Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting
Part 1 (held in Public)

Wednesday 4 December 2024

10.00am -12.30pm

Lecture Theatre, Education Centre – Halton Hospital
WHH/MS Teams



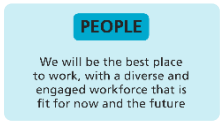
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 4 December 2024, 10.00am – 12.30pm
Education Centre, Halton Hospital













Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/24/12/118	**10:00**	Engagement Story - Support my needs	***To note***	**Presentation**	Patient – Lorraine Woolley Jen McCartney Head of Patient Experience and Inclusion Yasmin Habib, UEC Lead Nurse.
BM/24/12/119	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/24/12/120	**10:17**	Minutes and Action Log of the previous meeting held on **2 October 2024**	***For approval***	***Minutes***	Chair
BM/24/12/121	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/24/12/122	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/24/12/123	**10:30**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/24/12/124	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:		QUALITY We will always put our patients first, delivering safe and effective care and an excellent patient experience PEOPLE We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future SUSTAINABILITY We will work in partnership with others to achieve social and economic wellbeing in our communities			
BM/24/12/125	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports Quality and Assurance Committee 08.10.24, 12.11.24	***For assurance***	***Report & Presentation***	Chief Nurse, Chief Operating Officer & Deputy Chief Executive, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee 16.10.24, 20.11.24	***For assurance***	***Report***	Chief People Officer Julie Jarman, Committee Chair
		Sustainability Dashboard	***For assurance***	***Report & Presentation***	Chief Finance Officer

(c)		**Including** Assurance Reports Finance and Sustainability Committee 28.10.24, 25.11.24			John Somers, Committee Chair
(d)		**Audit Committee** Assurance Report 21.11.24	***For assurance***	***Report & Presentation***	Mike O'Connor – Committee Chair
Strategic aim:					
BM/24/12/126	**11:05**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/24/12/127	**11:15**	Compliance Update Q2	***To note for assurance***	**Report**	Chief Nurse
BM/24/12/128	**11:35**	Maternity & Neonatal Update Summary Report to cover: I. Monthly Maternity and Neonatal review II. WHH Maternity Services – Compliance with Ockenden III. Monthly Maternity Quality & Safety review IV. Maternity Self-Assessment tool V. Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report Q2 VI. Maternity Incentive 5-Year Update including Saving Babies Lives Care Bundle V3 Update VII. Midwifery Safe Staffing Report (SPC) Q2 VIII. Avoiding Term Admissions into Neonatal Units (ATAIN) Q1 IX. Transitional Care Audit Q1 X. Review of Harm	***To note for assurance***	***Report***	Director of Midwifery
Strategic aim:					
BM/24/12/129	**11:50**	Communications & Engagement Dashboard Report Q2	***To note for assurance***	**Report**	Director Communications & Engagement

Strategic Aim					
BM/24/12/130	**12:00**	Strategy Programme Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer
BM/24/12/131	**12:10**	EPRR Core Assurance Update	***To note for assurance***	**Report**	Chief Operating Officer & Deputy CEO

Governance					
BM/24/12/132	**12:20**	Updates to Scheme of Reservation & Delegation (SORD)	***For approval***	**Report**	Chief Finance Officer

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/24/12/133	Director of Infection Prevention & Control Q2	Quality Assurance Committee Date: 12.11.24 Ref: QAC/24/11/181 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/12/134	Learning from Experience Summary Report Q2	Quality Assurance Committee Date: 12.11.24 Ref: QAC/24/11/180 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/12/135	Patient Experience 6 monthly report	Quality Assurance Committee Ref: QAC/24/10/154 Date: 08.10.20.24 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/12/136	Guardian of Safe Working Report Q2	Strategic People Committee Date: 20.11.2024 Ref: SPC/24/11/141 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/24/12/137	Digital Strategy Group Update	Finance & Sustainability Committee Date: 24/11/?? Ref: 25.11.2024 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
Closing					
BM/24/12/138	**12:25**	Review of the Meeting	To discuss	**Verbal**	Chair
BM/24/12/139	**12:30**	Any Other Business	To discuss	**Verbal**	Chair
Date and Time of next meeting – 10am, Wednesday 5 February 2024 – Trust Conference Room, Warrington Hospital					

Supplementary papers are available to members of the public on request by email whh.foundation@nhs.net

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Support my needs

Presenter Lorraine Woolley

Yasmin Habib, Lead Nurse Urgent and Emergency Care

Jen McCartney, Head of Patient Experience and Inclusion



Hello my name is Lorraine

Married living in fully adapted own home working at Warrington Disability Partnership (WDP) full time as Employment Advisor

Medical Conditions

Charcot Marie Tooth Type 3 (Degenerative Muscle Wasting Condition)
Respiratory Failure
Double Scoliosis
Osteoporosis
Hearing Loss

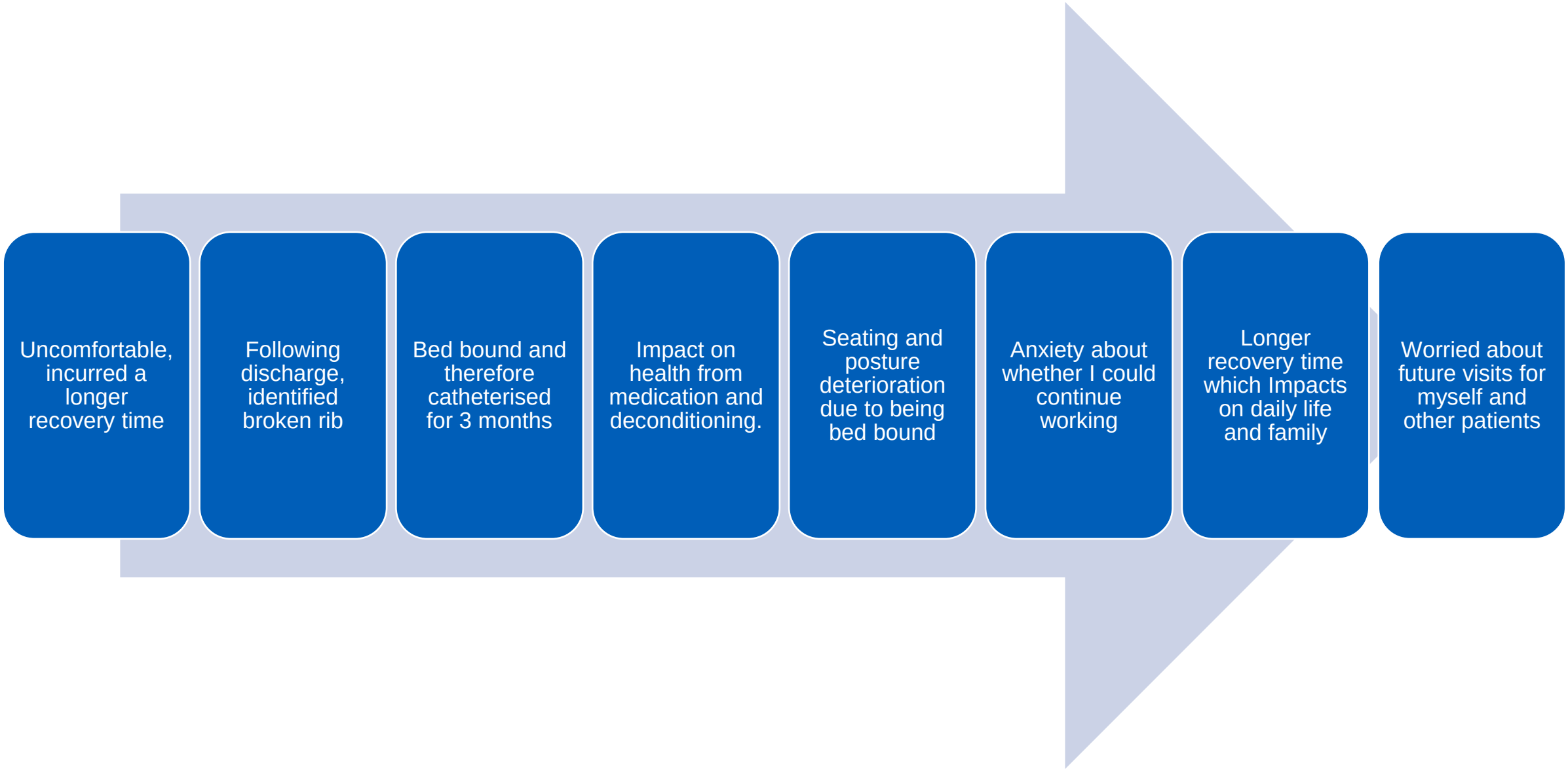
Support required when in hospital

Hoist
Personal Care Needs Met (Accessible Bathroom Facility)
Ventilator Care
Clear Communication
Allow PA's to stay to support

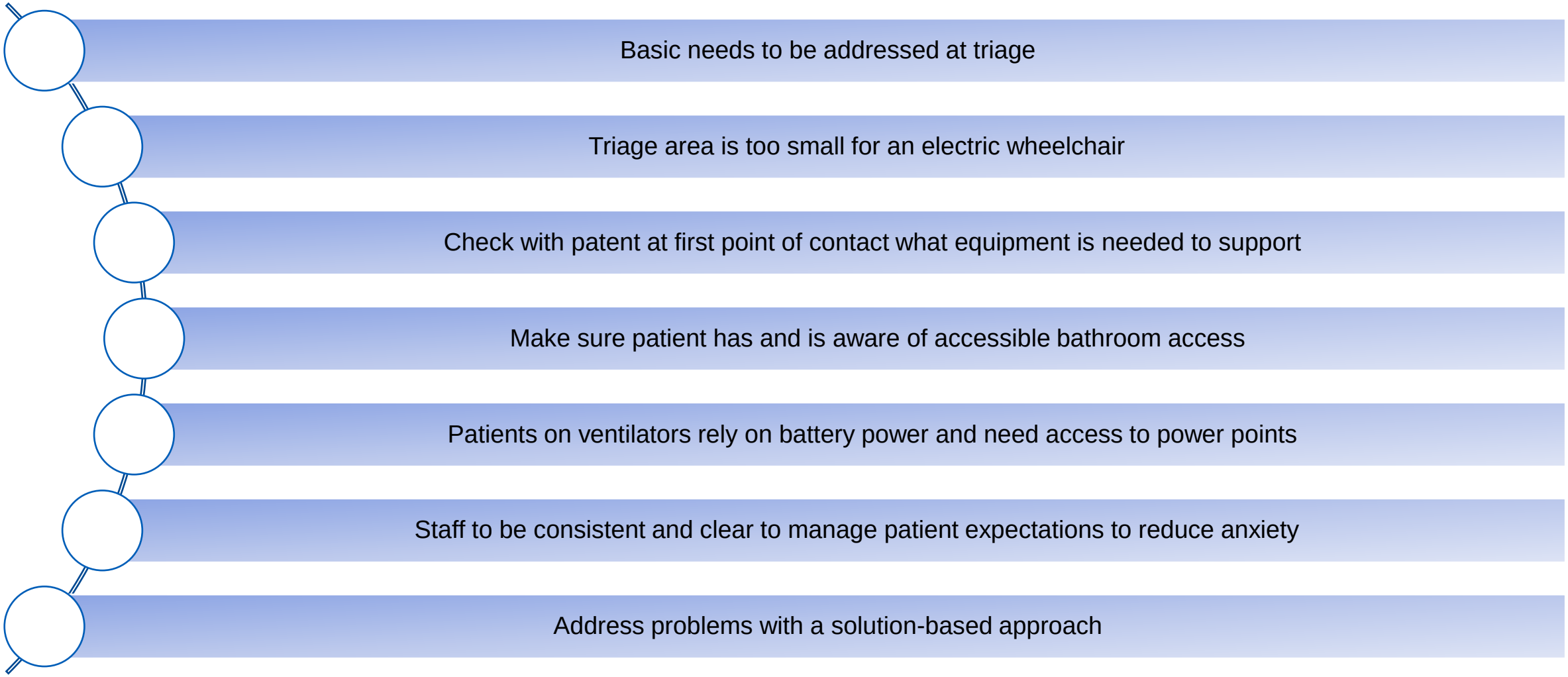
Attendance at Warrington Hospital Emergency Department

- December 2023 referred to Aintree with a 46-week waiting list
- Condition worsened; attended ED with abscess size of grapefruit
- Explained and potential further risks
- no hoist - navigated to SDEC as informed better equipped to support
- SDEC couldn’t help , argument ensued who could support, transferred back to ED
- Husband collected own mobile hoist to support transfer to bed.
- Treatment provided and discharged after 8 hours

Impact on me


Uncomfortable, incurred a longer recovery time
Following discharge, identified broken rib
Bed bound and therefore catheterised for 3 months
Impact on health from medication and deconditioning.
Seating and posture deterioration due to being bed bound
Anxiety about whether I could continue working
Longer recovery time which Impacts on daily life and family
Worried about future visits for myself and other patients

How can patient experience be improved



Next steps



Safety Brief; Trustwide communications to ensure staff aware and educated of location of equipment. Highlighted in local daily safety brief for day shift and night shift staff.



Staff; Spoken to staff involved for reflection of how it could have been managed with the patient as a focus for their care needs. Ensuring staff are booked on Moving and Handling training.



Patients; Having open conversations with patients regarding to their needs and how they can be met. Focusing on seeing the person in the patient.



Lessons Learnt; Reviewing the SOPs and educated staff on ED & SDEC. GIRFT; Getting it right first time.



Improvements; Communication with patients with reasonable adjustments/support on how we will strive to meet their needs. Alert to staff that patients own equipment should not be used.

Questions

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 2 October 2024 Trust Conference Room/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Dan Moore (DM)	Acting Chief Executive
Ali Kennah (AK)	Chief Nurse
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Apologies	
Jan O'Driscoll	Partner Non-Executive Director
John Somers (JS)	Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy and Partnerships
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Susan Dean	Deputy Head of Patient Experience and Inclusion (BM/24/10/91)
David Merriman	CBU Matron for Urgent and Emergency Care (BM/24/10/91)
Ian Holbrook (IH)	Patients Son (BM/24/10/91)
Emily Kelso	Corporate Governance and Membership Manager (minutes)
Observing	
Nikhil Khashu	Incoming WHH Chief Executive (from 1st November)
Carol Ann Kelly	Public Governor
Rachel Bold	Staff Governor

Agenda Ref	Agenda Item
BM/24/10/91	**Engagement Story - Till death us do part** SMcG introduced SD, DM and IH and welcomed them to the Board meeting to present the engagement story. IH shared the story of his elderly parents Margaret and Jim who had both been admitted to the Trust with separate cases of ill health and with the support of Trust staff passed away peacefully together, with their family close by.

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	Following the facilitation of bed moves, two beds were set up in a single cubicle allowing Jim and Margaret who were not far from celebrating their 70th wedding anniversary to remain side by side during their stay. Margaret passed away holding Jims's hand whist they both slept. Staff cared for and supported Jim whist the formalities of last offices were conducted. At Jims request he returned to the same cubicle to continue his care, just 2 days later Jim was place on end-of-life care and passed away. SMcG thanked IH for sharing his very emotive story, he explained the comfort and assurance the Board took from his story, which described the high quality of care and support received at WHH. The Board reflected on the work behind the scenes of staff to facilitate the bed move appreciating that some exceptions would have been made to policies and procedures i.e. mixed-sex wards. AK explained the typically high turnover of patients, and fast pace in AMU and the reassurance the story provided to the Board around the quality of care and compassion being provided by staff. It was agreed learning would be shared across wards. **The Trust Board discussed and noted the Engagement story.**
BM/24/10/92	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, attendees and observers to the meeting Apologies were noted as detailed above, there were no declarations of interest made. SMcG welcomed Nikhil Khashu to the meeting, who was attending as an observer prior to commencing his role as Chief Executive of the Trust from the 1 November 2024, in the interim DM was acting Chief Executive. **The Trust Board noted the apologies and declarations of interest.**
BM/24/10/93	**Minutes and Action Log of the previous meeting held on 7 August 2024** The minutes of the meeting held on 7 August 2024 were agreed as an accurate record. The Action Log was reviewed, completed actions were noted. The Board discussed in detail the ongoing action around Health Inequalities, agreeing that a focused session should take place with Bridgewater Community colleagues, to build better understanding of how integration would help to support closing gaps around health inequalities. **The Trust Board approved the minutes of the meeting held on 7 August 2024 and noted the Action Log agreeing a Board Development session on Health Inequalities would be scheduled with BCHFT Board colleagues.**
BM/24/10/94	**Matters Arising** **The Trust Board noted that there were no matters arising.**

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BM/24/10/95	**Chief Executive's Report** DM introduced the paper, which was taken as read, highlighting the following key points from the paper: • As agreed by the Nomination & Remuneration Committee, interim arrangements have been put in place, DM was now acting as the Chief as Executive until Nikhil Khashu commences on the 1 November. • Plans for closer integration with Bridgewater continue to progress. Both Executive Teams were overseeing the delivery of the agreed priorities across a number of work streams and identifying opportunities for efficiency savings in line with the operational plan. Documents around joint branding and initial strategic case for changed were being presented to both boards for ratification. • The new Endoscopy Hub had officially started operating this week. The £5m facility, had been developed as part of the wider Cheshire and Merseyside Endoscopy Transformation Programme, aiming to increase the number of patients that can be seen by providing a central hub for endoscopy services. • Plans and contract for a new "Theatre 3" in the Nightingale Building at Halton had commenced. This new facility would provide much needed capacity to reduce waiting times for our patients and potential opportunities for income growth. • In the lead-up to the August bank holiday weekend the Trust ran a Multi-Agency Discharge Event. This helped the prepare for the long weekend operationally by unblocking delays in the system and ultimately freeing up beds and de-escalating wards. **The Trust Board noted the Chief Executive's Report**
BM/24/10/96	**Chair's Report** SMcG provided a verbal update on activities since the last Boad meeting, highlighting the following: • Integration work was progressing, during the current week The BCHFT Council of Governors would be asked to approve the appointment of NK as Chief Executive from 1st November 2024. This would be the initial step in moving towards a single Executive Team for both Trusts • SMcG would be participating in three weekly meetings, with the Chair of BCHFT, NK would be involved in these meetings from 1st November. • Capital Investments such as; the new operating theatre and endoscopy hub as detailed in the CEO report, would help to support system working and ultimately reduce wating times for patients • The new WHH website had been launched, which was now live in the public domain and provided more streamlined access to information • SMcG had met with the new Warrington MP Sarah Hall, who was understanding of the Trusts strategic issues. **The Trust Board noted the verbal update from the Chair.**
BM/24/10/97	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the strategic risks.

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The key highlights from the report, were as follows:

- No new risks had been added.
- There was a proposed change to the description of two risks: risk 1757 relating to Industrial Action and risk 224 regarding capacity constraints in ED.
- It was proposed that the scoring rating of risk 1757 is reduced to 9 from 20. No other risk scores had changed
- It was proposed that risk 1757 is deescalated, no other risks have been deescalated.

The Board discussed in detail the proposed de-escalation of risk 1757 around Industrial Action, it was explained that the reduced risk score, description change, and de-escalation, were due to the improved position in relation to industrial action. Several pay disputes had been resolved nationally including the resolution of the junior doctor's dispute. MC explained that the Trust did not have any operational and live strike mandates for any staff groups within the Trust or across the NHS (except for the GP collective action).

The Board discussed the rejection of the nursing pay offer. MC explained that each staff group goes through different national body. MC further explained the volatile nature of the risk, which would continue to be closely monitored via the corporate risk register and should matters escalate, the risk would be re-Escalated to a strategic rick to be monitored through the BAF.

PF confirmed that given the current climate it was sensible to de-escalate the risk and reduce the risk rating to 9.

The Board discussed whether the EPRR should be a strategic risk, given the shift from compliant to non-compliant. It was explained that the risk currently sat on the CBU risk register with a rating of 12.

It was noted that further assurance around the EPRR position was to be provided under agenda item BM/24/10/106.

ZH explained the new process announced in May 2023, introducing more robust governance and rigour around the assessment process. It was noted that NHS England are currently reviewing the EPRR assurance process to ensure that it continues to develop and support continual improvement.

JJ confirmed that significant assurance was being received through the Finance and Sustainability Committee (FSC) around the work being undertaken to support progress towards partial compliance.

DM explained that the new assessment process meant that organisations no longer simply undertook a self-assessment instead the process was robust and following peer assessment a national team now reviewed evidenced based compliance for all organisations. When the new standards were introduced, no organisations were complaint, however given this was the 2nd year there was expected to be an improved position nationally.

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	The Board discussed the current national climate and more specifically recent local examples, which highlighted the increased likelihood for EPRR to be called upon and the importance of having a robust plan in place. **The Trust Board discussed and approved the changes and updates to the Board Assurance Framework.**
BM/24/10/98	**Integrated Performance Report** DM introduced the agenda item which provided a summary of Trust performance, the report was taken as read. The Executive team presented a set of summary slides which highlighted the KPIs within the IPR that were both failing and had special cause variation of a concerning nature DM explained that the cover report introduced a new KPI 4-hour performance including Walton Walkin Centre, it was noted that the centre should be referred to as the Widnes Urgent Treatment Centre. It was noted that there were 3 indicators that were both failing and had special cause for variation of a concerning nature. This was unusually small and was considered a good indicator that work undertaken to embrace an SPC approach was working well. The three indicators were: **Quality:** **1. Healthcare Acquired Infections (CDI)** AK provided reassurance that despite the underperformance the Trust was a low outlier compared to other NW Trusts, it was noted that there was a National and regional increase in CDI cases. There had been a slight decrease in Antibiotic Point Prevalence Audit (85%) and IVOS CQUIN increase (38%*) which was being addressed by Consultant Microbiologists. A Trust-wide Deep Clean was being implemented. Following the 2023/24 Audit findings, learning had been shared and an action plan implemented. In addition, the annual plan of CDI training was in progress and awareness raising events around IPC and Antibiotics had been scheduled for Q3. SMcG queried whether Benchmarking data was available to share with Board members. PF confirmed there was some IPC data available via model hospitals, which could be shared. JD sought clarity on the increase in open incidents and plans to address. AK responded that there had been a change in process, moving to more local ownership, this change in process meant that CBUs were now responsible for closing down actions, and some delays had been experienced. It was noted that an improved position would be evidenced in future months as the process embedded. PF added that safety oversight meetings received assurance that whilst more incidents were being reported, these were low level, displaying a positive culture around incident reporting. **Access and Performance:** **2. Uncapped Theatre Utilisation** PF explained that Uncapped Utilisation was the total operating time and inclusive of any early starts or late finishes. The Trust had achieved 79.1% in

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	August against a target of 85% and had moved from bottom quartile to a mid-position in model hospital benchmarking over the last 6 months. PF noted the impact of reconfiguration work in theatres, and the temporary closure of some theatres in nightingale, which had created challenges. Focus to improve the position was on start times and cases per list in worst performing specialties and on the day cancellations. **Finance and Sustainability:** **3. Better Payment Practice Code (NEW, with a target of 95%)** JH explained the KPI being around how quickly the Trust pays invoices, the decrease in BPPC in July (76.53%) and August (84.41%) was due to invoices not being placed on hold / in query or transferred to an alternative approver whilst the budget managers were on annual leave. It was noted that If an invoice is place on hold / in query this stops the clock with respect to BPPC. JH reassured the board of the guidance routinely emailed to budget managers advising them of this. The guidance was to be re-enforced especially at times when higher annual leave was expected. NK commented that the Trust's underperformance would likely spark interest from the national team. NK further highlighted the responsibility of the Trust particularly in regard to small and medium sized businesses. **Cash support request for Trust Board approval** JH explained that At Month 5 the plan was a £16.4m deficit. The actual deficit was £17.4m with the overspend being due to the impact of Industrial Action with cost and loss of income totalling £1m. As a result the board were being asked to approve the request for cash support of up to £14.954m from NHSE for Q3, however the Trust may not need to draw it down JH confirmed that the delays in paying invoices had not been linked to cash flow. **The Trust Board noted the contents of the report, and:** • **Approved cash support of up to £14.954m from NHSE for Q3 noting that the Trust may not need to draw it down.** • **Noted the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.** • **Noted the 2023/24 NCC was completed and submitted in line with national guidance.**
QUALITY	
BM/24/10/99	**Fragile Clinical Services Update** PF introduced the report which provided a status update on the Trust's oversight of Fragile Clinical Services. The following key highlights were taken from the report: • Two services were being deescalated as fragile services these were **Gynaecological Surgery** and **Stroke Services** • **Cardiorespiratory services/cardiology** was entering fragile services oversight, which had been escalated at the PSCESC meeting 24 September. The concerns were around diagnostic delays and fragility of cardiology medical staffing. Analysis was currently taking place and would

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	be presented to the Quality Assurance Committee (QAC) as a Hot Topic in November. • **ENT** - the waiting list position had improved predominantly due to insourcing. Mitigations were in place for medical staffing challenges, currently a significant cost pressure, a cost reduction plan was in progress. There were ongoing concerns across the region and strategic conversations were taking place with MWL and LUHFT regarding the process to develop a sustainable ENT model for Mid and North Mersey • **Theatres (procedural Safety)** – there had been Improved performance and no never events in the last 6 months, the ARHQ Safety Culture survey had been completed which would guide the next phase of improvement work **The Trust Board:** • **Noted the current list of Fragile Services, associated clinical risk and high-level progress updates** • **Noted the escalation of Cardiorespiratory Services / Cardiology into the Fragile Services oversight program** • **Note the de-escalation of Stroke Services and Gynaecological Surgery out of the Fragile Services oversight program** • **Noted the stabilised position with regards to ENT Medical Staffing, associated cost pressures and the plan to reduce these**
BM/24/10/100	**Compliance Q1 Update** AK introduced the report which included Q1 items reported to the Quality Assurance Committee Meeting held on 13 August 2024; • Maternity Update • Warrington Living Well Hub 3 • Compliance Group & Mock Inspection Programme • Care Quality Commission (CQC) Engagement and Risk Meeting – January 2024 and April 2024 • Single Assessment Framework The following key points were taken from the report: • A mock CQC inspection had taken place in the Urgent and Emergency Care Department (UEC) over 2 days (13/14 June). It was noted that the service continued to carry four regulatory breeches since the CQC inspection in February 2019. However, reassurance was provided that 3 of the 4 breaches were close to closing. Overcrowding was an ongoing issue with corridor care in place at the time of the mock inspection. The assessment team found no safety issues that required immediate escalation. The positive team culture was evident throughout the assessment and the environment was calm and well managed. • Trust extended an invitation to CQC colleagues to visit UEC. The informal visit took place on 6 August, in line with the planned CQC Engagement Meeting. Feedback received had been positive • A schedule of mock assessments was underway. The next assessment would be theatres (starting with the Warrington site) in September • There were 2 new CQC enquiries raised in Q1 ▪ Reg 28 – coroner in relation to death - was awaiting closure

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	▪ Death in Custody was currently open • The Framework of Assurance, Compliance Pillars were detailed within the report. AK reiterated the Trusts commitment to a positive assessment culture as detailed within the framework particularly visible, strong compassionate, supportive and inclusive leadership. • The board were reassured of the ongoing work in relation to the Single Assessment Framework (SAF) preparation, it was agreed this could be presented to Board for assurance in the future and would include detail of external awards and accreditations. SMcG queried whether any whistleblowing allegations (anonymous) would be raised during regular CQC meetings, and whether the Board could be assured that the absence of any mention reflected the fact that none had been made? AK confirmed this to be the case. **The Trust Board noted the contents of this report.**
BM/24/10/101	**Maternity & Neonatal Update** AGJ introduced the report which provided Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme, alongside emerging local and regional matters. The paper also provided a summary in relation to the following reports for oversight and discussion: • August Maternity Quality & Safety update – appendix 1 • September Maternity Quality & Safety update – appendix 2 • Maternity Incentive Scheme Year 5 and 6 – appendix 3 • Transitional Care Q4 2023/24 – appendix 4 • Ockenden position – appendix 5 – there was one outstanding action with placs to close. • PMRT Q1 2023/24 – appendix 6 It was exlained that the Q1 Midwifery Summary Safe Staffing Report and annual workforce plan were included as Appendix 7a and 7b. There were no escalations in relation to workforce metrics. JD highlighted the ongoing programme of Maternity Champions Walkarounds, which had provided assurance on the positive staff culture across maternity wards, with many student midwifes confirming that they wished to work at WHH on completion of their studies. In relation to patient safety AK highlighted the increase in readmission rates due to wound infections, an update on the work to improve the position would be presented to the QAC. CR queried the workforce metrics specifically the position at 30th June 2024 showing a positive variance of 8.564wte, and whether this truly reflected the establishment needed to provide quality of care. AGJ confirmed the outcomes of the Birthrate Plus® modelling helped to establish appropriate midwife establishment in order to meet compliance. The Birthrate Plus® workforce planning tool was required every three years in line with Maternity Incentive Scheme Year 6 - Safety Action 5.

