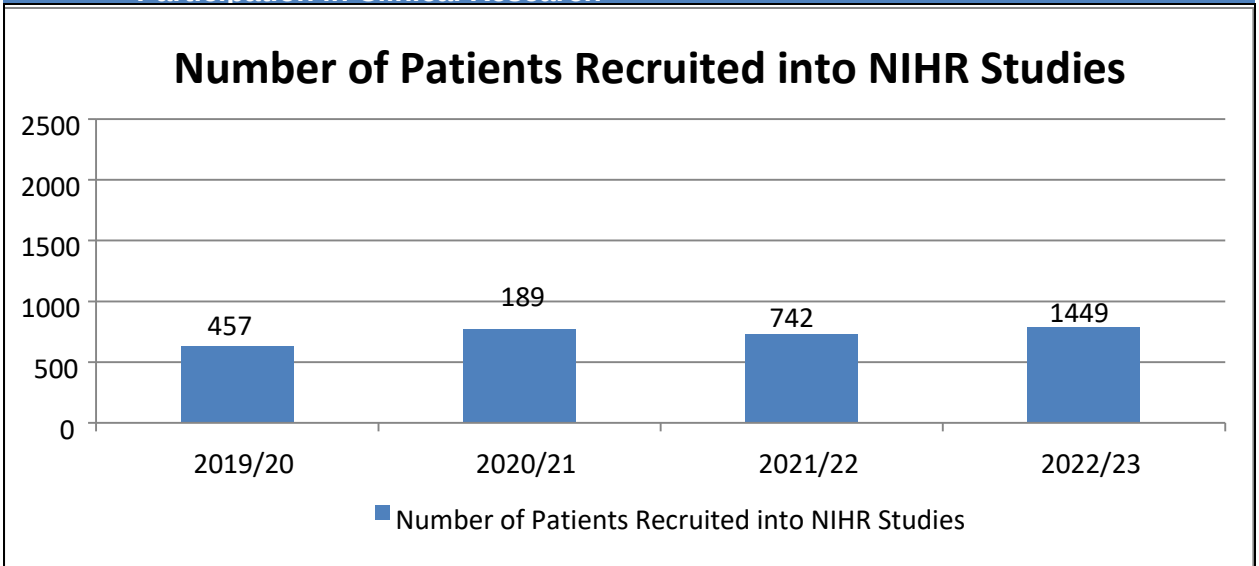
Participation in Clinical Research and Development (R&D) 2022-23

What is clinical research: Clinical Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. The Trust is only involved with research studies that have received a favourable opinion from the Research Ethics Committee within the National Research Ethics Service (NRES), signifying the research projects are of high scientific quality and have been risk assessed.

The Research and Development Department is committed to providing patients with the opportunity to participate in research if they wish. We aim to ask all eligible patients if they would like to participate in a clinical trial.

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2022/23 during that period to participate in research approved by a research ethics committee was 1449 (95% growth) when compared to the previous financial year). It should be noted that in 2022-23, NIHR Portfolio Study data is not signed off nationally until 30th June 2023 and the patient participation figure is, therefore, un-validated at this time.

- Participation in Clinical Research



Data Source: NIHR Portfolio Database of studies . *This data is governed by standard national definitions.*

The National Institute of Health and Care Research (NIHR) portfolio studies are high quality research that have full funding and have undergone a rigorous peer review in order for them to be adopted onto the portfolio.

Participation in clinical research and the growth in participants evidences the commitment of Warrington and Halton Teaching Hospitals, NHS Foundation Trust to improving the quality of care offered, contributing to wider health improvement. The opening of the Halton Clinical Research Unit has been fundamental in creating an accessible platform for the public to access research trials.

Warrington and Halton Teaching Hospitals NHS Foundation Trust was involved in conducting 19 clinical research studies during 2022-23, covering 13 healthcare specialties as outlined in the Table below.

Study Type	Sponsor	Short Name	Study Title	Managing Speciality	Recruits
Non-Commercial	University of Nottingham	Routine testing for Group B Streptococcus	The clinical and cost-effectiveness of testing for Group B Streptococcus: a cluster randomised trial with economic and acceptability evaluations (GBS3)	Reproductive Health and Childbirth	881
Commercial	MODERNA, INC.	mRNA-1273.529-P206	A Phase 2/3, Randomized, Observer-blind, Active-controlled, Multicenter Study to Evaluate the Immunogenicity and Safety of mRNA-1273.529 (B.1.1.529, Omicon Variant) in Comparison with mRNA-1273 (Prototype) Booster Vaccine	Infection	200
Non-Commercial	AECC UNIVERSITY COLLEGE	STOPPAGE: STandardisation Of suPine Pelvic rAdioGraph tEchnique	STandardisation Of suPine Pelvic rAdioGraph tEchnique (STOPPAGE). Validating a different centring point for pelvic radiographs in a supine position.	Health Services Research	100
Non-Commercial	INTENSIVE CARE NATIONAL AUDIT AND RESEARCH CENTRE (ICNARC)	UK-ROX	Evaluating the clinical and cost-effectiveness of a conservative approach to oxygen therapy for invasively ventilated adults in intensive care.	Critical Care	71

Study Type	Sponsor	Short Name	Study Title	Managing Speciality	Recruits
Non-Commercial	PUBLIC HEALTH ENGLAND	SIREN Winter Pressures	SIREN Winter Pressures Study	Infection	56
Commercial	SANOFI	HARMONIE	A Phase IIIb randomized open label study of nirsevimab (versus no intervention) in preventing hospitalizations due to respiratory syncytial virus in infants (HARMONIE)	Children	52
Non-Commercial	LOTHIAN	GenOMICC	Genetics of susceptibility and mortality in critical care (GenOMICC)	Critical Care	21
Non-Commercial	University of Oxford	ORION-4	HPS-4/TIMI 65/ORION-4: A double-blind randomized placebo-controlled trial assessing the effects of inclisiran on clinical outcomes among people with atherosclerotic cardiovascular disease	Cardiovascular Disease	18
Non-Commercial	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	NAFLD BioResource	The NAFLD BioResource, part of the NIHR BioResource – A Research Study to Characterise Novel Clinical and Genetic Phenotypes, and Understand the Natural History of Non-Alcoholic Fatty Liver Disease (NAFLD)	Hepatology	17
Non-Commercial	BELFAST HEALTH AND SOCIAL CARE TRUST	MARCH	Mucoactives in Acute Respiratory failure: Carbocisteine and Hypertonic saline	Critical Care	14
Non-Commercial	University of Oxford	EVAREST	The Use of Blood Biomarkers, Including Extracellular Vesicles, to Improve the Diagnostic Accuracy of Cardiac	Cardiovascular Disease	8

Study Type	Sponsor	Short Name	Study Title	Managing Speciality	Recruits
			Assessment by Stress Echocardiogram		
Non-Commercial	King's College London	The PARROT-2 Trial	Placental growth fActor Repeat sampling for Reduction of adverse perinatal Outcomes in women with suspecTed pre-eclampsia	Reproductive Health and Childbirth	2
Non-Commercial	University of Liverpool	Visual scanning training for hemianopia	A randomised controlled trial of scanning eye training as a rehabilitation choice for hemianopia after stroke (SEARCH)	Ophthalmology	2
Non-Commercial	University of Lancaster	Developing palliative care research within North West Coast (V 1.0)	Developing palliative and end-of-life care research partnerships and capacity in the North West Coast of England	Public Health	2
Commercial	SANOFI	DRI16804	A randomized, double-blind, placebo controlled, dose-finding study to assess the efficacy and safety of SAR443122 in adult patients with moderate to severe ulcerative colitis	Gastroenterology	1
Non-Commercial	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	UK Childhood ITP Registry	The UK Paediatric ITP Registry	Haematology	1
Non-Commercial	University College London	Perioperative Quality Improvement Programme: Patient Study	Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme	Anaesthesia, Perioperative Medicine and Pain Management	1

Study Type	Sponsor	Short Name	Study Title	Managing Speciality	Recruits
Non-Commercial	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	The 'Big Baby Trial'	Induction of labour for predicted macrosomia	Reproductive Health and Childbirth	1
Non-Commercial	THE WALTON CENTRE NHS FOUNDATION TRUST	Developing a preconception care pathway for women with epilepsy	Developing a preconception care pathway for women with epilepsy in the UK: Identifying key interventions and patient-reported outcomes using mixed methods Delphi consensus approach	Neurological Disorders	1
Data Source: NIHR Open Data Platform					1449

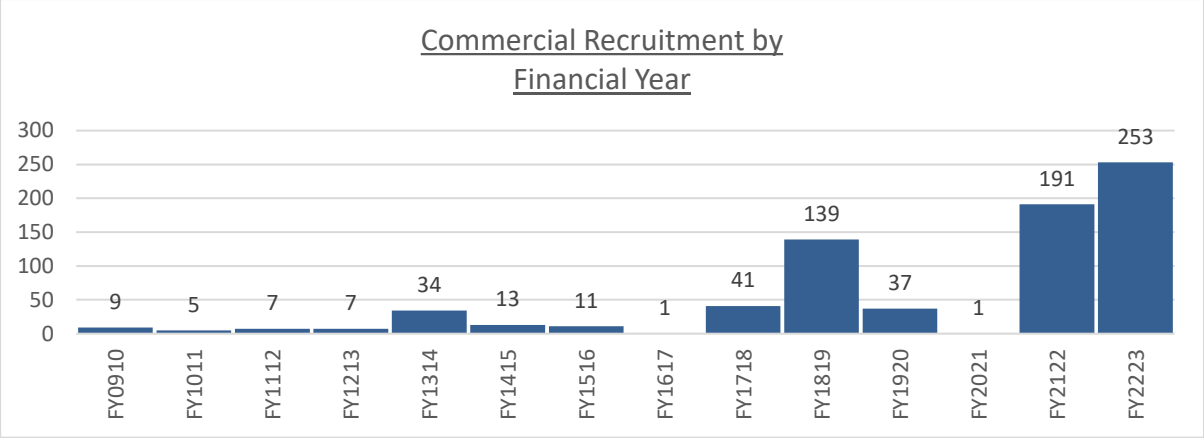
Growth in Commercial and Non-commercial Portfolios

The NIHR Portfolio includes both commercial and non-commercial studies. Warrington and Halton Teaching Hospitals, NHS Foundation Trust are pleased to have been able to increase the research opportunities for patients across both commercial and non-commercial portfolios.

The following tables demonstrate the growth in NIHR Portfolio studies opened to recruitment in year for both commercial and non-commercial studies in FY2021-22 and FY2022-23.

	Commercial		
	FY 2021-22	FY 2022-23	% Improvement
Number of studies opened	2	3	33.3%
Number of participants recruited	191	253	24.5%

	Non-Commercial		
	FY 2021-22	FY 2022-23	% Improvement
Number of studies opened	15	16	6.3%
Number of participants recruited	551	1191	53.7%



R&D continue to work closely with Halton Clinical Research Unit (HCRU) partners, National Institute for Health Research (NIHR), Clinical Research Network North West (CRN NWC) and Liverpool University Hospitals NHS Foundation Trust (LUHFT). The partnership has seen recruitment on the HCRU increase from 191 in FY21-22 to 253 in FY22-23.

HCRU has achieved some notable milestones in the financial year 2022-23:

- Gastroenterology supported by HCRU achieved a global first recruit onto a commercial study sponsored by Sanofi. This is an achievement recognised by the NIHR Coordinating Centre and demonstrates that Warrington and Halton Teaching Hospitals, NHS Foundation Trust has the ability to be first in the world to open and recruit to a study, indicating the potential to be competitive on the global stage.

- Highest number of recruits to a commercial covid-19 vaccine study sponsored by Moderna.

- Warrington and Halton Teaching Hospitals, NHS Foundation Trust, supported by HCRU partners, have been selected to present a poster to the Research and Development Forum Conference 2023, one of the largest national conferences for the research delivery workforce, titled "*The Power of Partnerships: Success through Collaboration*".

Research Partnership Board

Oversight for the HCRU is provided by the Research Partnership Board, consisting of senior representatives from each of the HCRU partners (Clinical Research Network North West Coast and Liverpool University Hospitals Foundation Trust). The Partnership Board has been an essential oversight and action group, supporting Warrington and Halton Teaching Hospitals, Foundation Trust in establishing itself as a preferred site for phase II+ commercial research studies with a good reputation for delivery to time and target.

Developing Principal Investigator Capacity

The capacity of the Trust to conduct research is heavily influenced by the number of Principal Investigators (PIs) employed. To have a sustainable research workforce, the PI pool needs to be both rich and diverse.

Warrington and Halton Teaching Hospitals, NHS Foundation Trust plan to improve the overall capacity of the Trust for research through two schemes:

- A pilot to embed research culture into departments via funding and careful activity planning, ensuring resilience of research provision.

A workforce development scheme in Allied Health Professionals 9AHP), led by a research active advanced physiotherapist, to map current research knowledge and activity amongst the AHP and nursing workforce. The research portfolio is also supported by a clinical lead and clinical fellow.

Collaborations

Primary Care Research Alliance

The Clinical Research Network, North West Coast 9CRN NWC) released a strategic funding call for projects addressing the organisation's key strategic priorities in January 2023. This presented opportunity to collaborate with primary care colleagues to improve research access for the residents of Halton, starting with Runcorn.

Alder Hey Children's NHS Foundation Trust

Collaboration opportunities have been discussed with the CRF (Clinical Research Facility) Clinical Lead at Alder Hey Children's NHS Foundation Trust with the aim of making research opportunities more accessible for the children and young people of Warrington and Halton. The team at Alder Hey agreed to act in an advisory capacity for a commercial study on the HCRU that both Trusts were involved in. Future opportunities are being explored.

Academic Collaborations

Warrington and Halton Teaching Hospitals, NHS Trust has scoped opportunities to partner with Higher Education Institutions (HEIs), including Edge Hill, John Moore's and Chester Universities, and through the Applied Research Collaboration North West Coast, to develop the academic research portfolio. Collaborations of this nature will enhance opportunities for WARRINGTON AND HALTON TEACHING HOSPITALS, NHS FOUNDATION TRUST staff and patients to co-produce research proposals which meet the needs of the local population and secure the necessary funding to undertake that research.

This will enable Warrington and Halton Teaching Hospitals, NHS Trust to apply to competitive funding streams in partnership with other Health and Social Care organisations to secure research funding which has the potential to attract further research capacity funding in later years also supporting recruitment and retention.

Recognition

The Research and Development Team achieved the following recognition in 2022/2023:

- North West Coast Awards 2022 finalists in Research Collaboration of the Year for HCRU and partnership with Liverpool University Hospitals NHS Foundation Trust and NIHR Clinical Research Network North West Coast.

- Trust You Made a Difference Award in August 2022 for recruiting 200 participants, the highest recruitment in the country, to a commercial vaccine study.

- Winners of Trust Thank You Awards 2023 for Innovation and Quality Improvement

- Highest screening rate for rapid-testing arm of GBS3 for January 2023. This GBS3 trial is looking at whether testing pregnant women in labour for Group B Streptococcus reduces the risk of infection in new-born babies compared to the current strategy in place in the UK.

Pathway to Research

The Research and Development Team have started a consent to contact registry called Pathway to Research for patients who would like to hear directly about research opportunities available. This will enable patients to access new research in a timely way and provide another avenue of recruitment for research at the Trust.

Over 100 people have consented to the register since the soft launch in January 2023.

Quality Academy

Bringing together our Clinical Audit, Quality Improvement, Knowledge and Evidence Services and Research, Development and Innovation teams together, the Quality Academy promotes innovation and delivers improvements in line with the Trusts quality priorities.

Objectives

Our Key priorities for the Quality Academy are:

- To support the delivery of the Quality Priorities.
- Work collaboratively with other services across the Trust to embed and sustain improvements.
- Develop training programs including training in QI Methodology and other QA work streams.
- Ensure QI work is aligned to the quality priorities.
- Support to move toward best practice with use of data and evidence services.
- Support improvements alongside system partners.
- Support programmes of work to sustain and optimise clinical improvements.

Engagement

It is key to ensure that we are listening to our stakeholders and addressing what matters to them. The Quality Academy actively seeks, listens and acts on feedback received from patients, the public, staff and groups such as Governors, HealthWatch and Health Scrutiny Committees. The academy supports work undertaken by all teams across the organisation including; Communications and Engagement, Patient Experience and Workforce and Organisational Development. The Quality Academy continue to work closely alongside the Advancing Quality Alliance and the Innovation Agency.

Quality Academy Showcase

Each year the Quality Academy hold learning events and in 2023/2024 a showcase event is planned. The showcase presents the latest innovation, best practice, innovation and research. The teams in the academy work alongside internal and external partners to deliver the latest knowledge in innovation and improvement in healthcare. The event is a unique opportunity to discover the art of the possible, bringing teams together to deliver better outcomes for patients as well as raising the profile of the Quality Academy and the services available.

Quality Improvement

The Quality Improvement Team has two main areas of focus:

- Support the implementation and delivery of a number of Quality Improvement projects Trustwide.
- Enhance QI capacity and capability through a programme of work. This has been identified as a quality priority for 2023/ 2024.

Trustwide Quality Improvement Projects overview

Gram Negative Bloodstream Infections (GNBSI) Collaborative

Work around GNBSI continues with the following mechanisms in place. This is being led by the Associate Director for Infection and Prevention and Consultant Microbiologist. The Trust continue to

monitor performance against NHSE GNBSI thresholds through the IPC Sub-Committee. QI resource has been redirected to support specific targeted projects that will support the prevention of GNBSI including:

(1) Hydration – dehydration is a key risk factor for urinary tract infections. This has been identified as a source of GNBSI. A focus on hydration will support the work around GNBSI and wider health factors including Acute Kidney Injury, pressure ulcers and falls. Nutrition and hydration are also encompassed within the 23/24 CQUIN relating to surgical patients.

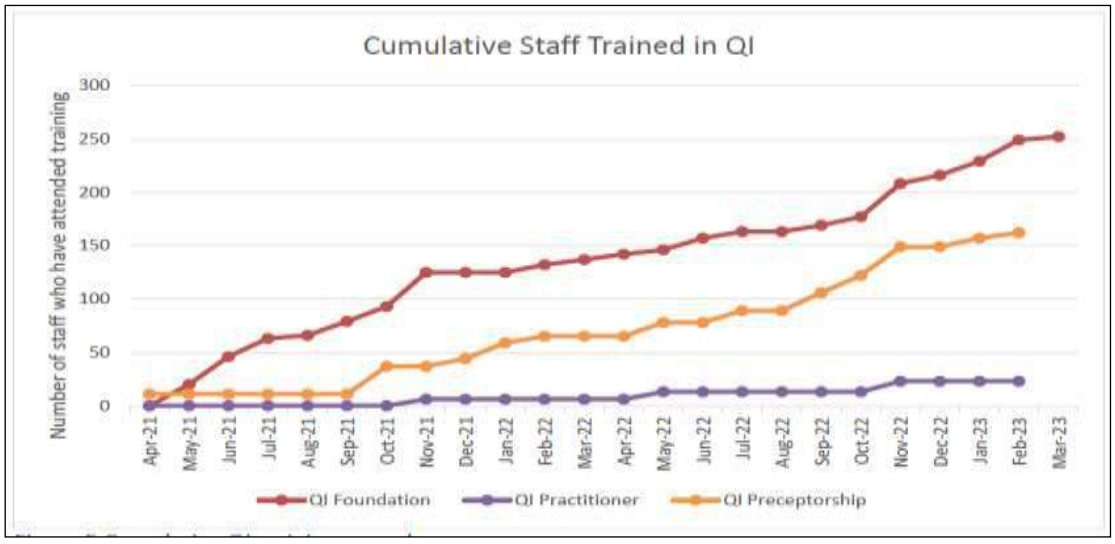
(2) UTI pathway was reviewed as part of the 2022/23 CQUIN related to appropriate antibiotic prescribing for UTI in adults 16+. Warrington and Halton Hospitals, NHS Foundation Trust were compliant with this CQUIN.

Quality Improvement Projects (QIPs)

The Quality Improvement Register was established in 2019 to capture improvement projects that are being undertaken across the Trust and enable the QI Team to allocate the appropriate level of support to individuals/teams undertaking improvement work. A total of 59 QIPs have been registered since 1st April 2022. To ensure that projects are well supported, the QIP form requests that a permanent member of staff is identified as a sponsor for all projects.

Quality Improvement Capability Building Programme

In 2021, the QI Team relaunched the QI Capability Building Programme, delivering refreshed training to over 350 staff to date. Increasing Quality Improvement (QI) capability and capacity, to help embed a culture of QI across the organisation, has been identified as a Trust Quality priority for 2023-24. An improved position has been identified during financial year 22/23 across all current QI training programmes. This is also identified as a Quality Priority for 2023/2024.



Local Quality Initiative's

Improving quality provides an opportunity to deliver better outcomes. There are many examples at Warrington and Halton Teaching Hospitals NHS Foundation Trust that show that even relatively small-

scale quality improvement initiatives can lead to significant benefits for patients and staff. The section below details some of the positive work that we have achieved in 2022-2023.

Working as an Anchor Institution to positively impact our communities

As part of our documented, strategic intention to play a more significant role as an Anchor Institution within the boroughs of Halton and Warrington, the Trust has delivered and is leading a number of key strategic projects at 'place' designed to enhance social value, reduce the organisation's carbon footprint and address identified health inequalities within our local communities. As an example the Halton Health Hub, a standalone outpatient unit situated within Shopping City in Runcorn, opened in November 2022 and provides a range of services including optometry, orthoptics, audiology and dietetics for adults and children. The Hub also provides space for partners to deliver preventative and early intervention services, such as a drop-in vaccine outreach service for Covid-19 and flu vaccinations provided by Halton Borough Council, and primary care services offered by our local GPs. The Trust continue to work with additional providers in the area to expand this offer where beneficial for our population.

Working with partners to address health inequalities

The Trust is working in close partnership with a wide group of stakeholders to develop two new Health and Wellbeing/Education Hubs in Warrington and Runcorn town centres. Both Hub projects are funded from central government's Towns' Fund initiative as part of the 'Levelling Up' agenda. These specifically target areas of high deprivation, the aim being economic regeneration, whilst advancing quality. They will deliver targeted services from a range of providers to support the integration of physical and mental health with social care, wellbeing, voluntary and third-sector services and education to support a reduction in health inequalities.

Due to open in 2023, the Living Well Hub will address health inequalities in Warrington through the provision of a range of services focused on prevention and early intervention in a town centre location. The Hub will be a key project for the local health and care system by working collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project has been co-designed with patients and system partners through extensive engagement.

The Runcorn Health and Education Hub will be delivered in partnership with Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare, Halton Borough Council, voluntary and third sector partners and Riverside College. It will deliver services targeting populations of high need, including Young People and Families, and those with Long Term Conditions from the heart of Runcorn Old Town. In addition to health and care services, flexible education facilities will support the growth of our future workforce, helping local people into local jobs.

Introduction of virtual wards

Advances in digital technology and the improvements in NHS IT infrastructure means the Trust has been able to introduce Virtual Wards. These allow patients to receive the care they need at home, including in care homes, safely and conveniently rather than in hospital. The development of virtual wards has been underpinned by partnership working across secondary, community and primary care to ensure a quality service is provided.

Taking a holistic approach to discharge

Warrington Wellbeing workers are supporting the Trust's Integrated Discharge Team to ensure a holistic patient centred approach is offered to patients on discharge from hospital. Through use of social prescribing, the wellbeing workers are able to support patients to live happier, healthier and independently for longer, whilst reducing the changes of readmission following discharge from hospital care.

Achieving the highest of standards at national JAG accreditation

In February 2022 our Endoscopy service (at both Warrington and Halton hospital sites) underwent JAG (Joint Advisory Group, GI Endoscopy) Accreditation.

The Endoscopy service performs over 8000 endoscopic procedures annually across both the Warrington and Halton sites. The endoscopy service offers a full range of diagnostic and complex treatments including Bowel Cancer Screening.

The report stated that the service is a highly effective patient-centred service that is exceptionally led by a dynamic team. Both sites operate to an equally exceptional standard and easily some of the highest standards the assessors have seen in the UK. The whole team demonstrated pride and passion in their work and all team members interviewed clearly cared about the standards of patient care. The policies and processes adopted throughout the patient pathway are exceptional and there is an embedded culture of safety with team huddles, WHO safety checks and empowering nursing staff. The service offers high-quality endoscopy training to trainees. The assessors also highlighted the exceptional administration team and their processes.

The service has demonstrated excellent achievement in the following areas:

- Developments and progress of service despite the challenges of the pandemic.
- Excellent patient feedback.
- Patient centred approach and passionate workforce.

- Both Units are well organised with excellent patient centred pathways.
- Excellent patient information leaflets and website.
- There is an excellent, supportive approach to staff learning and progression. With high commendation on succession planning for clinical leadership roles.
- The quality of endoscopist performance against key performance indicators is excellent. Governance and safety structures are well structured and well organised.
- The service provides an excellent endoscopic service for patients with acute upper Gastro-intestinal haemorrhages.
- The decontamination environments in both sites demonstrate excellent adherence to decontamination processes observed at the site visit.
- Outstanding and unique exemplars of nursing practice – mental health passport, ED admission, PEG passport.
- Exceptional clinical leadership/outstanding commitment and support.

Research and Development – Success in collaboration

As described earlier within this account the Research and Development Team have excelled in collaboration with LUFT and the CRN. The Halton Clinical Research Unit first opened in March 2021.

This has been a unique and successful partnership, bringing about the launch of one of the only dedicated research units to sit in a district general hospital, and increases the range and complexity of studies that can be delivered.

The multi-organisational, multi-disciplinary research team secured its pivotal first clinical trial for Valneva's covid19 vaccine, becoming HCRU's inaugural study which recruited in April/May 2021.

This led on to the successful delivery of the Sanofi covid19 vaccine study and the exciting new Moderna Omicron variant booster study, which expects to recruit 100 participants.

Any site taking part in a covid19 trial is helping to fight the pandemic. Valneva is currently undergoing rolling submission for approvals from the MHRA and EMA[1] and Sanofi will be applying for regulatory approval with a number of regulatory bodies[2]. This means that two Cheshire and Merseyside towns have made major contributions to both the national and international efforts to eradicate covid19.

The Trust further extended its collaboration with the CRN by participating in the Clinical Research Fellow programme, which has been incredibly successful and beneficial to not just HCRU, but to the wider team and Trust.

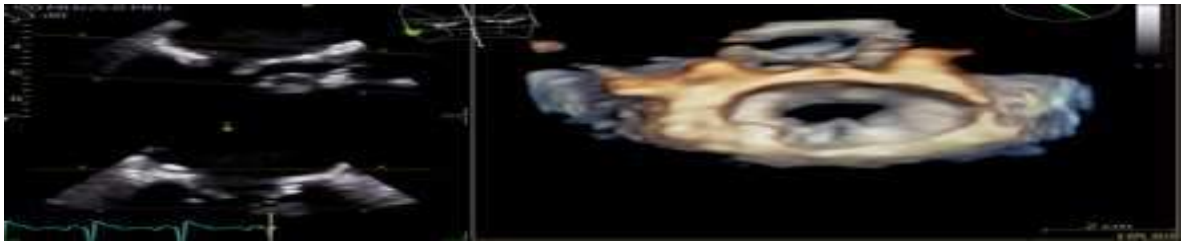
Having had an overwhelmingly positive experience of a fully collaborative partnership the team is now keen to seek further partners and consider innovative ways of working. This partnership, we believe, is a showcase of what Trusts working together can achieve.

Growing our future workforce by becoming a nationally accredited host training centre for the Echocardiography Training Programme (ETP).

The Trust currently performs 6,000 echocardiograms annually across both hospital sites.

There is currently a national shortage of suitably trained and Accredited Echocardiographers across the NHS workforce. The National School of Healthcare Science (NSHCS), in collaboration with the British Society of Echocardiography (BSE) has developed a pilot pathway that will respond rapidly to the urgent workforce needs for Accredited Echocardiographers. The pathway is an 18-month, full-time integrated training scheme to deliver academic and workplace training leading to both a post-graduate certificate in Echocardiography and Level 2 BSE Accreditation in Transthoracic Echo. There are currently only two universities offering the academic portion of the ETP programme; Manchester Metropolitan and University of Newcastle, making the Trust's hospitals ideally situated for students on the programme.

The Clinical Leads for echocardiography recognised the value of the programme and applied to be a host training centre for the Echocardiography Training Programme (ETP). The application was successful, and the trainee application process will begin in Spring 2022, leading to one trainee arriving at the Trust in September 2022to train over 18 months to become accredited and potentially recruited by the Trust. The ETP is in its infancy and Warrington and Halton Teaching Hospitals, NHS Foundation Trust are forward thinking in getting involved so early in the programme.



Achieving Anaesthesia Clinical Services Accreditation (ACSA) accreditation

Anaesthesia Clinical Services Accreditation is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review and is the RCoA's flagship scheme. Engagement with the scheme entails a period of detailed self-assessment against the ACSA standards and gap analysis.

The Trust commenced the process toward ACSA accreditation some time ago and achieved the accreditation in August 2022. ACSA engages anaesthesia departments in quality improvement through peer review. The scheme is voluntary and simply carries a small subscription fee for engagement. Participating departments benchmark their performance against a set of standards based on the College's Guidelines for the Provision of Anaesthetic Services (GPAS), which is produced via a National Institute for Health and Care Excellence (NICE) accredited process. Departments then work towards the goal of becoming accredited.

There are well over 100 standards covering equipment, facilities, staffing, training and clinical governance. Warrington and Halton Teaching Hospitals, NHS Foundation Trust has been working towards accreditation for some years now, although progress was significantly delayed by the Covid-19 pandemic. We did however have a formal inspection at the end of March 2022. At the time, the review team gave excellent feedback about our anaesthetic and theatre teams on both sites and how they have collectively risen to the challenge, raised the bar and innovated in the best interests of patients and staff.

In August 2022 we learned that we had indeed achieved accreditation. It has been a massive team effort and collectively touches on one of our largest teams, in anaesthetics and theatres across both our hospitals. It has required significant capital investment in new kit and facilities, but more importantly a rigorous attention to detail in ensuring that our standards of care meet, if not exceed, a long list of requirements set by the 'national expert'. All of this has needed considerable time, effort, and hard work in excess of the 'day job' – we could not be more pleased.

Getting it Right: Addressing Shoulder Pain through clinical trial

Images courtesy of Oxford Clinical Trials Research Unit.

The Trust's Musculoskeletal Physiotherapy department was selected as one of just 20 trial sites nationally for clinical research into shoulder rotator cuff disorders funded by the UK National Institute for Health Research Technology Assessment Programme and led by the Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences at Oxford University.

Shoulder pain is very common, with around 70% of cases due to rotator cuff disorders which are often associated with substantial and persistent disability and pain and approximately half of patients continue to have pain or functional limitations for up to two years. Most problems with shoulder pain are managed in primary care settings by Physiotherapists, Advanced Musculoskeletal Practitioners,

and GPs. Current treatment options include rest, advice, analgesia, non-steroidal anti-inflammatory drugs, exercise, manual therapy, and corticosteroid injections. Despite widespread provision of Physiotherapy, there is uncertainty about which type of exercise and delivery mechanisms are associated with best outcomes. There is also uncertainty around the long-term benefits and harms of corticosteroid injection therapy, which is often used in addition to Physiotherapy. The aim of the 'The Getting it Right: Addressing Shoulder Pain trial' was to assess the clinical and cost-effectiveness of **individually tailored, progressive exercise compared with best practice advice, with or without corticosteroid injection, in adults with a rotator cuff disorder.**

What we did:

The team conducted the research programme looking at progressive exercise compared with best practice advice, with or without corticosteroid injection, for the treatment of patients with rotator cuff disorders (GRASP): a multicentre, pragmatic, 2×2 factorial, randomised controlled trial.

Participants were recruited to one of four randomised interventions: (1) progressive exercise (≤6 physiotherapy sessions); (2) best practice advice (one physiotherapy session); (3) corticosteroid injection then progressive exercise (≤6 sessions) or (4) corticosteroid injection then best practice advice (one session).

What we found: The GRASP trial showed that progressive exercise with multiple physiotherapy appointments was not superior to a best practice single advice session with a physiotherapist. Subacromial corticosteroid injection improved shoulder pain and function and provided modest short-term benefit. Best practice advice in combination with corticosteroid injection was found to be to be the cost-effective treatment combination for use of NHS resources.


THE LANCET

Our next steps: On completion of the trial and using this information the team established a shoulder tendinopathy education class which was held at Halton Hospital's Physiotherapy department. Patients attended a small group on one occasion where they receive the best practice advice as delivered in the trial. Some patients are offered a corticosteroid injection depending on severity of symptoms. Patient reported outcome measures were used to assess the effectiveness and quality of the class experience, and to ensure that the outcomes were as expected, and the patients' goals were met.

Conclusion: To be included as one of the randomised controlled trial centres was an honour and a major morale boost for our team. This work is directly linked to our quality objective of always putting

our patients first and delivering safe and effective care and an excellent patient experience and our mission of being 'outstanding' for our patients, our communities and each other.

Providing 100% Continuity of Carer

Warrington and Halton Teaching Hospitals, NHS Foundation Trust became the first Trust in England to achieve 100% continuity of carer for all births - positively impacting nearly 3K women and their babies and families since then. Midwives have moved out of GP surgeries and women are seen in the communities where they live with a named midwife and measures in place across all pathways to ensure continuity is maintained. Five mixed-risk teams have been launched and are delivering better outcomes, every time. This is critical for our local communities where we know that babies born to mothers in the most deprived quintile have a 30% increased risk of neonatal mortality and the gap between the most deprived and the least deprived quintiles is widening.

The Better Births initiative, researched by Baroness Cumberledge et al, describes a vision for the planning, design and safe delivery of maternity services and how women, babies and families will receive care they want and need. At the heart of this is the recommendation that there should be 'continuity of carer' (CoC) to ensure safe care, based on a relationship of mutual trust and respect in line with the woman's informed decisions. Research has shown that continuity of carer leads to safer pregnancy outcomes for mothers and babies. Our Maternity team set out to achieve:

- 100% of pregnant women to be on a CoC pathway.
- Five new continuity teams providing care across pregnancy and birth journey, including a designated homebirth team and specialist team to support families with additional vulnerabilities.
- Staff and women involvement in co-designing a structured approach.

- A link obstetrician per team.
- Key roles for maternity support workers and students/newly qualified midwives.
- Community care rooted in areas women live, working with other early years services and embedding a holistic family centred approach.

Warrington and Halton Teaching Hospitals, NHS Foundation Trust became the first Trust in England to achieve 100% continuity of carer for all births by March 2021, positively impacting nearly 3K women and their babies and families since then. These words from a very complex case are testament to the success of CoC at Warrington and Halton Teaching Hospitals, NHS Foundation Trust:

"I was and am under the specialist peri-natal service due to my bipolar disorder and risk of post-partum psychosis. I had a birth plan in place to have my partner with me throughout induction and labour but my perinatal nurse couldn't guarantee that would happen due to Covid-19. My named midwife contacted everyone possible and I received great care due to this. I spent 15 days in hospital from induction to discharge with my little girl being in neonatal for a while. The midwives and neonatal nurses were brilliant with me and my family. I'm aware CoC is quite a new thing but I just wanted to say how much it helped having that additional support."

The Team is extremely proud to have won the regional finals in the NHS Parliamentary Awards and will travel to Westminster in July 2022 to the national finals. This award is in addition to becoming a finalist in the 2021 Patient Safety Awards for the same programme.

Achieving accreditation to offer vital new-born lifesaving training for the region

The Resuscitation Council UK (RCUK) Newborn Life Support course focuses specifically on the resuscitation of the newborn infant, teaching the essential practical skills and theoretical knowledge needed to best aid the newborn infant in an emergency. The course is intended for any healthcare professional involved in the delivery and care of the newborn infant. This includes nursing staff, midwives, paramedics, resuscitation officers and both junior and senior medical staff.

The Trust is one of only two centres in the Northwest that offers the NLS course. RCUK has only accepted 10 centres nationally to deliver the course in 2022. As Warrington and Halton Teaching Hospitals, NHS Foundation Trust is only one of the handful of trusts able to offer a national qualification on resuscitation of the newborn infant, the trust is now considered to be a centre of excellence in resuscitation training and education on the national agenda.

The first NLS course at the Trust ran with 12 candidates, future NLS courses will allow for 16 candidates. With a minimum of four courses to take place each year. Warrington and Halton Teaching Hospitals, NHS Foundation Trust has the opportunity to grant 64 national qualifications to participants. The Trust Head of Resuscitation, and course lead at the Trust reflected on the outcomes of the course as “raising the profile of Warrington and Halton Teaching Hospitals, NHS Foundation Trust as a nationally recognised centre”.

Supporting, developing, listening to our nurses and midwives to improve professional practice

As the Chief Nurse I am passionate about ensuring every patient is provided with the standard of care that we would want for our loved ones. As nurses and midwives, we are in a very privileged position of caring and supporting patients and their families at some of the most vulnerable times in their lives.

The senior nursing team is committed to ensuring that our nurses and midwives are supported in their clinical and professional practice - enabling them to deliver the best possible care for our patients. Recognising the demands and challenges of the roles, we have developed a platform of support, using the established group communities and forums across the Trust and I am delighted to launch this today.

The aim of the support community is to provide easy access to guidance, policies, procedures, training and offer many ways of reporting a concern. The support community is presented using the framework of the Nursing & Midwifery Strategy and the Trust values and objectives; there are also details of the framework where you can share and report concerns. We have made a commitment to listen to staff by establishing several (and well attended!) professional forum meetings and would encourage as many staff as possible to join us at these meetings.

The Support Community is accessed by clicking on the icons which provides direct access to information on the following topics:

- Continuing Professional Development.
- Medicines Management.
- Professional Guidance.
- Supporting Staff and Raising Concerns.
- Revalidation.
- Looking after your Health and Wellbeing.

Innovating apprenticeships, building bright futures

The Theatres Team have been instrumental in bringing about an innovative new degree apprenticeship. The OPD Degree Apprenticeship concept came from a postgraduate certificate-enabled project at the Trust focussing on exploring the impact of professional apprenticeships in the peri-operative environment.

Using this experience, the Trust collaborated with other Trusts to enable the University of Bolton to devise and deliver the course. Each student is able to study alongside their practical work and is supported by an Educator within the department. The first cohort of the new BSc (Hons) Operating Department Practice (Degree Apprenticeship) at the University of Bolton have just completed their studies and are awaiting their pin numbers from the Healthcare Professional Council before becoming fully qualified ODPs.

Outstanding, compassionate professional practice and the gift of life

It is a privilege to chair the Trust's Organ Donation committee which brings together clinicians from ED, ICU, Theatres and our Chaplaincy. At our recent quarterly meeting it was heartening to hear that the numbers of referrals we had made in 2020-21 were 19, from which we saw two solid organ donors resulting in five patients receiving a life-saving or life-changing transplant. When we consider that there were only 189 donors from the whole of the North of England and that there are still 723 patients on the transplant waiting list, this is a vital contribution from a smallish Trust.

The law on organ donation also changed in May 2020 which now opts individuals in to organ donation unless they are under 18, have opted out or are in an excluded group. Ann Joyce is our new 'SNOD' specialist nurse for organ donation (from NHS Blood and Tissue Authority) with Laura Langton our 'CLOD' clinical lead.

At our meeting, beyond the business of governance, planning training and development for staff and the deployment of a new Lorenzo auto-referral form; we heard about two examples of outstanding, compassionate practice between the ICU and Theatres teams, supported by our chaplains. The first is the 'Walk of Honour', where our staff (plus those from B18 and other staff who came running) lined the route from ICU to see our dying patient, accompanied by their loved ones, escorted on their last journey. Silent, heads bowed in dignified respect. Honouring the gift that this patient and their family was about to make. The Team have prepared a presentation on how and why they do this (attached) but a family member's voice resonates…" *Walking down that corridor to the operating theatre, was the loneliest feeling ever".*

The heart-warming Xmas donation of recordable teddy bears to ICU through the Warrington and Halton Teaching Hospitals, NHS Foundation Trust Charity prompted a second, spontaneous gesture which will mean so much to a bereaved family for years to come. We sadly lost a female patient whose young daughter kept vigil at her bedside and who was supportive of her mum's organs being retrieved for donation. The ICU team suggested that they record mum's heartbeat on one of the teddies and, with the help of a bedside ultrasound of her heart, our patient's heartbeat was recorded and teddy presented to her daughter to keep. This is not just going 'above and beyond' it is spontaneous, compassionate and innovative care for the living and the dying. It is simply outstanding practice.

It is an honour to chair this committee and see that our patients' journeys don't always end on the ward, they live on in others. It is our amazing teams that support the process and those left behind in their own, unique, Warrington and Halton Teaching Hospitals, NHS Foundation Trust approach. Be proud!

Now that the law has changed, it will be considered that you agree to become an organ donor unless you opt out or are ineligible. To learn more, and make your wishes known, visit: https://www.organdonation.nhs.uk/

Continuous Improvement

The Post-Anaesthesia Care Unit (PACU) based at the Captain Sir Tom Moore Building on the Halton Hospital site was recognised for Continuous Improvement in the recent Cheshire and Merseyside Health & Care Partnership Professional Pride Awards.

PACU opened in January 2021, to enable the Trust to utilise the Halton site as a 'green pathway' for elective surgery and to increase the number of patients who could be safely managed there.

Prior to the Covid-19 pandemic, patients requiring elective surgery who were deemed to have a greater perioperative risk were booked for a postoperative critical care bed on the main Trust site (Warrington) which has the Emergency Department and Critical Care. This bed was not guaranteed depending on critical care occupancy and dependency, and often led to late cancellation of procedures.

During the Covid-19 pandemic and the increased pressure on critical care beds, it was imperative that an alternative to critical care was available to provide a safe level of care for this cohort of patients and facilitate the Trust's elective recovery plan; PACU has enabled that.

Over 600 patients have had their surgery on the Halton site since PACU opened, even if they have not needed admission to it; this has resulted in a significant reduction in elective demand for critical care and patient cancellations.

The key component of developing the PACU service was the opportunity to utilise the skills of critical care nurses who were unable to work within critical care during the pandemic due to underlying health conditions. These staff became the core team and were complemented by theatre and surgical nurses.

National recognition for Orthopaedic Services

Both Warrington Hospital and the Captain Sir Tom Moore (CSTM) unit at Halton Hospital have been awarded 'Quality Data Provider' by the National Joint Registry having completed a national programme of data audits in Orthopaedics.

The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and to reward those who have met registry targets. To achieve the award, hospitals had to meet a series of six ambitious targets during a 12-month audit period. One of the targets was achieve compliance with the NJR's mandatory national audit aimed at assessing data completeness and quality within the registry.

Dr Paul Fitzsimmons, Medical Director said the award was an excellent benchmark of quality in the thousands of hip, knee and other join replacements carried out across both sites each year.

"The Orthopaedics teams are to be congratulated for achieving this prestigious national recognition of their commitment to maintaining and improving both patient safety and quality in care. "We fully support the National Joint Registry's work in facilitating improvement in clinical outcomes and governance and are proud and pleased to be recognised in this way."

National Joint Registry Medical Director, Mr Tim Wilton, said: **"**Congratulations to colleagues at Warrington Hospital and the Captain Sir Tom Moore facility at Halton Hospital. The Quality Data Provider Award demonstrates the high standards being met towards ensuring compliance with the NJR and is often a reflection of strong departmental efforts to achieve such status. "Registry data provides an important source of evidence for regulators, such as the Care Quality Commission, to inform their judgements about services, as well as being a fundamental driver to inform improved quality of care for patients."

Enhancing patient experience with a warm welcome

Our newly staffed reception in the atrium of Warrington Hospital provides an immediate one stop shop for anyone visiting the hospital. The reception can be the first time a patient has face-to-face interaction on site, whether that's to request help with way finding, portering for patients with physical needs or a general query. The investment has significantly increased our ability to create a good first impression and ensure an immediate point of contact for patients.

Support for International Nurses

The Trust developed an Objective Structured Clinical Examination and support booklet to help international nurses to fully prepare for their clinical examination assessments. The learning and resources prepared were shared with the Mid Cheshire Collaboration as best practice.

Nursing Times Awards

Ward A7 and the Acute Care Team collaboration were shortlisted for the Nursing Times Awards 2020 Team of the Year.

HSJ Awards

The Trust were finalists for the HSJ Awards for the Urgent & Trauma Care initiative for introduction of the Thoracic Injury Pathway.

Stroke garden

The Trust opened a new Stroke therapy garden to support patients on the Stroke Unit. The garden is used by patients and families and was funded through Warrington and Halton Teaching Hospitals, NHS Foundation Trust Charity fundraising, donations and supported by Sellafield Ltd and Warrington Lions Club.

PEWS testing

The Trust was successful in becoming a pilot site for the introduction of a National Paediatric Early Warning Score - SPOT. The PEWS inpatient trial was successfully piloted between April and September 2021

Employer Recognition Scheme - Silver award 2021 - Proudly serving those who serve

The Trust is one of thirty-six organisations from across the North West of England that have been awarded Silver under the Ministry of Defence Employer Recognition Scheme for their support to Defence and the wider Armed Forces community. The Employer Recognition Scheme was launched to reward employers who support Defence People objectives and encourage others to do the same. This includes employing serving and former members of the Armed Forces community and demonstrating flexibility towards training and mobilisation commitments for Reservists and Cadet Force Adult Volunteers.

Sharing best practice in Infection Prevention and Control

The triage tool for Covid used in our Emergency Department was recognised by NHSE as best practice and share across the North West Region.

Bereavement Garden

The Trust opened a remembrance garden, created as part of its COVID-19 legacy. The area is a quiet, peaceful and reflective space for staff, patients, bereaved relatives and members of the community to visit and remember.