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	The Board of Directors noted the appended maternity reports as per national recommendations.
BM/24/10/102	**GMC Re-validation Annual Report inc. Statement of Compliance** PF introduced the paper, which provided assurance to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce were robust. The following key highlights were taken from the paper and board Discussions: • 12 new concerns had been registered • 1 doctor had been suspended during the period • 1 claim had been made to employment tribunals by doctors • In relation to the Trusts responsibility to ensure future employees were informed of concerns in relation to individuals, PF confirmed that the GMC were kept informed and both the Trust and GMC would inform potential employees. • PF assured the Board of the procedures for handling concerns about the conduct, performance and health of Medical & Dental employees as detailed within the Maintaining High Professional Standards Policy, in accordance with the with the Maintaining High Professional Standards framework issued by the Department of Health • NK queried whether the Trust monitored from an EDI perspective, PF confirmed this was the case and that figures were proportionate to the WHH workforce. • PF highlighted the concerns around investigations taking too long, on average 115 days, which was a focus for improvement. • It was confirmed that Anne Robinson would remain the Trust responsible officer for the foreseeable future. **The Trust Board noted the update**
	PEOPLE
BM/24/10/103	**Freedom To Speak Up Guardian Bi-Annual Report** JH introduced the report, in the absence of Debborah Carter, Freedom to Speak Up Guardian, highlighting the following key points: • As of February 2024, a substantive Freedom to Speak Up (FTSU) Guardian and Deputy Guardian had been in post • Table 1 provided a breakdown of the number of disclosures over the last three years, up to Q1 of 2024/25. Notably, the Q1 data showed an increase in the number of disclosures compared to the previous year, this was being attributed to the dedicated FTSU resource, re-engagement with FTSU champions, additional walk rounds, and awareness-raising activities and events. • October was Freedom to Speak Up Month, during which a range of promotional activities were scheduled, including a short video providing staff with insight into FTSU. MC emphasised that the Staff Survey was now live and included four new questions related to FTSU, encouraging Board colleagues to promote completion among their staff groups. JJ added that the Strategic People Committee had received a significant amount of assurance regarding FTSU, and that the increase in low-level disclosures was evidence of a positive Speak Up culture across the Trust.

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	SMcG noted the importance of FTSO but also acknowledged the financial challenges facing the Trust and that nothing was off-limit for consideration however important. So, he queried whether any tangible data was available to determine the value for money around the increased FTSU resource. DM confirmed that figures would be analysed and presented via the bi-monthly FTSU updates. **The Trust Board noted the update.**
SUSTAINABILITY	
BM/24/10/104	**Warrington & Halton Teaching Hospitals NHS FT and Bridgewater Community Healthcare NHS FT Integration** **I. Joint Branding** **II. Initial Strategic Case for Change** The following key highlights were taken from the report and board discussion: • The current versions built upon the Joint Board Session held on 4 September, incorporating all feedback received since then. It was noted that both were also scheduled on the agenda for BCHFT Trust Board meeting - 3 October 2024. • The proposed joint branding was 'Better Care Together.' Potential sensitivities were discussed, along with progress to date and next steps. • The importance of the strategic case for change and the next steps were explained. It was noted that the document was produced for commissioners and system partners to provide an update on the strategic intentions surrounding integration. CR enquired about some of the language used within the document, which may require further attention to provide clarity to external partners, such as the terms 'fragile services,' 'significant financial savings,' and 'vast opportunities.' It was agreed that this would be reviewed. CR also inquired about the possibility of increased buying power through integration. LG responded that initial investigations indicated that there would be opportunities to amalgamate contracts across the two organisations. NK summarised the board discussions, stating that the Case for Change provided a good foundation for both organisations to build upon, but would require some refining to meet the needs of the Trust's stakeholders. NK reiterated the main drivers for integration, which were the benefits to patients and staff, the development of resilient clinical services, and the provision of high-quality care. **The Trust Board approved the Joint Branding and the Initial Strategic Case for Change, subject to minor amendments and further discussion at the Trust Board Part 2 meeting**

DRAFT

BM/24/10/105	**Strategy Programme Highlight Report** LG introduced the report which provided a progress update on key strategic projects and initiatives that underpinned a number of WHH's strategic (QPS) priorities. The following key highlights were taken from the report: • As recently reported in the Warrington Guardian, the Living Well Hub in Warrington had seen over 5000 visitors attend since the doors opened in mid-March 2024. Around 60% of these attendances have been people "dropping in" to the hub to access a service. • The Trust had submitted the CDC activity reprofile which in line with national submission of activity plans for the year. The contribution to CIP remains the same. The Trust was not receiving the anticipated number of referrals for spirometry. • The New Hospitals Terms of Reference had now been published new hospitals programme. It was likely that in the current plan only those Trusts with reinforced concrete would be stay. Should this be the case the Trust had plans for smaller levels of investment. • Pathology collaboration – It was anticipated the Outline Business Case would go to November's board development session for approval. • Runcorn town deal - the tender process was starting for the refurbishment of the library, it was noted that key partners commitment to revenue would be bought back through FSC and QAC. **The Trust Board noted the programme updates.**
BM/24/10/106	**EPRR Assurance Letter/Statement of Compliance** ZH introduced the report which had been discussed in detail under agenda item BM/24/10/97. The following key points were highlighted from the report: • The Trust was currently 45/62 fully compliant and 17 partially complaint. Under the new EPRR NHS England core assurance process, this leaves the Trust with a non-compliant rating. • Details were provided of the outline workplan to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance, this would be monitored through FSC. • The Trust has agreed to host NWAS train the trainer courses in August 2024, to assist the resilience of responses to CBRNe incidents and support the development of the Trust's CBRNE and HAZMAT Plans. **The Trust Board noted the significant work and achievements undertaken during 2023-24 and the planned work programme for 2024-25 in support of improvements in EPRR and the Trusts objectives.**
GOVERNANCE	
BM/24/10/107	**Committee Terms of Reference:** • **Nomination and Remuneration Committee** • **Finance and Sustainability Committee** **The Trust Board reviewed and approved the Committee Terms of Reference and Cycles of Business**
Supplementary Papers	

DRAFT

BM/24/10/108	WHH Charity Committee Chair's Annual Report
BM/24/10/109	Committee Chair's Annual Report – Audit Committee
BM/24/10/110	Director of Infection Prevention & Control Q1
BM/24/10/111	Learning from Experience Summary Report Q1
BM/24/10/112	Learning from Deaths
BM/24/10/113	Guardian of Safe Working Report Q1
BM/24/10/114	Senior Information Risk Owner Report
BM/24/10/115	Digital Strategy Group Update
BM/24/10/116	**Review of the Meeting** The Board reflected on the Engagement Story and again thanked IH for sharing his heartwarming and emotional story with the Trust Board. A particular thanks was noted to the staff who helped facilitate the exceptional end-of-life care. SMcG reminded Board members of the Annual Members Meeting, which was starting at 3:30pm in the Education Centre, Warrington site. **The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items**
BM/24/10/117	**Any Other Business** No further business was raised. **Meeting ended at 12:45pm**
The Date and Time of the next Trust Board Meeting is Wednesday 4 December, Lecture Theatre, Education Centre Halton Hospital	

DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE	BM/24/12/120ii	SUBJECT:	ACTION LOG	DATE OF MEETING	4 December 2024

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/08/70	7.8.24	Health Inequalities	A separate session to be organised to discuss in more detail	**LG**			To be scheduled as an agenda item for a future Board Development Day with Bridgewater colleagues	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/122**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	4 December 2024			
AUTHOR(S):	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/24/12/122

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 2 October 2024, but more specifically since I started in my role as the Chief Executive at Warrington and Halton Teaching Hospitals NHS FT and Bridgewater Community Healthcare NHS FT, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 A Welcome from your new Chief Executive

I am incredibly honoured to step into the role of CEO at Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare. I want to take this opportunity to introduce myself and share some of the values, principles, and beliefs that will shape how I lead, as we begin this journey together.

First and foremost, patients are at the heart of everything we do. Our mission is to provide outstanding care to the communities we serve, and every decision we make must ultimately benefit them. Whether it's through clinical excellence, compassionate care, or the innovation and efficiency of our services, our focus must always be on improving patient outcomes and experiences.

Our staff are our greatest asset. Each member of staff contributes to the strength and success of the two organisations. I believe in creating a culture where everyone - no matter their role - feels valued, respected, and supported. I will work to ensure that our organisations foster an environment where talents are nurtured, and people feel empowered to excel in their work. I want our teams to be collaborative, with open communication and mutual respect driving everything we do.

Integrity and transparency are non-negotiable. Trust is earned through honesty and accountability, and I am committed to being open about the decisions we make and the reasons behind them. I will listen to ideas and concerns and ensure decisions are made always in the best interests of our patients and staff.

Innovation and improvement will propel us forward. The NHS faces many challenges, but I see those challenges as opportunities to rethink how we deliver care. We must be willing to embrace new ways of working and encourage creativity at every level. This doesn't just mean adopting new technologies but also fostering an environment where small changes can make a big difference.

Kindness and compassion must be at the core of our culture. How we treat each other impacts the care we give to patients. Compassionate leadership and a supportive workplace go hand in hand with compassionate care. I am committed to creating a workplace where we look after not only our patients but also each other.

Lastly, I believe that **bringing both organisations together is the right thing to do.** As we move forward in uniting WHH and Bridgewater, we have an incredible opportunity to deliver more integrated, patient-centred care. We are stronger together, and I am excited about the potential we have to break down silos and collaborate across all sectors of health and social care.

2.2 Integration

I have now chaired a number of joint Executive Management Team meetings. These meetings take place weekly and have replaced the separate executive meetings held previously within each organisation. It is a great opportunity to have the shared executive team in one room discussing both organisations to help identify further opportunities to work closer together

The Boards of both WHH and Bridgewater came together for a second time. We discussed our Better Care Together integration programme and took stock of the tremendous amount of work that has taken place, and continues to take place, to help us achieve true transformational change and improving services and pathways for the benefit of our communities

2.3 Leadership Changes

To support the great work that has already taken place as part of the Better Care Together integration programme, the boards of both Warrington and Halton Teaching Hospitals NHS FT and Bridgewater Community Healthcare NHS FT agreed to appoint Paul Fitzsimmons as joint Executive Medical Director for both organisations. The appointment is a secondment agreement for up to two years from 18 November 2024.

Similarly, Dan Moore has been appointed as the joint Chief Operating Officer for both organisations on a secondment agreement for up to two years effective from 9th December 2024.

2.4 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 7 - October 2024. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

The Trust continues to undertake an elective recovery programme; the priority this year has been on the elimination of waiting lists longer than 65 weeks. I am pleased to announce that we have received notification that due to satisfactory performance against this standard, the Trust will exit tier 2.

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

The most recent CMAST update for Boards is attached as Appendix 2.

2.6 Armistice Day

On 11 November, I was grateful to be part of the Armistice Day service at Warrington Hospital, as we joined together across our organisations to reflect and remember our armed forces. Thank you to everyone involved in organising the event, in particular the WHH Armed Forces and Veterans Community Staff Network, and to those who joined me across Bridgewater and WHH to mark the two-minute silence.

I am proud that the Trust is a Veteran Aware Trust and a Defence Employer, and we have dedicated support for our armed forces community, veterans and their families to ensure equity in our employment and when receiving healthcare.

2.7 Out and About

Since joining the Trust, I have taken as many opportunities as possible to meet with colleagues and take part in events and celebrations that truly make our organisation the place that it is.

It was a pleasure to tour the new diagnostic facility being built at the Captain Sir Tom Moore Building as part of my visit to Halton Hospital. I had the chance to see first-hand the difference the facility will make to the health and wellbeing of Warrington and Halton residents, and those further afield across Cheshire and Merseyside when it opens in 2025. Providing access to timely diagnostic tests in purpose-built environments like this is key to delivering high quality clinical services, reducing health inequalities, and improving our patient experience. Thank you to the team for showing me around.

I was also delighted to be invited to what I'm sure will be the first of many colleague celebrations. I joined the team in the WHH Gynaecology Department to celebrate Linda Williams, Staff Nurse, as she prepares for a well-deserved retirement after 47 years of service to the NHS! It was heartwarming to hear Linda's career highlights, listen to speeches from colleagues past and present, and see the wealth of appreciation for her teamwork, support to students and dedication to compassionate patient care over the years.

I'm sure Linda will not be alone in celebrating her length of service, and I want to say thank you to everyone who has recently marked or will soon be marking a significant service milestone - your commitment and dedication does not go unnoticed.

2.8 Staff Survey

I have been enjoying hearing more from colleagues about what it is like to work for the Trust and the Staff Survey is one of the best ways I can continue to do this.

As the new Chief Executive, the survey will allow me to understand your experiences, what we're doing well and where we can improve. This helps us to ensure that everyone has a good day at work.

It is through our workforce that we can continue to create the best employment and patient experiences, based on our organisation's values. This creates a space where you can all thrive, with our leaders and managers sustaining and creating the best possible conditions for you to do so.

Since becoming your chief executive, I have seen first-hand how our staff and patients are at the heart of everything we do.

We are committed to continuous listening, but I am aware it's not just the listening part that's important. We need to demonstrate that we're acting on your feedback and we continue to do this through our 'you said, we did, we are doing' approach.

The Survey closed on 29 November and at the time of writing, the response rate was 50.9%. I would like to extend a huge thank you to everyone who took the time to complete it.

2.9 Flu Vaccination

I ended my first week with the Trust by being jabbed! I was pleased to receive my flu jab after our Board meeting - a big thanks to Jill Kenyon and Beth Youlton from WHH's Occupational Health Team who popped in to make sure we were vaccinated and protected.

Now's an ideal time to remind you that if you haven't already, the flu vaccine is still available for all colleagues and is one of the best ways we can defend ourselves and our patients this winter.

The flu crew will be roaming departments across WHH, with several drop-in sessions available in the Occupational Health Department.

2.10 National News

It was announced in mid-November that the UK government is implementing a series of reforms to improve the NHS, including:

- **League tables:** NHS providers will be ranked in a public league table to increase transparency and accountability.
- **Turnaround teams:** Struggling hospitals will receive support from expert teams to improve performance.
- **Rewarding performance:** High-performing providers will receive greater funding and flexibility.
- **Accountability:** Persistently failing managers will be replaced, and senior managers will be held accountable for poor performance.
- **Reducing agency staff:** The government plans to reduce reliance on agency staff, particularly for lower-level roles.

These reforms aim to improve the efficiency and effectiveness of the NHS, reduce waiting times, and ensure that taxpayers' money is well spent.

I also attended a regional meeting focused on the ambitious NHS 10-year plan. Discussions were focused on the three key levers that will help the NHS to thrive and become more sustainable as we move forward under our new Government:

- Driving care from **hospital to community,** treating patients closer to home
- Shifting from **analogue to digital,** using technology to transform practice
- Moving from **treatment to prevention** to reduce ill health and tackle inequalities

These aren't small changes, but one thing that is clear for me from this is that joining forces with Bridgewater is absolutely the right thing to do and sits at the heart of shaping our healthcare service for the future. So many of you have already told me how empowering it feels to know that we can work together as one to bring out the best of our organisations. Together we are stronger, and this will only make things better for you and for our patients.

Whilst we are all members of staff, we are also members of the public too and I would encourage you to visit the Change NHS website, or join one of the upcoming staff sessions to share your views, feedback and ideas for change.

2.11 Induction

Like all new starters, I attended have attended the Trust induction. It was lovely to be welcomed to the organisation along with our other new starters. It was also well timed ahead of meetings later in the week as a reminder of the history and values on which the foundations of our NHS and organisations were built.

2.12 Chief Midwifery Officer Visit

I was delighted to welcome the Chief Midwifery Officer for England, Kate Brintworth on her visit to Warrington Hospital on Thursday 21 November. Kate took a tour of our maternity services and presented a Chief Midwifery Officer Award to a member of the maternity team. The tour showcased the Trust's investment into the maternity service's estate, commencing in the Maternity Triage Assessment Unit, before moving to The Nest (midwifery-led unit) and then finally to the recently opened Induction of Labour Unit on Birth Suite.

2.13 Special Days/Weeks for professional groups

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

October

- Speak Up Month
- Stoptober
- Black History Month
- Breast Cancer Awareness Month
- Baby Loss Awareness Week
- World Mental Health Day
- International Infection Prevention Week
- Allied Health Professional (AHP) Day
- World Menopause Day

November

- Mouth Cancer Action Month 2024
- Diwali
- #MedSafetyWeek 2024
- Remembrance Sunday
- Armistice Day
- World Quality Week
- Anti-Bullying Week 2024
- International Fraud Awareness Week

2.14 Employee Recognition

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

You Made A Difference Award (October 2024): Wards B18 and A3

The winners of the October 2024 You Made a Difference Award were Wards B18 and A3, for going above and beyond and working together to support the move of a critically ill patient to be with their husband, who was also critically unwell, to allow the couple to be together in their final moments. All teams involved demonstrated compassion, thoughtfulness and kindness as they supported person centred care above usual process.

The impact this had on both of the individuals before they passed away but also on their family members will never be forgotten. This is an example of exemplary holistic care.

Chief Executive's Award (October 2024): Dr Colin Wong, Dr Fitzsimmons & all of the Resuscitation staff.

A Chief Executives Award was arranged to be awarded to Dr Colin Wong, Dr Fitzsimmons and all of the resuscitation staff involved in an incident whereby a visitor to the hospital who was attending to visit their friend, suddenly and unexpectedly collapsed by a lift and stopped breathing. The individuals wife wrote in after the incident and couldn't speak more highly of the staff that supported both her husband and her throughout the traumatic ordeal, and who saved her husband's life.

Further Recognition – Chief Executives Cards:

Daniel Moore, Acting Chief Executive at the time intended to specifically and personally recognise the contributions of the following colleagues via a handwritten thank you card:

- Breast Screening Team
- Orthopaedic Surgery at CSTM
- A3 team (and all others involved)
- Maxial Facial Dept
- Howard Evans – Palliative Care Team

You Made A Difference Award (November 2024): Hazel Lenden, CT Booking Clerk, Radiology

The winner of the November 2024 You Made A Difference Award is Hazel Lenden from the Radiology Department, for going above and beyond in supporting an elderly patient with poor sight to access an appointment at the hospital.
Following a conversation with a 90 year old patient who expressed concerns about not being able to read letters in the post due to her sight, so potentially missing a letter from the hospital, Hazel took it upon herself to print the letter in large font and personally hand deliver the letter to the patient at their home, explaining the contents of the letter to them to ensure they did not miss out on an important appointment.
Hazel has also demonstrated going above and beyond for the service, taking her laptop home on weekends to do additional work to ensure no patients were left without appointments due to staff shortages and sickness. The nomination stated "there are probably only one in a million staff members that would take their job role to such exceptional standards".

Chief Executive's Award (November 2024): Ward A7

Ward A7 will be recognised as Novembers Chief Executive Award winners, for their hard work and diligence in remaining pressure ulcer free for 168 days. This is an outstanding achievement for the ward and their patients.

Further Recognition – Chief Executives Cards:

I have, or intend to, specifically and personally recognise the contributions of the following colleagues via a handwritten thank you card:

- AMU
- Paul James, WHH Volunteer

2.15 Signed under Seal

Since the last Trust Board meeting, no have been signed under seal:

3 MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended since I joined the Trust:

- CQC Engagement
- Graham Urwin, Chief Executive Cheshire & Merseyside Integrated Care Board
- Carl Marsh, ICB Place Director (Warrington)
- Linda Buckley, Managing Director CMAST Provider Collaborative
- Kate Brintworth, Chief Midwifery Officer
- C&M Financial Incident Command Meetings (FICC)
- MHLDC Provider Collaborative Chief Executive Forum

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 7 (October 2024)
Appendix 2: CMAST Board Update (October 2024)

Appendix 1 - CEO Dashboard Month 7 – October 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	82.72%	F
RTT 18 Weeks	92.00%	58.61%	F
RTT 65+ Weeks	0	1535	F
A&E % patients seen within 4 hours	> 75.00%	64.37%	F
A&E % waiting longer than 12 hours	< 2.00%	18.93%	F
Cancer 28 Day Faster Diagnostic Standard	75.00%	68.00%	?
Cancer 62 Day Wait	85.00%	75.10%	No SPC
Ambulance Handovers within 60 mins	100%	89.87%	F
Discharge Summaries 24 hours	95.00%	92.04%	F
Cancelled Operations – 28 days	0	0	?
Super Stranded Patients	Trajectory	136	No SPC
Uncapped Theatre Utilisation	85.00%	79.80%	F
Capped Theatre Utilisation	85.00%	74.40%	F

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	9	?
Sepsis Screening Emergency	90.00%	56.00%	F
Sepsis Screening Inpatients	90.00%	59.00%	F
Sepsis Antibiotics Emergency	90.00%	62.00%	F
Sepsis Antibiotics Inpatient	90.00%	73.00%	F
Inpatient Falls	20.00% reduction	40 YTD	?
VTE	95.49%	94.81%	?
Pressure Ulcers	10.00% reduction	14	?
Medication Reconciliation (24 hrs)	80.00%	55.00%	F
Complaints over 6 months	0	0	P
Healthcare Infections - MRSA	0	1 YTD	P
Healthcare Infections - MSSA	N/A	25 YTD	No SPC
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	62 YTD	F
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	64 YTD	?
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	19 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	6 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	4.50%	F
MUST nutritional assessment completion	85%	67.30%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (£m)	-£0.13	-£0.37	No SPC
Capital Spend (£m)	£8.14	£5.62	?
Cash Balance (£m)	£4.77	£23.15	No SPC
Better Practice Payment Code (£m)	95%	86%	F
CIP In Year Delivered (£m)	£7.78	£7.78	?
CIP Forecast (Recurrent) (£m)	£7.78	£6.00	?
Agency Ceiling	Less than 3.7%	0.7%	P

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.70%	F
Retention	85.00%	87.30%	P
Core/Mandatory Training	85.00%	89.79%	P
PDR Compliance	85.00%	77.51%	F

Strategy

- A **single Chief Executive Officer** has been appointed for Warrington and Halton Hospitals NHS Trust and Bridgewater Community Healthcare NHS Trust. Nikhil Khashu started in post on the 4th of November.
- The **Living Well Hub** in Warrington has seen over 7,500 visitors attend since the doors opened in mid-March 2024. Around 55% of these attendances have been people "dropping in" to the hub to access a service, and the remainder have been for pre-booked appointments.
- **Over 64,000 additional diagnostic tests** have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023.
- A **new pathway for paediatric respiratory diagnosis** in CDC Phase 2 (Runcorn Shopping City) is due to be implemented by the end of the year. Clinical posts are currently being recruited to and the project team are engaging with primary and secondary care colleagues to develop the clinical pathway.
- Work continues with **the integration programme between Bridgewater Community Healthcare Trust and Warrington** and Halton Hospital Trust. A high-level strategic case for change has been approved along with the high- level milestone plan. Workstream teams are developing delivery plans and the Clinical and Operational services group have facilitated their first workshop to bring senior clinical and operational staff together to shape the way forward and begin prioritising services for integration.
- The **Urgent and Emergency Care System Improvement Programme** continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to Urgent Community Response (UCR) and Same Day Emergency Care (SDEC) have increased and are consistently above target, ED attendances are down by 4% compared to the same period last year and time spent on the ED corridor has reduced from 10 hours to 4. Trusted assessor and direct referrals have been implemented in Halton. Over 65 admissions remain a challenge.
- The contract was recently signed to develop a **new virtual health and wellbeing hub** for Warrington following work to secure funding and support from across place partners. A new project manager has now commenced in post to lead the project over the next 12 months.

CMAST Leadership Board
Update to Boards November

CMAST Leadership Board met on 1st November discussing a number of system issues as follows:

The Leadership Board was provided with an analysis of the aggregate C&M position in respect of NHS corporate services benchmarking (previously referred to as Model Hospital data) for 23/4 following recently released data.

Model Hospital data highlights variation across the system using a variety of benchmarking tools, the review presented used the national median as a comparison, but did not take organisational differences into account, for example demographics, organisation type.

The Board was then provided with an update on the development of a Liverpool Adult Acute and Specialist (LAASP) Trusts programme of work and the direction of travel toward a group model.

The Board received an update on progress in delivery of the C&M Pathology target operating model and LIMS as a key enabler of this area of work.

Discussions concluded by sharing UEC experiences from across each locality, summarising the initiatives that are seen to have had most impact.

Update papers were also provided on the following areas:

- System financial report
- System performance update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/124**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	4 December 2024			
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an update on the Trust's 11 strategic risks as per the Board Assurance Framework, following review by the assigned monitoring Committee. Each strategic risk is linked to one or more of the Trust's strategic objectives. 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 Trust Board meeting:** • No new strategic risks have been added. • There is a proposed change to the description of risk 145 following discussions at the Audit Committee			

<table>
<tr><td></td><td colspan="4">where it was agreed that integration work with Bridgewater should be included (details are provided in section 2.3 of the report)
• There have been no changes to risk ratings
• No risks have been closed or deescalated

Key updates to existing risk; controls, assurances and gaps are detailed within section 2.6 of the report.

Detailed individual BAF risks reports are included as Appendix 1.

The Trust has an overall Risk Appetite Statement (Appendix 2) which is reviewed and approved annually by the Trust Board. In addition, each strategic risk on the BAF has been assigned a unique risk appetite as approved by its monitoring committee.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval
✓</td><td colspan="2">To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to:
• Discuss and note the updates to the Board Assurance Framework.
• Approve the amendment to the description of risk 145</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee, Audit Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">Multiple</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">Multiple</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">Approved</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/24/12/124

1. BACKGROUND/CONTEXT

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

The latest Board Assurance Framework (BAF) is included as **Appendix 1,** and a summary of the current status of each of the Trusts 11 strategic risks is provided in the table below:

Risk ID	Exec Lead	Risk Description	Current Rating	Risk Appetite	Monitoring Committee
224	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	20 (L5xC4) ⟷	Open	QAC
1215	COO	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.	20 (L4xC5) ⟷	Open	QAC
134	CFO	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	20 (L5xC4) ⟷	Open	FSC
2001	EMD	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	20 (L5xC4) ⟷	Minimal	QAC
115	CN	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.	16 (L4xC4) ⟷	Minimal	QAC
1114	EMD	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.	16 (L4xC4) ⟷	Minimal	FSC
1372	EMD	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	16 (L4xC4) ⟷	Cautious	FSC
1898	CSPO	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.	16 (L4xC4) ⟷	Seek	FSC
125	COO	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	15 (L3xC5) ⟷	Open	EMT
145	CSPO	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	12 (L3xC4) ⟷	Open	EMT

		outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			
1134	CPO	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	12 (L3xC4) ⟷	Open	SPC

The Trust has an overall Risk Appetite Statement **(Appendix 2)** which is reviewed and approved annually by the Trust Board. In addition, each strategic risk on the BAF has been assigned a unique risk appetite as approved by the monitoring committee.

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New risks

The have been no new strategic risks added to the Board Assurance Framework.

2.2 Amendment to risk ratings

There have been no amendments to any of the strategic risk ratings.

2.3 Proposed amendments to descriptions

There is a proposal to amend the description of risk 145. This follows on from the discussions at the Audit Committee meeting (21 November 2024) where Non-Executive Directors agreed that the risk around integration should be specified within the risk description.

It is proposed that the description of risk 145 is amended:

From

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.

To:

If the Trust does not deliver our strategic vision, including two new hospitals along with the integration with Bridgewater Community Healthcare FT 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 the inability to provide best outcomes for our patient population, possible negative impacts on patient care, reputation and financial position.

2.4 De-escalation of risks

No strategic risks have been closed or deescalated.

2.5 Risk appetite

There have been no amendments to risk appetites for any of the Trusts strategic risks.

2.6 Existing risks - updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
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.	**Controls:** • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • 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 day case unit and increased CT and MR capacity, due Spring 2025 (all phases to be complete)	**20 (L5xC4)**	none ⟷
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	**Controls** • Counter Fraud campaign took place for national anti-fraud week in November 2023 and is planned for w/c 18/11/24 • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the FSC with Deep Dive at FSC on highest cost • PWC support to review theatre opportunities, grip & control nad coolaboration, with weekly feedback meetings during November 2024 • FICC weekly meetings ICS & PWC and the 4 Trusts in mandated support to review and challenge process on improving fuinacial position **Assurances** • We have allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing and an additional 1% in second half of the year • In November 2024 submitted revised risk adjusted forecast with £8.5m variance from the control total, following full review of CIP, cost pressures, IA and pay award • Agency is 1.5% of pay bill YTP (ceiling is 3.2%)	**20 (L5x4C)**	none ⟷
2001	If the Trust is unable to mitigate for the challenges faced by its Fragile Services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	Current services included in the Fragile Services Oversight program are: • Urology • Orthopaedics – Fractured Neck of Femur • ENT Surgery • Cardiology/Cardiorespiratory Gynaecology and Stroke Services have been removed from fragile services oversight	**20 (L5xC4)**	No impact ⟷
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may	**Assurance** • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.72 % in September 2024	**16 (L4xC4)**	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	impact the delivery of basic patient care.	• Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.06% in September 2024 • Golden key initiative has reduced agency spend by £547,524 since April 2024 • Increased cohort of Care Support worker Development Programme (CSWDs) for 2024 • The number of wards achieving 90% fill rate increased to 20 wards in September 2024 from 17 in December **Gaps** • Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – Beds were opened in escalation areas 113 times in September 2024 • 48% increase in the number of Red Flags reported in September compared to August 2024- 70 red flags were linked to difficulties in providing enhanced care. • Between June – September 2024 over 1200 patients were admitted to WHH with a mental health condition •		
1372	If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	**Assurance** • Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch with partner Trust. • Program Governance and PMO function refreshed and improved following lessons learnt exercise • **Controls** • 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 • Partnership procurement will lead to identification of further realistic cash releasing / cost reduction benefits **Gaps in assurance** • New Frontline Digitisation EPR Convergence Guidance (November 2024) represents significant challenge • Requires partnership procurement and a single EPR instance to be fully compliant with guidance • Consolidation to a single EPR instance appears non-viable in current timeframe • Convergence approach requires agreement with procurement partner and negotiation with NHSE / FD RE route to EPR convergence • Complexity of coterminus LIMS implentation presents an emerging risk which requires a mitigating plan	**16 (L4xC4)**	None ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Gaps in Controls Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date with significant financial and clinical risk		
125	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	**Controls** • Prioritised schemes communicated to the capital programme and report monthly provided **Assurance** • PLACE assessment with subsequent action plan produced, implemented and monitored **Assurance Gaps** • Implications of the intergration programme not yet clear	**15 (L3xC5)**	none ⟷
145	***From*** *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* . **To:** If the Trust does not deliver our strategic vision, including two new hospitals along with the integration with Bridgewater Community Healthcare FT 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 the inability to provide best outcomes for our patient population, possible negative impacts on patient care, reputation and financial position.	**Controls** • Joint Executive Team and Board to Board meetings & programme of collaboration established with Bridgewater Community Healthcare NHS FT, as well as the creation of a steering group of senior representatives from both Trusts and system partner organisation • Nikhil Khashu started in post as joint CEO on the 4th of November. • Paul Fitzsimmons started in post as joint Executive Medical Director on the 18th of November **Assurances** • A high-level strategic case for change has been approved along with the high- level milestone plan. • Established the eight core workstreams of the Better Care Together Programme. These are Clinical and operational services integration, corporate services integration, Finance, Workforce, Estates, Digital, Communications and engagement, Governance and programme management • Workstream teams are developing delivery plans and the Clinical and Operational services group have facilitated their first workshop to bring senior clinical and operational staff together to shape the way forward and begin prioritising services for integration.	**12 (L3xC4)**	**none** ⟷
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	**Sickness absense** • The rolling 12-month sickness absence rate is 5.2% as at September 2024 and is showing minimal variation. This is a slight month on month increase since the lowest sickness	**12 (L3xC4)**	None ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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	absence rate reported in December 2023 (5.56%) since April 2020. Target remains 4.2% however following a recent benchmaking exercise across the C&M region this target is under consideration **Assurance** • 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 2.67% % in September 2024. **<u>Turnover and Attraction</u>** • Turnover in September 2024 remains below target at 12.16% and is showing an improving variation. Turnover of permanent staff in September 2024 was 11.33% which was below Trust target. Target is 13%. • The Trust's September 2024 vacancy rate has significantly reduced to 7.80%, the Trust, target is 9%. This significant reducition is reflective of the Trust's current vigorous scruitiny of vacancies through the ECF panel. **Controls** • Implementation of ECF panels throughout the organisation ensuring vigorous scruitiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunites for Bridgewarer staff and vice versa. **<u>Temporary Staffing and Agency spend</u>** • Bank and Agency reliance in September 2024 was 14.68% . Target is 9%. Bank reliance continues to increase and is 12.8% and agency reliance continues to decrease to 2.2%. • 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, overtime and WLI's approval		

5 RECOMMENDATIONS

The Trust Board is asked to:

- Discuss and note the updates to the Board Assurance Framework.
- Approve the amendment to the description of risk 145

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	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	1	20 (L5xC4)	8 (L2xC4)	Open	Quality Assurance Committee
1215	COO	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 (L4xC5)	6 (L3xC2)	Open	Quality Assurance Committee
134	CFO	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 (L5xC4)	12 (L4xC3)	Open	Finance & Sustainability Committee
2001	EMD	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (L4xC4)	8 (L2xC4)	Minimal	Quality Assurance Committee
1114	EMD	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 (L4xC4)	5 (1x5)	Minimal	Finance & Sustainability Committee
1372	EMD	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 (L4xC4)	8 (L2xC4)	Cautious	Finance & Sustainability Committee

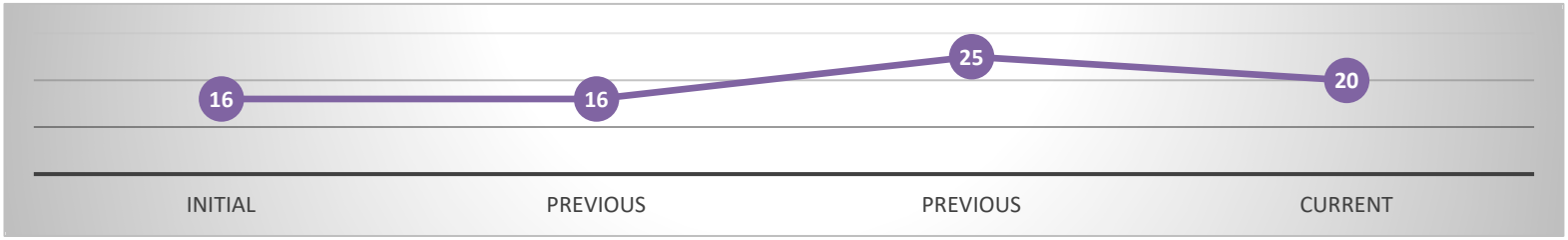
1898	CSPO	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive 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 (L4xC4)	9 (3x3)	Seek	Finance & Sustainability Committee
125	COO	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	1	15 (L3xC5)	10 (L2xC5)	Open	Executive Management Team
145	CSPO	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 (L3xC4)	8 (L4xC2)	Open	Executive Management Team
1134	CPO	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	12 (L3xC4)	8 (L2xC4)	Open	Strategic People 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

Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Finance Officer (CFO), Chief People Officer (CPO), Executive Medical Director (EMD), Chief Nurse (CN), Chief Strategy and Partnerships Officer (CSPO)

Board Assurance Framework

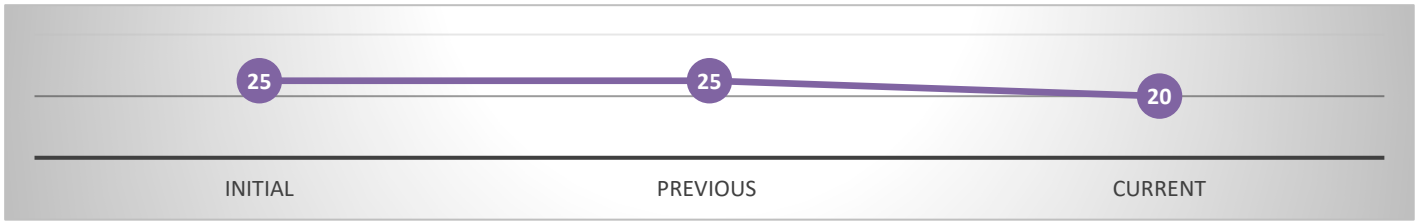
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk ID	224	**Executive Lead**	Chief Operating Officer	**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 then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.			**Initial**	16(L4xC4)
				Current	20(L5xC4)
				Target	8 (L2 xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** • Regular Trust Wide Capacity meetings led by the Tactical Manager for the day • Discharge Lounge/Patient Flow Team/Silver Command • ED Escalation processes/intentional rounding with ED Consultant and Nurse in charge. • Private Ambulance Transport to complement patient providers in and out of hours • Frailty Assessment Unit FAU/ operational 5 days per week. • Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational 7 days per week. • Relaunch of the deflection policy for minor injury patients overnight, where appropriate. • Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. • 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. Became operational April 24. • 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. • Co-located and upgraded Minor Injuries nit. • Meetings with senior leaders from the ICB 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 • CT scanner co-located in the main body of the ED department in 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. • 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 • Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy. • Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience				

	• Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2024/25 to support flow and urgent care • The Performance Improvement & Oversight Group has been established in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group • The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee **Assurances** • 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. • Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved • 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. • Following closure of the Lilycross facility at the end of May 2023, additional capacity has opened 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 continue working with ECIST to support a service improvement programme. • Continuous flow commenced on 8th October 2023. • Triage and streaming test of change commenced in November 2023 to improve productivity and utilisation of assessment areas to support lowering ED occupancy. • Transition to type 5 SDEC reporting went live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. • Reconfiguration of the ED footprint took place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12-hour time in department as referenced in the Tier 1 urgent care metrics. • As part of being in tier 1 urgent care, the Trust and wider system were supported by Newton to undertake a place diagnostic on capacity and demand. The outcome has instigated a project to help improve flow, reduce attendances and thus lower bed occupancy. • Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds into the ICB Urgent Care programme of work. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. • Updated nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor
Assurance Gaps	**Gaps in Controls** • Ongoing industrial action across a number of staffing groups including junior medical staff. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

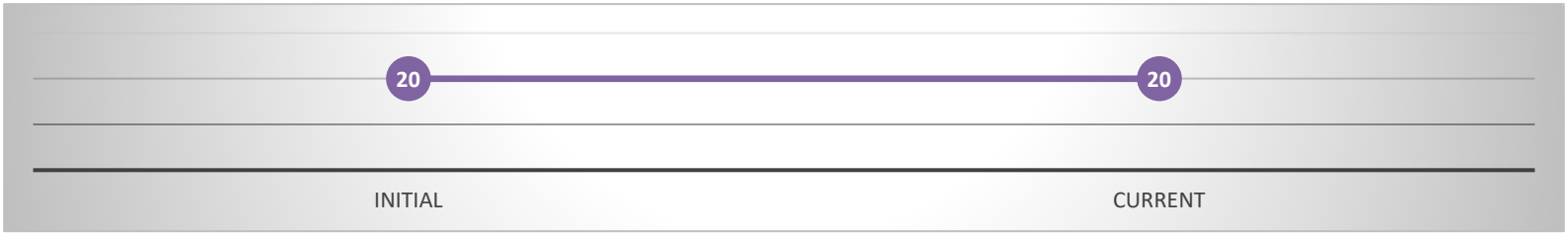
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12-hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Tactical Command and SMOC (out of hours) and Executive on Call.	Bowman, Karen	31/03/2025 (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.	Bowman, Karen	31/03/2025 (ongoing)	

		Weekly PRG and monthly Unplanned Care Performance Meetings.			
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Risk ID	1215	**Executive Lead**	Chief Operating Officer	**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 (L5xC5)
				Current	20 (L4xC5)
				Target	6 (L3xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls**. • 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. • . • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • 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 • 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 day case unit and increased CT and MR capacity, due Spring 2025 (all phases to be complete) • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside Productive Partners • 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 & 65weeks • 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. • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2024/2025 to support 65 & 78-week target. Following approval by Execs. • Ongoing validation of the trust waiting lists to improve data quality **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. • 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. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • The Trust has been confirmed as the regional diagnostic hub to support the reduction of local and system waiting lists. • New CT and MR scanner replacement to be undertaken in 2023/24 • CDC phase 1 gone live in July 2023. CDC phase 3 including CT & MRI due to open in spring 2025 • Trust Board support for additional use of independent sector to treat all outpatients in 65-week wait cohort. The Trust Board supported £4.6m for third party providers to treat all 78 & 65 waiters by the end of September 2024 & significantly reduce 52-week waiters. Monthly reporting to the Finance and Sustainability Committee. • Regional funding secured to support reduction in the echocardiogram waiting list. This is with third party providers and commenced on 1st November 2023.
Controls & Assurance Gaps	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint on the Warrington site. • Workforce capacity challenges in the medical workforce

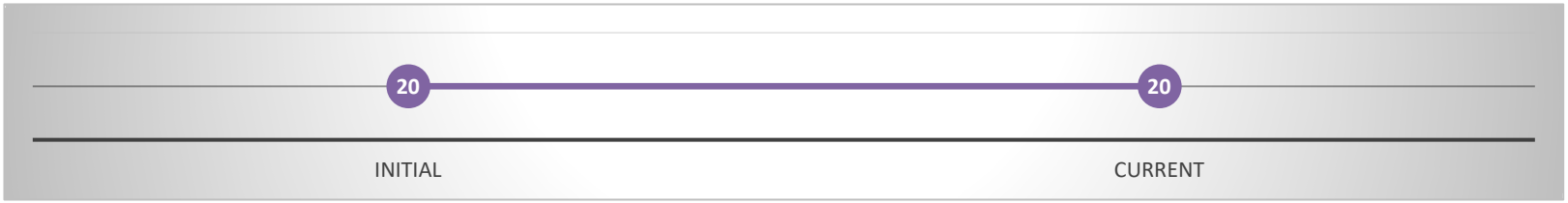
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Risk ID	134	**Executive Lead:**	Chief Finance Officer	**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 (L5xC4)
				Current:	20 (L5xC4)
				Target:	12 (L4xC3)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** •Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning • CEO led improvement meeting (inc finance & improvement) now take place three times per month • Procurement/tender waiver training in place • TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years) • Latest guidance from MIAA Counter Fraud Team circulated • Counter Fraud campaign took place for national anti-fraud week in November 2023 and is planned for w/c 18/11/24 • Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to FSC introduced. • Appointed GIRFT Finance Lead and 5 PAs allocated. • Appointed Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5 year plan presented to the Finance & Sustainability Committee in April 2024 • CDC phase 1 & 2 complete. Phase 3 to be completed by 31st March 2025 • Capital Plans for 2024/25 approved by the Trust Board in March 2024. • Revenue plans 2024/25 approved by the Trust Board in June 2024 • Introduced system of escalation where there are risks to CIP delivery • 2023/24 position was in line with original plans and with the reported likely forecast throughout the year • New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified. • In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the FSC with Deep Dive at FSC on highest cost • Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023 • Tightening controls of non-pay expenditure with executive review of catalogue spend and implemented cease option to purchase some items				

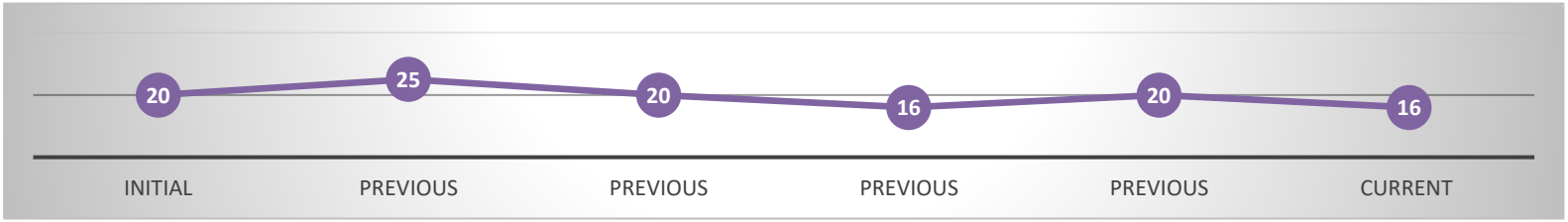
	• NHSE have approved (March 2024) Cash support Q4 2023/24 c£7m and Q1 £3m, Q2 £10.4m 2024/25 requested, Q3 15m requested – Enhanced controls regarding pay and non-pay expenditure must be adhered to and are part of the controls outlined above. • Enhanced ECF meetings in place with Chief Executive sign off, with ICS attendance. Bridgewater Community Healthcare NHS FT invited to attend. • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible • Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 & 52 Week recovery. • Daily huddle at 4pm to manage any financial issues • Daily review of Nurse variable pay • Weekly review of medic variable pay • PWC action tracker in place – monitored through Execs • PWC support to review theatre opportunities, grip & control nad coolaboration, with weekly feedback meetings during November 2024 • FICC weekly meetings ICS & PWC and the 4 Trusts in mandated support to review and challenge process on improving fuinacial position **Assurances** • Achieved ICS control total in 2022/23 • The 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 Capital Plan • Unqualified audit opinion (2023/24) submitted on time • 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. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge is to keep agency to below the 3.2% ceiling and reduce bank. Month 4 agency is 1.4% • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We have allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing and an additional 1% in second half of the year • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • Final 2024/25 Operational Plan has been submitted in June 2024 • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements • In November 2024 submitted revised risk adjusted forecast with £8.5m variance from the control total, following full review of CIP, cost pressures, IA and pay award
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high-risk schemes, 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. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • 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 • Additional capacity remained open in quarter 1 closed in June 2024. • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR

	• Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP • Agency is 1.5% of pay bill YTP (ceiling is 3.2%)

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Output of review undertaken of CIP, cost pressures and benefits realisation to be monitored via the Committee structure	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane	31.03.2025	
Review of 2024/25 CIP / GIRFT / Improvement plans	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane; Fitzsimmons Paul, Gardner, Lucy; Moore, Dan	31.03.2025	

Risk ID	2001	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.			**Initial**	20 (L5 xC4)
				Current	20 (L5xC4)
				Target	6 (L2 xC3)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'. Current services included in the Fragile Services Oversight program are: • • Urology • Orthopaedics – Fractured Neck of Femur • ENT Surgery • Cardiology/Cardiorespiratory **Controls** • Formal process in place for identification and designation of Fragile Services • Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams • Appropriate prioritisation of Fragile Service Revenue and Capital Requests **Assurances** • Monthly oversight through standardised Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • • Escalation to Quality Assurance Committee via PSCESC escalation reports Bi-monthly Fragile Services report to Trust Board				
Assurance Gaps	•Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bed base) •Ongoing industrial action •Increasing demand				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Risk ID	115	**Executive Lead**	Chief Nurse	**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 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details:	**Controls** • 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG) • Weekly ERostering KPI sign off meetings in place. • NHSP Request Review Meetings chaired by Chief Nurse or Deputy Chief Nurse 3 times a week • 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. • Agency reduction plan in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive Team • Local recruitment in place targeting ED and Endoscopy who have had recent investment / establishment increases. • Open advert for RN / HCSW recruitment • Quarterly recruitment events in place • Sickness absence being manged in line with Trust policy. • Monthly Cost Pressure Clinics in place reviewing sickness management/recruitment/skill mix/supernumerary status/maternity leave cover plans **Assurances** • Increase in registered nursing establishment in the Emergency Department, January 2024 reducing band 5 vacancy rate to 39.1 WTE from 46.84 WTE in May 2024 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.72 % in September 024 • Overall CHPPD sustained improvement at national standard of 8.1 in Q1 • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.06% in September 2024 • Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy, • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. 35 students recruited in Summer 2024 who will commence in post in Q3. • Cost avoidance of £2,031,805m from agency managed service contract started August 2022				

	• International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus. • 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 • Rolling recruitment for RN and HCA posts, weekly interviews • Leaver data is closely monitored, and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner. • Internal Transfer process in place for staff to support retention. • Nurse Staffing and Clinical Outcomes Group provides a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk. • Increased cohort of Care Support worker Development Programme (CSWDs) for 2024 • The number of wards achieving 90% fill rate increased to 20 wards in September 2024 from 17 in December 2023.
Assurance Gaps	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – Beds were opened in escalation areas 113 times in September 2024 • Increased request to provide enhanced care. • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients. • Continued escalation during winter of ward A10 and intermittent escalation of Cardiac Catheter Lab • Partially funded revenue requests • Time to post when recruiting new staff. • 48% increase in the number of Red Flags reported in September compared to August 2024- 70 red flags were linked to difficulties in providing enhanced care. • Between June – September 2024 over 1200 patients were admitted to WHH with a mental health condition

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 – complete? • 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.	Chief Nurse	19/10/24	

Risk ID	1114	**Executive Lead**	Executive Medical Director	**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 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	**Assurance:** • [DSPT Standard(s): 1.3.5] & 1.3.6] Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • [DSPT Standard(s): 1.3.5] & 1.3.6] Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • [DSPT Standard(s): 9.4.5] Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • [DSPT Standard(s): 7.1.4] Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) • Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness. **Controls:** • [DSPT Standard(s): 1.3.5, 7.1.2. 7.1.3, 7.2.1, 7.2.2 & 7.3.2] **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. • [DSPT Standard(s): 9.5.1] **Digital Change Management** regime including including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • External NHS England approved Cyber Training for the Trust Exec Board • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] 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. • [DSPT Standard(s): 7.3.4] Secondary secure backup at Halton Data Centre				

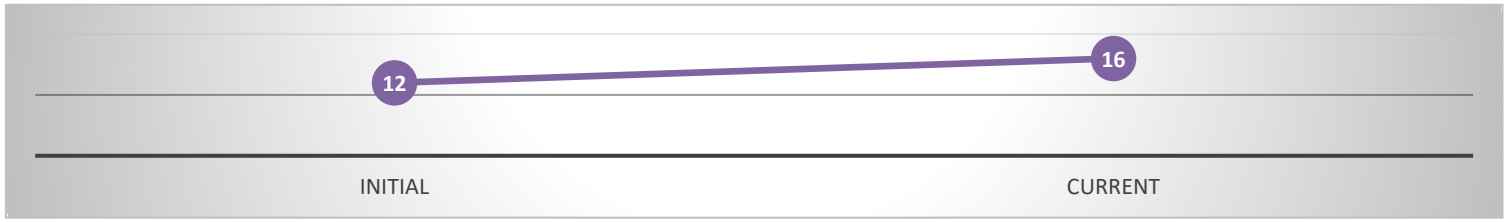
	• [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy • New Phishing exercise by NHS England has been arranged for 24/25 • [DSPT Standard(s): 8.4.1, 9.6.6] Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • [DSPT Standard(s): 4.5.3] MFA active on new starters for NHSMail • [DSPT Standard(s): 8.1.4 & 8.4.2] MUSE migrated to new server
Assurance Gaps	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24). • 24/25 DSPT has been aligned to the new Cyber Assurance Framework. No Trust is expected to be compliant until 2030. **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" • [DSPT Standard(s): 4.2.3 & 4.4.1] No dedicated logging tool to pull all key logs together and provide useable alerts. • [DSPT Standard(s): 8.3.6] Lack of process to check antivirus/MDE alerts in console. MIAA to review processes and tools • [DSPT Standard(s): 4.4.2] Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • [DSPT Standard(s): 8.1.4 & 8.4.2] Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • [DSPT Standard(s): 8.1.2] Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • [DSPT Standard(s): 4.5.3] MFA on limited number of systems • [DSPT Standard(s): 8.3.4] 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 • [DSPT Standard(s): 8.1.4] Version 7 of Clinisys Ice is end of life • [DSPT Standard(s): 9.3.8] Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • [DSPT Standard(s): 4.1.2] No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • [DSPT Standard(s): 7.3.4 & 7.3.5] Backup storage being end of life and out of support • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network.