The garden features an array of flowers, trellises and seating areas with wooden benches and was designed by a local landscaper on a previously unused and rather unloved patch of grass between the new Habab Training Centre and the old K23. At the centre of the garden is a beautiful stone birdbath that was donated by the family of the late Tony Nicholson, who sadly passed away last year in the ICU with COVID-19. The Trust held a short ceremony to formally open the garden and some of Tony's family members attended the event, including his sister and brother-in-law Sue and Matthew Walker and his nephew.

As well as being a beautiful place for staff and bereaved families to visit and reflect, the Trust also recognises the value that this, in partnership with our Bereavement Service, adds to those who lose loved ones at the Trust's hospitals.

Ambulance Handover Times

The Trust's Emergency Department has featured in Hospital Handover Improvement as a case study outlining the quality improvement piece of work undertaken to improve hospital handovers from ambulances to the Trust's ED Team. The improvement work has been shared across the North West region with other Trusts as best practice, having consistently demonstrated an improvement in ambulance handover times.

HSJ Partnership Awards

The Trust was highly commended at the HSJ Partnership Awards 2022 for the Best Elective Care Recovery Initiative.

Capacity For Research Pilot Scheme (CapRS)

WARRINGTON AND HALTON TEACHING HOSPITALS, NHS FOUNDATION TRUST is committed to conducting high quality clinical research, with has ambition to increase its clinical research activity: There is compelling evidence that hospitals with high research activity have better patient experiences and outcomes. An active research organisation contributes to Trust reputation and attracts and retains high-calibre health professionals. Therefore, integrating research into the culture of everyday business is a key Trust priority.

A limiting factor to research activity has been identified as availability of Principal Investigators. Warrington and Halton Teaching Hospitals, NHS Foundation Trust is proposing a pilot scheme to increase Trust capacity for research and promote growth of research activity through funding of Principal Investigators at the Clinical Business Unit level, with Principal Investigator funding opportunities open to all clinical staff.
A recent research awareness survey undertaken by the RD&I team has highlighted the main barriers to research involvement as lack of time, lack of funding and lack of opportunity. It was concluded from survey findings that there is potential to improve research participation. However, research is a collaborative endeavour and, while leadership is an essential component of research, it is important to have a team that can flex around the demands of research and clinical duties. Protecting the time

of one clinician for research activities does not necessarily embed research skills or culture into the department.

It is proposed that a pilot of supporting CBU funding for Principal Investigators is undertaken. Funding would be allocated to a CBU, for determination of division of funding to individual staff members as Principal Investigators. The RD&I department would closely monitor progress, evaluated against agreed performance measures at 3, 6 and 12-months. Funded Principal Investigators would be expected to support development of new Principal Investigators, and participation in activity at Halton Clinical Research Unit may be expected. The pilot will be initially implemented in one Clinical Business Unit, with the intention that following successful outcome measures, the pilot scheme can be rolled out to other CBUs.

The team are looking forward to this exciting opportunity to implement this pilot which will focus on growing departmental capacity for conducting research with a view to giving the department time and funding to move toward self-supporting research portfolios.

1. MONISTORING / REPORTING ROUTES

The Quality Strategy is monitored by the Director of Governance and Quality, interim Chief Nurse. Progress against the priorities are reported quarterly to the Patient Safety and Clinical Effectiveness Sub-Committee and annually to the Quality Assurance Committee.

2. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the update and progress made on the implementation of the key quality and patient safety priorities for 2022-23 in line with our Quality Strategy 2021-2024.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/88**			
SUBJECT:	**Fragile Clinical Services**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ 		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#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			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper outlines the Trust's approach to identification and oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: Gynaecological surgery Urology Paediatric Ophthalmology Opthalmology – ARMD/Medical Retina Orthopaedics – Fractured Neck of Femur			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	Trust board is asked to: - Note the newly introduced process for designation and oversight of Fragile Clinical Services - Note the current list of Fragile Services and associated high level progress updates - Receive further Fragile Services reports			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Clinical Services	AGENDA REF:	BM/23/08/88

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 was incorporated in the PSCESC ToR and ratified at QAC in July 2023.

This report aims to outline the Fragile Service Oversight process and provide a high-level overview of services currently identified as being Fragile.

2. FRAGILE SERVICE OVERSIGHT AND GOVERNANCE

Definition

A Fragile Service for the purposes of the PSCESC Fragile Services oversight is defined 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'.*

Fragile services will typically have some or all the following characteristics:

- Significant risk of that service deteriorating
- Significant risk (volume and/or severity) of negative impact to quality should deterioration occur
- Significant risk of moderate or severe patient harm should deterioration occur
- Concerns over robustness or reliability of controls in place for managing the above risks
- Fragile services would be expected to feature on the Corporate or Trust Risk Registers

Where services meet this definition but are subject to a formal improvement program/plan with an agreed alternative reporting structure and schedule (Eg ED improvement, Paediatric Audiology), these will be noted on the Fragile Service list, along with details of their reporting mechanism, but will not be required to report in duplicate to PSCESC.

Designation of Fragile Services

A request for inclusion on the PSCESC Fragile Services oversight list can be made by Executive Directors, their Deputies, Care Group Associate Directors, and the Chairs of Board Reporting Committees. The request should be addressed to the PSCESC chair.

The decision as to whether a service should be added to the Fragile Service will be made by the Medical Director (PSCESC Chair), Chief Nurse/Deputy CEO and Chief Operating Officer and ratified at the next PSCESC.

Services added to the Fragile Services list will usually, subject to the agreement of the QAC chair, be the subject of a QAC Hot Topic presentation at on the next available QAC agenda.

Reporting Requirements

Fragile Services will be required to report to PSCESC every month until such a time that they can be de-escalated. Monthly update reports will be provided to PSCESC on the standardised Fragile Services Meeting Template, which is intended to be brief and will include:

- Background and initial position
- Current position, trends and recovery trajectories
- Risk and evidence of harm
- Action plan and progress against this

A summary of Fragile Services will be included in the PSCESC escalation report to QAC with any concerns regarding deterioration, lack of progress or increased risk being escalated from PSCESC to QAC via this escalation report.
Fragile Services reports will be shared monthly for information at Executive Meetings following presentation at PSCESC.
A summary report will be presented at each Trust Board meeting

De-escalation

Services will be stepped down from PSCESC Fragile Service monthly reporting once the sub-committee can be assured that the risk to patient care and safety has been mitigated and reduced to a more acceptable level through demonstrable actions.

It would be expected that this action would be accompanied by a reduction in the associated risk Register score.

Services being stepped down from the PSCESC Fragile Services oversight list will be included in the PSCESC escalation paper to QAC for information with accompanying narrative for assurance.

3. SERVICES ENTERING FRAGILE SERVICE OVERSIGHT SINCE PREVIOUS BOARD

Gynaecological Surgery

- Demand and capacity issues – driven predominantly by workforce issues with some diagnostic equipment pressures (hysteroscopes)
- 4 incidents of moderate harm identified (Jan – Jun 23) which have been subject to appropriate investigation and Duty of Candour has been discharged
- Current mitigations
    - Insourcing as appropriate/available
    - Waiting list validation process underway
    - Emergency revenue request approved – scope delivery imminent

    - Improvement supported by approved elective c-section revenue request
- Improvement plan ongoing
    - Consultant posts to advert
    - Triage/Advice and Guidance workstream
    - Individual job plan reviews informed by demand/capacity exercise

Urology

- Demand and capacity issues – driven predominantly by workforce issues and increased demand.
- 2 incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged
- Current mitigations
    - Robust stent register process in place
    - Hot stone list implemented at Warrington site
    - Short term increase in capacity through WLI sessions
    - Mutual aid request to C&M Hub
- Weekly task and finish group in place to implement Improvement plan

4. SERVICES REMIANING UNDER FRAGILE SERVICE OVERSIGHT

Ophthalmology - Paediatric Ophthalmology

- Demand and capacity issues – driven predominantly by workforce issues
- 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 of risk as clinically indicated
    - Agreement with Specialist Trust to support undated patients
- Ongoing actions
    - Recruitment – posts out to advert
    - Further negotiation with Specialist Trust underway regarding mutual aid for listed and dated patients

Ophthalmology - AMD/Medical Retina

- Demand and capacity issues – driven predominantly by increased demand.
- 2 cases of moderate harm identified March 2023 - subject to appropriate investigation and Duty of Candour, no identified harm since then due to mitigating actions.
- Current mitigations:
    - 100% utilisation of existing sessions
    - Additional theatre sessions in core hours
    - WLI and insourcing to meet any shortfall in capacity to maintain patient safety
- Further action - Revenue request approved to deliver required additional capacity in a more sustainable and cost-effective fashion, CBU now moving to delivery phase of plan

Orthopaedics – Fractured Neck of Femur

- Demand and capacity issues – driven predominantly by increased demand, increased pressures on bed base and insufficient theatre capacity for Trauma workload
- Workforce issues impacting on provision of Orthogeriatric service
- Current mitigations:
  - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
  - Additional orthogertiatrican in post
- Task and finish group in place to further develop and implement detailed action plan

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

Histopathology

Significantly improved position with new recruitment. Consistently improved turnaround times – felt to no longer represent a significant risk to patient safety. Stepped down to Care Group oversight.

Diabetic Foot Clinic

Triage processes improved to ensure that high risk patients are risk stratified and prioritised appropriately without delay. Additional podiatry capacity to manage backlog. Capacity escalation process introduced. No further high-risk patient capacity breaches since March 2023. Stepped down to Care Group oversight.

6. RECOMMENDATIONS

Trust board is asked to:

- Note the contents of this report and the newly introduced process for designation and oversight of Fragile Clinical Services
- Note the current list of Fragile Services and associated high level progress updates
- Receive further Fragile Services reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/89**			
SUBJECT:	**Patient Safety Incident Policy & Plan (PSIRF)**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	Deborah Carter Patient Safety Project Director			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ 		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			
EXECUTIVE SUMMARY *(KEY ISSUES):*				
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the Patient Safety Incident Policy and Plan			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	11 July 2023		
	Date of meeting	QAC/23/07/146		
	Summary of Outcome	Supported to submit to Trust Board for approval		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Patient Safety Incident Policy & Plan (PSIRF)	AGENDA REF:	BM/23/08/89

1. BACKGROUND/CONTEXT

The Patient Safety Incident Response Framework (PSIRF) launched in September 2022 sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The PSIRF is nationally mandated in England for all providers of NHS funded care and is therefore in the national delivery contract.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'.

2. KEY ELEMENTS

The PSIRF removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. The PSIRF is not a different way of describing what came before – it aims to act as a culture change programme and fundamentally shift how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate, it:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

NHS England outlined implementation phases for Trusts to adopt the new PSIRF.

PSIRF orientation	Months 1 – 3
Diagnostic and discovery	Months 4 – 7
Governance and quality monitoring	Months 6 – 9
Patient safety incident response planning	Months 7 – 10
Curation and agreement of the policy and plan	Months 9 – 12.

Specific roles for Implementation have been allocated in line with NHS England guidance, these along with all the actions taken are mapped in the PSIRF project plan.

The WHH core PSIRF implementation group meets fortnightly, to assess progress against the project plan, and to keep abreast of communications and shared learning from the regional teams. The Executive PSIRF oversight group currently meet weekly in order to support the progress and implementation requirements.

The National Patient Safety team and Northwest collaboration forum have provided regular contact sessions, to ensure all regional Trusts are sharing learning and collaboratively progressing together. Early adopters of PSIRF remain fluid in their approach, acknowledging that PSRIF implementation requires adjustment and flexibility to meet organisational needs.

Progress remains on trajectory for full implementation by 1st September 2023, with good engagement from the Trust to date.

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) have been progressing through the arrangements to curate and agree the PSIRF Policy and Plan. This has been supported by extensive patient safety data analysis and engagement with the Care Groups and Clinical Business Units.

Using an iterative and risk based process the Trust's local priorities have been agreed are be shared in the attached plan.

ACTIONS REQUIRED

To approve both the draft PSIRF policy and plan.

See
Appendix 1 – Patient Safety Incident Response Policy
Appendix 2 – Patient Safety Incident Response Plan

3. MEASUREMENTS/EVALUATIONS

The measures to reliably assess the impact of the change in approach are being evaluated. Some of these will link to improvements in organisational culture as well as the in the way in which the Trust is able to describe its improvement activities directly linked to patient safety.

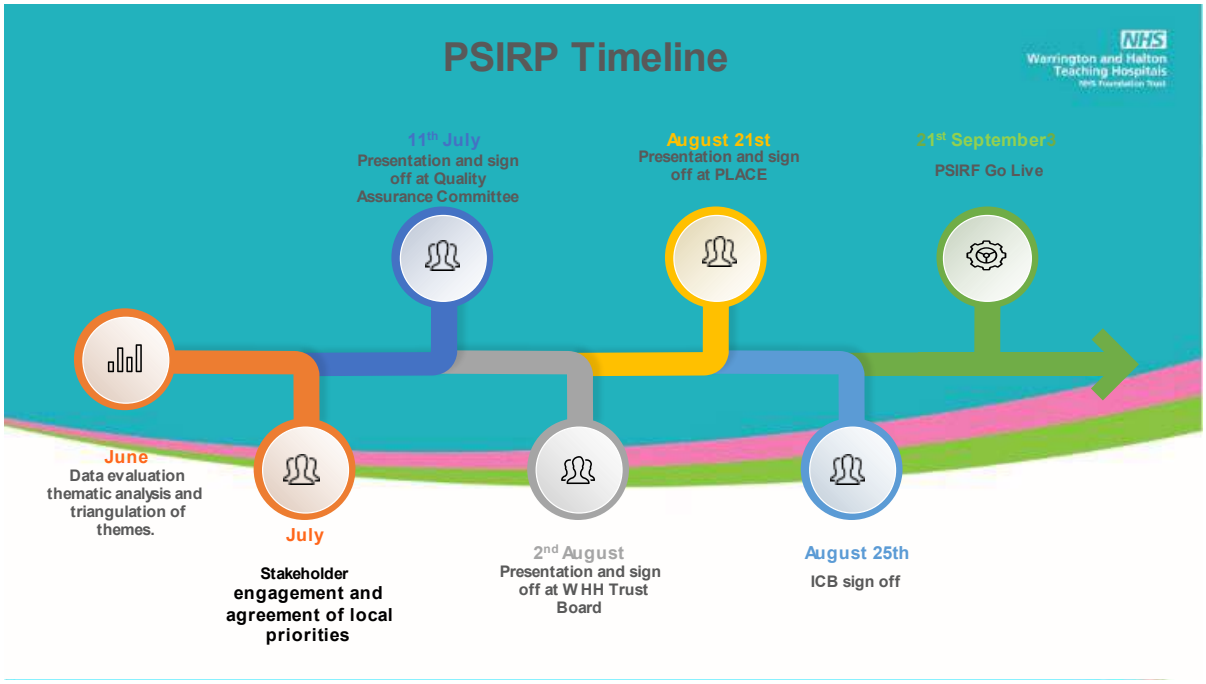
4. TRAJECTORIES/OBJECTIVES AGREED

Implementation of the PSIRF is anticipated over a period of months and years. Reducing patient harms and improving outcome measures as well as

developing and improving the culture of the organisation will also focus in the objectives.

5. TIMELINES

In order to meet the go live date of 1st September, the following time line has been developed.



6. ASSURANCE COMMITTEE

The Quality Assurance Committee has had oversight of the PSIRF work programme and has signed off both the policy and the plan.

7. RECOMMENDATIONS

The Trust Board are asked to note the content of this report and to approve the attached policy and plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Patient Safety Incident Response Policy

Effective date: 1st September 2023

Estimated refresh date: 1st September 2024

	NAME	TITLE	SIGNATURE	DATE
Author	**Deborah Carter** **Maresa Kelsall** **Nicola Edmondson**	**Project Safety Project Director** **Patient Safety Manager** **Assistant Director of Governance and Compliance**		
Reviewer	**Layla Alani**	**Director of Integrated Governance and Quality**		
Authoriser	**Kimberley Salmon Jamieson**	**Executive Nurse Director & Deputy Chief Executive**		

Foreword

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. "

Aidan Fowler, National Director of Patient Safety, NHS England

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to, and we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We need to engage meaningfully with our patients, families, and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our appointment of patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We have fostered a culture in which people feel they can highlight incidents knowing they will be psychologically safe. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure demonstrating compassionate engagement, one of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and

adapting as needed if our approach is not achieving what we expect it to. We have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Contents

1. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Warrington and Halton Teaching Hospitals NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It aims to embed patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can also align to our existing Trust values:

- compassionate engagement and involvement of those affected by patient safety incidents (Kind)
- application of a range of system-based approaches to learning from patient safety incidents (Embracing Change & Excellence)
- considered and proportionate responses to patient safety incidents and safety issues (Inclusive)
- supportive oversight focused on strengthening response system functioning and improvement (Working together)

This policy should be read in conjunction with our patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy:

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance concerns
- estates and facilities concern
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3. Our patient safety culture

As a Trust, Warrington and Halton NHS Trust have worked over a number of years to work towards a supportive and remedial approach to types of incidents, such as patient safety and workforce, in order to establish a restorative just culture within the organisation.

We are now embarking on an organisation wide culture change programme focusing on key priorities to enable effective cultural change through the impact of collective, compassionate, and inclusive leadership to foster a culture of psychological safety. This is essential to underpin the ongoing development of a high-quality safe patient care system and a just, fair and learning culture. Through embracing change in how we support our staff members through an incident with a compassionate and just approach, ensuring there is no focus on blame or punitive measures for individuals involved in events. Working collaboratively across services and teams to ensure a supportive, fair, and just approach in the management of incidents and reviews, that is consistent across all areas and teams.

In this context the wellbeing of our workforce is paramount and as such an increased wellbeing offer will be provided for those involved in incidents from our mental health and wellbeing team, supporting to recognise the needs of those involved in incidents and near misses with the aim of avoiding the creation of a second victim and any work related absence.

Through the lens of the People Promise of “we are always learning”, the learning from events will be shared widely across the organisation and incorporated into existing learning pathways such as the safety brief and team huddles, with the development of ‘celebration of learning’ events to further enhance and optimise our learning opportunities. This learning can then also be incorporated into patient safety training packages and within leadership development offers so that the learning from events is embedded to support in prevention of recurrence. It is envisaged that whilst working through our organisational cultural change that there will be an improvement in near miss reporting and in reporting incidents at the correct level to further support learning and prevention through staff feeling safe and able to report without fear of reprise or blame.

Our patient safety culture will also be reflected in our organisational cultural change workstreams of kindness, civility, and respect. Civility saves lives will be a platform to encompass both the wellbeing and emotional impact of an event, the impact of our actions and behaviours on others and ultimately patient care. How we can all build a culture of inclusivity, belonging and kindness to positively impact on our patient and workforce experience and ultimately on how we provide safe, high quality patient care.

PSIRF will further enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such

learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time alongside the development of our incident management system which will align our internal reporting to the Learn From Patient Safety Events system (LFPSE), thereby contributing to wider system learning across the NHS.

To enhance our safety culture, we have safety huddles at all levels of the organisation which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

4. Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK. Warrington and Halton Teaching Hospitals NHS Foundation Trust have been an integral part of the national implementation group for PSP's (Involving Patients In Patient Safety – IPIPS) and have supported and contributed to the development of national guidance to support the role.

Warrington and Halton NHS Trust are excited to welcome the PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. We have recruited PSPs from the local community in order that they can present their views as patients, carers or family members. Their appointment offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in Warrington and Halton NHS Foundation Trust the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this will include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will need support to provide feedback to ensure that patient safety is always our priority. As the role evolves, we may ask PSPs to participate in the ongoing development of our Local Priorities as well as investigation of patient safety events. PSP's will assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.

The PSPs will be supported in their role by the Trust's Patient Safety Specialists and Head of Patient Experience and Inclusion who will also provide expectations and guidance for the role. Warrington and Halton NHS Trust have developed a PSP role profile based on national best practice as well as other supporting documentation.

PSPs will have regular scheduled reviews and regular one-to-one sessions with our Patient Safety Specialists and training needs will be agreed together based on the experience and knowledge of each PSP. In addition, they will have access to the Trust's

Wellbeing and Occupational Health services, to ensure they are afforded appropriate support, acknowledging some of the sensitivity of issues they will be involved with.

The PSP placements are on a voluntary basis, (whilst still being remunerated in line with the NHSE Reimbursement Policy) in order for them to be independent of the Trust and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

5. Addressing health inequalities

The Trust recognises that at both a national and local level the NHS has a pivotal role in reducing and removing health inequalities which impact on people's outcomes and experiences, across all our services. We will do this by reviewing how people access our services by ensuring equality of opportunity where we know there is a disproportionate risk to patients with specific characteristics. In addition, we will continue to develop and review informative datasets and intelligence to proactively reduce the likelihood of poor health inequalities occurring.

The Trust has a legal responsibility under the Equality Act 2010[1] to ensure that no one is disproportionately impacted on the grounds of their specific characteristics. In addition, the act identifies that as a public sector body the Trust must meet the statutory obligations outlined in the Public Sector Equality Duty[2]. Part of the duty outlines how the organisation should monitor the characteristics of its patients ensuring that no disproportionate harm occurs. Where this does, the Trust will ensure that action is taken imminently with information informing the Trust's local patient safety incident response.
As part of the patient safety incident response framework (PSIRF) the Trust will utilise the available protected characteristic datasets held on the incident management system to allow for incidents and intelligence to be analysed by protected characteristics, providing insight into any apparent inequalities.

In addition to the current equality analysis process in the Trust, known as the Equality Impact Assessment, when constructing our PSIRF actions and local priorities in response to any incidents we will consider local inequalities. This will be built into our governance, documentation and risk management processes. In addition to the local equality analysis process, we will address health inequalities as part of our safety incident response work, utilising the national NHS England Core20PLUS5[3] approach. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. By establishing our local priorities, plan and policies aligned to the patient

[1] The Equality Act 2010: https://www.legislation.gov.uk/ukpga/2010/15/contents
[2] The Public Sector Equality Duty: https://www.legislation.gov.uk/ukpga/2010/15/part/11
[3] NHS England - Core20PLUS5 (adults) – an approach to reducing healthcare inequalities: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

safety incident response framework we will work to triangulate intelligence, ensuring that potential inequalities are considered. Where data suggests additional areas for improvement this will be aligned to future PSIRF plans and this policy. As a Trust we are aware that data continuously provides up-to-date intelligence in association with addressing health inequalities and therefore the use of our incident management system, aligned to patient characteristics and local intelligence, is pivotal to supporting health equality and the reduction of inequalities.

On an annual basis the Trust completes the Equality Delivery System[4], of which Domain 1 is associated with patient and service user health outcomes. This is aligned to the Core20PLUS5 model and learnings from this system review will be triangulated against local priorities at the Trust in the final quarter of each financial year.

Whilst triangulating data provides us with quantitative information, qualitative intelligence is essential to ensure that our priorities and plans associated with PSIRF are coherent with the needs and known inequalities of our local boroughs. Therefore, part of our local priorities and plan is met through the engagement of patients, families and our workforce – this includes engagement following a patient safety incident. Recognising different communication styles and the Accessible Information Standard[5] we will ensure that our communication and engagement methods are available in different formats, including Easy Read, different languages, large print. In addition, the Trust utilises interpretation and translation providers to ensure that where English is not an individual's first language, they do not suffer any detrimental impact as part of the patient safety incident review process. By proactively acting in an accessible manner, we aim to maximise the potential of patients, families, and our staff to be involved in the patient safety incident response framework at our Trust.

The Trust is committed to ensuring that "our hospitals are the best places to receive care and to work", therefore as a Trust this means that we do not tolerate, under any circumstances, any form of racial abuse or discrimination by our patients, visitors or by our staff. This includes all protected characteristics as our focus is to deliver the best care to our patients, regardless of, their skin colour, culture, ethnicity or faith, gender or sexuality, age or if they have a disability. This commitment is led by our Trust Board, and staff are encouraged to report incidents using our incident reporting system. We will use this commitment to underpin future patient safety training, communications and the rollout of our local priorities and plan. In addition, this will feature as part of our wider organisational cultural change programmes. Recognising this, we will ensure that this is pivotal to upholding a system-based approach to reducing health inequalities and poor experience of our staff and ultimately patient outcomes based on individuals' specific characteristics.

[4] NHS England – Equality Delivery System 2022: https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/
[5] NHS England – Accessible Information Standard: https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

6. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. We will work with the principals contained within the guidance document "Engaging and involving patients, families and staff following a patient safety incident" and ensure that these are at the heart of our approach.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy. This will be underpinned by a network of Family Liaison Officers (FLO) within our Patient Safety Team, the Care Groups and Clinical Business Units who are able to guide patients, families and carers through any investigation or learning review.

In addition, in Warrington and Halton NHS Teaching Hospitals has a Patient Advice and liaison Service (PALS) (palsandcomplaints@.nhs.net). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services

are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with the following:

• advice and information

• comments and suggestions

• compliments and thanks

• informal complaints

• advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

Our PALS team can be contacted at the email address above or by post or telephone as follows: -

PALS Team, Tel: 01925 662281

Corporate Nursing & Governance Department

First Floor Kendrick Wing, Warrington and Halton Hospitals Foundation Trust

Lovely Lane, Warrington, Cheshire WA5 1QG

Email: palsandcomplaints@.nhs.net www.whh.nhs.uk

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

National guidance for NHS trusts engaging with bereaved families:

https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families

https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/ explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide

https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support

https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support

https://www.childbereavementuk.org/grieving-for-a-child-of-any-age

https://www.lullabytrust.org.uk/bereavement-support/

Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy

https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate

the NHS complaints system, attend meetings and review information given during the complaints.

Healthwatch

https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site:

https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman

https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau

https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

7. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. Our approach will align to the principles in the documents "Guide to responding proportionately to patient safety incidents" and the "Patient safety Incident response standards". To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

7.1 Resources and training to support patient safety incident responses

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Clinical Business Unit (CBU) in collaboration with the Patient Safety team. A learning response lead will be nominated by the Care Groups and CBU's, and the individual should have an appropriate level of seniority and influence within the Trust, this may depend on the nature and complexity of the incident and response required, and learning responses are led by staff at Band 8a and above.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. CBU Governance leads including the designated member of the senior leadership team and the Patient Safety manager will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our just culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Clinical Business Units will have processes in place to ensure that managers work within this framework to ensure psychological safety for staff.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

Training

The Trust has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and

to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

- **Level one**

Internal - This comprises a local incident eLearning module setting out the Trust's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour.

National – Health Education England patient safety syllabus module (Essentials for patient safety).

These have been aligned to be role specific and will be completed on induction and to repeat each three years.

National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams)

- **Level two**

National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all clinical staff at AFC Band 7 or above, with potential to support or lead patient safety incident management.

These modules are available as eLearning via ESR access.

Learning response leads training and competencies:

- Training

Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained by the individual as part of their professional practice requirements. In addition, individuals may wish to have these held as part of their ESR skill portfolio, and any training certificate can be uploaded by email it to whh.clinicaleducationteam@nhs.net.

Learning response leads must have complete Level one and two of the national patient safety syllabus available via ESR.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all learning response leads via a Trust-wide learning forum.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional risk and Governance teams and the Patient Safety team will support this.

- Competencies

As a Trust we expect that those staff leading learning responses are able to

a. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
b. Summarise and present complex information in a clear and logical manner and in report form.
c. Manage conflicting information from different internal and external sources.
d. Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from both the Care Group and CBU senior managers, Governance leads and the Patient Safety team.

Engagement and involvement training and competencies

- Training

Engagement and involvement with those affected by a patient will be undertaken those who have undergone a minimum of six hours training.

Those who have previously undertaken training as a Family Liaison Officer will be able to undertake this this role, supported by the training.

Records of such training will be maintained by the individual as part of the professional practice requirements. In addition, individuals may wish to have these held as part of their ESR skill portfolio, and any training certificate can be uploaded by email it to whh.clinicaleducationteam@nhs.net.

Engagement leads must have complete Level one and two of the national patient safety syllabus.

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via a Trust-wide learning forum.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety team and supported by Divisional Governance leads.

- Competencies

As a Trust we expect that those staff who are engagement leads to be able to

a. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
b. Listen and hear the distress of others in a measured and supportive way.

c. Maintain clear records of information gathered and contact those affected.
d. Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
e. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight roles training and competencies

- Training

All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the individual as part of their own professional development.

Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

- Competency

As a Trust we expect staff with oversight roles to be able to

a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
b. Apply human factors and systems thinking principles.
c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
e. Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
f. Summarise and present complex information in a clear and logical manner and in report form.

7.2. Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

A copy of our current plan can be found at WHH hyperlink to external website.

7.3. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12-18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12-18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with the Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

8. Responding to patient safety incidents

8.1. Safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident on the Trust's local incident reporting and management system (currently Datix) and will record the level of harm they know has been experienced by the person affected (see Appendix A).

Clinical Business Units will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (See Trust Duty of Candour policy). Most incidents will only require local review within the service. However, for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the CBU (see Patient safety incident response decision-making below).

CBU's will highlight to the Patient Safety team (Corporate Governance) any incident which meets the requirement for reporting externally. This will be to allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

8.2. Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan (Hyperlink to plan).

The PSIRF does not set further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has used the PSIRF guidance documents to develop its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear 'Ward to Board' set of mechanisms allowing for oversight of incident management and our PSIRF response.

Clinical Business Units have clear escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as a immediate safety review due to possibly meeting the criteria as PSII or other Patient Safety Response or due to the potential for learning and improvement or an unexpected level of risk. Local Patient Safety Panels within the Care Groups and CBU's will consider any such incidents for further escalation to the Trust Patient Safety Summit.

The Trust Patient Safety Summit will have delegated responsibility for the consideration of incidents for PSII or PSR and for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The Trust Executive Patient Safety Oversight Meeting will have overall oversight of such processes and will challenge decision making of the Patient Safety Panels to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards.

Local level incidents – managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until a further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved

or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust guidance (see DOC Policy)

Care Group and CBU Patient Safety Panels may commission thematic or cluster reviews of such incidents to consider and understand potential emerging risks.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through CBU/Trust escalation processes (including out of hours) and this must include the CBU and Corporate Patient Safety team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the CBU or department should notify the Patient Safety team as soon as practicable so that the incident can be shared to executive level staff. The incident will be escalated to the CBU and then Trust Patient Safety Team. An initial safety review will be undertaken by the CBU supported by the Patient Safety team to inform decision making at the Local Patient Safety panel and onward escalation following this.

Other incidents with unclear potential for PSII, must also be reported to the Patient Safety team. Decision making with regard to escalation to the Trust Patient Safety summit can be considered at the next possible CBU Patient Safety panel. An initial patient safety review will be undertaken by the CBU to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The Trust Patient Summit panel will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the initial safety review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The panel will define terms of reference for a PSII to be undertaken by an appropriate member of the Patient Safety team. The panel will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the Trust Patient Safety Summit may request a patient safety review (PSR) or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the panel's discretion in such circumstances to specify a particular tool is used to complete a PSR. The Trust Patient Summit panel will also indicate how immediate learning is to be shared.

Incidents requiring possible patient safety review (PSR) – all staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review response as soon as practicable after the event through CBU escalation processes (including out of hours) and this must include the Local Governance Lead or

senior manager. An initial safety review will be undertaken by the Care Group or CBU to inform decision making following this.

The CBU Patient Safety Panel will meet at the earliest opportunity to discuss the nature of the incident, immediate learning (which should share via an appropriate platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met.

Where it is clear that a PSII is not required, the Local Patient Safety panel will consider any incident as having potential for a PSR. The tool to be utilised for the review will be specified and a suitable member of the divisional team to undertake the review will be allocated. This will not be any staff involved in the incident or by those who directly manage the staff. The Care Group or CBU will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process.

Local Safety panel arrangements will include the recording of safety actions arising from any PSR or other learning response and these details will be used to inform potential safety improvement plans (see safety actions on p28 below).

The Patient Safety Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety team will work with the CBU's to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Trust Executive Patient Safety Oversight Group

The Trust clinical Executive-led Patient Safety Oversight Group is to oversee the operation and decision-making of the Trust Patient Safety panel and the incident responses it has delegated responsibility to commission. This will support the final sign off process for all PSIIs. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

8.3. Responding to cross-system incidents/issues

The Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

The Trust will work with partner providers and the relevant Place/ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the Place/ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.4. Timeframes for learning responses

Timescales for patient safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Trust Patient Safety Oversight Meeting.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

8.5. Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps.

Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from CBU's and the support of the Quality Improvement Team with their improvement expertise.

Safety Action Development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken to safety action development

3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved

4. Prioritise safety actions to decide on testing for implementation

5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow SMART (see appendix B page 37) principles and have a designated owner

Safety Action Monitoring

Safety actions must continue to be monitored within the CBU governance arrangements to ensure that any actions put in place remain impactful and sustainable. CBU reporting on the progress with safety actions including the outcomes of any measurements will be made to the Patient Safety Oversight Group.

For some safety actions with wider significance, this may require oversight by the Quality Assurance Committee.

8.6. Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing (legacy) patient safety incident reviews (SI RCA reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The CBU's will work collaboratively with the Patient Safety and Quality Improvement teams and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through CBU governance processes and reporting to the Strategic Patient Safety Oversight Group who may commission a safety improvement plan. Again, the CBU's will work collaboratively with the Patient Safety and the Quality Improvement teams and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by reporting by the designated lead to the Strategic Patient Oversight Safety Group on a scheduled basis.

9. Oversight roles and responsibilities

Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

The Trust followed the 'mindset' principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3).

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities set out within the Framework.

In order to meet these responsibilities, the Trust has designated the Executive Chief Nurse and Deputy Chief Executive to support PSIRF as the executive lead.

1. Ensuring that the organisation meets the national patient safety standards

The Executive Chief Nurse & Deputy Chief Executive will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the just and restorative working culture that the Trust aspires to.

To achieve the development of the plan and policy the Trust will supported by internal resources within the Patient Safety team led by the Director of Integrated Governance and Quality and the Deputy Chief Nurse.

To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

2. Ensuring that PSIRF is central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality Assurance Committee and Patient Experience & Safety and Committee. Both meet bi-monthly, safety reporting will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The Strategic Patient Safety Oversight Group will provide assurance to the Quality Committee that PSIRF and related workstreams have been implemented to the highest standards. CBU's will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review

of the patient safety incident response plan and delivery of safety actions and improvement.

Care Groups and Clinical Business Units will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development. alongside a review of all safety actions.

3. Quality assuring learning response outputs

Via the Trust's Patient Safety Oversight Group to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

10. Complaints and appeals

Warrington and Halton Teaching Hospitals NHS Foundation Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and the services (including the response to incidents) provided by the Trust.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the Trust is the patient Advice and Liaison service (PALS) who will support the resolution of any concerns raised (complaintsandpals.nhs.net)

It is important to address any issue raised at the earliest opportunity and may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

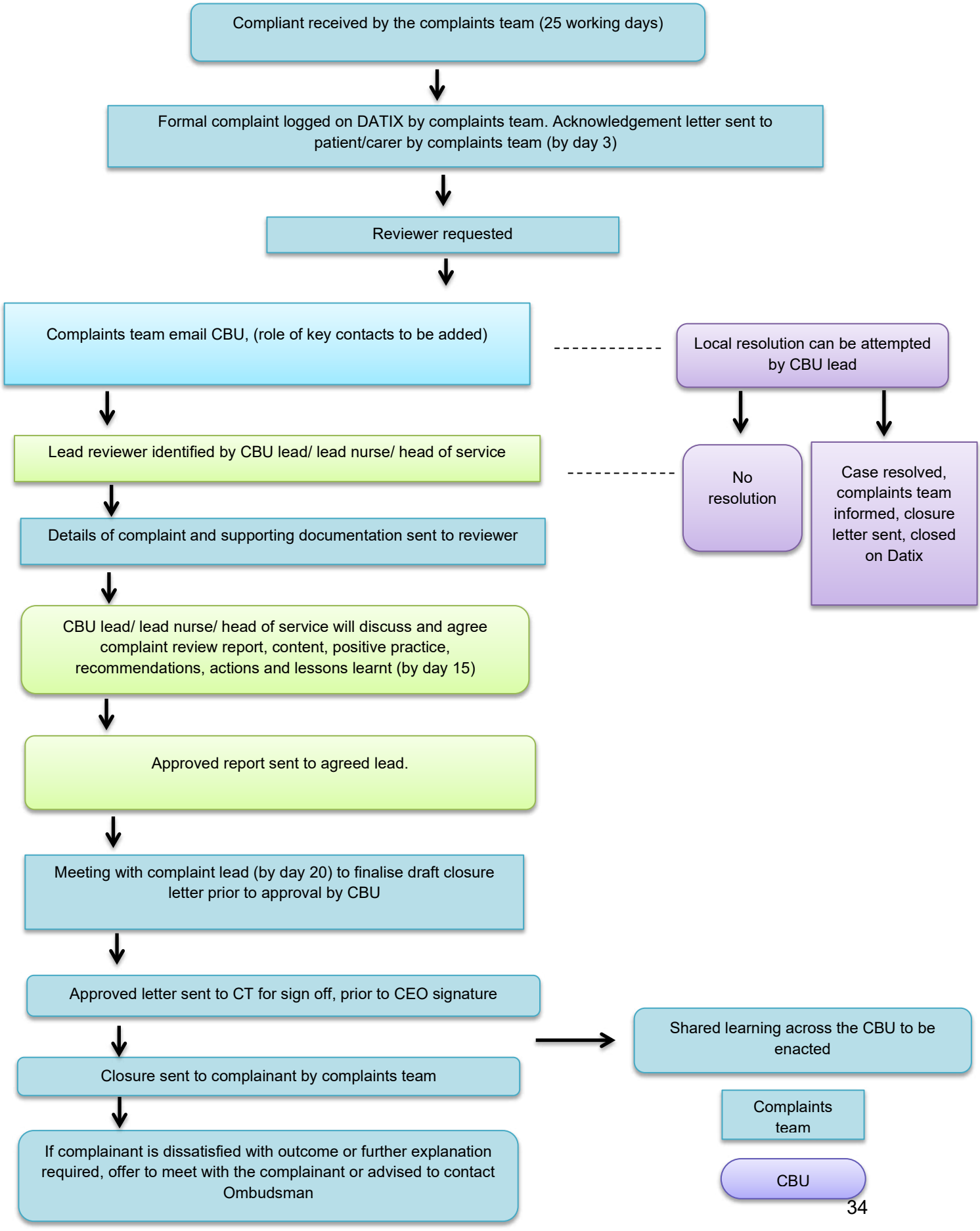
Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services and processes.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

If a concern cannot be resolved and the complaints team are undertaking a formal review the complaints team will contact the complainant and can be contacted directly (whh.complaints.nhs.net)

The flow chart below outlines the process for the management of a complaint.



Appendix A

Level of Harm

Levels of harm were previously set out in the National Reporting and Learning Service guidance on reporting patient safety incidents.

In summary harm is defined as follows

No harm

This has two sub-categories:

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a ‘near miss’.

No harm (impact not prevented) - Any patient safety incident that ran to completion, but no harm occurred to people receiving NHS funded care. Ensure that the

Low harm - Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm - Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death – Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Appendix B

Glossary of terms

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

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Equality Impact Assessment

1. **This section asks you to consider a few questions relating to your policy, process, procedure or decision.**

Initial Screening	Yes	No
1.1. Does your policy affect people (Patients/Workforce/Public)?	☒	☐
1.2. Does the policy affect one or more group of people in a different way to another?	☐	☒
1.3. Does the policy offer opportunity to promote equality?	☒	☐

1.4. Does your policy impact positively, negatively or neutrally on any of the below characteristics/groups?

If yes, please indicate how and which type (positive or negative) in the 'Barriers/Impact' section:

Neutral impact is where there will be no change in actual/potential impact on this protected group.

Initial Assessment	Scale	Barriers/Impact
▪ Age	Neutral	
▪ Disability - learning disabilities/difficulties, physical/hidden disability, sensory impairment and mental health problems	Neutral	
▪ Gender reassignment	Neutral	
▪ Race	Neutral	
▪ Religion or belief	Neutral	
▪ Sex	Neutral	
▪ Sexual orientation including lesbian, gay and bisexual people	Neutral	
▪ Marriage and civil partnership – including same sex relationships	Neutral	
▪ Pregnancy and maternity/paternity	Neutral	
▪ Carers	Neutral	
▪ Social factors - deprivation, homelessness, education etc.	Neutral	
▪ Armed Forces and Military Veterans	Yes/Neutral	

1.5.	Is the impact of the policy likely to be negative?	☐ **Yes**	☒ **No**

1.6.	If yes, please summaries if the impact can be avoided or are there any alternatives?	

1.7.	Does your policy support positive action for underrepresented groups.	☒ **Yes** ☐ **No** ☐ **N/A**

If you have answered no and neutral to all of the questions in section 1 then a full Equality Impact Assessment is not required. Where you have answered yes, please move to section 3.

2. Does your policy support the general aims of the Public Sector Equality Duty (Equality Act 2010)?

Yes ☒ **No ☐**	**1.** Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Equality Act 2010 **2.** Advance equality of opportunity and remove disadvantages between those who share a protected characteristic and those who do not **3.** Foster good relations between people who share a protected characteristic and those who do not

3. Please assess your proposals analysis equality reference scale:

☐	**High –** This policy shows a **high degree of negative or positive** impact to one or more protected characteristics or one or more general aims of the Equality Act 2010 or Armed Forces Act 2021 (where rationale cannot be justified)
☐	**Medium –** This policy shows a **medium degree of impact** (positive or negative) to one or more protected characteristic.
☒	**Low –** This policy **does not have any impact to any protected characteristic** or general aim of the Equality Act 2010 or Armed Forces Act 2021.

If your analysis has scored **high**, then a full Equality Impact Assessment should be completed (Stage 2). This can be found here. If your analysis has scored **low or medium** when considering the evidence detailed above, then a full Equality Impact Assessment may not be required.

If you require any support, please contact the Equality, Diversity and Inclusion Team at whh.equalityimpactassessments@nhs.net

References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities

core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards

B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: 1st September 2023

Estimated refresh date: 1st September 2025

	NAME	TITLE	SIGNATURE	DATE
Author (s)	**Deborah Carter** **Maresa Kelsall** **Nicola Edmondson**	**Project Safety Project Director** **Patient Safety Manager** **Assistant Director of Governance and Compliance**		
Reviewer	**Layla Alani**	**Director of Integrated Governance and Quality**		
Authoriser	**Kimberley Salmon Jamieson**	**Executive Nurse Director & Deputy Chief Executive**		

Foreword

Warrington and Halton Teaching Hospitals NHS Foundation Trust

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. "

Aidan Fowler, National Director of Patient Safety, NHS England

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to, and we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We need to engage meaningfully with our patients, families, and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our appointment of patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We have fostered a culture in which people feel they can highlight incidents knowing they will be psychologically safe. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure demonstrating compassionate engagement, one of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. We have been supported by

our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and

carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Contents

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Introduction

This patient safety incident response plan sets out how Warrington and Halton Teaching Hospital and NHS Trust (WHH) intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on Duty of Candour and the new Trust patient safety incident response policy.

A glossary of terms used can be found at Appendix A

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Our services

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) provides services to a population of approximately 330,000 living in and around Warrington and Halton boroughs. The demographic of the area shows most people are born in England and there are a very small percentage of people from other nationalities.

Warrington and Halton Teaching Hospitals NHS Foundation Trust provides acute care from Warrington Hospital in Warrington and the Halton Hospital Nightingale building in Runcorn, alongside the Halton Hospital Captain Sir Tom Moore Building the home of the breast care centre and surgery.

Warrington Hospital was formed in 1898 and merged with Halton Hospital in April 2001 to become North Cheshire Hospitals NHS Foundation Trust. Before becoming Warrington and Halton Hospitals NHS Foundation Trust on 1 December 2008.

The Trust has a total of 668 beds across all three sites: acute care inpatient, day case and specialist beds at Warrington, elective surgical beds, and intermediate care beds at Halton Hospital Nightingale Building and Halton Hospital Captain Sir Tom Moore Building for surgery.

WHH employs more than 5,000 staff from over 50 nationalities, many who live in the boroughs we serve and provide a range of services such as urgent and emergency care, maternity, surgery, outpatients, therapies, and children's health. On average 3000 babies are born at Warrington Hospital each year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Defining our patient safety incident profile

The Trust has a commitment to continuously learning from patient safety incidents and has developed an understanding and insights into patient safety matters over a period of years. WHH have weekly Executive-led Safety Oversight Meetings (SOM), and daily patient safety triage within the Care Groups and CBU's and Clinical Governance Team with weekly review at our Patient Safety Summit Meeting (PSSM).

Trust Executive teams, Clinical Governance Team and appropriate Clinical Business unit (CBU) leaders are alerted by email of any incidents of moderate or above grading. The Clinical Governance Team will, support a review to ascertain actual level of harm, and identify any immediate actions to ensure patient safety. These incidents are monitored daily and presented at PSSM weekly with collaborative discussion informing organisational learning and the most appropriate level of investigation.

Incidents meeting a lower harm threshold that may be of concern, or where themes are developing, are monitored by the Care Groups and CBU's and at the PSSM and taken forward to SOM for executive oversight when required.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p12-13 below. To fully implement the Framework the Trust has completed a review of the types of patient safety incidents that occur to understand the learning needs that will inform improvements.

The PSIRF SRO and leadership group has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on p14.

Stakeholder engagement

Planning for PSIRF was commenced on release of documents in August 2022. WHH has worked with a number of the PSIRF early adopters to learn from their approaches, with support from the North-West PSIRF Collaborative network to better understand the practicalities of planning for and implementation of PSIRF.

WHH have had a proactive approach to patient safety incidents embedded for some years now, with consideration given to organisational learning ultimately guiding the investigation response. Incidents that did not meet the current SI framework have also been reported as

an opportunity for leaning. This approach supports the embedding of the PSIRF culture, and as such sees WHH further developing these attributes as PSIRF transitions and embeds further within the organisation.