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	Migrate all 2003 and 2008 servers to 2016.	Clinical Audit Manager has confirmed the full migration of their clinical documents. Head of Employment Services has asked for an extension regarding some HR elements of the ECF process needs migration. NHSE are putting pressure on Trusts for all unsupported servers to be switched off. SIRO is setting this month for the switch off of all unsupported servers. SIRO to write to asset owners of the affected	Deacon, Stephen	30/11/24	

Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).		systems. Any clinical concerns to be raised to the CNIO. Draft communications are ready to be sent out announcing the shutdown to the HUB. This will be sent out by the Senior Information Risk Officer (SIRO)			
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/decommission Server 2012 servers	Update to the 2012 EOL project: Endoscopy Server Not on schedule due to the need to merging of patient records is required to migrate the last of the records. CBU speaking to HD Clinical, as if anything goes wrong merging the patient records would cause a clinical risk. Digital Analytics and CBU to migrate the remaining patient records from the old server to the new, before HD Clinical complete the migration. NHSE are putting pressure on Trusts for all unsupported servers to be switched off. SIRO is setting this month for the switch off of all unsupported servers. SIRO to write to asset owners of the affected systems. Any clinical concerns to be raised to the CNIO.	Waterfield, Tracie	30/11/24	
Multifactor authorisation (MFA) review of Trust critical systems	Multifactor authorisation (MFA) review of Trust critical systems as data has shown that majority of cyber attacks can be prevented within 20 minutes of the initial attack starting with MFA compared to organisations who don't use MFA.	Create a document that details the Trust's critical systems and contact the vendors to inquire whether they have Multi-Factor Authentication (MFA) and, if not, where it is on their roadmap.	Deacon, Stephen	31/03/2025	
Review Digital BCP Documentation	Review Digital BCP Documentation	Review Digital BCP Documentation, after the recent unplanned downtime of clinical systems. MIAA to audit the new documentation in November 24	Deacon, Stephen	30/11/2024	
Attend the C&M Cyber Desktop Exercise	Attend the C&M Cyber Desktop Exercise	Attend the C&M Cyber Desktop Exercise with NHS England in	Deacon, Stephen	30/11/2024	

		September 24 (Has been delayed until the end of November 24)			
Perform Cyber Assurance Service (CAS) with NHS England	Perform Cyber Assurance Service (CAS) with NHS England	Engage with NHS England and their 3rd part for onboarding to be cyber assed by the Cyber Assurance Service (CAS). Current status: Accepted and completing the onboarding documentation.	Deacon, Stephen	31/12/2024	

Board Assurance Framework

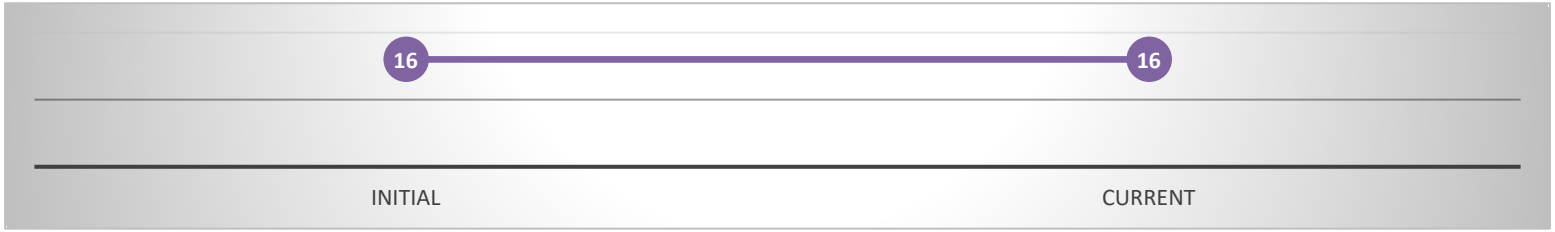
<table>
<tr><td>Risk ID</td><td>1372</td><td>Executive Lead</td><td>Executive Medical Director</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.</td></tr>
<tr><td>Risk Description</td><td colspan="3">If the Trust is unable to procure a new Electronic Patient Record 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 a risk to patient safety</td><td>Initial
Current
Target</td><td>12 (L3 xC4)
16 (L4xC4)
8 (L2 xC4)</td></tr>
<tr><td>Risk Appetite</td><td colspan="5">Cautious – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.</td></tr>
<tr><td>Risk Movement</td><td colspan="5"> 
</td></tr>
<tr><td>Assurance Details</td><td colspan="5">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 with partner Trust.
• Program Governance and PMO function refreshed and improved following lessons learnt exercise
• EPR project group has oversight on state of readiness for deployment and associated risks

Controls:
• 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 5-year Lorenzo costs
• ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance.
• Senior Programme Manager assigned, Program Director post to be advertised
• Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs
• Partnership procurement will lead to identification of further realistic cash releasing / cost reduction benefits</td></tr>
<tr><td>Assurance Gaps</td><td colspan="5">Gaps In Assurance
• New Frontline Digitisation EPR Convergence Guidance (November 2024) represents significant challenge
• Requires partnership procurement and a single EPR instance to be fully compliant with guidance
• Consolidation to a single EPR instance appears non-viable in current timeframe
• Convergence approach requires agreement with procurement partner and negotiation with NHSE / FD RE route to EPR convergence
• Complexity of coterminus LIMS implentation presents an emerging risk which requires a mitigating plan

Gaps In Controls
• Lorenzo is at end of life and is unlikely to see significant future development or enhancements
• Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date with significant financial and clinical risk
• Phasing of frontline Digitisation Funding with funding availability does not match the timing of forecast expenditure
• Deficit in programme year 3
• Further assurance required regarding state of readiness for implementation</td></tr>
</table>

Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE FDIB leadership fully sighted and remain supportive of procurement approach including Tender format	Ongoing engagement with ICS and NHSE FDIB leadership	Fitzsimmons, Paul	01/12/2024	
Develop plan to manage risk posed by coterminous LIMS implementation	To ensure the Trust has a plan to ensure is in a position to deploy EPR and LIMS over similar timeframes	Plan to mitigate for potential coterminous implementation of LIMS	Poulter, Tom	01/12/2024	

Risk ID:	1898	**Executive Lead:**	Chief Strategy and Partnerships Officer	**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 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 (L4xC4)
				Current	16 (L4xC4)
				Target	9 (L3 xC3)
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).				
Risk Movement					

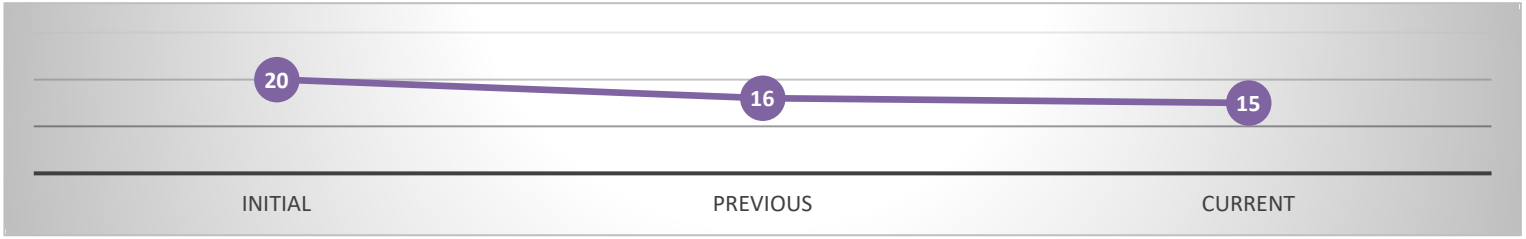
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have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

Assurance Gaps	• Confirmation received that the Trust was unsuccessful in securing funding via NHP phase 3. • Requirement to secure funding to complete the development of the phased new hospital plan				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work	Lucy Gardner	30.12.2024	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Lucy Gardner	31.03.2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk ID	125	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns			**Initial**	20 (L5xC4)
				Current	15 (L3xC5)
				Target	10 (L2xC5)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					

Assurance Details

Controls

- Annual capital funding is allocated to mandated and statutory estates projects
- The estates team operate a Planned Maintenance Program (PPM)
- The estates team operate a reactive maintenance process via the Computer aided facilities mananagement software (CAFMS)
- Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
- Prioritised schemes communicated to the capital programme and report monthly provided
- Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out
- Capital Planning Group and associated capital funding allocation process
- Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding

Assurance

- Health and safety sub committee acts as an esclation point for issues
- Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers
- Non funded capital schemes are risk rated and monitoired through the above group
- Fire Safety Group – monitors fire safety issues across the trust
- PLACE assessment with subsequent action plan produced, implemented and monitored
- Capital Planning Group – determine how the trust capital is spent
- Cleanliness monitoring identifies estates issues that are addressed through the CAFMS system
- Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations
- Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk
- Completed a formal Reinforce autoclave aerated concrete (RAAC) survey across whole estate. Small extension building identified as having RAAC present.
- Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension and the roof has now been replaced.
- Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been supported and phase 2 is due for completion October 2024
- Establishment of the Tactical Estates Group (TEG), reporting to the Capital Planning Group, to help support efficient decision making relating to estate allocation.

	• Associate Director of Estates & Facilities and Director of Strategy & Partnerships represents the Trust on ICB Estates meetings from an operational and strategic perspective • Funding identified in the 2024/25 Capital Plan to Support refurbishment of another patient lift on the Warrington Site to improve operational efficiency to commence in november 2024. • Plan are in development to undertake roof repairs to pathology as part of the backlog maintenance plan for 2024/25.
Assurance Gaps	• Limited capital funding to address entire backlog • Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more, with less and the estates maintenance team is currently under resourced and further impacted by non clinical CIP target. • 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. • Delays in approvals of PO resulting in risk to compliance and delivery of standards • Implications of the intergration programme not yet clear

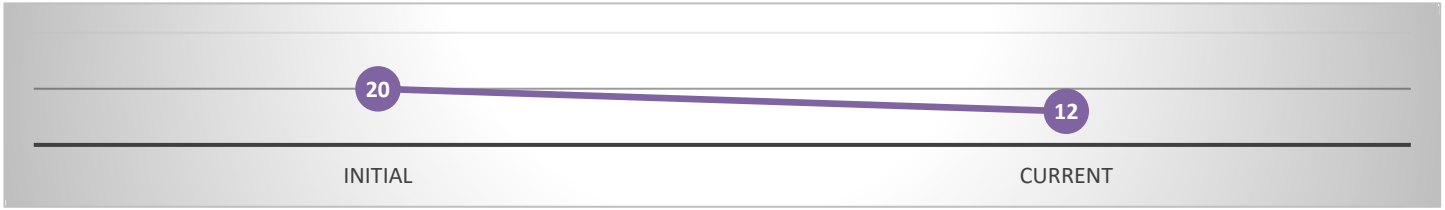
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities Phase 1 completed Phase 2 due for completion in October 2024	Lee Bushell	31/10/2024	29/11/2024
Upgrade Warrington lifts	Conditional report completed Undertake refurbishment or replacement of all lifts	Lift 1 to commence in November 2024 Lift 4 completed early 2024 Lift 5 plan in development Croft and Burtonwood lifts next for refurbishment	Kieran Beech	01/04/2027	
To replace the roof on the pathology department	Following a roof survey and persistent leaks a new roof is required	Business case required for funding	Kieran Beech	01/04/2025	

Risk ID	145	**Executive Lead**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, 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.			**Initial**	20 (L5xC4)
				Current	12 (L3xC4)
				Target	8 (L4xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
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. • Council and Place Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level are refreshed annunallly • 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. • Refreshed programme for pathology collaboration shared by the Cheshire & Mersey Pathology Network. The first phase is to develop an outline business case for the hub model expected by the end of October 2024. • CSPO 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. • Health & Wellbeing Hub (Living Well Hub) opened in March 2024 • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. • Consistent Trust representation within Cheshire & Merseyside ICS.				

	• Trust representation on place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • Funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • CSPO co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Trust Estates priorities now also reflected in the ICB infrastructure plan • Adaptive Reserve Fund created with Warrington Place partners • Discussions with neighbouring Trust to accelerate collaboration taking place • Joint Executive Team and Board to Board meetings & programme of collaboration established with Bridgewater Community Healthcare NHS FT, as well as the creation of a steering group of senior representatives from both Trusts and system partner organisation • Nikhil Khashu started in post as joint CEO on the 4th of November. • Paul Fitzsimmons started in post as joint Executive Medical Director on the 18th of November **Assurances** • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • 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. • National funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case approved by the Trust Board in June 2024. • Detailed work commenced, supported by external consultants, to help address no criteria to reside & enable admission avoidance. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside. Endoscopy Hub – opened September 2024 • CDC phase 2 including ultrasound, spirometry, sleep studies, audiology & phlebotomy opened in Halton Health Hub in December 2023 • CDC phase 3 including CT & MRI due to open in spring 2025 • A high-level strategic case for change has been approved along with the high- level milestone plan. • Established the eight core workstreams of the Better Care Together Programme. These are Clinical and operational services integration, Corporate services integration, Finance, Workforce, Estates, Digital, Communications and engagement, Governance and programme management • Workstream teams are developing delivery plans and the Clinical and Operational services group have facilitated their first workshop to bring senior clinical and operational staff together to shape the way forward and begin prioritising services for integration.
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.	Lucy Gardner	30/04/2025	
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Interim arrangements to support delivery given lack of available funding	Lucy Gardner & Dan Moore	30/04/2025	

Development of a joint Senior Leadership Team across BCHT and WHH	To appoint into joint Executive Director posts	NK appointed as joint CEO – 4th November PF appointed at joint EMD – 18th November COO – currently being considered by NARCs of both Trusts	Nikhil Khashu	TBA	

Risk ID	1134	**Executive Lead**	Chief People Officer	**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 (L4xC5)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Control & Assurance Details	**Sickness Absence** The rolling 12-month sickness absence rate is 5.2% as at September 2024 and is showing minimal variation. This is a slight month on month increase since the lowest sickness absence rate reported in December 2023 (5.56%) since April 2020. Target remains 4.2% however following a recent benchmaking exercise across the C&M region this target is under consideration **Controls** • 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. • Focused welcome back conversation recording and internal audit • Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. • Sickness absence, turnover and attraction workstreams have been reviewed in line with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been considered. **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 2.67% % in September 2024. • 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 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. Well attended by staff. • As a result of the sickness absence data analysis undertaken by the People Health and Wellbeing Group, OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within				

the last 12 months who have experienced an absence of depression/stress/anxiety, and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required.

Turnover and Attraction

Turnover in September 2024 remains below target at 12.16% and is showing an improving variation. Turnover of permanent staff in September 2024 was 11.33% which was below Trust target. Target is 13%.

Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving.

The Trust's September 2024 vacancy rate has significantly reduced to 7.80%, the Trust, target is 9%. This significant reducition is reflective of the Trust's current vigorous scruitiny of vacancies through the ECF panel.

Controls

- Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review.
- Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.
- Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work
- Grief and Menopause cafes implemented to support individuals
- Social media accounts have been created to support recruitment attraction across a number of social media platforms
- Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream
- A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working. Pilots commence January 2024
- HR are working with pilot areas to review their approach to rostering and the impact on agile/flexible working to support a reduction in turnover.
- Implementation of ECF panels throughout the organisation ensuring vigorous scruitiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunites for Bridgewarer staff and vice versa.

To support with attraction, the Trust has adopted a coordinated approach to recruitment which has included:

- International recruitment
- Enhanced HCA recruitment events
- Investment in TRAC (Recruitment system)
- Enhanced Student Nurse recruitment
- Enhanced wellbeing benefits package (financial and mental)
- Improvements in agile/flexible working
- Enhanced retirement support/offers

Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention.

Assurances

- The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.
- As a result of analysis of exit interviews, a theme identified was working hours and flexible working. Pharmacy are working towards changes to working hours, which have been raised as a factor by leavers and potential joiners as a barrier.
- The responses to Exit Interviews are positive, only 7.21% (July 2024) of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions.
- As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. July 2024 staff in post is 4,193 FTE, which is reducing in line with th additional scrutiny exerted to the recruitment process.
- Staff completing apprenticeships is above target at 3.9%, target is 2.3%

	Temporary Staffing and Agency spend Bank and Agency reliance in September 2024 was 14.68% . Target is 9%. Bank reliance continues to increase and is 12.8% and agency reliance continues to decrease to 2.2%. **Controls** • The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. • The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies, overtime and WLI's approval • The Resourcing Task and Finish group worked with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this has enabled the organisation to develop plans to improve the effectiveness of workforce deployment. The Trust is engaging with the ICB relating to next steps. **Assurances** • Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee • To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings has been introduced. • Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives and an options appraisal put forward.
Assurance Gaps	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Lack of assurance regarding industrial action ending which impacts bank and agency utilisation. • Exit interview completion rates are low, currently reviewing process to improve completion rates.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff	Laura Hilton	31.03.2025	
Embed an agile and flexible working culture within all WHH Teams – linked to WHH Culture Plan	As part of the WHH Culture Plan, 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	Carl Roberts	31.03.2025	

		• Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests			
Review of Exit Interview Process to Support Improvement of Completion Rates	As part of the Delve OD programme within the People Directorate there is a further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	31.12.2024	
Develop an approach to exert greater pay and discretionary spend controls.	In line with the work with PWC and the Trust Vacancy Control processes (ECF), develop similar approaches to ensure appropriate controls are in place relating to all pay spend, including: • Overtime • WLIs • Bank • Agency Substantive roles	• Complete a gap analysis to understand the current levels of pay control across all staff groups. • Using the gap analysis and working with the Staff Group leads, develop systems/processes to ensure appropriate pay controls are in place. • Where required, make recommendations for process/system improvements. • Establish a long-term approach to monitoring pay controls at a staff group and/or CBU level.	Gemma Leach	31/11/2024	

Appendix 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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.

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

<u>Financial and Operational Sustainability</u>
We aim to be a highly productive organisation that consistently delivers on all our constitutional performance standards whilst demonstrating public value for money with integrity and probity. We aim to continuously

improve and innovate in the best interests of our patients, staff and communities. We are therefore open to seek out risk through innovative approaches, subject to appropriate procedures and controls.

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/12/125**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	4th December 2024	
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

<table>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table></td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">The Trust has 76 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance.

Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>3 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality:
• 5.Healthcare Acquired Infections (CDI)
Access and Performance:
• 61. Uncapped Theatre Utilisation
Finance and Sustainability:
• 72. Better Payment Practice Code

These indicators have remained in the top category since In Month 5 2024/25 IPR.

In Month 6 the Trust was allocated deficit support funding of £16.458m therefore reducing the Trust deficit plan from £27.8m to £11.3m. At Month 7 the revised plan was an £11m deficit. The actual deficit was £12m with the overspend being due to a shortfall in funding in relation to Industrial Action (£0.7m) and the pay award (£0.3m).</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td colspan="2">Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to:</td></tr>
</table>

	1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 2. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	FSC/24/11/176
	Date of meeting	25/11/2024
	Summary of Outcome	Changes to the capital contingency supported and approved.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/24/12/125

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 76 Integrated Performance Dashboard (IPR) indicators have been placed into one of several “Assurance” categories and one of several “Variation” categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

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

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

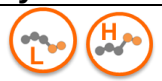
- Quality
- Access and Performance
- Workforce
- Finance and Sustainability

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

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

Table 1: KPIs by Assurance and Variation Categories

	 Special Variation of a Concerning Nature	 Common Cause Variation	 Special Variation of an Improving Nature	 No SPC/Not Enough Datapoints/NA
 **Consistently Fails the Target (based on the last 7 months)**	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) **(62 YTD - *61 annual threshold*)** **A&P** 61. Uncapped Theatre Utilisation **(79.8% - *80% target)*** **Finance & Sustainability** 72. Better Payment Practice Code **(86% - *95% target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 13. Medication Safety - Reconciliation within 24 hours 21. Friends and Family (ED and UCC) 22. Mixed Sex Accommodation Breaches (ITU Only) 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 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage 31. MUST nutritional assessment completion **A&P** 35. A&E Wait Times - % patients waiting under 4 hours 41. Ambulance Handovers within 15 minutes 42. Ambulance Handovers within 30 minutes 44. Discharge Summaries - % sent within 24hrs 62. Capped Theatre Utilisation	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **A&P** 32. Diagnostic Waiting Times 6 Weeks 33. Referral to treatment Open Pathways 34. RTT - Number of patients waiting 52+ weeks 36. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge ⬆ 43. Ambulance Handovers within 60 minutes ⬆ 76. A&E 4 hour wait (including WUTC) **Workforce** 63. Supporting Attendance 66. Bank and Agency Reliance 68. PDR	**CONSISTENTLY FAILING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **Finance & Sustainability** 71. Capital Programme ⬇	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 1.Incidents 6. Healthcare Acquired Infections (Ecoli) ⬇ 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 10. VTE Assessment 11. Inpatient Falls & harm levels 12. Pressure Ulcers 15. Staffing Care Hours per patient day (CHPPD) **A&P** 38. 28 Day Faster Cancer Diagnosis Standard ⬆ 47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** **A&P** 45. Discharge Summaries - Number NOT sent in 7 days **Finance** 74. Cost Improvement Programme (recurrent forecast) – In year performance to date ⬆	**INCONSISTENTLY PASSING TARGET & NO SPC**

		53. Elective Outpatient Activity ⬇ 55. Patients seen in the Fracture Clinic within 72 hours **Finance** 73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)		
Consistently Passes the Target (based on the last 7 months)	**CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
	A&P 46. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. ⬇	**Quality** 2. Duty of Candour (serious incidents) 3. Healthcare Acquired Infections (MRSA) 19. Complaints 20. Friends and Family (Inpatients & Day cases) 28. Acute Kidney Injury **A&P** 48. Urgent Operations Cancelled for 2nd Time	**Quality** 14. Staffing - Average Fill Rate 18. NICE Compliance **Workforce** 64. Retention 65. Turnover 67. Core/Mandatory Training **Finance** 75. Agency Ceiling	
No SPC/Not Enough Datapoints/Not Applicable	**NO ASSURANCE SPC & DECLINING PERFORMANCE**	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**
		Quality 4. Healthcare Acquired Infections (MSSA) 30. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 37. Average time in department ED 49. Super Stranded Patients 50. No Criteria to Reside (NCTR) 58. Reduction in Outpatient Follow Ups	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 16. Mortality ratio – HSMR 17. Mortality ratio - SHMI **A&P** 57. Type 5 attendances ⬆ 59. % Patients discharged to their usual place of residence 60. Virtual Appointments	**A&P** 39. Cancer 31 Days First Treatment 40. Cancer 62 Days First Treatment 51. Elective Recovery Activity (Grouped SPCs) 52. Elective Recovery Diagnostic Activity 56. % patients referred to long COVID service not assessed within 15 weeks **Finance** 69. Trust Financial Position (£m) 70. Cash Balance (£m)

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**

⬆ Improved category from previous IPR

⬇ Declined category from previous IPR

2.2 IPR Update

A breakdown of the current 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**.

2.3 Financial Update

The Income Statement for October 2024 is attached in **Appendix 5**.

At the beginning of the financial year Cheshire & Merseyside ICS set the Trust a control total of £27.8m deficit (including a £3m integration stretch target). In month 6 the Trust was allocated deficit support funding of £16.458m therefore reducing the Trust deficit plan from £27.8m to £11.3m. There are several risks to the achievement of the revised deficit plan of £11.3m. The key risks are as follows:

- CIP delivery including the £3m integration stretch target.
- Funding for the pay award – the Trust has been allocated funding associated with the pay award however this has left a shortfall compared to the total cost.
- Funding for industrial action – there is a shortfall in funding compared to the cost and loss of income from industrial action to date.
- Cost pressures – there was an overspend of £4.9m year to date at month 7 with a forecast overspend of £7.7m. The cost pressures in the year to date position have been mitigated, if the future cost pressures are not mitigated in the same way, then the Trust will have an overspend of £2.8m. An enhanced monitoring process is in place to mitigate these cost pressures where possible.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), activity delivered is under plan resulting in loss of income.
- Utilisation of additional capacity due to the levels of no criteria to reside patients.

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

Cash

The cash balance at the end of October is £23.1m, of which, £4.1m is related to capital creditors. The Trust has been allocated a share (£16.458m) of the £150m deficit support provided to the Cheshire and Merseyside ICS. £9.601m of this was received in October and £1.372m is expected to be received each month between

November and March. Funding of £10.4m has been allocated to the Trust (leaving the Trust with a shortfall/pressure of £x1.7m?) for the impact of the Agenda for Change and Medical pay awards of which £7.7m was received in October.

Given the planned deficit for 2024/25 the Trust is in receipt of cash support. A cash support request for September was submitted to NHSE for £5.228m, however only £4m was approved. Further cash support is not required in Q3 following receipt of the deficit support and pay award funding.

CIP

At 31 October 2024, the Trust has delivered a CIP of £7.8m against a target of £7.8m, therefore is on plan. It should be noted that the delivery year to date has been mainly achieved from central items and reduction in non-clinical posts. The full year CIP target is £19.4m which has been fully identified however there is £2.5m of high-risk schemes included in the plans. The current level of identified recurrent CIP is £18.3m.

Capital Programme

The Trust total capital funding consists of £7.63m CDEL (Capital Departmental Expenditure Limit) and £15.33m external funding, a total of £22.96m. The Trust also has £1.84m CDEL associated with lease expenditure (IFRS16).