Regular contact with Place and the Integrated Care Board (ICB) has seen this approach progress and provides assurance to internal and external stakeholders.

Awareness of PSIRF began early, following initial preparatory work and then the launch of the PSIRF in August 2022, with communications sent trust wide through the communications teams. This was supported with engagement sessions to trust board and the wider senior clinical teams. Governance meetings and relevant groups from across the Trust have participated in presentations and discussions to share PSIRF updates and widen knowledge.

An initial series of engagement meetings were held from the end of May 2023 with key stakeholders from various disciplines to outline the impact PSIRF might have, and to begin to explore the nature of incidents reported, what processes are in place to currently manage and review these and how such reviews might change under PSIRF. Views were collated to support the next stage of the process in order to inform this plan.

A resource analysis exercise has also been undertaken, with support from the CBUs and using our own patient safety data, details on this are provided in the Patient Safety policy document, but this was invaluable for understanding current resource and capacity for responding to patient safety incidents.

Data sources and how they were used to define the safety profile at WHH is detailed below. Once the data was collated, a series of workshops have been carried out with our key internal and external stakeholders to review this together to finalise our local focus and priorities. The Trust also carried out a series of workshops with our CBUs and Care Groups to identify our approach to other patient safety incidents requiring a response. It should be noted however, that whilst priorities have been identified, the Trust remain flexible in utilisation of the toolkit, and aim to collaboratively commission the most appropriate investigation based upon the findings of initial investigations. Likewise, incidents of concerns that may not be outlined within stated priorities, must be shown due diligence by investigating appropriately.

Data sources

To define our patient safety response profile, data was drawn from a variety of sources. Data was collated on the actual incidents that had taken place over the period of the 3 years, that is, from 2020 to 2023. It was decided to look at these years to minimise the possibility of any variation in data arising from the COVID-19 pandemic. Data was collected in financial years – 01/04/2020 to 31/03/2023.

This data was extracted for our initial engagement meetings with key internal stakeholders.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident reporting systems
- Complaints, both formal and informal
- Safeguarding reviews
- Freedom to Speak Up
- Mortality Reviews
- Staff survey and learning surveys
- Claims
- Risk
- Data from Quality Surveillance processes
- Coronial information Inquests.

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. As part of our workshops, we have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

Safety issues highlighted by the data

From the original data review, we were able to identify the top ten reported incidents by category, level of harm was also considered as part of this review. These are shown in the table below. (The term patient is used to describe an individual in receipt of care and treatment, for some services the term service user is preferred):

Category	Descriptor
Medication	All medication issues, including errors, administration and prescribing.
Infection Prevention and Control	All incidents relating to infection control concerns.
Access, Transfer & Discharge	All incidents related to accessing care, transferring in or out of WHH and discharging concerns.
Patient Fall	All patient falls.
Clinical Care - ongoing &review	All incidents related to a concern in treatment
Skin Damage – Admitted with	All incident where skin damage has been noted upon admission to the Trust.
Assessment, diagnosis and Investigation	All incidents relating to assessment diagnosis or investigations.
Security	All security incidents
Staffing	All staffing related incidents.
MASD – other wound to skin	All incidents where skin damage has been attributed to a Trust admission.

These were the themes considered in our engagement workshops, with further details on the subcategories within the themes considered to identify and hone our overall profile. We have also considered items identified which link to current improvement programmes of work and assessed the potential for new learning.

This led to the local focus priorities highlighted on p14 below and which will be our priorities for review under PSIRF.

Whilst the final list has been agreed we are conscious that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

At Warrington and Halton NHS Foundation Trust, we are committed to embedding a culture of continuous improvement to provide the best care possible for our patients. We do this by working together to make small changes every day as part of our daily work, therefore continually building on the great care that we already provide and striving to make continual improvements for our staff and patients.

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into continuous improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the continuous improvement work we need to undertake.

The trust established the Quality Academy in June 2018. Its ethos is to apply cutting edge research and innovation to ensure that clinical excellence is embedded throughout the organisation. This is achieved through continuous quality improvement, working with staff in collaboration with our partners and the public.

The Quality Academy is focusing on building quality improvement capacity and capability at all levels of the organisation by providing different types of improvement training in order to achieve spread and maximise the opportunities for improvement work across the trust.

Our improvement priorities are informed by data analysis and engagement with the CBU's and Care Group teams around operational and pathway improvement priorities from across the organisation and in line with national requirements. Our improvement work currently comprises a combination of:

- Key improvement priorities arising from national reports, audits, incidents and complaints (e.g. Infection Prevention and Control, communication with relatives, optimising patient flow)
- Supporting teams taking part in National Collaborative (e.g. MatNeoSIP, MedSIP)
- Trust wide harms reduction priorities supported by the Corporate Nursing Team and the Trust Safety Nurses (e.g. safety huddles, pressure ulcers, falls, VTE)
- CBU and service specific improvement projects (e.g. medicines safety, Sepsis)

We have brought together all elements of improvement work currently underway within the Trust. This can be found at Appendix C. Not all categories we have identified within our Trust incident profile have an impact on patient safety and therefore may not have an associated workstream noted.

We plan to focus our efforts going forward on the development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Given that the Trust has finite amount of resources for patient safety incident responses, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

A review of those incidents reported as per Serious Incident Framework (SIF) that required full comprehensive investigations was undertaken for the last three years:

In 2020/21, 40 comprehensive investigations were undertaken and 65 concise investigations.

In 2021/22, 56 comprehensive investigations were undertaken and 78 concise investigations.

In 2022/23, 71 comprehensive investigations were undertaken and 91 concise investigations.

We estimate, due to the services we provide, we will complete approximately 15 - 20 PSII reviews where national requirements have been met per annum.

	National priority	**Response**
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII by WHH
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by WHH
3	Maternity and neonatal incidents meeting HSIB criteria	Refer to HSIB for independent PSII
4	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the Panel review
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the Panel review
6	Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of willful neglect or domestic abuse / violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.

7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
9	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII by the provider in which the event occurred with WHH participation as required
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and WHH participation if required

11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through analysis of patient safety insights, based on the review of incidents and engagement meetings and workshops the Trust have determined 3 patient safety priorities as local focus. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII's to inform our patient safety improvement planning through continuous improvement.

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. We have embraced the methodologies within the PSIRF framework to support our incident investigations and learning. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

	Incident type	Description	Response type
1	Assessment, Diagnosis and Investigation	Potential for harm when there is a missed or delayed diagnosis of a cancer.	PSII
2	Clinical Care - ongoing &review	Potential for harm when there is a delay in the identification, recognition and response to patient deterioration resulting in delayed escalation and treatment.	PSII
3	Assessment, diagnosis and Investigation	Potential for harm when there is a delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)	PSII

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Appendix B

NHS
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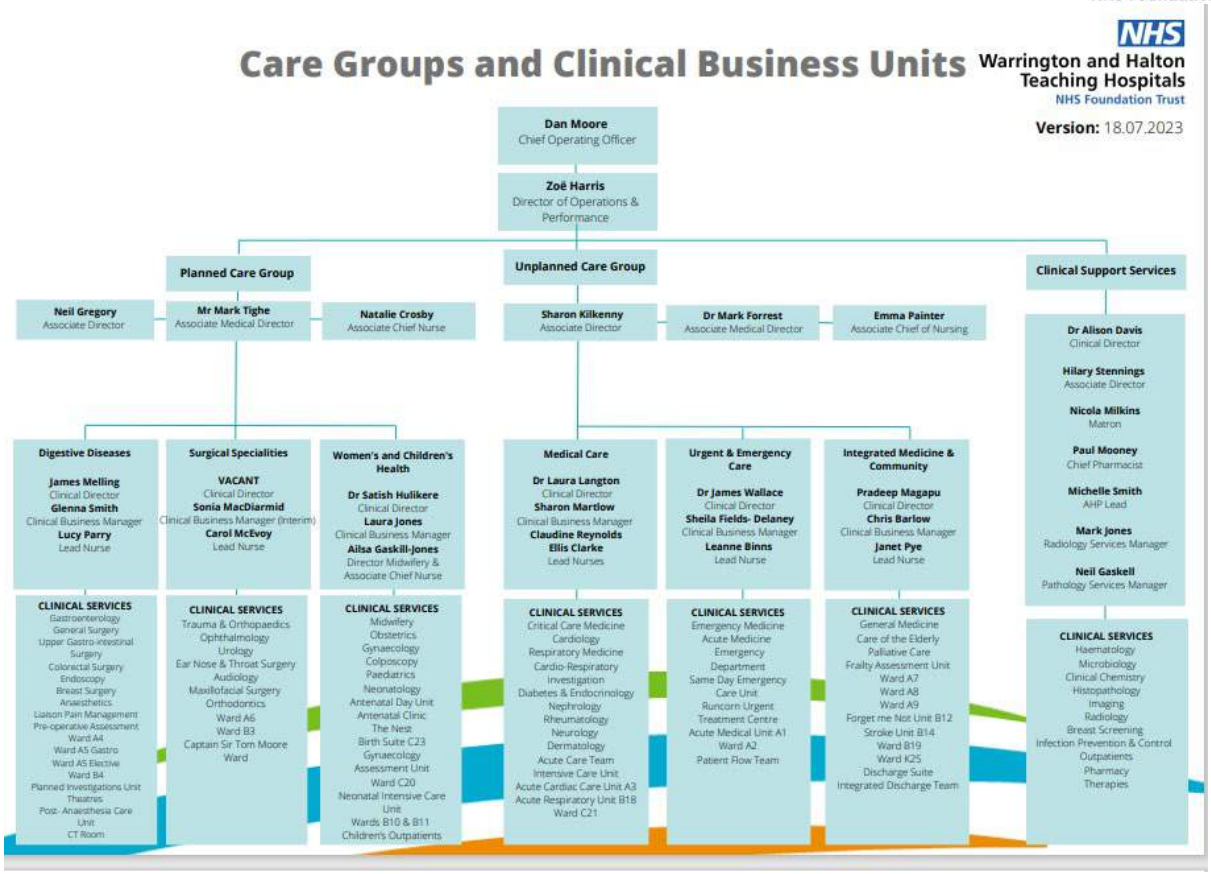
NHS Foundation Trust



Appendix C

Improvement programmes

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	Action to be taken	How will you measure/monitor whether this has been achieved?	What resource is required?	How does this link to Trust strategy?	Deadline for delivery
	Building improvement capability				
1	Increase uptake of existing QI training programmes through: - improved communications - engagement with care groups and CBU leadership - exploring CPD accreditation	Participation in QI Foundation and QI Practitioner training *Aim: 10% of staff (400) trained to QI Foundation level and 2.5% of staff (100) completed QI Practitioner.*	Support from Comms team to deliver Comms and engagement plan Care group and CBU leadership Support and governance arrangements for monitoring in place QI team capacity and capability to deliver Suitable venues Budget for	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Growing our WHH Workforce for the future	Ongoing Q1-Q4
2	Implement the QI training delivery plan including: - Develop a leadership for improvement training offer, aligned to emerging NHS England programme (Q2-Q3) - Develop and implement a QI coaching programme (Q2-Q4) - Develop a series of bitesize modules (Q2) - Explore options for development of e-learning package (Q4)	Course content developed Participants enrolled Options appraisal for e-learning	Support from Comms team to deliver Comms and engagement plan Care group and CBU leadership Support and governance arrangements for monitoring in place Support from partners e.g. AQuA, Q community Coaching SIG, subject matter experts QI team capacity and capability to deliver Suitable venues Budget for	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work People - Growing our WHH Workforce for the future	Q2-Q4
3	Internal QI team development to meet the evolving needs of the service and Trust	PDR with training and development plan in place for all team members, aligned to service need alongside personal priorities Staff Retention	Access to CPD funding where required Access to external training courses	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Growing our WHH Workforce for the future	01/06/2023 Ongoing

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	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	**Action to be taken**	**How will you measure/monitor whether this has been achieved?**	**What resource is required?**	**How does this link to Trust strategy?**	**Deadline for delivery**
	Build and sustain a culture of continuous improvement				
4	Support CQC Preparedness: Moving to Outstanding by: - QI involvement in the CQC mock inspection prgoramme - support to use QI methods and tools where requirements for improvement identified - support the use of SPC charts and regular measurement to monitor QI outcomes and ensure sustained improvement	Completion of self-assessment of QI, learning and innovation section of CQC well-led framework *Aim: Achieve 80% Quality Improvement assessment score in line with CQC maturity matrix.* Attendance at relevant CQC meetings and involvement in mock inspections QIPs identified through or	QI team capacity	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Q1-Q4
5	Implementation of QI communication and engagement plan	Improved uptake of training courses Increase in QIP registrations Improved quality and outcomes of completed	Support from comms team	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Ongoing Q1-Q4
6	Improve oversight and governance arrangements for QI work at Care group and CBU level	Clear escalation routes for QIPs Reduction in number of discontinued QIPs Improved quality of QIPs Improved oversight and uptake of training Improved alignment of workplans with other teams e.g. transformation	Care group and CBU leadership Support	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	Q2
7	Continue to showcase Quality Academy and improvement work and celebrate successes across the organisation, including: (e.g. World Quality Week) - promoting and supporting annual events e.g. Quality Academy Showcase, world Quality Week - Celebration events for QI practitioner participants	Attendance and engagement with celebration events Spread of improvements beyond original location/service	Senior leadership support and attendance at events Support from communications team Budget for refreshments, etc	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Ongoing Q1-Q4
8	Support the develoment of a systematic approach to shared learning, e.g. through the development of a trustwide learning forum	Attendance at learning forum Evaluation of learning forum events	Senior leadership support and attendance at events Support from communications team Budget for refreshments, etc	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework Quality Priority 6 - Improve and embed a culture of Quality Improvement	Q3

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	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	**Action to be taken**	**How will you measure/monitor whether this has been achieved?**	**What resource is required?**	**How does this link to Trust strategy?**	**Deadline for delivery**
	Support application of QI methods to Trust and service strategic improvement areas				
9	Support the delivery of 2023-24 Quality Priorities through coaching, advice and guidance to support use of QI methodologies	Attendance and involvement in relevant working groups Application of QI methods to delivery	Support and leadership from identified project leads	Quality: Patient Safety Quality: Clinical Effectiveness Quality: Patient Experience	Ongoing Q1-Q4
10	Support the delivery of the 23-24 CQUINS through coaching, advice and guidance to support use of QI methodologies	Application of QI methods to CQUIN delivery QIPs identified through or linked to CQUINS	Support and leadership from identified project leads	Quality: Patient Safety Quality: Clinical Effectiveness Quality: Patient Experience	Ongoing Q1-Q4
11	Support the implementation of PSIRF	Active involvement in the PSIRF implementation group QIPs identified through or linked to local priorities identified within PSIRP	Support and leadership from identified project leads	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	Ongoing Q1-Q4
12	Support Trust participation in national patient safety collaboratives, e.g. Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), Medicines Safety Improvement Programme (MedSIP)		Support and leadership from identified project leads	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	
13	Support Care Groups and CBUs to apply QI methods to deliver annual priorities and ad hoc	Application of QI methods QIPs registered within each CBU	Care group and CBU leadership Support and governance arrangements for monitoring in place QI team capacity	Quality People Sustainability	Ongoing Q1-Q4

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	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	**Action to be taken**	**How will you measure/monitor whether this has been achieved?**	**What resource is required?**	**How does this link to Trust strategy?**	**Deadline for delivery**
	Further develop QI systems and processes				
14	Review and further develop the QIP registration process, including: - QIP registration form - Clear criteria for registering as a QIP - Development of a standardised approach and crtieria to assess QIP quality and outcomes	Revised process following workshop with relevant staff Digitised registration form Updated project type flow chart (to include transformation, patient experience, etc)	Support and engagement from other team leads to clarify distinctions between project types	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work	Q2
15	Further develop the QI toolkit, resources and project documentation	Updated toolkit/resource pack ? Number ofownloads	Support from Comms team to format and ? access download data	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Q3
16	Establish and raise awareness of defined QI project roles and responsibilities e.g. SRO, project lead, team member	Clearly defined and documented roles and responsiblities Engagement of key project roles in QI projects	Support from senior leaders, project leads and team members	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work	Q1
17	Increase involvement of patient and service users in QI projects	Number of projects involving service user representation	Support from engagement and involvement officer and experts by experience	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation Quality: Patient Experience People - Innovating the way we work	Ongoing Q1-Q4

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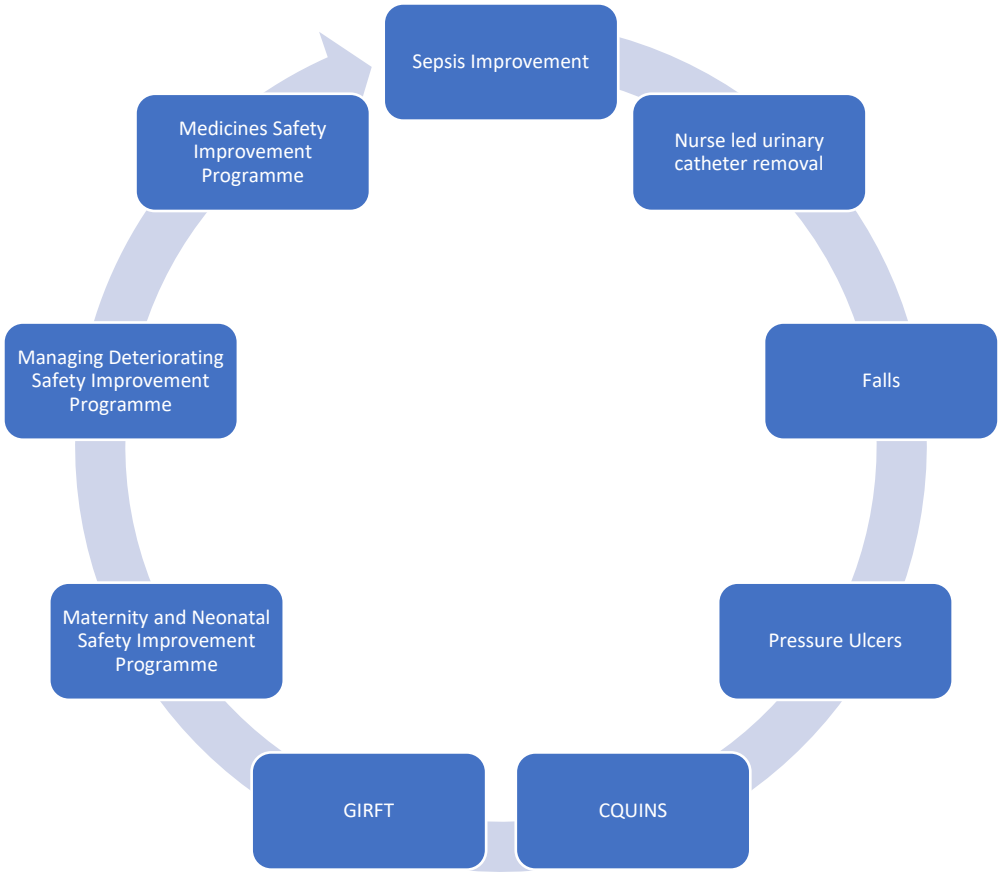
Supporting application of QI methods to strategic improvement areas



Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/90**				
SUBJECT:	**Communications and Engagement Dashboard Q1 2023-24**				
DATE OF MEETING:	2 August 2023				
AUTHOR(S):	Alison Aspinall, Head of Communications & 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):	All				
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Q1 dashboard format has been refreshed to show not only the outputs of the Communications and Engagement Team, but to highlight the impact of key campaigns during the quarter. In this report the dashboard has highlighted: • Active Hospitals campaign • Children and Young People's Outpatients video • Where best next? campaign The dashboard includes examples of media releases issued during the quarter, plus engagement with social media, our website and internal communications channels. For the first time we have also been able to include metrics for the staff extranet following some changes by our web and extranet provider. The figures for the first month are partial due to the cutover period. An overview of the engagement and involvement activity undertaken during the quarter is also included. This quarter the dashboard also includes reference to the brand evolution work to ensure our WHH Trust brand is fully compliant with NHS brand and accessibility guidelines. The format of the dashboard has been updated to reflect the current branding approach and to improve accessibility. Feedback on the revised dashboard format is welcomed as we aim to further develop it as a useful report on communications and engagement activity in each quarter.				
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision	

RECOMMENDATION:	The Trust Board is asked to note the progress made during the first year of the Working with People and Communities Strategy 2022-25.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	GEG/23/08/26
	Date of meeting	1st August 2023
	Summary of Outcome	noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Warrington and Halton Teaching Hospitals
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Communications and Engagement Impact report

Quarter 1 (April to June) 2023

The team

The Communications and Engagement team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including – content development for trust's corporate social media channels and updates to the website
- Identity and branding
- Design work
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information
- Freedom of Information (FOI) requests

During the Q1 period (April to June 2023) the Communications and Engagement Team…..

- processed and allocated **132** separate communications 'Job Request' forms for design, film, photography and communications campaign support
- handled with **23** enquiries from local, regional and national print and broadcast media
- responded to **472** enquiries through the enquiries inbox
- received **158** Freedom of Information (FOI) requests
- processed and issued **153** FOI request responses

Q1 achievements overview

- Supported the Home for Easter/'Where Best Next?' campaign to support good discharge planning practices and improved patient/carer awareness.
- Supported ongoing communications to minimise the impact of industrial action
- Worked as part of the Warrington Together partnership to promote the development of the town centre Living Well Hub
- Showcased the trust's 'Guide to being a WHH Governor' as best practice at the NHS Providers Governor Focus event in London on 23 May
- Promoted the Halton Clinical Research team and Pathway to Research opportunities as part of International Clinical Trials Day
- Worked with strategy team and partner organisations to deliver an event for the enhanced breast screening facilities at Bath Street on 22 June
- Engaged 17 staff and 23 patients in sharing their stories ahead of the NHS75 birthday celebrations in July
- Continued to develop our engagement and involvement offer including working with Aqua to develop a 'Lived Experience' training programme for our Experts by Experience
- Communications support for the Acute Respiratory Infection Virtual Ward including production of patient information leaflets and communications pack for pilot with Warrington East Primary Care Network.

The following slides detail the outputs and outcomes of key campaigns during the quarter

Active Hospitals

WHH programme to encourage inpatients to move more to prevent serious risks from hospital associated deconditioning.

To embed this approach, WHH participated in “National Reconditioning Games” and the challenge was on for wards to earn medals for their commitment to adopting the Active Hospitals approach.

- **January 2022:** patients active and out of bed in time for lunch = 12%
- **August 2022:** Active Hospitals launched, patients active and out of bed in time for lunch = 40%
- **November 2022:** Reconditioning Games began
- **April 2023:** Reconditioning Games ended.
- Outcomes 68% patients are active and out of bed in time for lunch. Feedback from staff and patients has been universally positive with 44 medals awarded to staff, 17 wards/teams successfully engaged and the highest medal count across all organisations participating in the North West
- **June 2023:** Active Hospitals shortlisted for HSJ Patient Safety Award

Comms support:

- Patient promotional materials
- Staff promotional materials
- Social media: content to promote active hospitals was scheduled fortnightly and celebration content when wards won bronze, silver and gold certificates were promoted

Children and Young People's Outpatients

Following the redevelopment of the Children and Young People's Outpatients department in 2022, support was requested for an opening event to promote the new facility.

The approach included a focus on making visits to hospital outpatient appointments a less stressful experience for children and their carers.

The concept agreed was for a video tour of the department with a 'cast' of children and young people acting as staff to take the viewer on the tour.

Thanks to the support of our amazing children, young people and their families an informative subtitled film was produced, taking viewers on a journey from Warrington main entrance, past the welcome desk and throughout the department.

An opening event was scheduled in the Easter holidays to 'premiere' the film for all the cast, their families and the project team project with an 'Oscars' ceremony at the end.

Unfortunately, national industrial action meant the event was cancelled, but the cast all received their Oscars.

The film has received more than 500 views within the first three months since publication and feedback from patients and families has been overwhelmingly positive.

Where best next?

The impact of longer than necessary hospital stays for our patients can include worse health outcomes for some and an increase in long-term care needs particularly for older and vulnerable people.

To support the annual ‘Home for Easter’ **c**ampaign (Wednesday 29th March to Thursday 6th April) we provided additional resources from the ‘Where best next? - Why not home? Why not today campaign?’ including nationally available materials and specific WHH resources:

Information for staff including:

- Discharge Information Packs for each ward
- A Top Tips video
- An Extranet Where Best Next page
- A poster campaign
- GMWHH message and bulletin updates

Information for patients encouraging them to ask ‘When am I going home?’ including:

- website
- social media
- paid for editorial in external publications
- patient leaflets from the national campaign and a WHH patient letter

Feedback from the teams on the top tips video, extranet information and discharge packs has been positive so far.

Next steps are to continue promoting the ‘Where best next?’ resources and messaging with future ‘WHH Home for…’ campaigns.

Media

The **15** media releases/proactive external announcements issued during Q1 included:

Appeal for volunteers to support vital research work at WHH

Read the release.

Work begins on new Living Well Hub in Warrington town centre

Read the release.

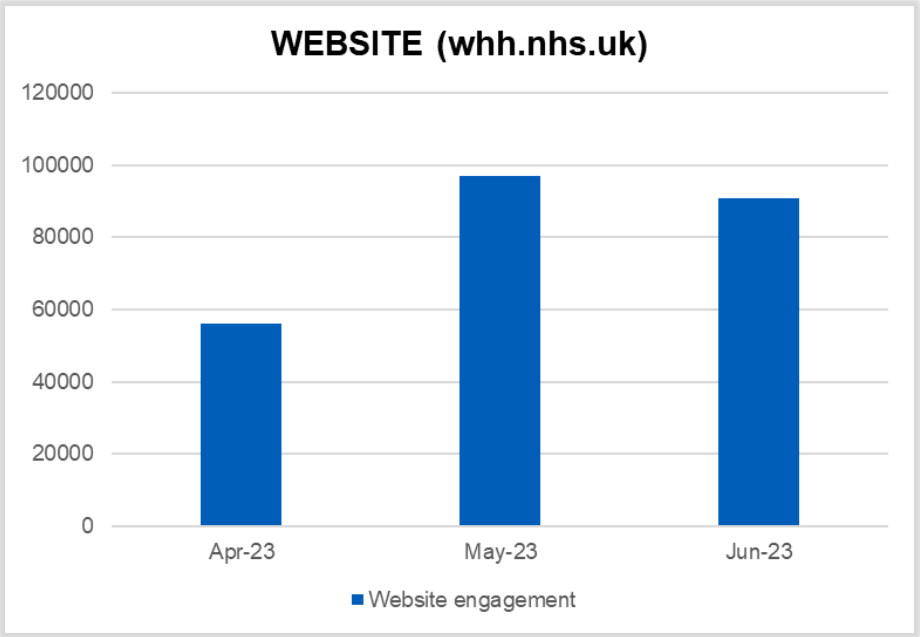
Expanded breast screening at Bath Street Health and Wellbeing Centre now open

Read the release.

Halton and Warrington to celebrate 75 years of the NHS

Read the release.

Digital communications



Most viewed pages	Total page views – 243,591
/work-at-WHH	8,794
/Contact-us	8,130
/Blood-test-clinic	7,132
/Search-results	7,065

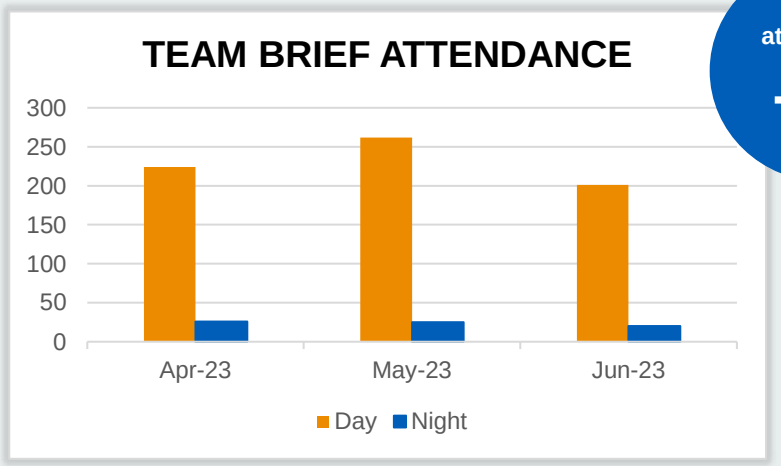
Social media

Facebook (12K followers)
Post reach: 387,746
Post engagement rate: 7.2%

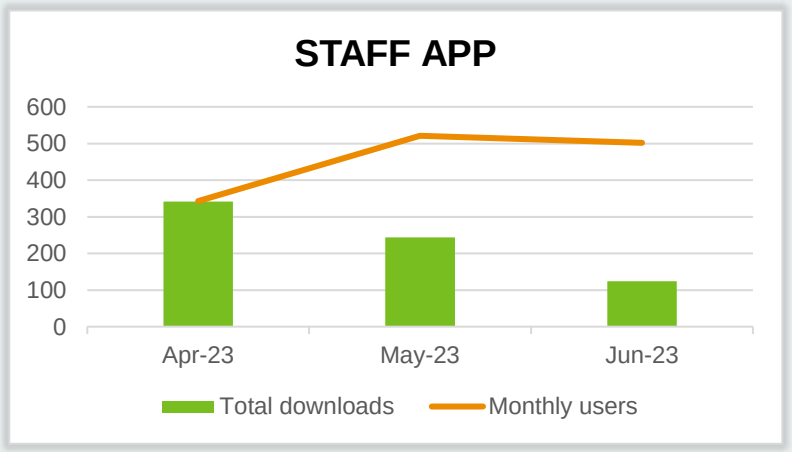
Twitter (13.2K followers)
Impressions: 196,774
Post engagement rate: 1.4%

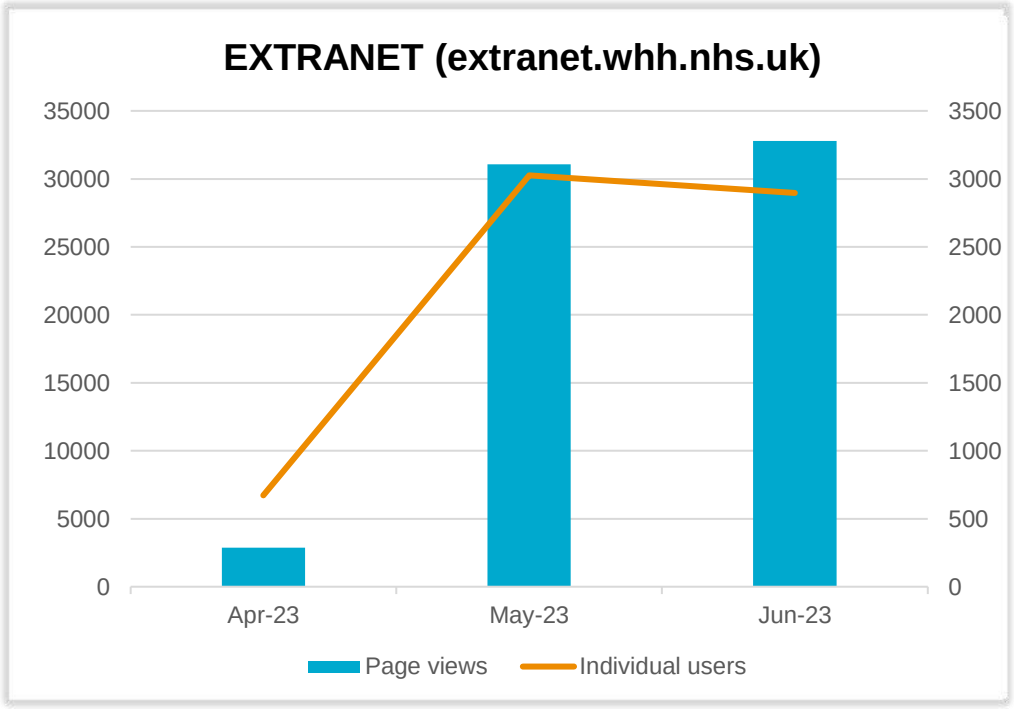
Instagram (3.5K followers)
Post reach: 105,253
Post engagement: 1,584

Internal communications



Total attendance in Q1: 758





Most viewed pages	Total page views – 125,000
/search-results	8,384
/vacancies	5,532
/workspace	3,575

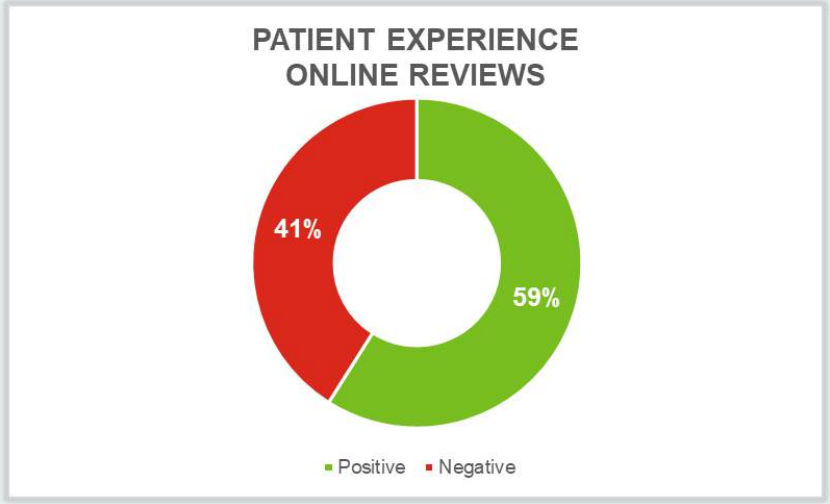
Engagement, Involvement & Insight

During Q1 (Apr to Jun 2023) we recruited **16** Experts by Experience

We received requests for engagement support for the following projects:

- Digital week survey
- Phlebotomy e-booking project
- Reception areas survey
- Experts by Experience input into the naming of the Community Diagnostic Hub
- Experts by Experience input into the design of branding for the One Halton Family Hubs

In June we invited the Experts by Experience involved in the design of our enhanced breast screening at Bath Street to be part of the opening event. This enabled them to view the finished clinic and to see how feedback had been incorporated.



A total of 39 online reviews from patients rating their WHH experience were published in Q1.

Sources of data:

- NHS Choices
- Google reviews
- I want great care

WHH brand refresh

Our Trust branding is being updated to ensure we are:

1. accessible to all, including those with a visual impairment
2. evidence-based and compliant with national NHS identity guidelines
3. clear and consistent in our messaging for staff, patients and the public

Important to note:

- Not a complete rebrand – our mission, vision and aims remain the same
- Gradual rollout - use up existing branded materials
- Accompanied by WHH brand guidelines and WHH Style guide
- Suite of templates for temporary signage and stationery

Core colours are white and NHS Blue

A curved ‘swoosh’ replaces the previous version with colours taken from the NHS colour palette – NHS Aqua Blue / NHS Orange / NHS Light Green

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/91**	
SUBJECT:	**Working with People and Communities Strategy 2022-25 Annual Report (June 2022 to end of Q1 2023-24)**	
DATE OF MEETING:	2 August 2023	
AUTHOR(S):	Alison Aspinall, Head of Communications & Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Working with People and Communities Strategy (WWP&C) 2022-25 was approved at the May 2022 board meeting. It replaced the previous Patient and Public Participation and Involvement strategy 2019-22. The strategy focuses primarily on the Trust's ambition to put the needs of patients at the centre of all service and capital developments where there is an impact on how and where patients/service users receive care. It aims to ensure that Warrington and Halton Teaching Hospitals NHS Foundation Trust fulfils its statutory obligations as set out in the legal duty to involve people in the planning, proposals and decisions regarding NHS services, as a minimum. It also seeks to embed within the Trust the principles of a 'Start with People' approach to ensure our planning and development of service delivers the best outcomes for patients, staff and the Trust. The strategy also aims to reflect that as an anchor institution in the two boroughs we serve, the trust has a key role to play in improving the economic, mental as well as physical health of our communities. This report provides an overview of the achievements and deliverables in the first year of the life of the strategy (from June 2022 to the end of Q1 2023-24) as well as providing an overview of the plans for the coming 12 months. Note: following the approval of the WHH WWP&C strategy NHS England published statutory guidance for trusts as well as place-based partnerships and ICBs titled 'Working in partnership with people and communities'. Although the	

	strategy is aligned with the principles of the guidance, a small amend has been made to the strategy to replace the ladder of engagement content with the framework for engagement and involvement now used by NHS England NHS Cheshire and Merseyside. **Progress against plan** Progress has been made in all four pillars of the strategy; however, it should be noted that there have been some areas where progress has not been at the anticipated pace. The reasons have been varied and include sickness absence, a three-month vacancy in engagement and involvement, change in role for a staff member and technological complexities. Objectives which have not been progressed as planned have been rolled over to the following year's work plan. A summary of the outputs and outcomes against each objective within the four pillars is included in the enclosed report.			
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the progress made during the first year of the Working with People and Communities Strategy 2022-25.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	GEG/23/08/27		
	Date of meeting	1st August 2023		
	Summary of Outcome	noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Working with People and Communities Strategy 2022-25 – Annual Report (June 2022 to end of Q1 2023-24)

Pillar 1: Co-production/design 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

Objective	Outputs and outcomes
1. Grow Experts by Experience (EbyE) capacity to embed co-production in service design within WHH	• Standard Operating Procedure for Expert by Experience involvement requests approved. • Engagement toolkit created on extranet to promote greater awareness of the legal duty to involve people in planning, proposals and decisions regarding NHS services and the benefits of such involvement for staff and patients. • Updates on Experts by Experience programme progress provided bi-monthly to Patient Experience Sub-Committee.
2. Support EbyE recruitment and retention	• More than 70 Experts by Experience registered with the Trust (end of June 2022). • Created online and printed Expert by Experience recruitment forms. • First Expert by Experience newsletter issued in December 2022.
3. Enhance our programme for EbyE involvement	• During the year EbyEs have been involved in user testing of the phlebotomy e-booking system implementation, digital services strategy survey, site visits to provide feedback on the enhancement of breast screening at Bath Street, surveys on the new hospitals programme and the naming of the Warrington and Halton Diagnostics Centre. • Seek information on Expert by Experience areas of interest at point of recruitment. • Surveys sent at the end of any Expert by Experience involvement and at the close of any major projects for both the Experts by Experience and the project leads, to support continuous improvement.

4. Undertake consultation and engagement training to enable effective support for services	• Attendance at NHS England Learning programme on service change and reconfiguration: preparing for public consultation in September 2022. • A six-week public consultation was conducted on proposals to cease provision of breast screening services at Kendrick Wing, Warrington hospital and centralise the service in Warrington at Bath Street Health and Wellbeing Centre. This consultation was fully informed by an Equality Impact Assessment and sought to involve those who may not traditionally have been considered including particular focus on members of the travelling community and members of the trans community. Feedback from NHSE Specialist Commissioning and local health and scrutiny committees on Trust consultations was positive and the process followed was robust and provided assurance.
5. Ensure representation to support Place-Based integrated care delivery	• Regular attendance on both the One Halton and Warrington Together Communications and Involvement Network meetings with partners. • Co-ordinated attendance by public governors for Halton and Warrington at the respective place-based People and Communities Voice forums. • Supported ICB engagement within our clinics on planned relocation of spirometry services from GP practices and transfer of services to WHH.
6. Enhance our Member communications	• Work undertaken to implement the Civica Membership database ahead of the 2022 governor elections and database cleansed. • Governor engagement events held at Warrington and Halton sites to promote opportunities to stand for election as a governor and to help people understand more about the role. The elections were supported by a communications campaign. • Work commenced with the Corporate Governance and Membership Manager to develop a format for a regular member e-bulletin to all those foundation trust members with a registered and valid email address.

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

Objective	Outputs and outcomes
1. Reconvene AIS Task and Finish Group	• The group was reconvened in early 2022, with meetings held between March and October 2022. • Items on the deployment plan were worked through including a campaign to launch the AIS Policy with and a Communication Passport document, but the roll-out of both was postponed due to technical challenges relating to the collation of a patient's accessible communication and information needs on the current EPR and the functionality to transfer this information to Synertec to generate letters in each patient's required accessible formats. • Information on the campaign and the bespoke WHH animation created is available on the Accessible Information and Communication extranet page.
2. Patient Letters	• Experts by Experience were engaged in a short workshop in June 2022 to sense check the findings of an earlier 'Letters Be the Best' workshop held in 2019. Representatives from the EPR team were in attendance and summarised feedback from the workshop was shared. • Feedback from the workshop led to the general information accompanying each patient letter being updated with QR codes linking to the website, where visitors can use accessibility tools to access information in more detail. A phone number for PALS was also provided, to offer an alternative means of accessing information. This change was submitted for letters generated by Synertec and via operations to those services who generate their own patient letters.
3. Ensure website technical compliance with WCAG standards	• A web accessibility upgrade to ensure compliance with WCAG 2.1 was completed by our external website provider in August 2022. • A further housekeeping exercise was conducted by the Digital Content Officer to review accessibility of content starting in late 2022 and concluded by end of May 2023.
4. Accessible content creation	• The Communications and Engagement team completed a training session on online accessibility in September 2022 to increase awareness of accessibility guidelines in relation to website, extranet, social media, video and design.

	• A checklist has been put in place within the communications team to aid the production of accessible content. • All videos and animations are now produced with subtitles. • Where possible BSL versions of content have been shared on social media, where these are available. Requests have been submitted to national/regional NHSE and UKHSA teams for BSL and alternative language versions of national campaign materials.
5. Patient Information	• Patient Information will be provided in alternative formats on request. • Patient information has been recorded onto audio CD at the request of patients to support communication needs.
6. Chat Bot pilot	• Although work was completed to develop the content for WHH, the project was put on hold due to issues with the Alder Hey software licence and has not been pursued at this time.
7. Signage/Wayfinding	• Signage and wayfinding signage is within the remit of the First Impressions workstream. • Refreshed branding guidelines available from late July 2023 will ensure all future signage is accessible.

Pillar 3: Reducing health inequalities

Using WHH 'Your health matters' approach and mapping health inequalities to geographical areas of Warrington North, Warrington South and Halton (Widnes and Runcorn)

Objective	Outputs and outcomes
1. Strengthen 'Your health matters' engagement programme	• A number of areas for engagement activity were identified to support awareness of preventable illness and reduce ill health. These were informed by the ICB and place level priorities including; respiratory, cardiac, diabetes, cancer (breast, bowel, cervical, prostate/urology). The ability to offer such sessions is dependent on capacity being available within the respective clinical areas. • Successful events have been held during the year out in the community including Diabetes Awareness Day, mouth cancer screening for Mouth Cancer Action month and supporting an event at The Gateway in Warrington for residents who have recently relocated from Hong Kong. Earlier this year two of our consultants from women and children's attended a Healthwatch Warrington Women's Health event to talk about menopause, fertility and cervical screening.
2. Engage governors in your health matters and other involvement opportunities	• All governors are invited to key events co-ordinated by the Trust's Communications and Engagement team, which during the first year have included charity fundraising events at Laskey Farm, Warrington Disability Awareness Day plus the Annual Members' Meeting marketplace. • Governors were also able to showcase the work they do with the Trust on engagement at the NHS Providers Governor Focus conference in May, when the 'Guide to being a WHH Governor' was selected to feature in a best practice showcase. The guide covers the role of a foundation trust governor but also provides useful information about the trust to support governors in answering questions from members and local community representatives.
3. Support place-based activity and other key local events	• Attendance was co-ordinated at an event for nationals from Hong Kong who have recently settled in the Warrington area, Women's event hosted by Healthwatch Warrington and Warrington Disability Partnership's Disability Awareness Day. • Market place attendance was co-ordinated for the ICB board which was held in Warrington in November.

4. Increase participation in research	• Research opportunities are promoted when requested and the Pathway to Research initiative has been recently promoted via local media, social media, a pop-up stand in Warrington Hospital main entrance as part of activity for International Clinical Trials Day.

Pillar 4: Reducing health inequalities

Use Trust estate and resources in partnership with others for the benefit of the wider community

Objective	Outputs and outcomes
1. Establish WHH's position as an anchor institution in our communities	• The Trust shares information with staff, social media followers and partners on health improvement and economic wellbeing activities. This has been further aided by recent developments to provide more healthcare services out in the community.
2. Promote opportunities for work, training or volunteering	• Clinical recruitment events are promoted across all social media channels and via our partner universities. • Volunteers Week in June provided opportunities to share the range of volunteer roles in the Trust. • Copies of the NHS health careers booklet '350 Careers, One NHS, Your Future' are taken to all public engagement events by members of the Communications and Engagement Team, governors and are shared widely by our apprenticeship and work experience teams at all events in schools, colleges and community events such as Disability Awareness Day and Armed Forces Day. • Work experience is encouraged by the Trust and there is a formal process to follow, links to which are included in the 'Guide to being a WHH Governor' so that all trust representatives can provide information to prospective applicants.
3. Utilise local suppliers and venues	• Off-site events are held at venues in the boroughs we serve, wherever possible. Suppliers for transport, promotional materials and print are sourced locally where cost effective to do so.

4. Give back to our communities	• We provide opportunities for our local schools and community interest groups to work with us on enrichment activities which benefit pupils and group members, as well as the Trust and our patients. Examples include a competition with Halton schools for designs to decorate the privacy glass at the front of Halton Health Hub at Runcorn Shopping City and the PossAbilities Signing Choir who regularly perform for staff, patients and visitors in Warrington main entrance. Our WHH Charity regularly go into schools to talk about the work of the charity and the difference it makes for patients as well as engaging pupils in useful workplace skills including setting up a project, fundraising, marketing and measuring success.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/92**			
SUBJECT:	**Quality Assurace Committee Chairs Annual Reports 2022-23**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	Cliff Richards Non-Executive Director & Chair of the Quality Assurance Committee			
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)***	**2245 -** 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) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **115** - If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **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			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Trust Board that the: • Quality Assurance Committee Have met their Terms of Reference and have gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review the document and ensure it meets its purpose.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/23/07/144		

	Date of meeting	11th July 2023
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

QUALITY ASSURANCE COMMITTE

SUBJECT	Quality Assurance Committee Chair's Annual Report	AGENDA REF:	BM/23/08/92

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Quality Assurance Committee Annual Report which covers the reporting period 1 April 2022-31 March 2023.