The Trust year to date capital spend at month 7 is £5.62m which is £1.04m below the Trust plan of £6.66m.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 7		266
Proposed changes in month		
VAT Recovered		5
Contingency as at end of month 7		271

The Trust Board is asked to note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

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
- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the changes to capital contingency as supported and approved 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	Incidents	0	0	Oct-24		13	Sep-24	
2	Duty of Candour (serious incidents)	100.00%	100.00%	Oct-24		100.00%	Sep-24	
3	Healthcare Acquired Infections (MRSA)	0	0	Oct-24		0	Sep-24	
4	Healthcare Acquired Infections (MSSA)	No threshold set	6	Oct-24		3	Sep-24	No SPC
5	Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	6	Oct-24		7	Sep-24	
6	Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	11	Oct-24		15	Sep-24	
7	Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	2	Oct-24		3	Sep-24	
8	Healthcare Acquired Infections (PA)	Less than 2 - annual	1	Oct-24		2	Sep-24	
9	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Oct-24		1	Sep-24	No SPC
10	VTE Assessment	95.00% (quarterly position)	94.81%	Oct-24		95.14%	Sep-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

11	Inpatient Falls & harm levels	20% or more decrease from previous year	40	Oct-24		34	Sep-24	
12	Pressure Ulcers	10% reduction	14	Oct-24		9	Sep-24	
13	Medication Safety Reconciliation within 24 hours	80.00%	55.00%	Oct-24		38.00%	Sep-24	
14	Staffing - Average Fill Rate	90.00%	97.77%	Oct-24		90.43%	Sep-24	
15	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.9	Oct-24		7.9	Sep-24	
16	Mortality ratio - HSMR	No target set	88.86	Oct-24		88.86	Sep-24	No SPC
17	Mortality ratio - SHMI	No target set	94.96	Oct-24		94.96	Sep-24	No SPC
18	NICE Compliance	90.00%	94.11%	Oct-24		93.59%	Sep-24	
19	Complaints	Zero complaints open over 6 months old/in the backlog	0	Oct-24		0	Sep-24	
20	Friends and Family (Inpatients & Day cases)	95.00%	96.00%	Oct-24		96.00%	Sep-24	
21	Friends and Family (ED and UCC)	87.00%	73.00%	Oct-24		78.00%	Sep-24	
22	Mixed Sex Accommodation Breaches (ITU Only)	0	16	Oct-24		16	Sep-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

23	Sepsis - % screening for all emergency patients.	90.00%	56.00%	Oct-24		60.00%	Sep-24	F
24	Sepsis - % screening for all inpatients	90.00%	59.00%	Oct-24		64.00%	Sep-24	F
25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	62.00%	Oct-24		84.00%	Sep-24	F
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	73.00%	Oct-24		80.00%	Sep-24	F
27	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	10	Oct-24		13	Sep-24	F
28	Acute Kidney Injury	Less than previous month	157	Oct-24		145	Sep-24	P
29	Maternity Postpartum Haemorrhage	3.70%	4.50%	Oct-24		6.30%	Sep-24	F
30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	8%	Oct-24		23%	Sep-24	No SPC
31	MUST nutritional assessment completion	above > 85%	67.30%	Oct-24		72%	Sep-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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- 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**	
32	Diagnostic Waiting Times 6 Weeks	95.00%	82.72%	Sep-24	H	80.34%	Aug-24	F
33	Referral to treatment Open Pathways	92.00%	58.61%	Sep-24	H	57.84%	Aug-24	F
34	RTT - Number of patients waiting 52+ weeks	0	1535	Sep-24	L	1728	Aug-24	F
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	75%	64.37%	Sep-24		65%	Aug-24	F
76	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	75%	68.79%	Sep-24	H	69%	Aug-24	F
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	18.93%	Sep-24	L	18.2%	Aug-24	F
37	Average time in department ED	No Target	378	Sep-24		365	Aug-24	No SPC
38	28 Day Faster Cancer Diagnosis Standard	75%	68.00%	Aug-24		61.90%	Jul-24	?
39	Cancer 31 Day Wait	96%	100.00%	Aug-24	No SPC	96.90%	Jul-24	No SPC
40	Cancer 62 Day Wait	85%	75.10%	Aug-24	No SPC	77.70%	Jul-24	No SPC
41	Ambulance Handovers within 15 minutes	65%	39.66%	Sep-24		35.60%	Aug-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

42	Ambulance Handovers within 30 minutes	95%	74.34%	Sep-24		74.66%	Aug-24	F
43	Ambulance Handovers within 60 minutes	100%	89.87%	Sep-24	H	92.13%	Aug-24	F
44	Discharge Summaries - % sent within 24hrs	95%	92.04%	Sep-24		91.71%	Aug-24	F
45	Discharge Summaries - Number NOT sent within 7 days	0	0	Sep-24	L	0	Aug-24	?
46	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%	0.84%	Sep-24	H	0.16%	Aug-24	P
47	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	0	Sep-24		0	Aug-24	?
48	Urgent Operations Cancelled for 2nd Time	0	0	Sep-24		0	Aug-24	P
49	Super Stranded Patients	Trajectory	136	Sep-24		120	Aug-24	No SPC
50	No Criteria to Reside (NCTR)	No Target set	203	Sep-24		165	Aug-24	No SPC
51	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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- Inconsistently passes and fail the target*
- Consistently fails the target*

*based on the last 6 datapoints/months

52	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
53	Elective Outpatient Activity	104%	87%	Sep-24		91%	Aug-24	
55	Patients seen in the Fracture Clinic within 72 hours	95%	93.20%	Jul-24		96%	Jun-24	
56	% patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Sep-24	No SPC	0	Aug-24	No SPC
57	Type 5 attendances	No Target set	1276	Sep-24	H	1257	Aug-24	No SPC
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	87%	Sep-24		91%	Aug-24	No SPC
59	% Patients discharged to their usual place of residence	No Current Threshold	96%	Sep-24	H	97%	Aug-24	No SPC
60	Virtual Appointments	No Target set	19%	Sep-24	H	20%	Aug-24	No SPC
61	Uncapped Theatre Utilisation	85%	79.80%	Sep-24	L	79%	Aug-24	F
62	Capped Theatre Utilisation	85%	74.40%	Sep-24		75%	Aug-24	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
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
63	Supporting Attendance	4.20%	5.70%	Oct-24		5.71%	Sep-24	
64	Retention	85.00%	87.30%	Oct-24		86.95%	Sep-24	
65	Turnover	Below 13%	12%	Oct-24		12%	Sep-24	
66	Bank and Agency Reliance	9% or Below	14.10%	Oct-24		14.49%	Sep-24	
67	Core/Mandatory Training	85.00%	89.79%	Oct-24		89.65%	Sep-24	
68	PDR	85.00%	77.51%	Oct-24		77.38%	Sep-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- Special Cause Variation of a improving nature.
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- Consistently passes the target*
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- Consistently fails the target*

*based on the last 6 datapoints/months

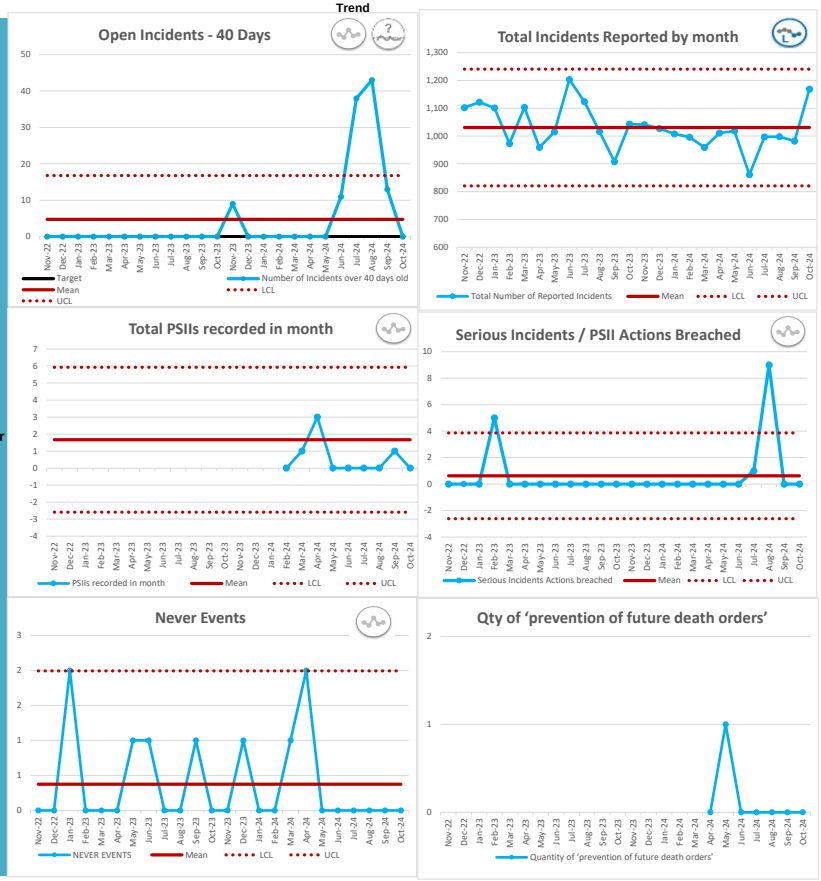
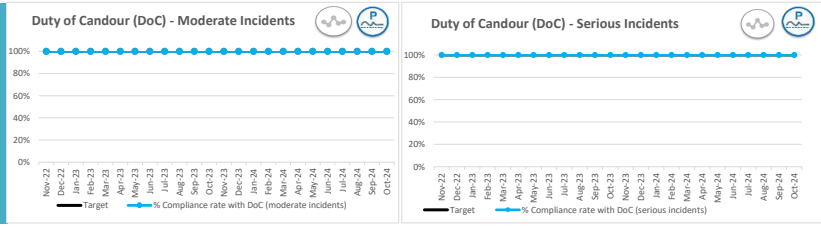
		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
69	Trust Financial Position (£m)	-£0.13	-£0.37	Oct-24	No SPC	5.76	Sep-24	No SPC
70	Cash Balance (£m)	£4.77	£23.15	Oct-24	No SPC	6.58	Sep-24	No SPC
71	Capital Programme (£m)	£8.14	£5.62	Oct-24	L	£4.22	Sep-24	?
72	Better Payment Practice Code	95%	88%	Oct-24	L	95%	Sep-24	F
73	Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£7.78	£7.78	Oct-24		5.83	Sep-24	?
74	Cost Improvement Programme (recurrent) – In year performance to date (£m)	£7.78	£6.00	Oct-24	H	5.83	Sep-24	?
75	Agency Ceiling	Less than 3.2%	0.7%	Oct-24	L	1%	Sep-24	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: System Oversight Framework; 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)?
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 inconsistently passes/fails the target.** **Variation: Special Cause variation of a concerning nature.**	**0 overdue 40-day incidents at the time of reporting. A spike in incidents was noted in month, no specific theme has been identified.** **0 PSIIs reported in October 2024 and 0 breached patient safety incident investigation actions at the time of report.**	**A weekly Governance Dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each Clinical Business Unit (CBU) is supported by a designated member of the Governance Team to ensure consistency.** **A daily report including overdue 30 and 40-day overdue incidents is sent daily to the Triumvirates for action.** **PSII's** **Weekly monitoring continues through the weekly Executive Led Safety Oversight Meeting with appropriate escalation to the CBU leads. An annual review of the Patient Safety Incident Review Framework is underway, and external evaluation is also taking place in December by MIAA in line with the Annual Audit Plan.**
2. Duty of Candour (serious incidents)	**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 in Duty of Candour, WHH continually achieves 100% compliance.**	**Weekly monitoring is undertaken to ensure that compliance continues to be sustained. Executive oversight continues through the weekly Executive Led Safety Oversight Meeting**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
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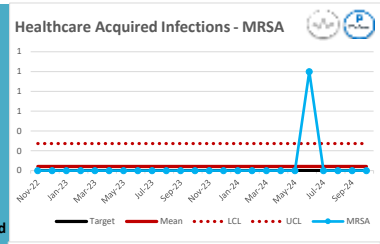
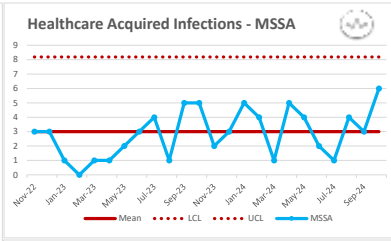
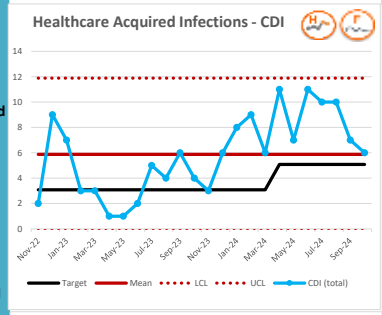
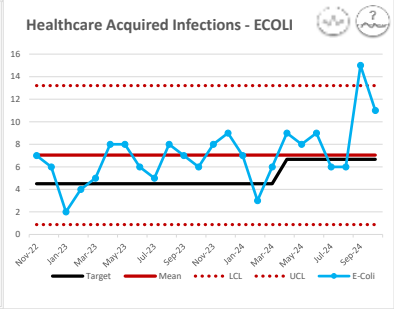
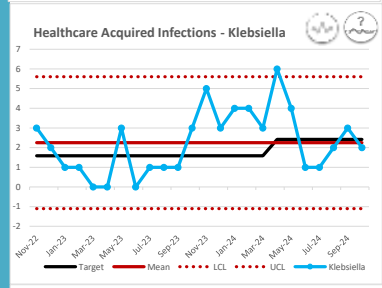
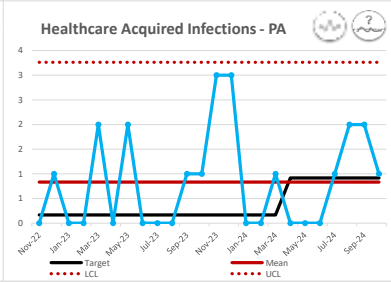
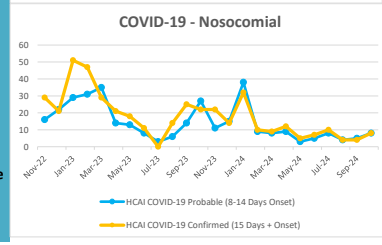
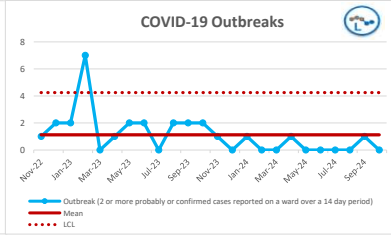
Quality Improvement - Trust Position

Appendix 2

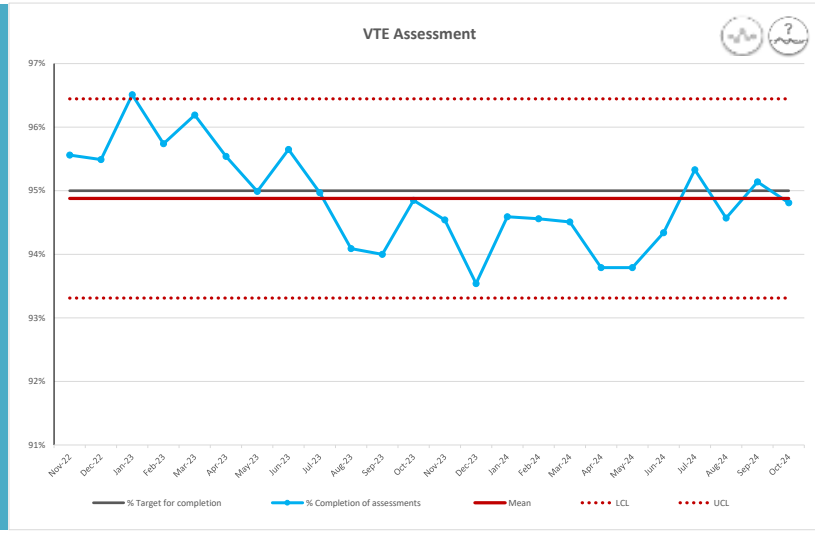
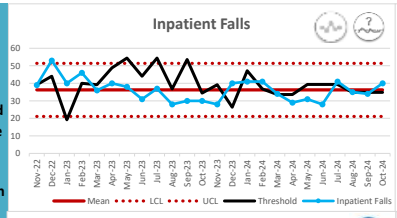
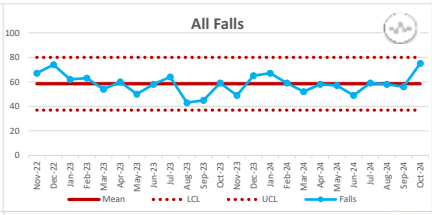
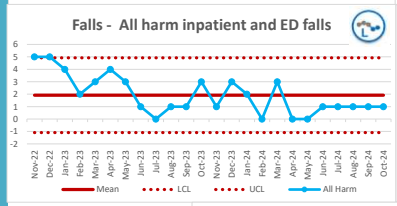
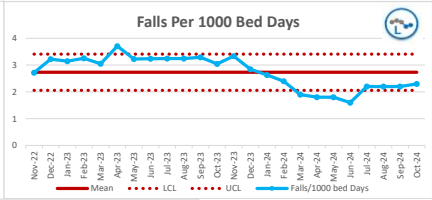
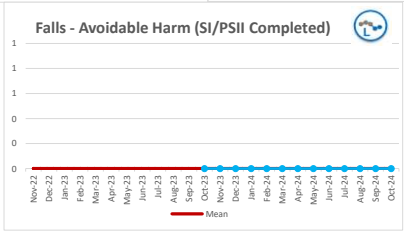
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO 4. Healthcare Acquired Infections (MSSA) Annual threshold: NA 5. Healthcare Acquired Infections (CDI) Annual threshold: 61 6. Healthcare Acquired Infections (Ecoli) Annual threshold: 80 7. Healthcare Acquired Infections (Klebsiella) Annual threshold: 29 8. Healthcare Acquired Infections (PA) Annual threshold: 11 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)	MRSA cases YTD - annual threshold exceeded by 1 MSSA 25 cases YTD - no threshold set CDI 62 cases YTD - annual threshold exceeded by 1 cases E. coli 64 cases YTD - annual threshold exceeded by 0 Klebsiella spp. 19 cases YTD - annual threshold exceeded by 0 P. aeruginosa 6 cases YTD - annual threshold exceeded by 0 0 in month COVID-19 outbreak. Covid-19: 8 day 8-14 cases probable healthcare associated cases in month. 8 day 15+ cases definite healthcare associated in month.	       	(MRSA) Assurance: The Trust inconsistently passes/fails the target. Variation: Variation: Common Cause (Normal) variation. (CDI) Assurance: The Trust consistently fails the target. (CDI) Variation: Special cause variation of a concerning nature. (ECOLI) Assurance: The Trust inconsistently passes/fails the target. (ECOLI) Variation: Variation: Common Cause (Normal) variation. (K) Assurance: The Trust consistently fails the target (K) Variation: Special cause variation of a concerning nature. (PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Common Cause (Normal) Assurance: N/A - No target. Variation: Special cause variation of an improving nature	Revised reporting rules in place since April 24 where decision to admit (instead of admission date) is used, resulting in additional HCAI cases being apportioned to acute Trusts. A rise in MSSA cases was noted in month. Regional/national increase in C. difficile cases. One ward outbreak of CDI, control measures implemented, outbreak has since been declared closed. Noted increase in MSSA cases nationally, NHSE are reviewing this. The outcome is awaited with no confirmed date for this from NHSE presently. NHSE set thresholds have been published and increased across all mandatory reportable HCAIs, with the exception of MRSA bacteraemia which remains at zero tolerance to avoidable cases.	MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revised audit schedule to provide assurance on compliance with care of invasive devices. Revised patient safety investigation template to align with PSIRF. CDI: CDI Prevention Action Plan in place. Brilliant Basics Action Plan remains on track. Communication strategy implemented which includes education across all staff groups. Deep dive of 2023/24 cases and thematic analysis completed, no new learning identified. Senior Nursing Leadership Team IPC visits and spot checks continue along with Efficacy MDT audits from October 24. Swarm Huddles commenced for all hospital onset healthcare associated cases. ECOLI: Klebsiella: Pseudomonas aeruginosa. In December plan to present at the system collaborative for IPC with the ICB Place Team the outputs from the Urinary Catheter prevalence survey undertaken in July 24 with associated actions. Revision and relaunch of the Gram Negative Blood Stream Infection (GNBSI) Prevention Group, medical staff membership from both planned and unplanned care has been requested. A high focus has been placed in Antimicrobial Stewardship, including a review of the national Action plan in December 2024. A decrease in Intra Venous to Oral Switch (IOOS) CQUIN has been noted to 42% (lower percentage indicated better performance), results shared with the clinical leads and actions agreed including training on use of the IVOS Tool for FY1 (10/10/24). World Antibiotic Awareness Week Campaign took place 18 - 24 November.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
Care Quality Commission

Quality Improvement - Trust Position

Appendix 2

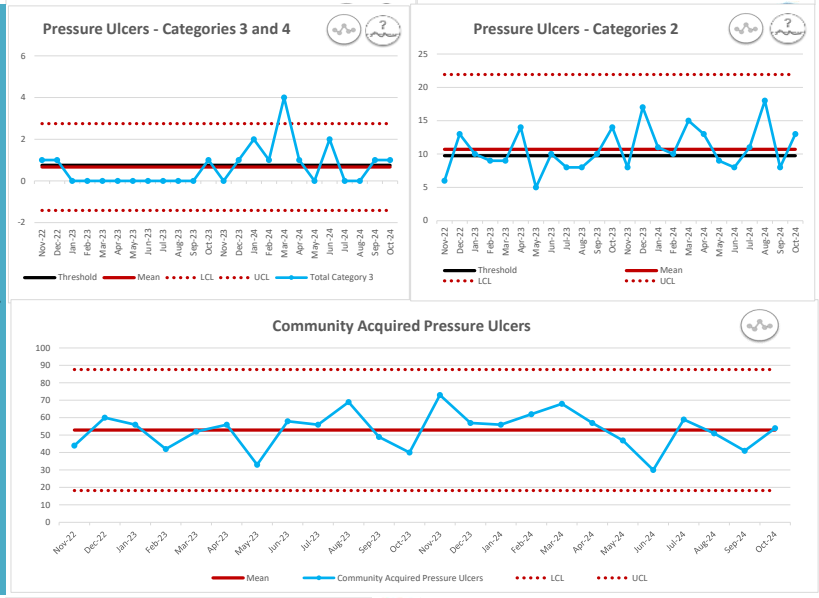
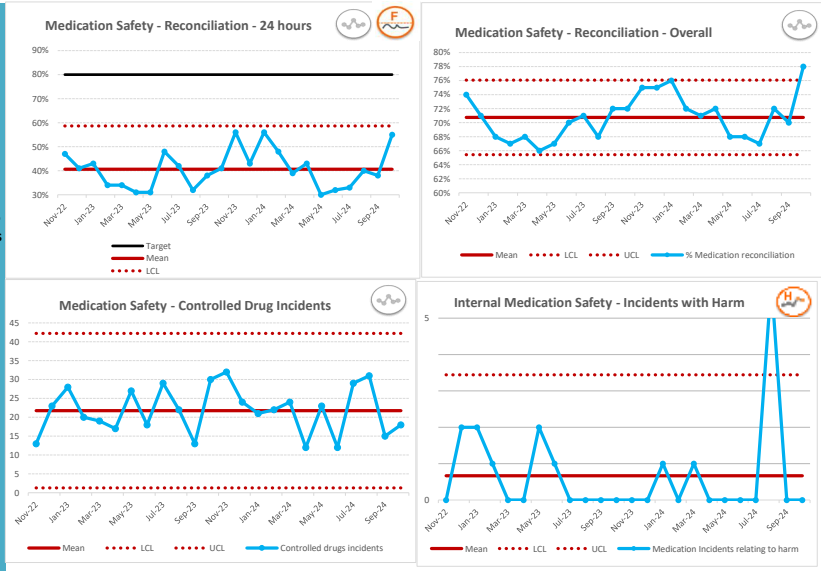
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment Target: 95% (quarterly position)	The Trust did not achieve the required target at 94.81% for VTE assessments in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	VTE risk assessment (RA) performance target in October 2024 was just below the mandatory threshold at 94.81 %. this is within normal variance.	Actions already taken to improve VTE RA compliance: Non-completion of VTE risk assessments data is displayed on the In-patients Ward Productivity Dashboards, these are projected on ward level e-whiteboards to encourage the completion of outstanding risk assessments in real time. Data on this dashboard can be drilled down at the ward level daily for identification of individual patients by clinicians to improve overall compliance. Further improvement actions for VTE RA compliance: VTE Risk Assessments Dashboard is now live on LION Dashboard monthly CBU Governance Meetings since October 2024. On the performance dashboard close monitoring of top ward 5 wards for non-compliance is also in place to highlight additional support required to drive improvements in performance. VTE Risk Assessments - Thrombosis Group monitors data trends seeks feedback from CBU's on progress against their Improvement Plans.
11. Inpatient Falls & harm levels Target: decrease from 23/24 (418 Inpatient Falls in 2023/24)	75 total falls were reported in month. 40 of these were inpatient falls. There was 1 fall(s) in month with harm. There were 671 total falls in 2023/24. There have been 412 total falls YTD in 2024/25. We are expecting a 5% increase in falls from last year. There were 418 inpatient falls in 2023/24. There have been 238 inpatient falls YTD in 2024/25. We are expecting a 2% increase in falls from last year.	    	Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	During October 2024 there were a total of 40 inpatients falls which remains within expected variation. There was 1 fall causing moderate harm resulting in a fractured humerus. This fall was deemed as unavoidable at Harm Free Care Meeting. WHH has seen sustained improvement in the number of falls per 1000 bed days since November 2023.	Use of an enhanced care presentation/video within healthcare assistant induction is proving effective. The video demonstrates good and poor practice examples of providing enhanced care (this has also been shared with all inpatient areas). Falls Policy update to be completed and ratified in Q3 following which the bedside eyesight vision check will be launched Trust wide. There is a plan to increase awareness of environmental hazards relating to falls throughout Quarter 4, these events will be open to all staff and learners.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
Care Quality Commission

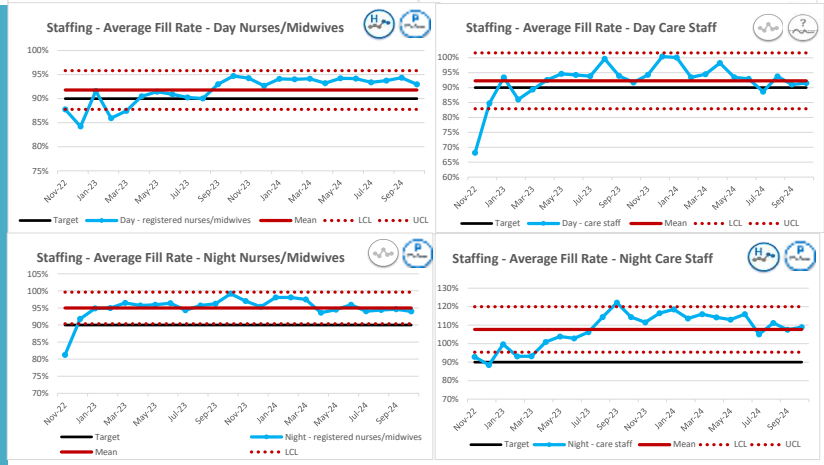
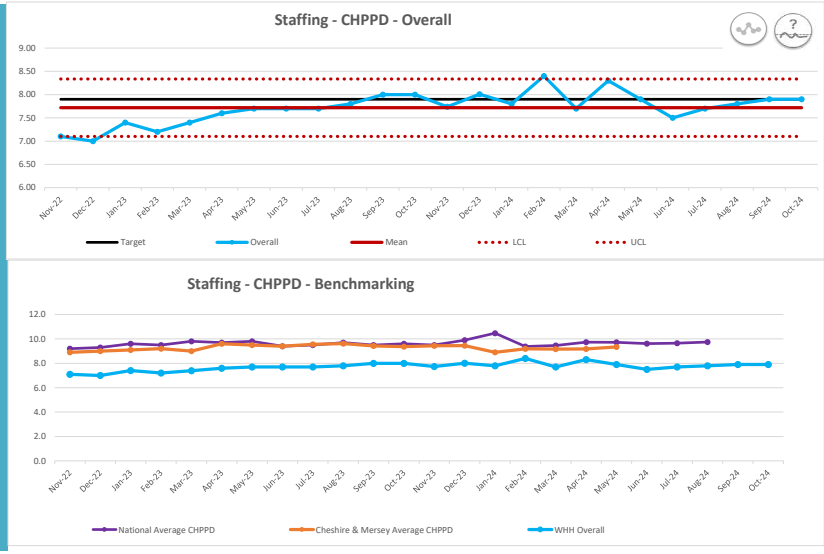
Quality Improvement - Trust Position

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)?
12. Pressure Ulcers (Category 2 and above) Target: 10% reduction based on 2023/24	There were 13 hospital acquired category 2 pressure ulcers, 1 Category 3 pressure ulcers and 0 Category 4 ulcers in month. There were 54 community aquired pressure ulcers in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	In October 2024, there were 12 category 2 pressure ulcers: These pressure ulcers were reported across a wide variety of wards. No Ward was highlighted as an area of specific concern in October. The frailty of patients was highlighted as a factor in a number of cases. There was one category 3 pressure ulcer in October 2024, There were no gaps in care identified within this case.	Actions to improve the position include: 1. After Action Reviews are taking place and lessons are shared with ward teams and via Operational Patient Safety Group. 2. TED stocking provider has been changed- no further incidents have been reported relating to TED stockings since mid-October. 3. High focus on nutrition being raised at the After-Action Review Meetings with the Deputy Chief Nurse/Director of Governance. 4. A new body map template has been launched. 5. The intentional Rounding Template is being revised following learning from After Action Reviews – this will be launched in December. 6. During November the Tissue Viablilty Team have been raising the importance of timely and appropraote use of Pressure relieving equipment in line with patient needs with Ward Teams across the Trust.
13. Medication Safety Reconciliation within 24 hours Target: 80%	Medicines reconciliation was completed within 24 hours of admission for 55% of patients. 78% of patients had MR completed during inpatient stay. There were 18 controlled drug incidents. There was 0 medication harm incident reported in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Improvement noted in both 24-hour reconciliation and overall medicine reconciliation. This is linked to successful pharmacy recruitment and reprioritisation of workloads. Controlled drug incidents: there is no target for this metric. Lower numbers were reported in September and October, this remains within expected variance. There is no single theme identified. Incidents causing harm: there is no target for this metric. No incidents with harm have been reported in September and October 2024.	Ongoing training of new Pharmacists continues, with two new Pharmasists are due to start in December 2024. Medicines Reconciliation (MR) Improvement Action Plan in place, overseen at Pharmacy Specialty Governance Meeting. Work is progressing to identify methods to capture medicines reconciliations completed by Midwives that is documented within Badgernet. A review is underway of all patients with LOS >72 hours who do not receive MR to identify lessons learned and enable improvement actions to be developed. Medication/controlled drug incidents: all incidents are reviewed by a Multiprofessional Group and lessons learned are disseminated. Themes are identified and action plans developed through the medicine's governance structure.

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)?
14. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 92.97% Day (Care Staff) 91.52% Night (Nurses/Midwife) 93.98% Night (Care Staff) 108.95%		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Additional beds in use across the Trust due to increased demand in AED, in addition to acuity and a large number of super stranded patients and escalated beds open.	Staffing is reviewed twice daily by the Senior Nursing Team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse. The current percentage vacancy for October 2024 for registered staff is 10.64% against a Trust target of 9%. This is mainly due to the Emergency Departments registered vacancy of 39 WTE following an increased establishment, recruitment is ongoing. A Trust Careers Event took place on the 16 October 2024 with 28 attendees who were signposted to apply for positions who are now progressing through recruitment processes. The current percentage vacancy for October 2024 for unregistered staff is 11.35% against a Trust target of 9%. A Health Care Support Worker (HCSW) event took place in Novemebr with circa 40 attendees who have been signposted to positions in the Trust. Cohort 42 of 12 NHSP CSWD staff commenced their ward placements in November 2024.
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: 3.5 hours Overall: 7.9 hours		Assurance: The Trust inconsistently passes/fails the target. Variation: Common cause variation.	The CHPPD for October 2024 has increased to 7.9 from 7.8 in September 2024 which is in line with the national target of 7.9.	Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety and work is ongoing to reduce agency usage, recruit to posts and migrate regular agency workers to NHSP. There are clear processes for escalation to ensure staffing is based upon acuity to ensure patient safety.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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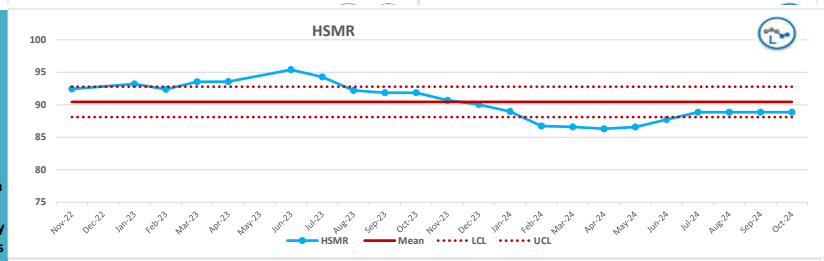
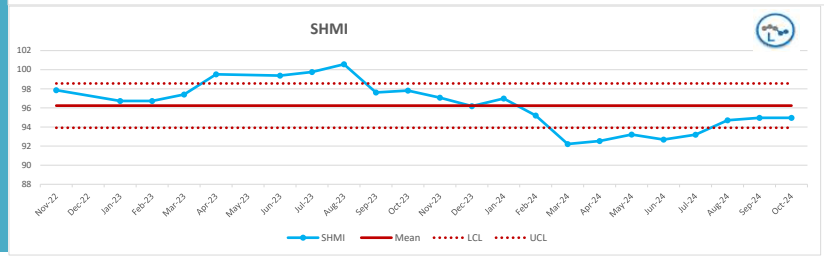
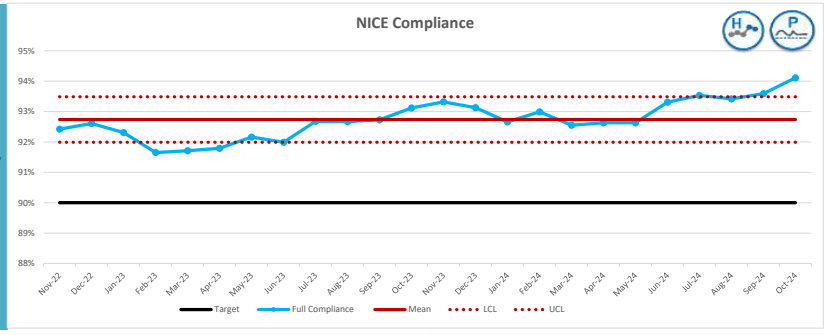
Quality Improvement - Trust Position

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)?
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 88.86. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 94.96.	 	(HSMR) Assurance: NA - no target Variation: Special Cause Variation of an improving nature. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of an improving nature.	WHH has a SHMI value of 94.96. This result is within expected levels. The 12-month rolling SHMI for WHH has consistently been lower than the average of other Acute Trusts. WHH has a HSMR value of 88.86 based on data spanning the 12 months leading up to and including May 2024. The 12 month rolling HSMR for Warrington remains lower than the rolling values of other Acute Trusts on average since December 2020.	There are a high number of records which still have a 'signs and symptoms' diagnosis in the most recent month, which is impacting the selection of cases to be included in Standard 56 CCS group HSMR. For this report we have 'rolled back' the HSMR analysis and look at the 12-month period up to and including May 2024 instead, which gives an HSMR value of 88.86 for Warrington. This result is a low value outlier based on the 95% Poisson method. Our Clinical Coding Quality improvement Manager has completed a coding review for the Acute Cerebral Vascular Disease Variable Life Adjusted Displays (CVD VLAD) alerts and as a result, stroke related deaths are being monitored and a focussed review will be undertaken in November.
18. NICE Compliance Target: 90%	The Trust achieved 94.11% 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 with month on month improvement since August 2024. WHH has exceeded the target of 90 % since June 2024.	We currently have 632 pieces of NICE guidance where a total of 540 are reported as fully compliant. 35 are agreed as partially compliant. 21 are for information only. 2 are currently under review. The Clinical Business Units' (CBU) are asked to review the partial compliant guidance. Once relevant actions have been completed the guidance is re-reviewed to determine the new compliance against the relevant guidance. As a Trust we have consistently remained above the 90% compliance target. Nice compliance is overseen at the Patient Safety and Clinical effectiveness Committee.

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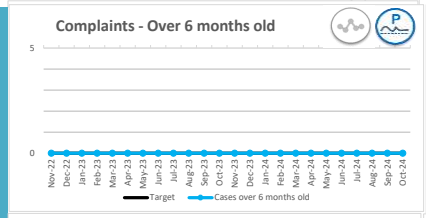
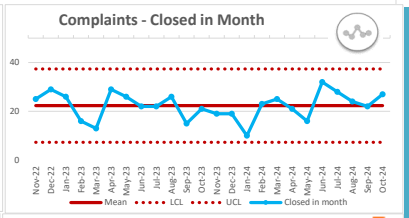
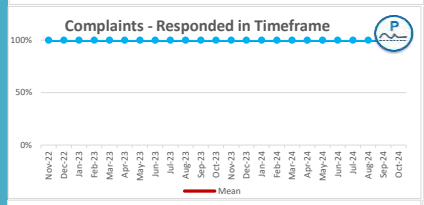
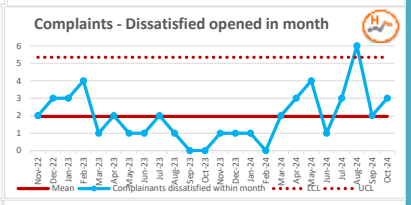
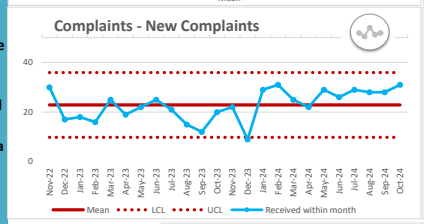
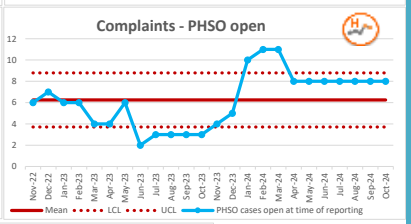
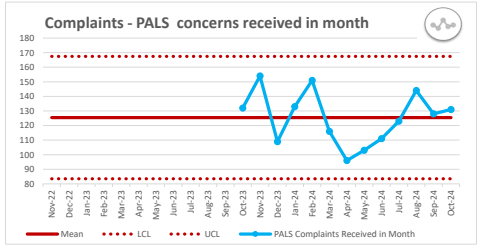
19. Complaints

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

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
In month, 31 new complaints were received to the Trust which was an increase of 3 from the previous month. There were 3 dissatisfied complaints received in month, which is an increase from the previous month. 8 PHSO cases were opened in September, these were not linked to a specific area or theme.	      	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	WHH continues to sustain performance in the timely completion of complaints. At the time of reporting, there are no complaints over 6 months old.	Complaints position of 82 open complaints at the time of reporting. All complaints continue to be closely monitored to ensure that a timely quality response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the Clinical Teams, as well as follow up meetings upon receipt of the initial response letter. The Team continues to consistently work to improve response times and often are able to provide letters of response prior to the due date. The Team has successfully recruited to 2 vacant posts of Complaints Resolution and PALS Officers. The newly appointed staff members are now in post. The response template has been updated to offer further contact with the Team following receipt of the first response letter. This enables complainants to meet with teams to discuss the response further in a bid to reduce the number of dissatisfied families.

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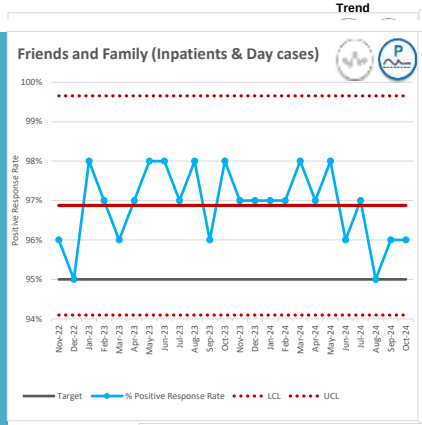
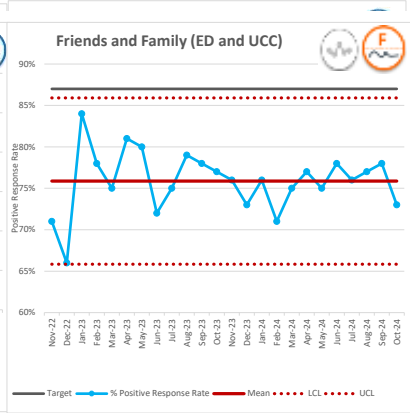
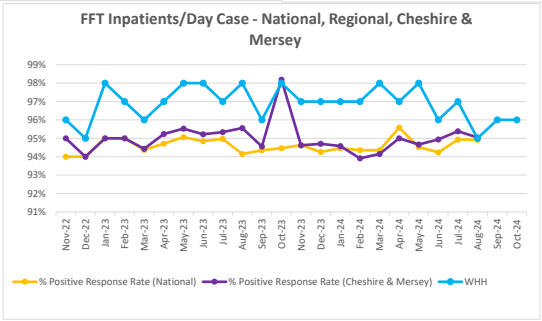
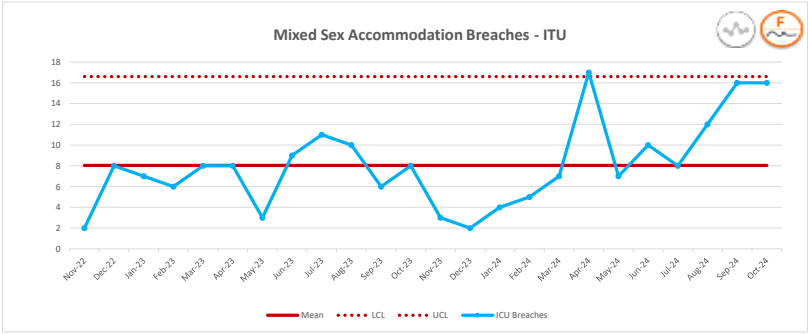
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) Target: 95% 21. Friends and Family (ED and UCC) Target: 87%	The Trust achieved 96% in month for Inpatient & Day case FFT and 73% for ED/UCC FFT.	  	(IP/DC) Assurance: The Trust consistently passes the target. (IP/DC) Variation: Common Cause (Normal) variation. (ED/UCC) Assurance: The Trust consistently fails the target. (ED/UCC) Variation: Special Cause variation of an improving nature.	Inpatient/Day Case - The Trust achieved a 96% positive recommendation rate in October 2024. ED/UCC - The Trust achieved 73% positive feedback in Friends and Family Test results in October 2024. This remains in line with peers.	All areas Monitoring of themes, through dashboard and freetext comments to identify areas for improvement, share best practice at Patient Experience and Inclusion Sub-Committee (PEISC). Trust Board, Governors, PLACE and Patient Experience Team observations directly fed back to wards/departments. Action plans are initiated and monitored through PEISC. Patient Experience Volunteers being recruited to increase the opportunities for patients to provide feedback. ED/UCC specific Key themes reviewed this has highlighted improvement areas such as communication, waiting times and the environment. Actions for improvement include Improved Visual communications to be prominent in areas. A charity bid submitted awaiting approval to procure a digital information TV screen with USB to promote patient Accessible Information Standards, key information, service details and promote FFT to our patients in ED Peadiatric ED, Outpatients and SDEC. Mapping patient journeys to understand the support required at each touch point. Volunteers are assisting with drinks rounds; other volunteer roles are being recruited to provide a wider range of support for patients who are waiting. The Urgent Emergency Care Service Improvement Project has commenced for 2024-2025, this is moniored via the Unplanned Care
22. Mixed Sex Accommodation Breaches (ITU Only) Target: Zero	There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There were 16 MSA incident(s) within the ITU.		Assurance: The Trust consistently fails the target. Variation: Variation: Special Cause variation of a concerning nature.	There were 16 mixed sex breaches in October 2024, this remains the same from September 24 . These were all within the Intensive Care Unit. Any delays in discharges are escalated to patient flow Team and the Tactical Manager of the day. They are also discussed at each bed meeting throughout the day. There were 0 breaches within any other ward areas.	Work continues within the Care Group and Patient Flow Team to ensure prioritisation is given to the Intensive Treatment Unit to step down level 1 patients to the appropriate areas. As there are a high number of super stranded patients within the Trust this is a contributory factor. The Trust policy relating to Mixed Sex accommodation breaches is currently under review expecting to be ratified by the end of Quarter 3.

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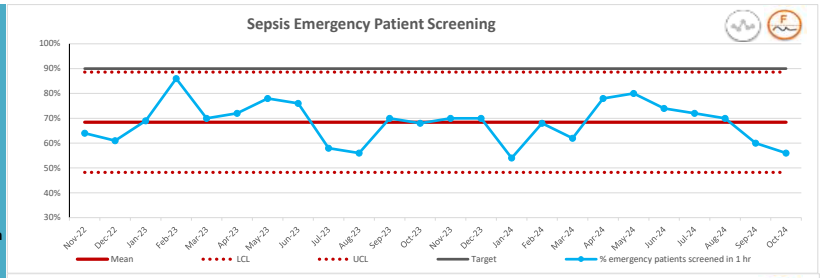
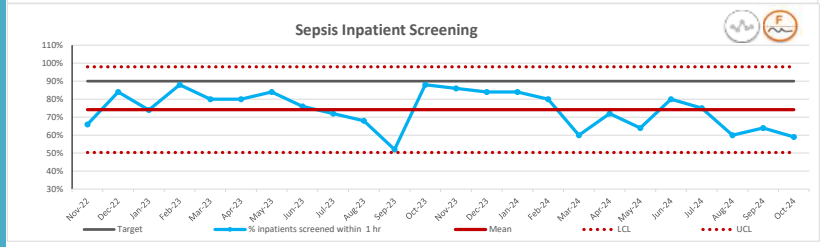
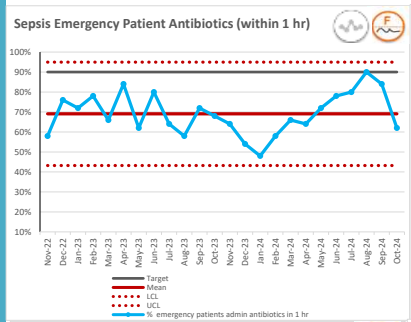
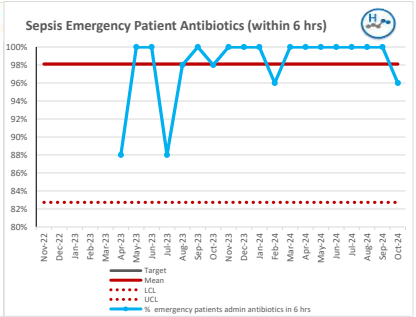
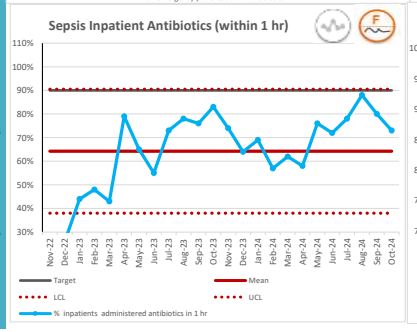
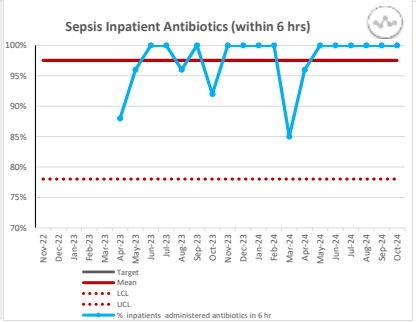
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%** **24. Sepsis - % screening for all inpatients** **Target: 90%** **The Trust achieved:** • **56% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** • **59% 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.**	**ED: 15 patients did not have all elements of screening completed in October 2024. Overcrowding and corridor care has remained consistent during October 2024.** **As the clinical undertaking of the screening are specific tasks undertaken separately due to the ANTT guidance for each intervention, this leads to challenges for clinicians to complete all elements of the screen in a timely manner when patients are moved throughout the department.**	**This month's sepsis compliance was captured using the new NG51 Guidelines, which considers a patients NEWS2 score to identify a level of risk as a moderate or high risk as opposed to the previous trigger of Red and Amber Flags.** **Sepsis management remains a focus on Safety Huddles and during the Trust Wide Safety Brief. The new NG51 Sepsis mandatory E-learning module is now live on ESR for all clinical staff to complete.** **On 17 November 2024 training sessions were delivered by a Midwife on MEWS. This was initially for ED staff to use when completing observations on pregnant and post-partum women in line with the new Sepsis guidance, with the objective to roll out to staff Trust wide in Quarter 4.** **Additional Blood Culture Training sessions have been launched; this will also raise the awareness for the need for complete screening.**
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:** • **62% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** • **96% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** • **73% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.** • **100% 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) cause variation.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**In ED there has been a 6% decrease in patients receiving their antibiotics within the 1-hour timeframe. This aligns with the increased pressures noted in the ED performance targets.** **For inpatients there has been a 7% reduction in patients receiving their antibiotics within the hour. For inpatients a theme to the delay was a prescribing delay.** **All inpatients included in the audit received their antibiotics within 6 hours.**	**The new Sepsis Tool with the high and moderate risk which has now replaced red and amber flags can now be found in the ED packs ready for use on a suspected sepsis patient.** **For inpatients: Reinformcment of use of the new Sepsis bundle will continue to be raised among cilinicians following the bundles launch on lorenzo in October 2024.** **Services have been encouraged to launch the Sepsis bundle on suspicion of Sepsis to support timely decision making. The new e-learning package has been promoted for completion. Compliance is being monitored via the Sepsis Improvement Group.**

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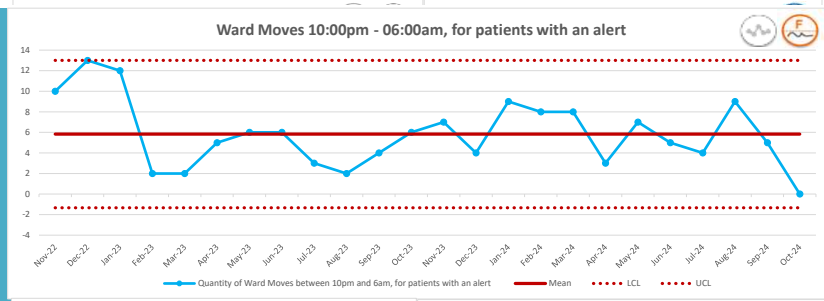
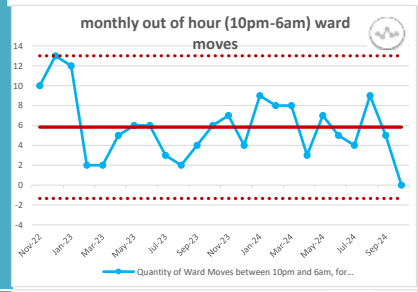
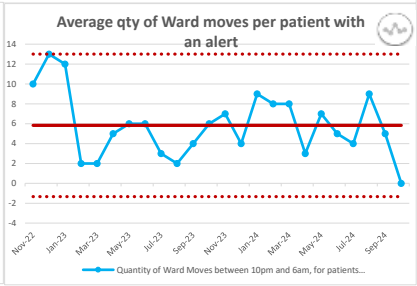
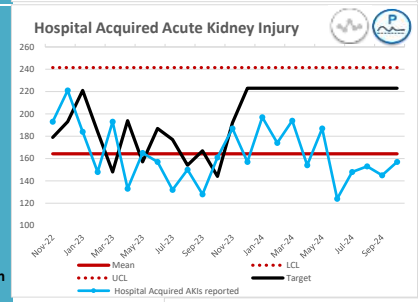
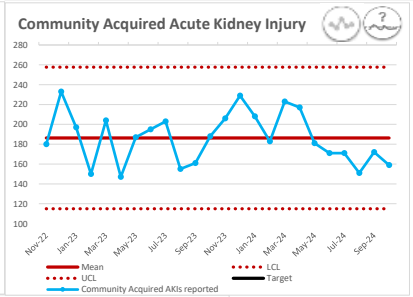
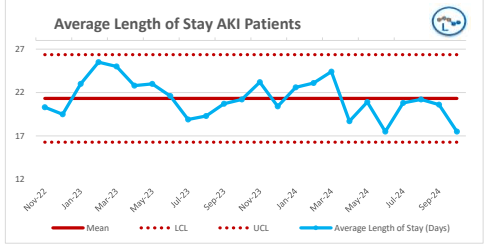
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am with a dementia, LD and/or Mental Health alert **No Target**	**There were a total of 0 ward moves in month between 10pm-6am for patients with an alert, compared to 6 in June 2023.**	  	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and Tactical Manager on call minimising non essential clinical patient moves.**	**The Tactical 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 month in previous year**	**There were 157 acute kidney injuries reported in month compared to 145 last month.**	  	**Assurance: The Trust Consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**No Variation with LOS and HA-AKI with both being below the mean and HA-AKI below target.**	**Focus on appropriate and accurate fluid balance completion across WHH, this will not just impact AKI but support the recognition of the deteriorating patient. Trust wide Fluid Balance Audit actions have been agreed including amendments to the AKI E-learning package to strengthen fluid balance guidance. Changes to fluid balance guideline to more clearly define roles and responsibilities. Increasing simulation activities related to fluid balance recording are now being used in HCA induction.** **Ward based further AKI education is ongoing.** **Drive to increase the AKI Bundle compliance is ongoing to improve practice.** **AKI Clinics in place each week to reduce the 30-day readmission rate.**