The Quality Assurance Committee (the Committee) was accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, quality improvement, delivery, clinical risk management and clinical governance, clinical audit and the regulatory standards relevant to quality and safety. This includes assurance around relevant Health and Safety matters.

The Quality Assurance Committee was accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational strategic risks are managed appropriately.

This report details the membership and role of the Committee and the work that it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of two Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director was able to attend the Committee to cover any absence.

During the reporting period, there were 12 meetings. The Quality Committee attendance record is attached in **Appendix 1**.

Terms of Reference

The Committee's Terms of Reference were reviewed during Quarter 3 of 2022-23, and the Cycle of Business in Quarter 4 2022-23, to ensure there was a focus on integrated systems of quality and assurance and also in line with the roll out of the revised Trust meetings structure. The terms of reference are attached in **Appendix 2.** The Quality Assurance Committee continued to focus on assurance monitoring, with its reporting sub committees meeting to deliver the agenda. High level briefings were provided to the Quality Assurance Committee from the Executive Led Sub Committees for assurance purposes.

Frequency of Meetings and Summary of Activity

Meetings continued to take place monthly throughout 2022/23 and subsequently the Committee met 12 times during the year. A summary of the activity covered at these meetings follows:

- **Strategy Development**

  The Committee received regular updates in relation to the Strategic Quality Priorities for the Trust. In addition, updates of enabling quality strategies were provided e.g. Mortality reports,

  Dementia Strategy, NHS Patient Safety Strategy, Patient Experience Strategy, Nursing & Midwifery Strategy and the Risk Management Strategy.

  The Quality Assurance Committee oversaw the Trust's strategic risks, as the designated Board Committee responsible for risk. The Committee liaised closely with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework was a driver for the internal audit plan and to provide the Audit Committee assurance regarding systems of internal control.

  The Committee oversaw a number of changes to the Board Assurance Framework., with the number of strategic risks on the board assurance framework decreasing significantly in year. In March 2023, there were 11 risks on the board assurance framework, which was a decrease from 18 in April 2022. 3 of the 11 risks related specifically to quality delivery.

  Risks were presented on a monthly basis at the following Committees:
  - Risk Review Group
  - Finance and Sustainability Committee
  - Strategic People Committee
  - Quality Assurance Committee
  - Clinical Recovery Oversight Committee

  along with any oversight Committees of Strategic/Corporate risks.

  The Risk Review Group continued to meet to ensure that there was scrutiny of the Corporate Risk Register and departmental, speciality and Clinical Business Unit risk registers, with appropriate escalation processes in place.

- **Quality Integrated Performance Report / Dashboard**

  The Committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored in the Integrated Performance Dashboard. A report of the Quality Dashboard was received bi-monthly to review performance and to determine assurance of mitigating actions as appropriate.

- **Assurance**

  The Cycle of Business for the Committee was reviewed, with focus on assurance monitoring. Reporting sub committees are constantly under review, ensuring ongoing scrutiny.

  The Committee approved several amendments to Quality Indicators on the Trust's IPR including the new indicators such as Fractured Neck of Femur, Postpartum

Haemorrhage >1500ml, Pregnancy Bookings before 10 weeks and 13 weeks and MUST nutritional assessment completion.

Key areas which have been monitored in year are Maternity Services, the Ockenden Review, Complaints, Serious Incidents, Falls Prevention, Infection Prevention, IT, Safeguarding, Pressure Ulcers, Sepsis, duty of candour, VTE, Health & Safety, DNACPR, Medicines Management and reconciliation.

As part of the Trust's response to the Ockenden review and the Local Maternity System requirements, serious incidents were reported to the Committee and then onwards to the Trust Board.

- **Investigations and Lessons Learned**

The Committee receives a regular update, to assure itself that investigations from Serious Incidents are being undertaken as per statutory and regulatory requirements. This also includes monitoring Duty of Candour for which the Trust has maintained 100% compliance.

The Committee receives regular updates on how the Lessons Learned Framework is being implemented, including having receipt and scrutiny of a Lessons Learned Audit, whereby actions and recommendations from Serious Incidents and Complaints are audited for assurance of completion.

The Complaints Quality Assurance Group, which is chaired by the Trust Chair, monitors the quality of the complaints responses in the Trust and also how we are implementing learning and change as a result of patient and public feedback.

- **Quality Academy**

Bringing together our Clinical Audit, Continuous Quality Improvement, Knowledge and Evidence Services and Research, Development, and Innovation teams together, the Quality Academy promotes innovation and delivers continuous improvements in line with the Trust's quality priorities.

In 2022/23, The Quality Academy work programmes were undertaken with the support of Communications and Engagement, Patient Experience, and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement. The Quality Academy also works with Workforce & Organisational Development, to ensure that staff engage in the agenda and are empowered and supported to make improvements in their work.

During the previous financial year, the **Clinical Audit Department** became integrated into the Trust's Quality Academy. Registered clinical audits are linked to the 5 domains referenced by the Care Quality Commission (CQC) clearly evidencing focused plans for improvement and monitoring. Since moving into the Quality Academy, clinical audits are now aligned to the 3 Quality priorities, Patient Safety, Patient Experience and Clinical Effectiveness, and includes learnings from audits specifically annual progress with the clinical audit forward plans. This

includes the attainment of National Clinical Audit and Patient Outcomes Programme (NCAPOP) and Quality Accounts requirements (QA).

In September 2022, Health Education England ranked the WHH Quality Academy's **Knowledge and Evidence Service (KES)** joint 1st out of 224 English Trusts, for delivering effective and proactive services based on the needs of the Trust. They ranked us joint 3rd / 224 for 2 other quality measures. The KES team have provided robust evidence summaries and syntheses of outstanding practice to underpin clinical and corporate decision making, service development, innovation, and quality improvements throughout the Trust and to Warrington CCG and Warrington Public Health Teams. A key focus has been reducing health inequalities, equality, diversity, and inclusion (EDI), harm-free care initiatives, women and children's programmes, infection prevention and control amongst others .

The **Continuous Quality Improvement (CQI)** team have two main areas of focus: the support in the successful implementation and delivery of a number of Quality Improvement projects Trust wide led by named project leads, sponsors and developing a QI capability building programme of work, increasing colleagues' knowledge of the theory and QI methodology. A total of 59 QIPs have been registered since 1st April 2022. To ensure that projects are well supported, the QIP form requests that a permanent member of staff is identified as a sponsor for all projects. Increasing Quality Improvement (QI) capability and capacity, to help embed a culture of QI across the organisation, has been identified as a Trust Quality priority for 2023-24. An improved position has been identified during financial year 22/23 across all current QI training programmes.

Research and Development has gone from strength to strength in the last 2 years since the Halton Clinical Research Unit opened its doors in 2021. The service has enjoyed growth and recognition locally, being awarded a Trust Thank You Award. The team have improved on income generation and performance to recruitment has improved significantly. Organisational ranking of Trusts in the North West Coast region shows WHH moving from 15th in FY21-22 to 5th in FY22-23. WHH R&D delivered research to twice as many people in Warrington and Halton than the year previous, expanding the opportunity to participate in and potentially benefit from research. The team has developed an excellent reputation for delivering high quality research across the commercial and non-commercial portfolio, made possible by collaborative approach to research involving departments across the hospital, and includes clinicians, nurses, pharmacists, AHPs, finance, contracts, administrators and more.

- **Deep Dives & Hot Topics**

At each meeting, the Committee received a 'Hot Topic' and 'Deep Dive' presentation. Hot Topics provided high level information that shared a story or a journey. These would be relating to areas of national, local, partner or internal focus; new services, accreditation of services or items escalated from a sub-committees or other meetings. Deep Dives provided an in-depth review of

a topic that had been escalated from sub-committees or other meeting, areas noted from other reports and wider triangulation, areas flagged by the CQC or items requested by the Trust Board.

Examples of Deep Dives that have place as part of the assurance process include: 12 hour breaches, hospital associated deconditioning, maternity governance, ED wait times escalation, medicines reconciliation and optimisation, missed fractures, paediatric ophthalmology and dental backlogs and paediatric audiology brainstem responses.

Hot topics received included: cancer inequalities, staffing levels and impact on harm, arthroplasty surgical site infection, histopathology, patient safety incident response framework (PSIRF), mortuary capacity and diabetic foot clinic.

- **Engagement Stories**

The Committee regularly commenced the meeting with an engagement or patient story relating to either patient or staff experiences. Examples of such stories from 2022-23 include:

  - A warm welcome isn't just 'hello'.
  - Equal importance of physical and mental health
  - Communication in its many forms
  - Parkinson disease, a family's perspective
  - Working with the community to improve health inequalities.

- **Regulatory and Statutory monitoring**

The Committee continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of the post Care Quality
Commission Inspection Action plan (also via the Moving to Outstanding agenda) national audit activity, NICE guidance, national surveys, quality KPIs and complaints improvement.

The Quality Assurance Committee received, supported and approved a number of annual reports including, Health & Safety, Medicines Management & Controlled Drugs, Safeguarding, Risk Management, Complaints, Infection Prevention & Control, Clinical Audit, Quality Strategy and Dementia Strategy.

- **Issues Carried Forward**

There are a number of issues which the Committee will carry forward into 2022-23.

- Implementation of the Quality Priorities for the year.
- Continued monitoring of fractured neck of femurs.
- Hot Topic and Deep Dive programme to March 2024 including AMD Ophthalmology, 3rd & 4th degree tears, ICU length of stay, Post Partum Haemorrhage, fragile services.
- Monitoring of the requirements of the Ockenden Review
- Palliative and End of Life care

Summary

I as Chair of the Quality Assurance Committee encourage honest and open discussion, so that areas of success can be celebrated, and areas of improvement escalated and actioned. To ensure that the patient voice is heard the meeting regularly commences with a patient/staff story. This has been a challenging year and the Committee has had to adapt and adopt a flexible approach in order to maintain the necessary level of oversight needed during the continuing pandemic. Committee members have responded to this challenge and provided the assurance required as well as managing the demands resulting from the pandemic.

I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Dr Cliff Richards
Chair of Quality Assurance Committee

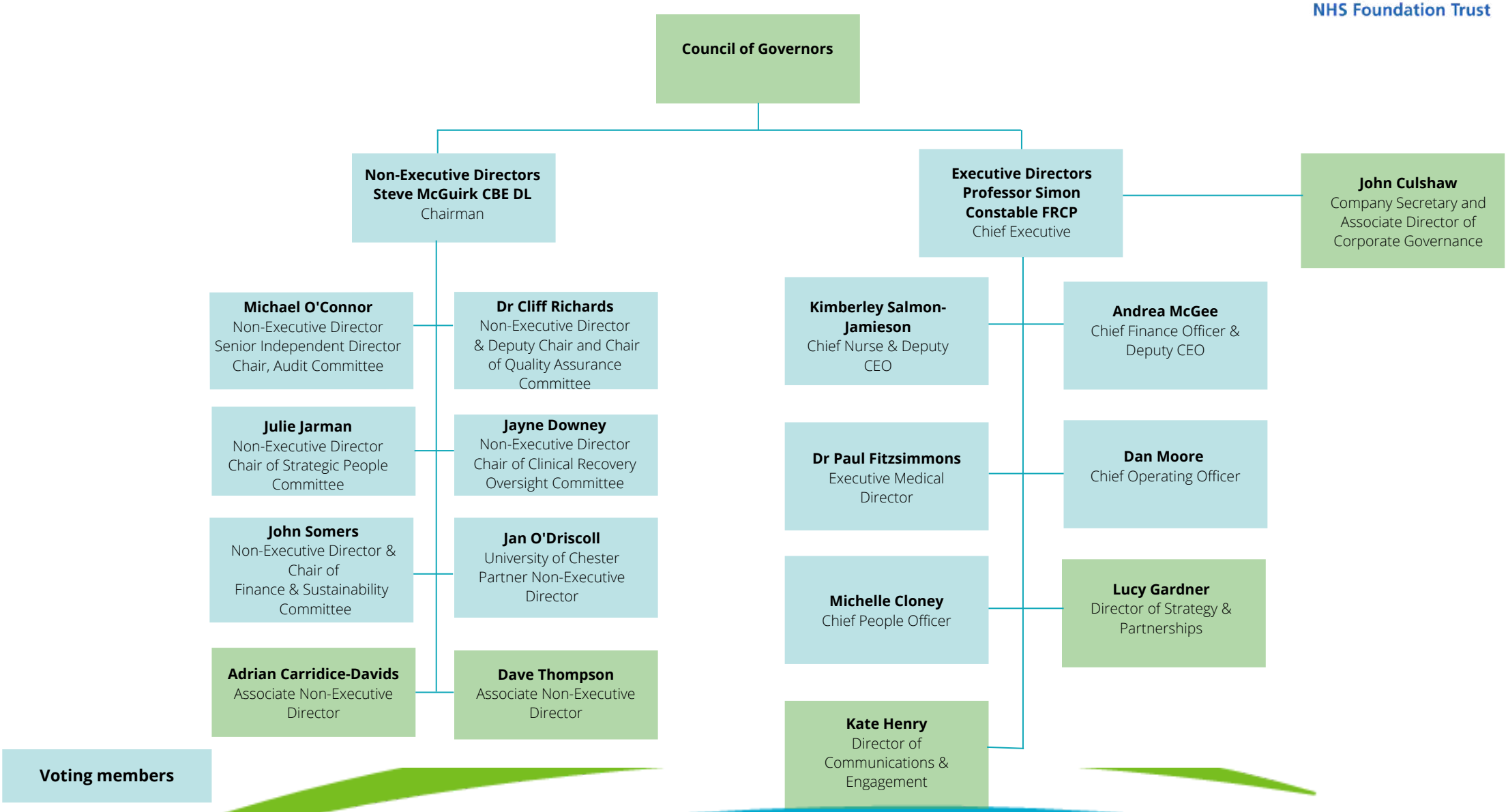
Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/93**			
SUBJECT:	**Trust Organograms - Updated**			
DATE OF MEETING:	2nd August 2023			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust Board is presented with the updated Trust Organograms. Each of the Organograms has been approved by individual Executives and is presented to the Trust Board for approval to be published on the Trust Website.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the updated Organograms for publishing on the Trust Website.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Executive Team		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Trust Board

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Version: 24.03.2023

Executive Team

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Professor Simon Constable FRCP
Chief Executive

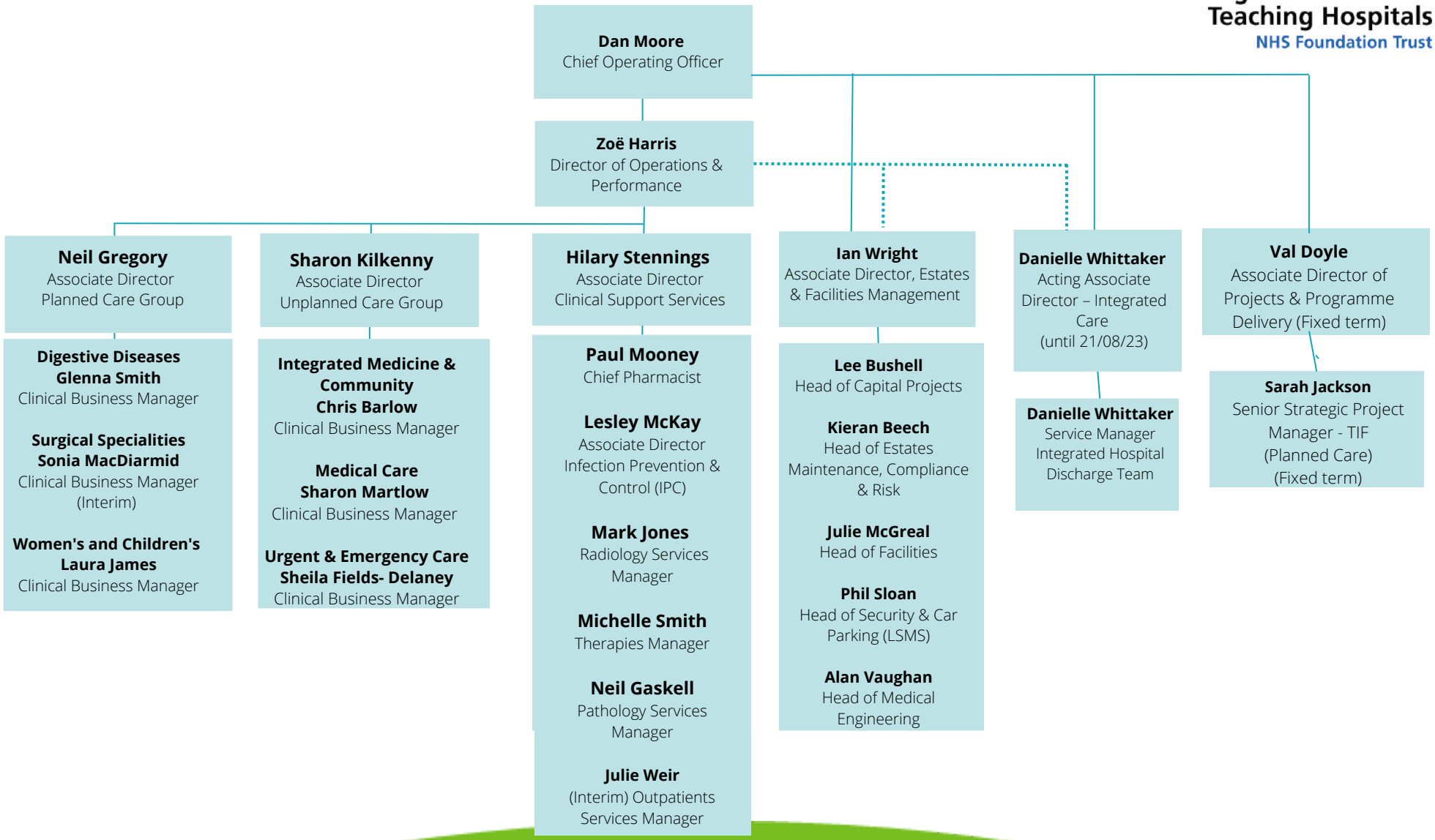
John Culshaw
Company Secretary and Associate Director of Corporate Governance

Andrea McGee Chief Finance Officer & Deputy CEO	**Kimberley Salmon-Jamieson** Chief Nurse & Deputy CEO	**Dan Moore** Chief Operating Officer	**Dr Paul Fitzsimmons** Executive Medical Director	**Michelle Cloney** Chief People Officer	**Lucy Gardner** Director of Strategy & Partnerships	**Kate Henry** Director of Communications & Engagement
PORTFOLIO Management Accounts Financial Services Financial Planning Contracts, performance & commercial development Clinical coding & service development Supplies & Procurement Informatics & Business Intelligence	**PORTFOLIO** Professional leadership for nurses, midwives & AHPs Clinical governance Risk management & Audit Regulatory compliance Infection prevention & control Patient safety Patient experience Quality Academy Clinical Education Clinical Research Safeguarding Maternity & Children's Safety Champion Palliative Care Clinical Research	**PORTFOLIO** Planned Care Unplanned Care Clinical Support Services Estates and Facilities	**PORTFOLIO** Professional leadership for doctors, dentists & physician associates Patient Safety Clinical effectiveness & productivity Learning from deaths Medicines management Appraisal & Revalidation Medical Education Digital Services	**PORTFOLIO** Human Resources Recruitment Payroll Pensions Workforce intelligence Occupational health & wellbeing Staff engagement Organisational development Learning & development	**PORTFOLIO** Strategy development & delivery New hospitals Town Deals - community health hubs ICS and Place developments Local Health and wellbeing strategy delivery Anchor programme, including green plan Partnerships & collaboration COVID-19 vaccination	**PORTFOLIO** Internal and external communications Media relations Community and stakeholder engagement Freedom of Information WHH Charity Fundraising

Version: 19.01.2023

Trust Operations

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 25.07.2023

Care Groups and Clinical Business Units

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Version: 18.07.2023

Dan Moore
Chief Operating Officer

Zoë Harris
Director of Operations & Performance

Planned Care Group

Neil Gregory
Associate Director

Mr Mark Tighe
Associate Medical Director

Natalie Crosby
Associate Chief Nurse

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
Breast Surgery
Anaesthetics
Liaison Pain Management
Pre-operative Assessment
Ward A4
Ward A5 Gastro
Ward A5 Elective
Ward B4
Planned Investigations Unit
Theatres
Post- Anaesthesia Care Unit
CT Room

Surgical Specialities

VACANT
Clinical Director
Sonia MacDiarmid
Clinical Business Manager (Interim)
Carol McEvoy
Lead Nurse

CLINICAL SERVICES
Trauma & Orthopaedics
Ophthalmology
Urology
Ear Nose & Throat Surgery
Audiology
Maxillofacial Surgery
Orthodontics
Ward A6
Ward B3
Captain Sir Tom Moore Ward

Women's and Children's Health

Dr Satish Hulikere
Clinical Director
Laura Jones
Clinical Business Manager
Ailsa Gaskill-Jones
Director Midwifery & Associate Chief Nurse

CLINICAL SERVICES
Midwifery
Obstetrics
Gynaecology
Colposcopy
Paediatrics
Neonatology
Antenatal Day Unit
Antenatal Clinic
The Nest
Birth Suite C23
Gynaecology
Assessment Unit
Ward C20
Neonatal Intensive Care Unit
Wards B10 & B11
Children's Outpatients

Unplanned Care Group

Sharon Kilkenny
Associate Director

Dr Mark Forrest
Associate Medical Director

Emma Painter
Associate Chief of Nursing

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 Investigation
Diabetes & Endocrinology
Nephrology
Rheumatology
Neurology
Dermatology
Acute Care Team
Intensive Care Unit
Acute Cardiac Care Unit A3
Acute Respiratory Unit B18
Ward C21

Urgent & Emergency Care

Dr James Wallace
Clinical Director
Sheila Fields- Delaney
Clinical Business Manager
Leanne Binns
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

Integrated Medicine & Community

Pradeep Magapu
Clinical Director
Chris Barlow
Clinical Business Manager
Janet Pye
Lead Nurse

CLINICAL SERVICES
General Medicine
Care of the Elderly
Palliative Care
Frailty Assessment Unit
Ward A7
Ward A8
Ward A9
Forget me Not Unit B12
Stroke Unit B14
Ward B19
Ward K25
Discharge Suite
Integrated Discharge Team