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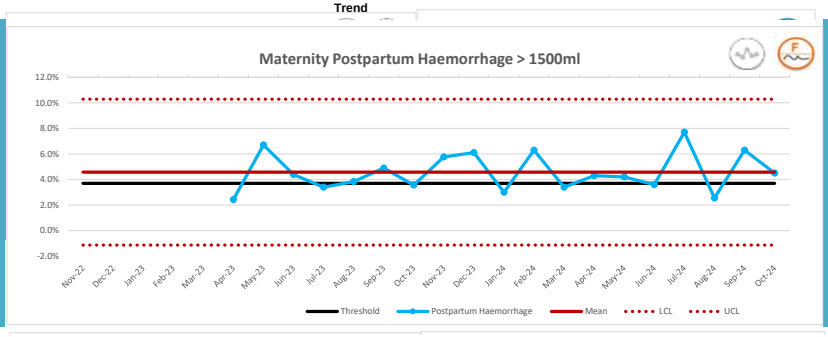
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 4.5% Postpartum Haemorrhages >1500ml in month.**		**N/A - Not enough datapoints.**	**Rates for pph >1500ML continue to fluctuate. QI work is ongoing. The benchmark is based on historical regional data. The service has recently received comparator data (position 3 months to April 2024) from the Cheshire & Mersey (C&M) LMNS which notes a WHH rate of 49.2 cases per 1000 births. The average for C&M is 34.4/1000 births.**	**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 meets regularly to review patterns and themes from incidents of PPH >1500ml.** **In addition a PPH QI Group has been established. This QI Group is leading on the improvements identified as part of the previous audit. The PPH Action Plan is reported monthly to QAC alongside an SPC chart from June 2024. No trend identified to date.** **WHH are collaborating with other providers to ensure the service is engaged in wide improvement work being implemented across C&M and the region.**

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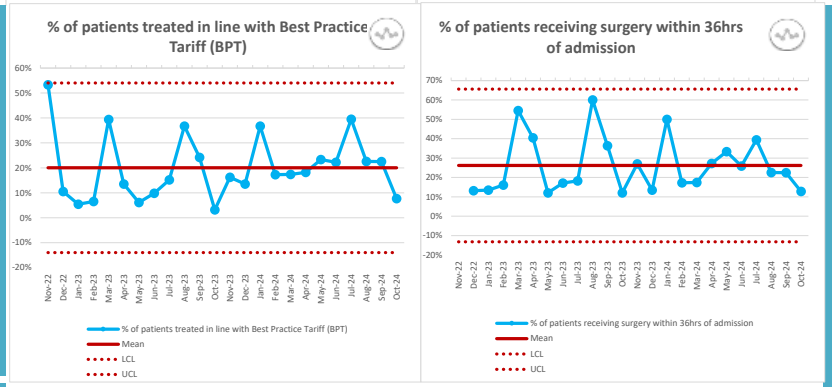
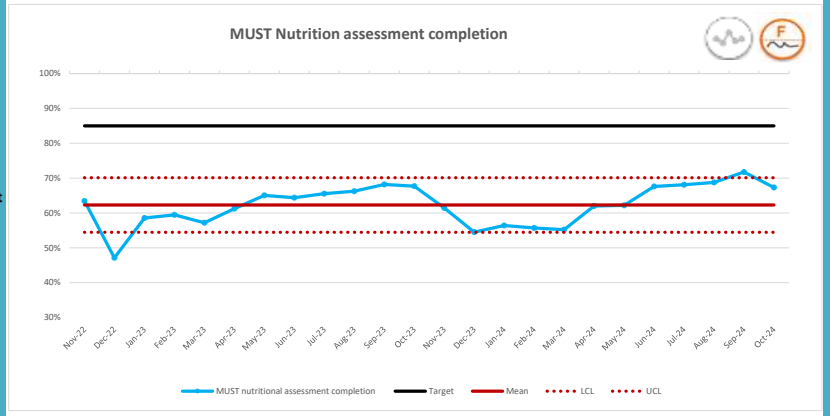
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
30. Fractured Neck of Femur Target: Best Practice Tariff	22.5% of patients were treated in line with Best Practice Tariff (BPT) in Sep-24.		Variation: Common Cause (Normal) variation.	In October, WHH noted a decrease in patients being admitted directly from A&E to Ward A6 and are working with our colleagues in A&E to develop a pathway for hip fracture patients. The aim of this is to improve direct admissions to the Orthopaedic Ward.	In October, a decrease in Best Practice Tariff performance was noted. Themes included challenges with physio assessments within 24 hours and pre-op delirium assessment which was introduced from October 2024. The Pre-Operative assessment documentation has not been added to the Clerking document on Lorenzo. Improvement actions are monitored via the Fragile Services Report to Patient Safety and Clinical Effectiveness Sub Committee.
31. MUST nutritional assessment completion Target: above 85%	MUST Nutrition assessment completion was 67.3% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	A slight reduction was noted in October. Generally since March 24 MUST compliance has continued to improve due to the work ongoing. There has been issues noted with the way the data is recorded on the dashboard that has been addressed to provide greater assurance around compliance with MUST scores.	Work is being completed towards improving the clinical indicators function on Lorenzo to enable teams to see compliance more clearly. A gap in training has been identified in EAU resulting in low compliance. This is creating a secondary impact on ward performance. Training has commenced and will conclude in December. Nutrition status and MUST assessments are being included in other harm profile reviews such as Pressure Ulcers After Action Reviews and compliance meetings with the Deputy Chief Nurse/Director of Governance to raise awareness of links and to promote improvements.

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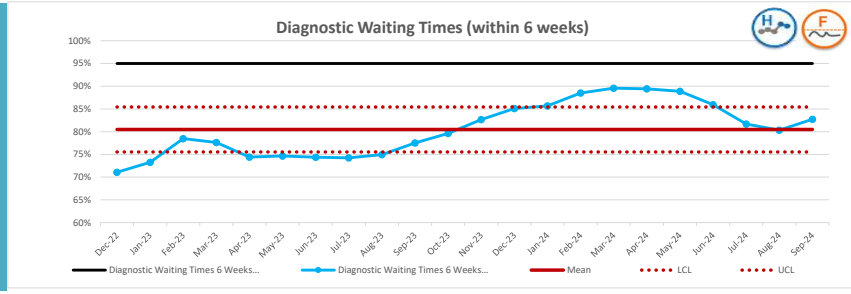
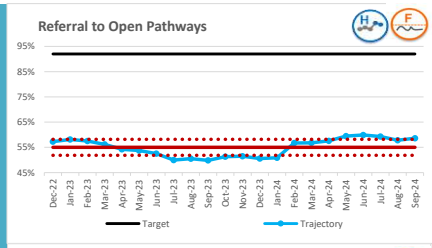
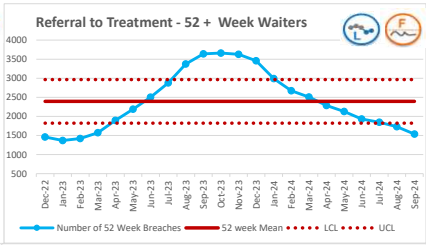
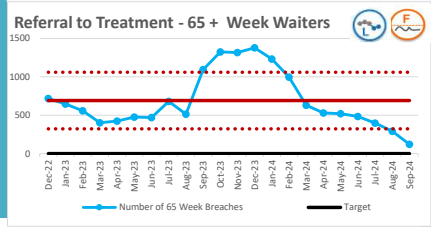
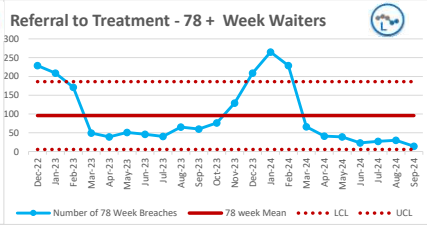
Access & Performance - Trust Position

	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)?
32. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 82.72% in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.	A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although radiological modalities remain fully recovered, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies and Endoscopy, Endoscopy is improving with the opening of the hub.
33. Referral to treatment Open Pathways Target: 92%	The Trust achieved 58.61% in month. There were 1535, 52 week breaches, 14, 78 week breaches and 121, 65 week breaches.	   	(Open Pathways) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature. (52+) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	RTT performance - 52 weeks is slightly behind trajectory, mainly in planned care. 65 weeks has a small residual number of patients remaining with 90 submitted for October with 9 capacity breaches, the remainder of the patients were choice or complex	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. • Restoration and recovery plans for 2024/25 have been drawn up in line with current Operational Planning Guidance. • Commencement of the TIF elective project has necessitated the closure of theatres 1 and 2 at Nightingale, Halton, sessions have been redistributed across both sites, once works have completed this will give an additional theatre at Halton Nightingale
34. RTT - Number of patients waiting 52+ weeks Target: 0					

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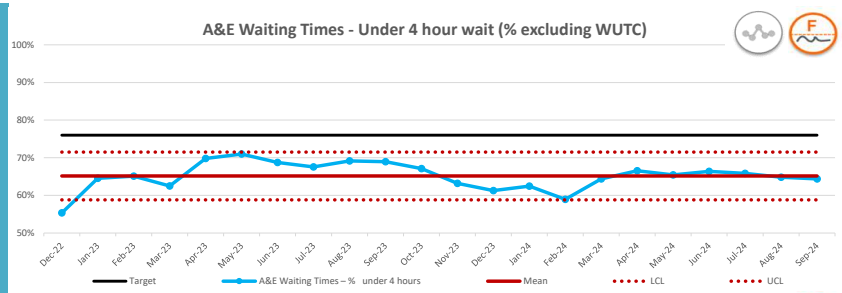
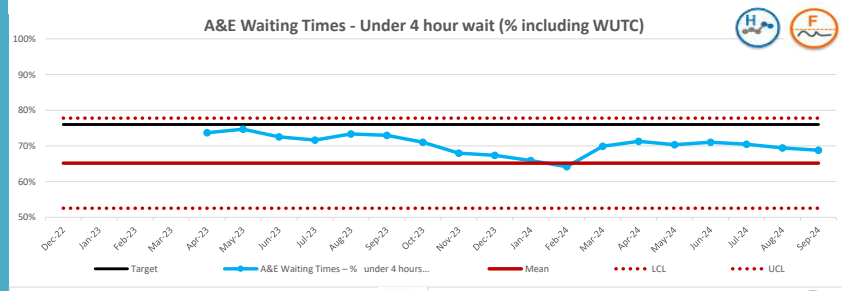
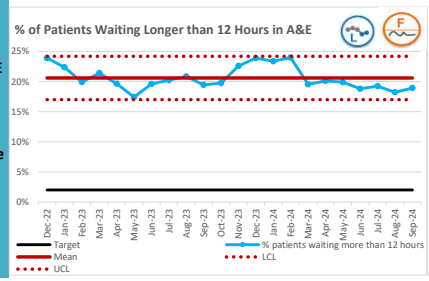
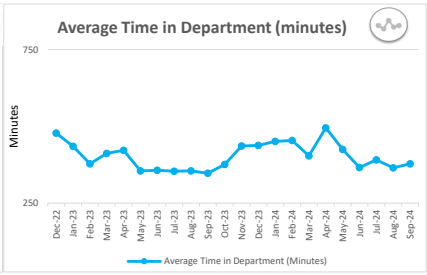
Access & Performance - Trust Position

	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)?
35.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC)	The Trust achieved 64.37% excluding Widnes UTC in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • System resource investment in order to support Pathway 1 discharges. • A10 escalation beds closed on 7th June taking out 14 beds which negatively impacts on ED performance. It has opened as planned on 3rd Nov which will support Novembers position
76.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.					
76.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC)	The Trust achieved 68.79% excluding Widnes UTC in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.		
36. Average time in department ED No Target	18.93% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 378 minutes.	 	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in 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 24/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 24/25 is set up to support improvement.

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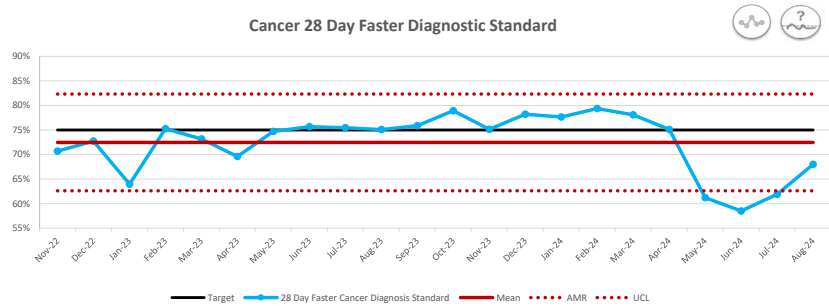
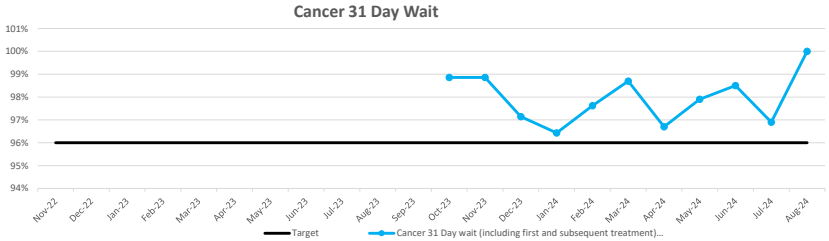
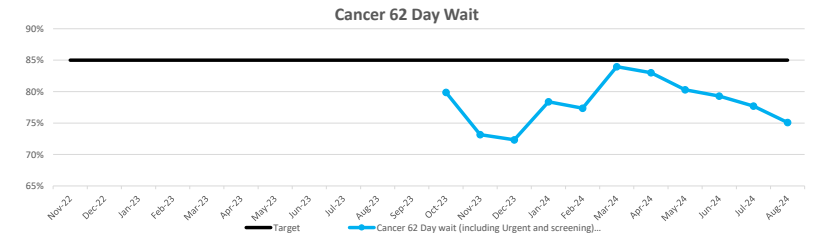
38. 28 Day Faster Cancer Diagnosis Standard Target: 75%	The Trust achieved 68% in month.		Assurance: Target failed for the past 3 months due to breast first appointment capacity. Capacity recovered in July. FDS recovering for Aug/Sept Variation: Common Cause (Normal) variation.	The Trust is currently not meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology and Breast that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG). A recovery trajectory has been developed to monitor recovery.
39. Cancer 31 Day wait Target: 96%	The Trust achieved 100% in month for Cancer 31 Day Wait.		Assurance: Target met consistently Variation: NA - not enough data	The Trust achieved the 31 day target.	
40. Cancer 62 Day wait Target: 85%	The Trust achieved 75.1% in month for Cancer 62 Day Wait.		Assurance: NA - Commitment to achieveing 70% by March 25 required nationally. This is currently being met Variation: NA - not enough data	The 62-day referral to treatment target remains challenging but is seeing some improvement due to the combined standards. From the 1st October 2023 this standard was combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 70% by March 2025. The Trust is currently achieving this.	Septembers position has improved to 72.5% and the Trust is anticipating a continuation of that improvement

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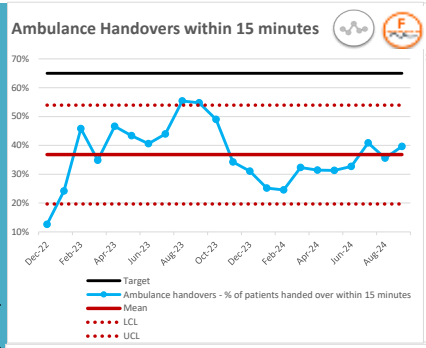
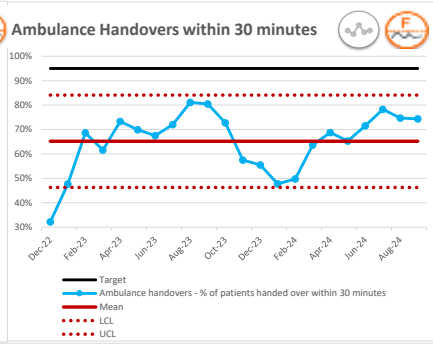
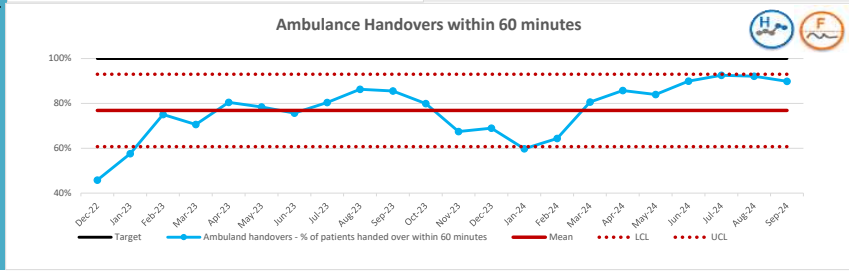
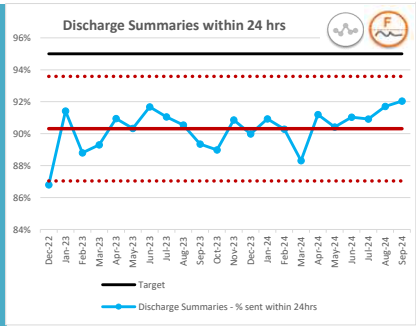
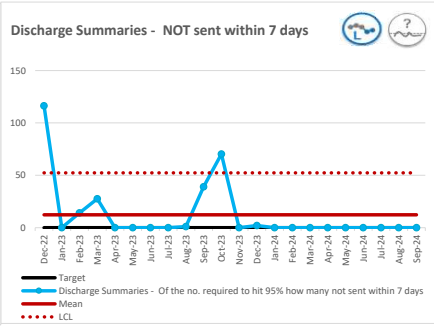
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
41. Ambulance Handovers within 15 minutes Target: 65% 42. Ambulance Handovers within 30 minutes Target: 95% 43. Ambulance Handovers within 60 minutes Target: 100%	In month 39.66% of patients were handed over within 15 minutes, 74.34% were handed over within 30 minutes and 89.87% were handed over within 60 minutes.	  	(15) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (29) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (60) Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an Improving nature	Handover performance continues to be a priority, it has been challenged due to surges in demand and workforce constraints	The Trust will continue to work in partnership with NWAS to identify and implement improvements.
44. Discharge Summaries - % sent within 24hrs Target: 95% 45. Discharge Summaries - Number NOT sent within 7 days Target: ZERO	The Trust achieved 92.04% in month for discharge summaries sent within 23 days, against the target of 95%. There were 0 discharge summaries in month not sent within 7 days, against the target of 0.	 	(24 hrs) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (7 Days) Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	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.

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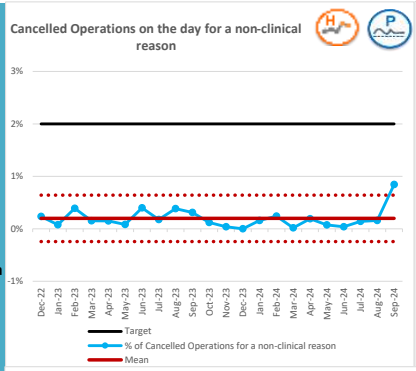
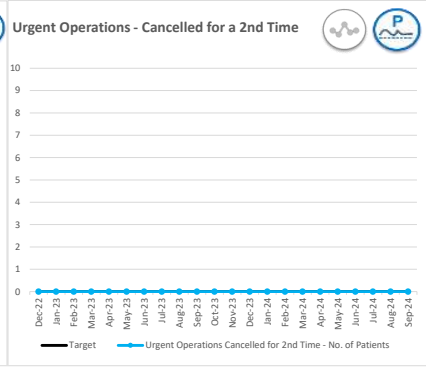
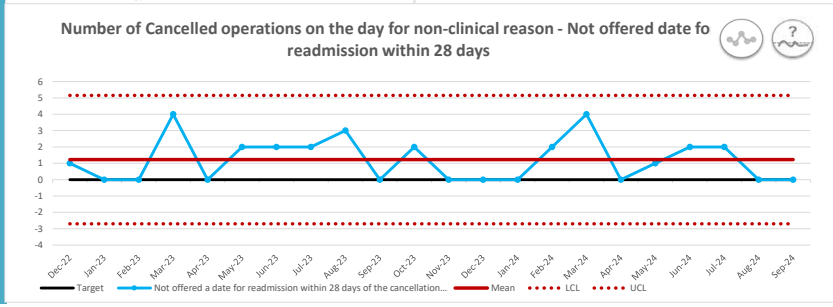
46. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	Cancelled operations for a non-clinical reason was 0.84% in month. 0 cancelled operations were not offered a date for readmission within 28 days.		(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: There is special cause variation of an declining nature.	The position is currently being reviewed by the Care Groups.	Recovery of elective activity continues to be monitored via Performance review group. A discrepancy in reporting has been identified by analytics this will mean an increase in reporting, it is anticipated that this will keep us in line with peers, this is reflected in the increase in position.
47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO			(Not offered 28 days) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.		
48. Urgent Operations Cancelled for 2nd Time			(Urgent Ops cancelled 2nd time) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.		

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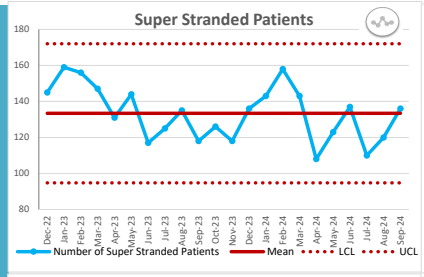
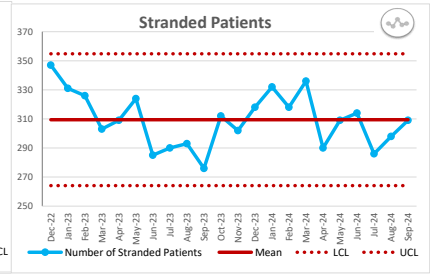
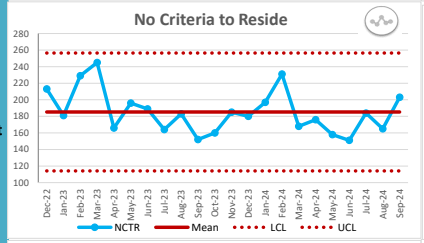
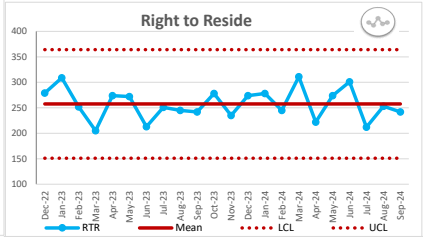
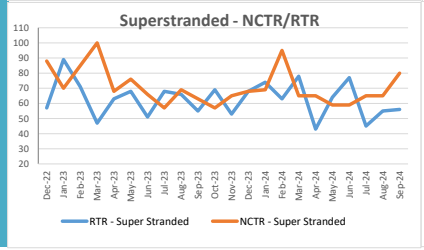
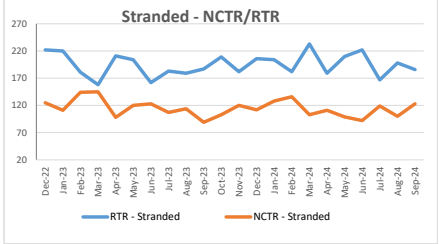
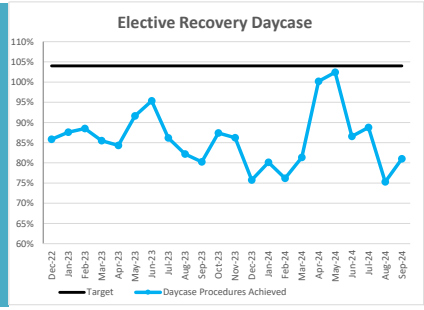
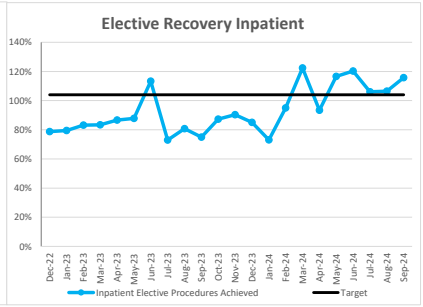
49. Super Stranded Patients Target: Trajectory 50. No Criteria to Reside (NCTR)	There were 309 stranded and 136 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	     	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (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 has increased in month showing a similar pattern to last year, this is being driven by NCTR patients, work is on-going with system partners to support a reduction	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
	In month, the Trust achieved the following % of activity against 2019. This included 81% of Daycase Procedures and 115.78% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient electives had a strong performing month a decrease in day cases was seen as a result of the focus on clearing the complex long waiters and the delay in Endoscopy hub	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

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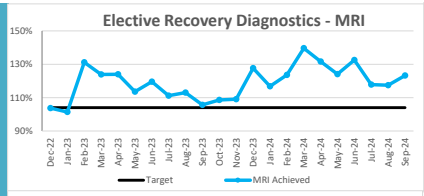
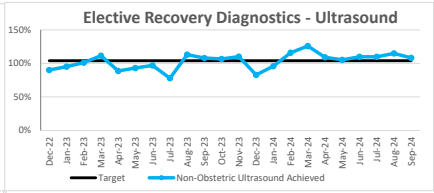
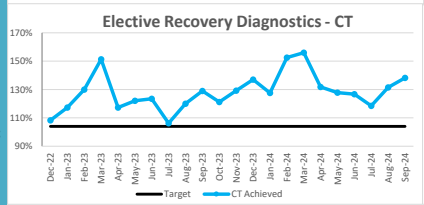
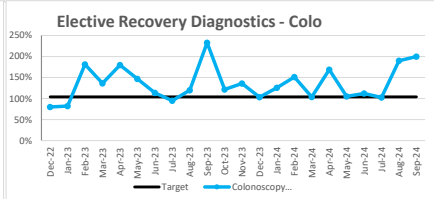
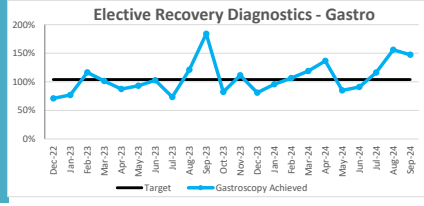
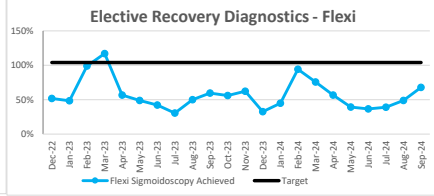
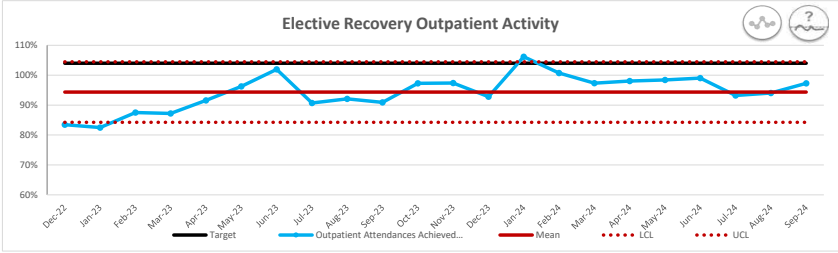
52. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	**In month, the Trust achieved the following % of activity against 2019.** **This included:** **123.24% of MRI** **138.25% of CT** **108.31% of Non-Obstetric Ultrasound** **67.89% of Flexi Sigmoidoscopy** **200% of Colonoscopy** **147.34% of Gastroscopy**	     	**N/A - Grouped indicator.**	**Radiology modalities remain fully recovered, Challenges in Endoscopy due to the delay in the hub being operational which have now been resolved and on-going pressure within cardiorespiratory remain** **Challenges remain in Cardiorespiratory services.**	**The Trust continues to restore clinical services in line with the national operating guidance.** **Additional insourcing support for Echo is being progressed to help reduce waiting times.** **Underperformance modalities are monitored at PRG with recovery trajectories in place for each service**
53. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	**In month, the Trust achieved 97.27% of Outpatient activity against 2019.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation**	**The Trust continues to deliver Outpatient activity inline with operational planning guidance**	**The Trust continues to restore clinical services in line with the national operating guidance.** **The August position will improve following completion of coding of OPD procedures**