Clinical Support Services

Dr Alison Davis
Clinical Director

Hilary Stennings
Associate Director

Nicola Milkins
Matron

Paul Mooney
Chief Pharmacist

Michelle Smith
AHP Lead

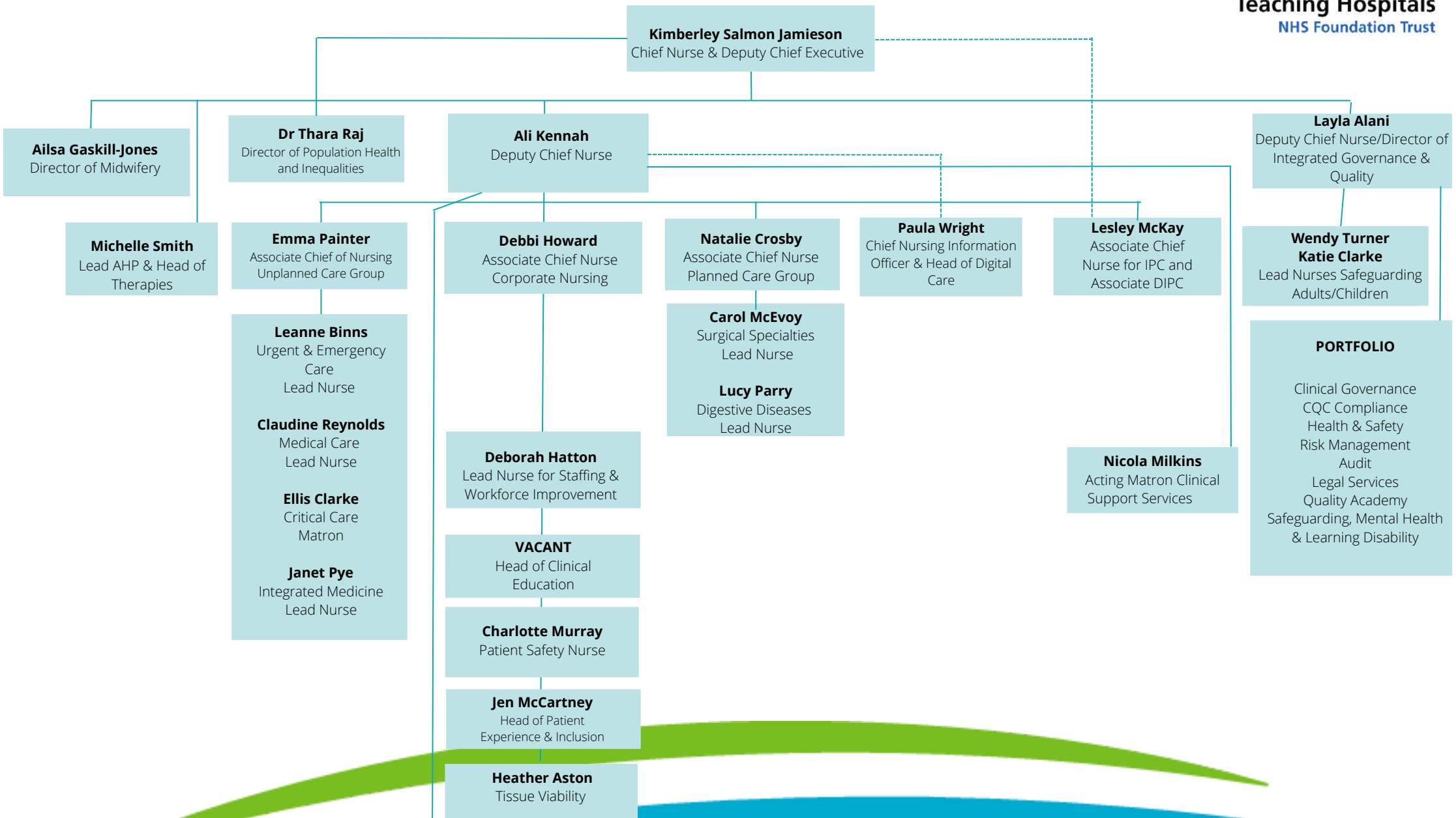
Mark Jones
Radiology Services Manager

Neil Gaskell
Pathology Services Manager

CLINICAL SERVICES
Haematology
Microbiology
Clinical Chemistry
Histopathology
Imaging
Radiology
Breast Screening
Infection Prevention & Control
Outpatients
Pharmacy
Therapies

Nursing and Clinical Governance

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 24.07.2023

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 Mallett
Medical Cabinet Business Manager

Dr Mark Forrest
Associate Medical Director
Unplanned Care Group

Dr Laura Langton
Clinical Director
Medical Care

Dr James Wallace
Clinical Director
Urgent & Emergency Care

Dr Pradeep Magapu
Clinical Director
Integration Medicine & Community

Dr Alison Davis
Clinical Director
Clinical Support Services

Mark Tighe
Associate Medical Director
Planned Care Group

VACANT
Clinical Director
Surgical Specialities

James Melling & 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 Anna Vondy
Deputy AMD for CE - Research

VACANT
Deputy AMD for CE - Cancer

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

Paula Wright
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: 18.07.2023

Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Andrea McGee
Chief Finance Officer & Deputy Chief Executive

Jane Hurst
Deputy Chief Finance Officer

Alison Jordan
Associate Director of Information

PORTFOLIO

Business Intelligence
Statutory Reporting
Governance of Data Quality
Digital Analytics
Data Warehouse
Enterprise Solutions

Janet Parker
Associate Director of Finance - Strategy

Heather Farrington
Head of Financial Planning

PORTFOLIO

Financial Planning
Clinical Income
PLICS/Benchmarking
Service Line Reporting
Overseas Patients
Private Patients
Charitable Funds
Strategic Business Cases
GIRFT
Reference Costs

Marie Garnett
Head of Contracts, Performance & Commercial Development

PORTFOLIO

Business Cases, Bids & Tenders
Benefits Realisation
Business Planning
Commercial Development
Contracts & SLAs
Performance Assurance Framework
Use of Resources

Paula Brereton
Head of Clinical Coding & Service Development

PORTFOLIO

Clinical Coding

Service Development

Internal/External Training

Internal/External Audit

Clinical Engagement

Quality Improvement

Alice Forkgen
Associate Director of Finance - Operations

Lynn Simpson
Head of Management Accounts

PORTFOLIO

Budget Setting
Budget Management
Forecasting
Costings & Financial Information CIP
Corporate Benchmarking
Service Improvement
Internal Monthly Reporting
Finance Systems

Karen Spencer
Head of Financial Services

PORTFOLIO

Financial Accounting
External Financial Reporting
Financial Controls
Treasury Management
Cash Flow
Cash Office
Internal & External Audit
Annual Accounts
Accounts Payable Accounts Receivable
Counter-Fraud
Capital Accounting

Claire Leather
Head of Finance (GIRFT)

Alison Parker
Associate Director of Procurement

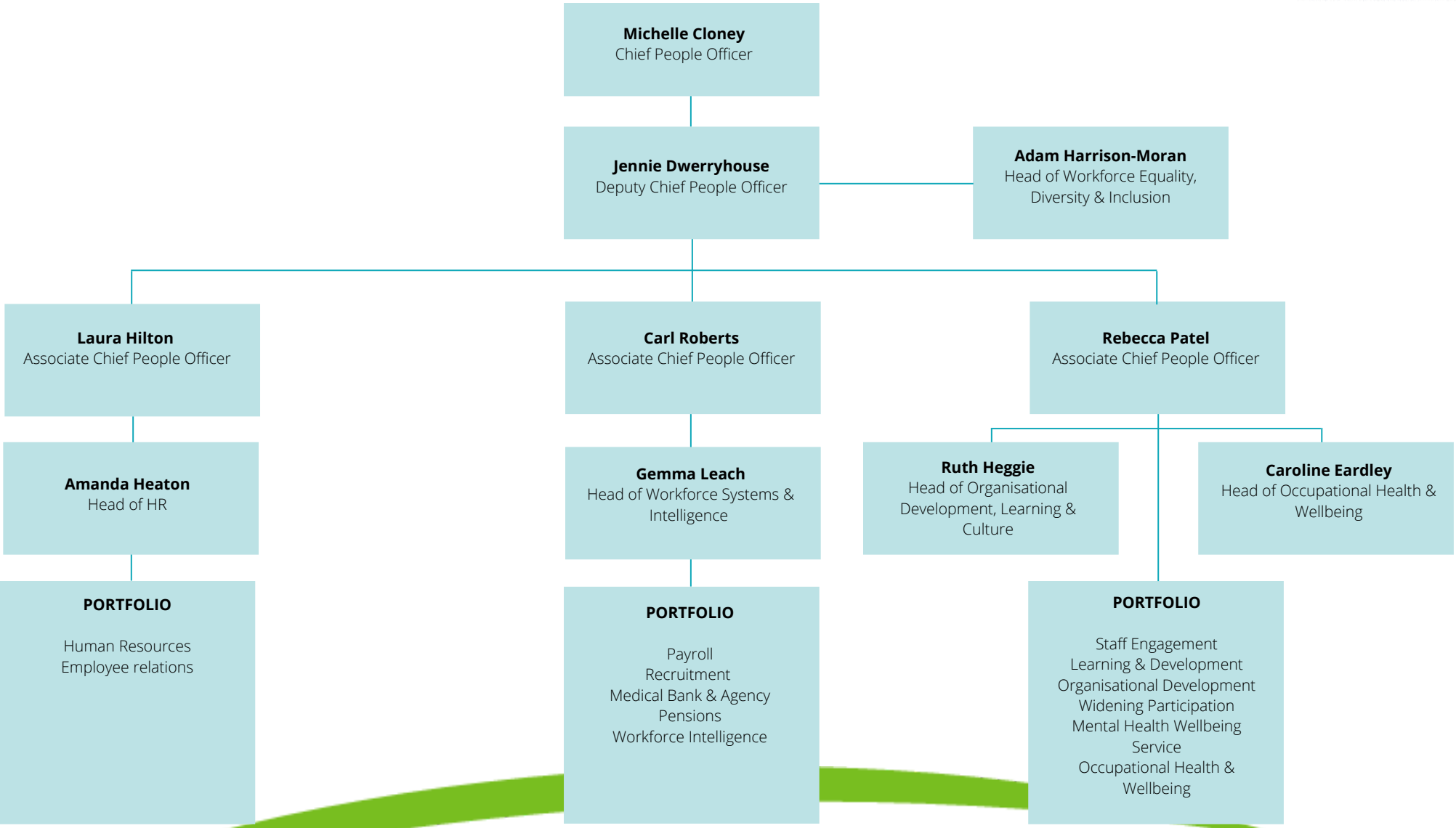
PORTFOLIO

Tendering and Commercial Contracts
Order Processing
Stores Receipt & Distribution
Materials Management
Workflow
Procurement Services to Bridgewater Community

Version: 21.07.2023

People

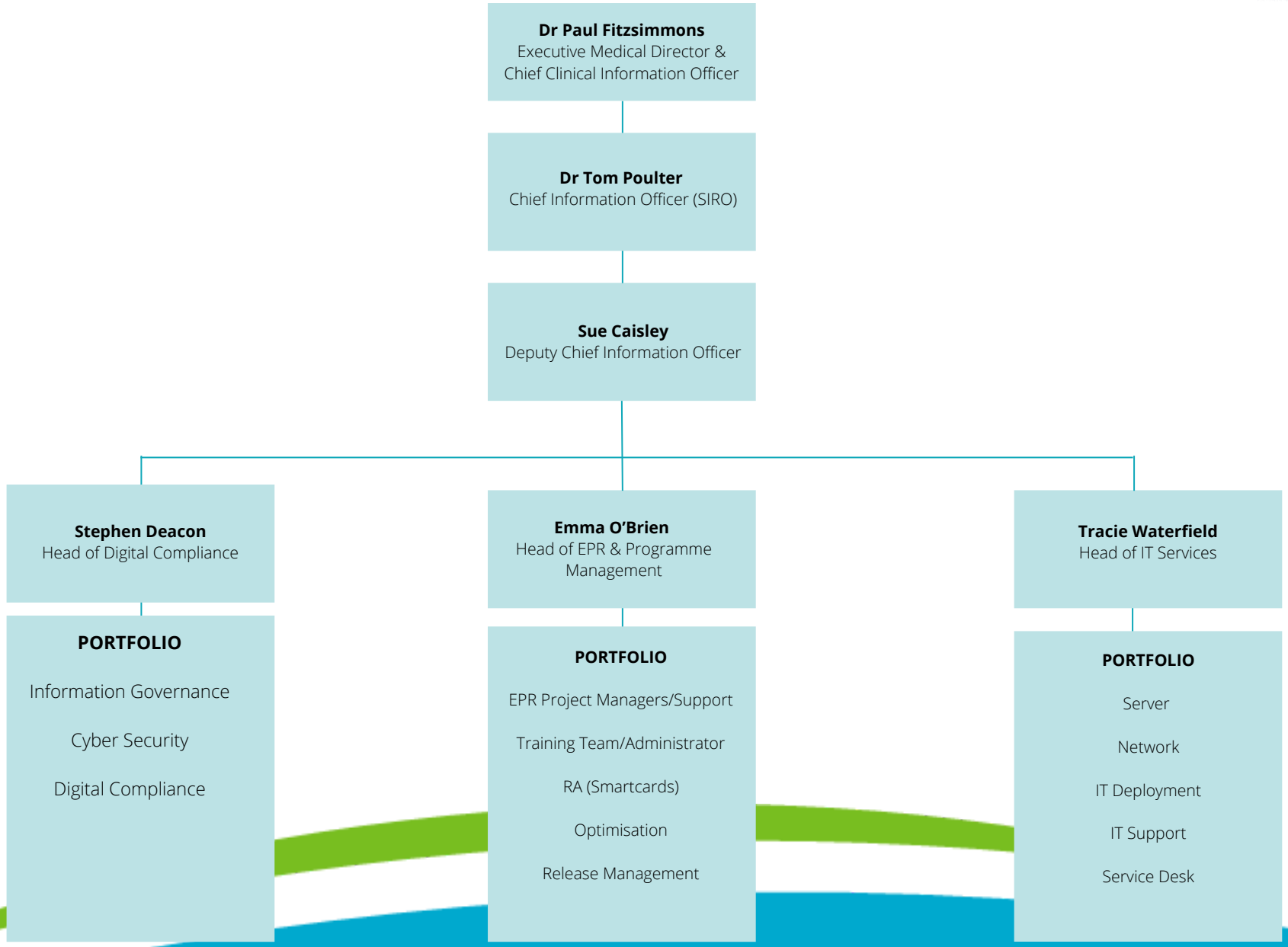
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Version: 15.03.2023

Digital Services

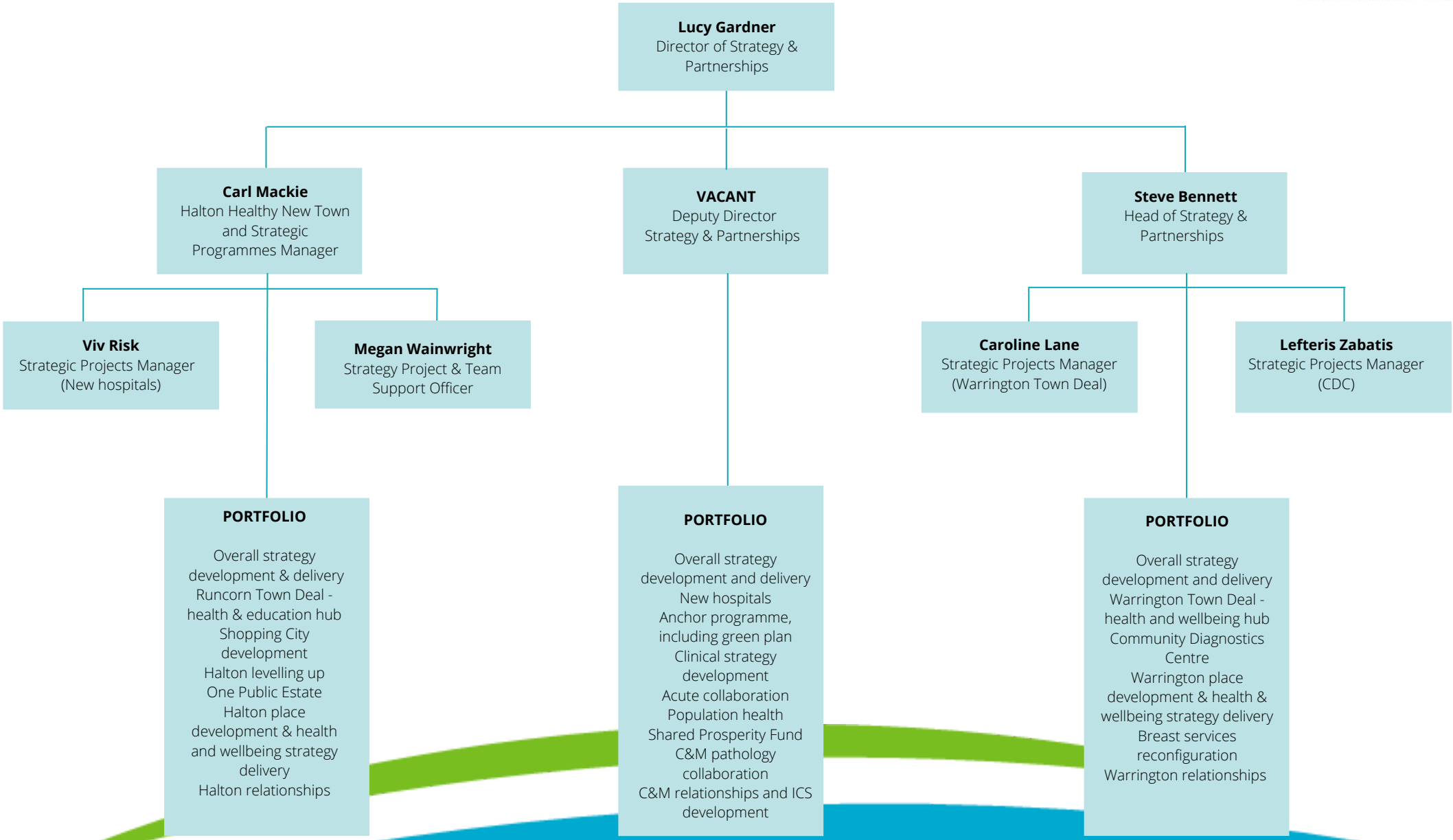
Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 19.03.2023

Strategy and Partnerships

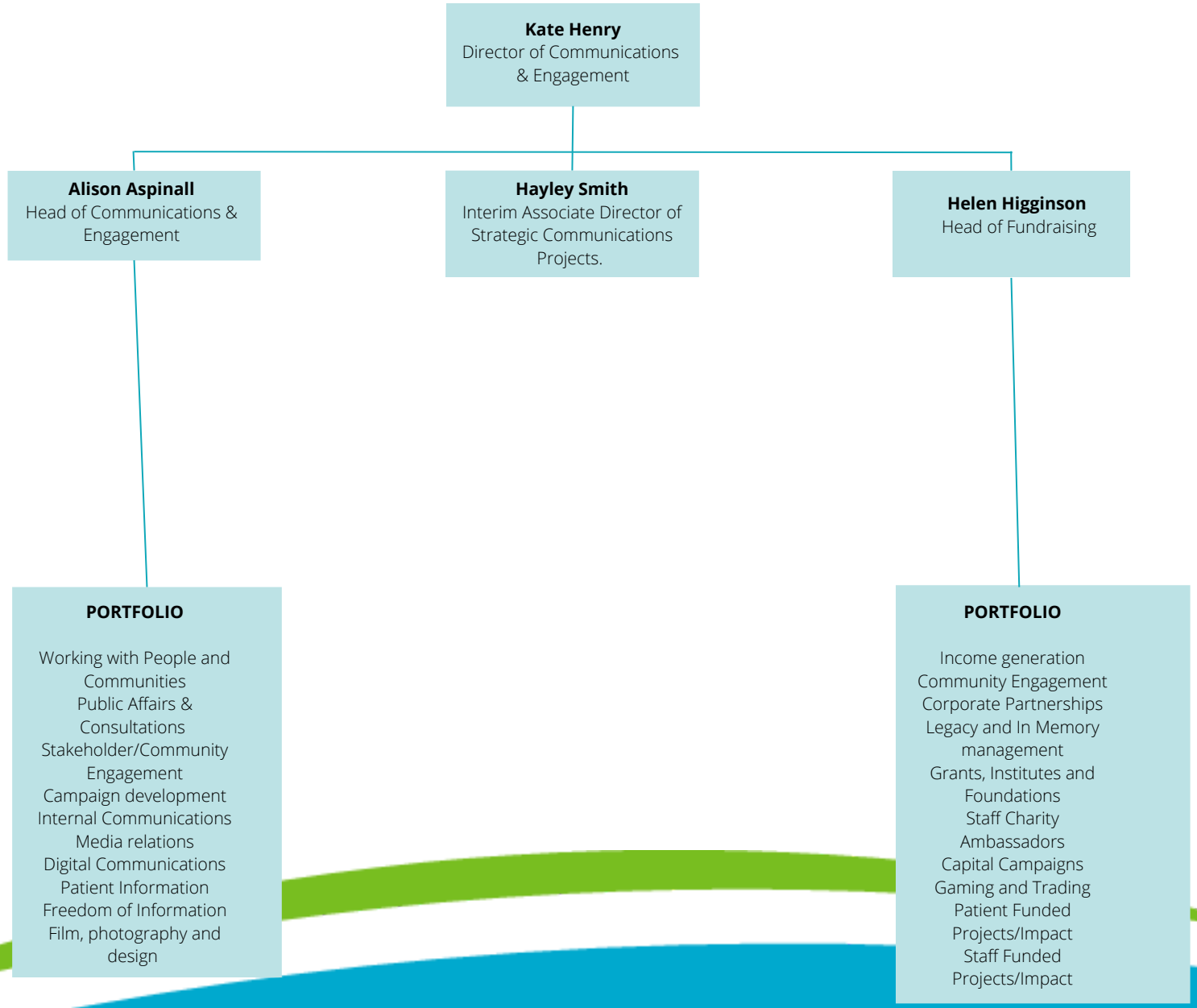
Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 21.07.2023

Communications and Engagement

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version: 24.07.2023

Governors

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Non-Executive Directors
Steve McGuirk CBE DL
Chairman

Norman Holding
Lead Governor

Keith Bland
Deputy Lead Governor

Warrington North (Public)	Warrington South (Public)	Halton (Public)	Rest of England (Public)	Staff	Partner
Norman Holding	Sue Fitzpatrick	Linda Mills	**VACANT**	Akash Ganguly (Medical & Dental)	Councillor Chris Loftus (Halton Borough Council)
Keith Bland	Diane Nield	John Fagan	Kevin Keith	Jonathan Cliffe (Nursing & Midwifery)	Councillor Paul Warburton (Warrington Borough Council)
Gillian McKinnen	Nigel Richardson	Nathan Fitzpatrick		Julie Astbury (Support Staff)	Kuldeep Singh Dhillon (Warrington Sikh Gurdwara)
Colin Jenkins	Paul Bradshaw	Edward Rawlinson		Gemma Leach (Estates, Admin & Managerial)	Nichola Newton (Warrington & Vale Royal College)
Anne Robinson	Mark Britton	Colin McKenzie		**VACANT** (Clinical Scientist/AHP)	**VACANT** Educational Sector
					VACANT Private Sector

Version: 12.07.2023