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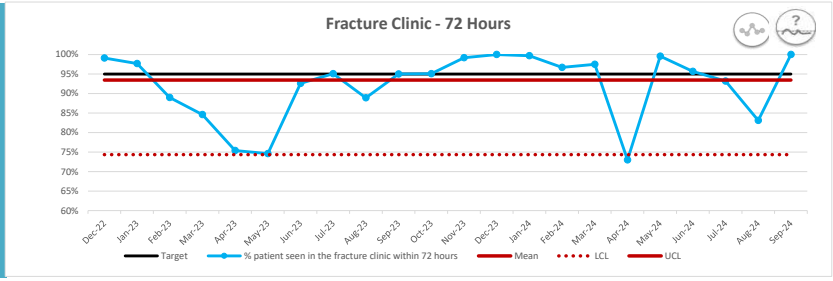
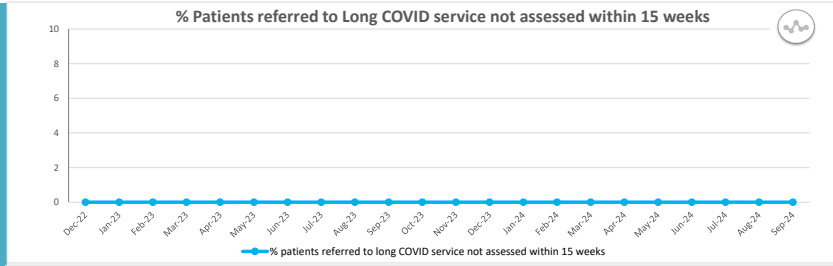
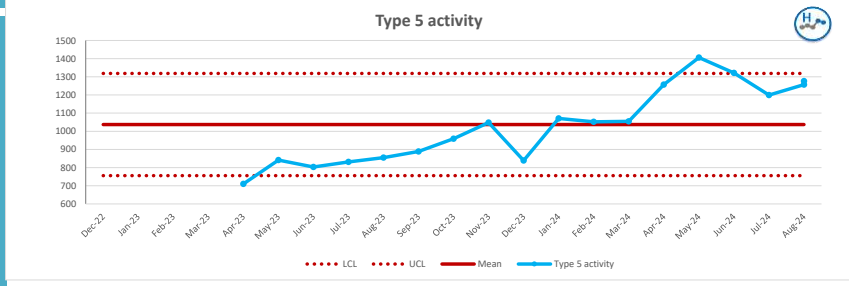
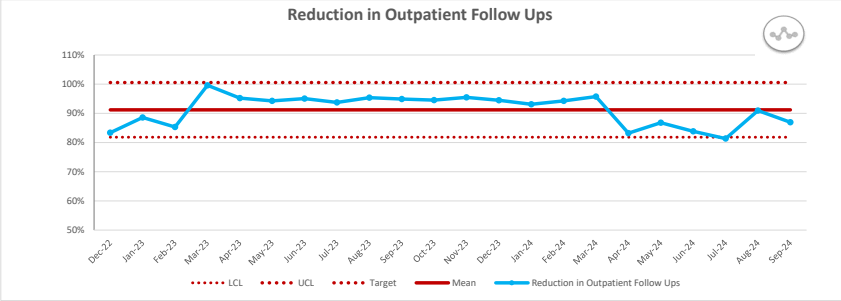
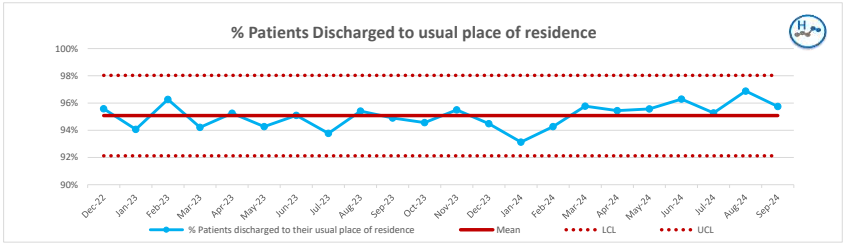
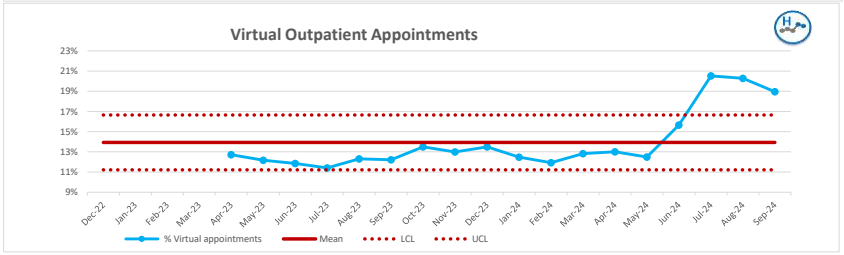
Care Quality Commission

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In monthly, the fracture clinic saw 100% of patients within 72 hours.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation	Good performance position is being sustained.	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.
56. % patients referred to long COVID service not assessed within 15 weeks	This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.		
57.Type 5 (previously SDEC) activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 127600 Type 5 Attendances.		Assurance: N/A Trajectory Not Agreed. Variation: Special Cause variation of an improving nature.	As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
System Oversight Framework
Care Quality Commission

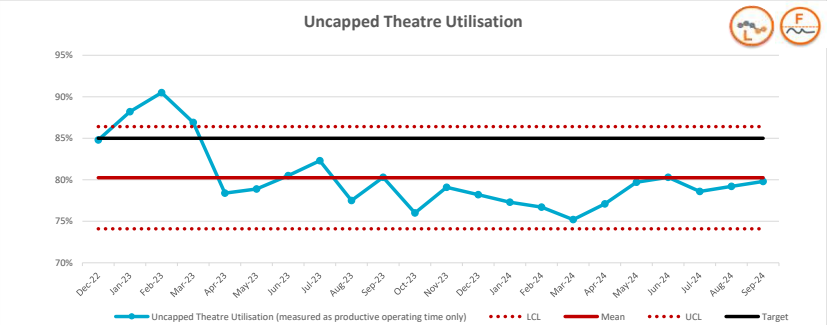
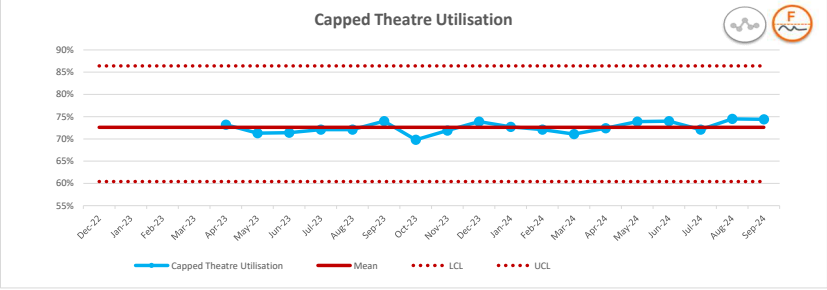
Access & Performance - Trust Position

	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)?
58. 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 86.94% of 19/20 activity in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Common Cause (Normal) variation.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
59. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.75% patients in month were discharged to their usual place of residence.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**		
60. Virtual Appointments (figures have been derived using SUS logic to determine the contact type and clinics which need to be held F2F have been excluded)	**18.95% Virtual Outpatient appointments in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**	**Use of the Virtual clinics for both Frailty and Respiratory is monitored via the bed meetings on a daily basis**	**Capacity in Frailty Virtual clinic has increased in line with the service maturing, case finders for both Respiratory and Frailty support utilisation**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

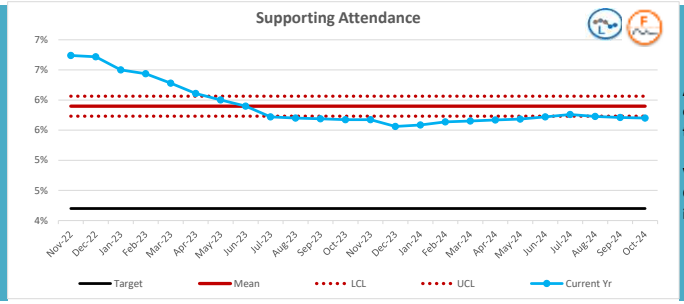
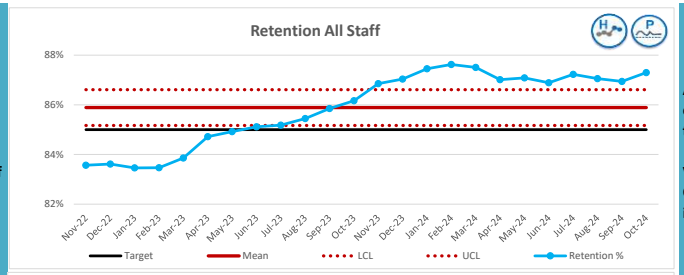
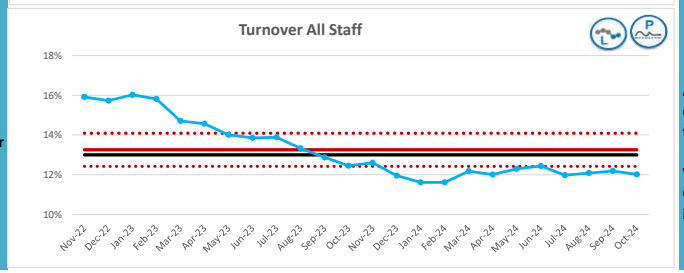
Key:
Risk Register
System Oversight Framework
Care Quality Commission

	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)?
61. Uncapped Theatre Utilisation (measured as productive operating time only) Target: 85%	**79.8% Uncapped Theatre utilisation in month (measured as productive operating time only).**		**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**Theatre Utilisation remains a challenged area, a focus on late starts and improving productivity are key priorities for 24/25.** ***Please note, data in the IPR has been revised to reflect utilisation - previously a combined utilisation and productivity figure. As a result, figures are different from those previously reported in the IPR.**	**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.**
62. Capped Theatre Utilisation Target: 85%	**74.4% Capped Theatre utilisation in month (measured as productive operating time only).**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**		**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)?
63. Supporting Attendance Target: Below 4.2%	The Trust's annualised sickness rate was 5.7%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence is showing an Improving Variation. The annualised sickness absence percentage in October 2024 was 5.7%, which is very similar to the previous 6 months. Reasons for the reduction in sickness absence from 2022 can be attributed to the reduction in long term sickness following implementation of the new Attendance Management policy and the People Health and Wellbeing Group being established which focuses on specific reasons for absence and interventions to reduce.	Sickness absence levels remain above target but are below 2022/23 absence rates. A regional review of sickness absence targets is currently being undertaken. Stress, anxiety and depression and MSK continue to be the highest reason for sickness absence. Rugby League Cares (RLC) is currently supporting 2 areas with high levels of sickness due to stress and anxiety. Targeted MSK support has been provided for those in sedentary roles to provide education on managing MSK, with the aim to avoid absence due to MSK issues.
64. Retention Target: 85%	The Trust's annualised retention of all staff was 87.3%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Annualised retention is showing an Improving Variation. Retention of all staff in October 2024 was above Trust target at 87.3%, a slight increase from 87.06% in August 2024. Retention for permanent staff in October 2024 remains above Trust target at 89.76%.	Retirement, work/life balance, relocation and promotion are the main reasons people leave WHH. Improving flexible working continues to be a priority to support work/life balance. As part of the Trust's We Are WHH Culture plan and in line with work/life balance week 7 – 11 October, the Trust relaunched a refreshed flexible working offer, renamed #MyFlexWHH.
65. Turnover Target: Below 13%	The Trust's annualised turnover of all staff was 12.02%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in October 2024 was 12.02%, a slight decrease from August 2024 at 12.08% Turnover of permanent staff in October 2024 remains above Trust target at 11.22%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

KEY:
SOF System Oversight Framework
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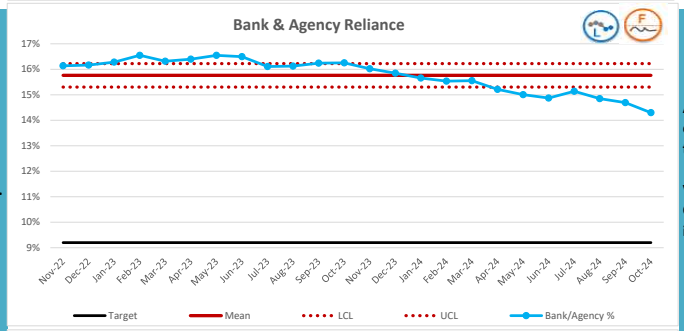
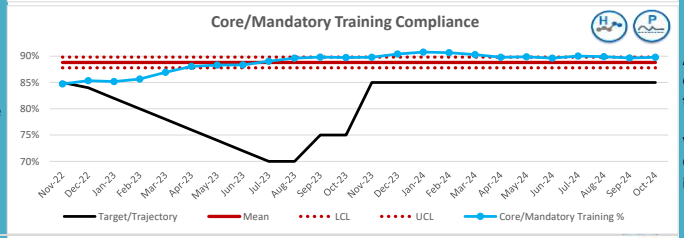
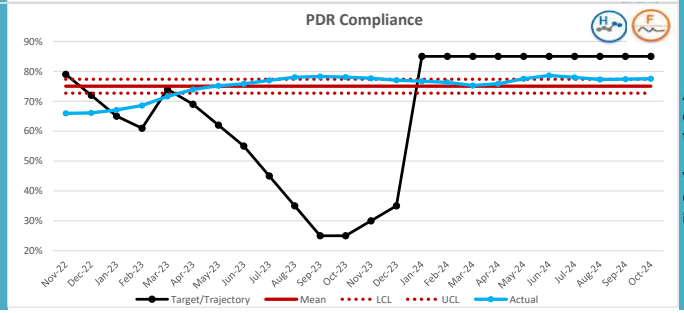
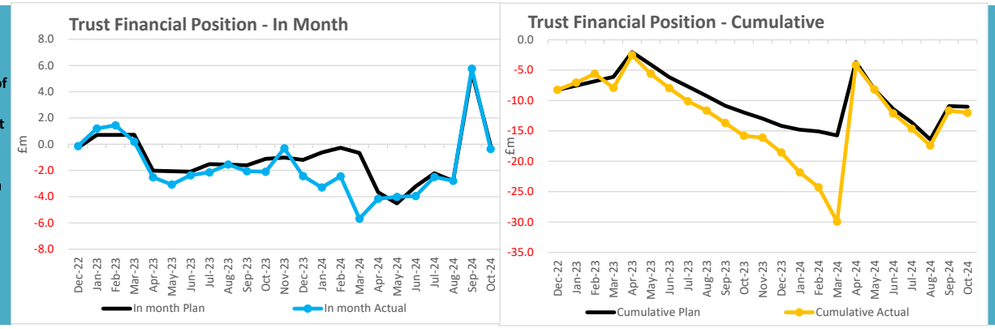
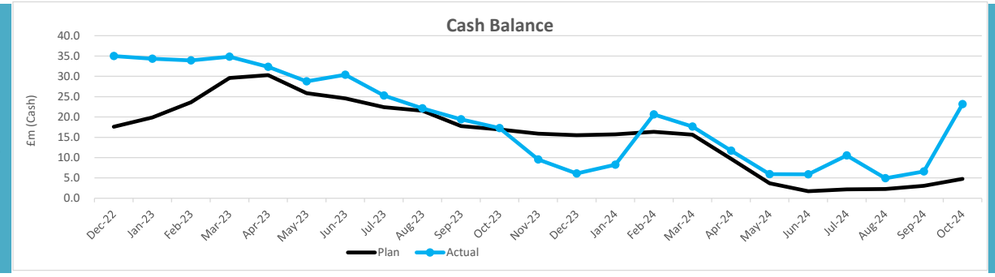
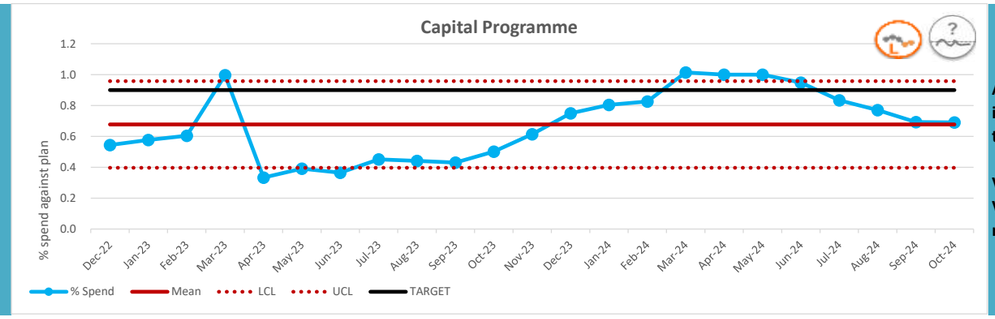
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Bank and Agency Reliance **Target: 9% or Below** UoR **Annualised Bank and Agency Reliance was 14.1%.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**Bank and Agency reliance is showing an Improving Variation.** **Bank and Agency reliance in October 2024 was 14.1%, an improvement from August 2024 at 14.65%.** **Bank reliance in October 2024 is 12.7%, a slight decrease from 12.8% in August 2024. Agency reliance continues to decrease and was 1.9% in October 2024 against a target of 3.2%.**	**The Medical and Nursing Workforce Review Groups are using information regarding agency and bank usage to target areas of high usage / high cost, and plan for reductions.** **In addition, the weekly ECF process now includes highest spend and longest length of agency and bank by staff group, with Care Groups required to review and include plans for turning off which is reported to the Executive team for further oversight and review.**
67. Core/ Mandatory Training **Target: 85%** UoR CQC **Core/Mandatory training compliance was 89.79% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**CSTF Training is showing an Improving Variation.** **In October 2024, CSTF Mandatory Training compliance was 89.79%.**	**Care Groups report compliance at Operational People Committee with actions required to ensure targets are met.** **National changes have been mandated regarding how Trusts deliver CSTF training. There are limited changes to WHH as the Trust has always closely followed the national guidance using the systems provided. Where there is variation, the Trust has made submissions nationally referencing the relevant legislation for consideration.**
68. PDR **Target: 85%** Trust Strategy CQC **Annualised PDR compliance was 77.51%.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a improving nature.**	**Appraisals are showing an Improving Variation.** **In October 2024, Appraisal compliance was 77.51%, a slight increase from 77.31% in August 2024.** **Currently Appraisal rates are below the trajectories but higher than 2022.**	**At OPC, Care Groups and Corporate areas discuss their PDR compliance and actions in place to address. Care Groups had set trajectories to achieve 85% compliance by July 24. Progress against the trajectories is discussed at OPC with best practice shared and further support offered where appropriate, including consideration to ensuring plans are in place to continue to improve compliance during winter months.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
SOF System Oversight Framework
UoR Use of Resources Assessment
RR 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)?
69. Trust Financial Position Target: Plan	In September 2024, the Trust was allocated deficit support funding of £16.458m therefore reducing the Trust deficit plan from £27.8m to £11.3m. The Trust has recorded a deficit position of £12m at 31 October 2024 against a revised deficit plan of £11m.		The drivers for the deficit being worse than plan is the impact of Industrial Action and the cost of the pay award in excess of funding received.		Seek funding to offset the impact of Industrial Action and the pay award. In addition, work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity to ensure delivery of the financial plan.
70. Cash Balance Target: On or better than plan	The cash balance at 31 October 2024 is £23.1m.		The current cash balance is £23.1m which is £18.4m higher than the cash plan. This is predominantly due to payment of £9.6m deficit funding and £7.7m pay award support funding for months 1 to 7. Of the £23.1m cash, £4.1m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A submission of £5.2m was submitted for September however only £4m has been approved. The Trust has been allocated a share (£16.458m) of the £150m deficit support provided to the Cheshire and Merseyside ICS and pay award funding of £10.4m via an increase in tariff income (£9.6m) and non-recurrent funding (£0.8m). Further cash support is not required in Q3 following the receipt of the deficit support and pay award funding.	
71. Capital Programme Target: On plan 90%-100%	Capital expenditure at the end of month 7 is £5.6m against a plan of £8.1m.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a declining nature.	The annual Trust Capital Plan of £23.3m is oversubscribed by £0.2m against £23.1m of capital funding. Capital expenditure at month 7 is £1m behind the Trust internal plan of £6.6m at month 7. This is due to timing and is expected to catch up later in the year.	The reason for the year to date variance is due to timing and is expected to catch up later in the year. Work has also started on planning for the 2025/26 capital programme with schemes being flagged if they could be brought forward to 2024/25 if required.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
SOF System Oversight Framework
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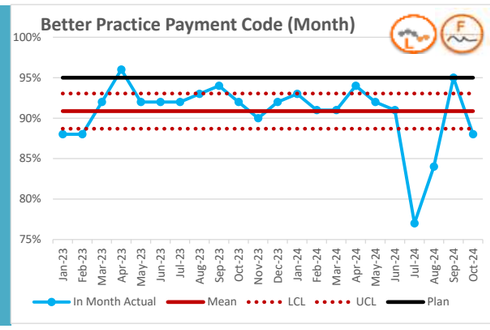
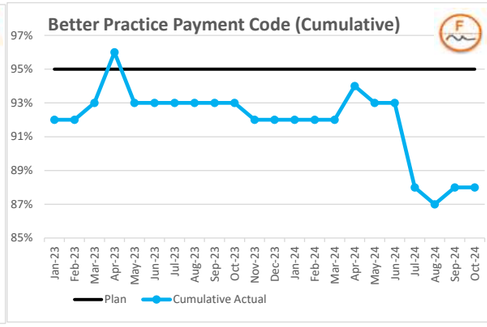
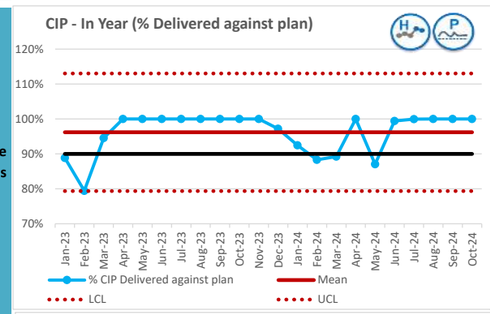
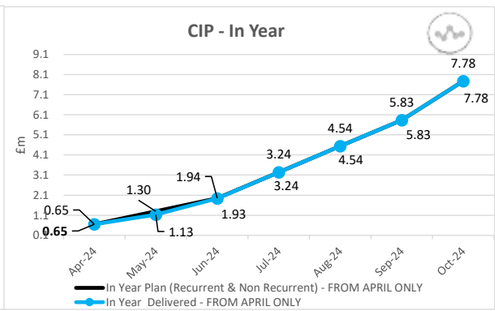
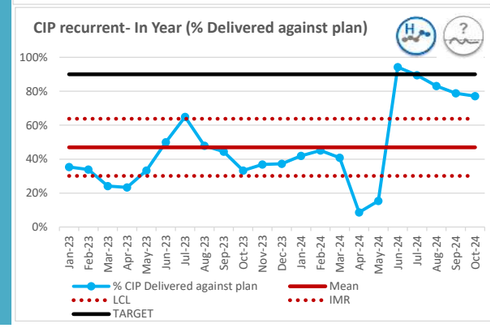
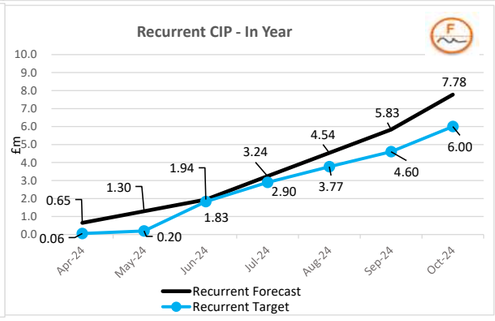
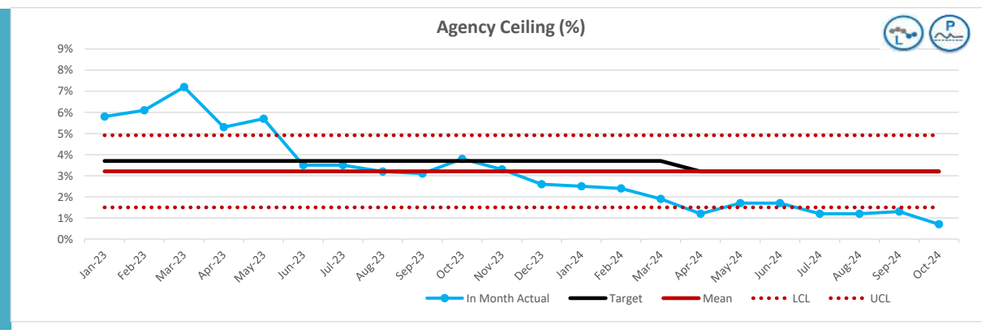
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
72. Better Payment Practice Code **Target: Cumulative performance 95%**				
Cumulative BPPC performance is 88% which is below the national target of 95%.			**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a declining nature.**	**Timely raising of requisitions, matching of purchase orders and approval of invoices enables invoices to be paid within the 30 day threshold for Better Payment Practice Code (BPPC). There are some occasions where this is not always possible which has led to the achievement of 88%.**	**Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.**
73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**				
The month 7 year to date CIP plan is £7.8m and has been fully delivered.			**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of an improving nature.**	**Although CIP has been fully delivered at M7, it should be noted that £1.8m has been achieved from non-recurrent central items.**	**CIP progress is reviewed on a weekly and monthly basis. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. These savings are dependant on delivering above planned income. At August 2024 coding freeze, the Trust achieved 98.8% which has deteriorated since July 2024 which was 100.1%.** **The Trust has identified all of the £19.4m CIP programme however there is a potential delivery risk of £2.5m, therefore schemes will continue to be identified in excess of the £19.4m to mitigate against this.**
74. Cost Improvement Programme (recurrent) – In year performance to date **Target: Recurrent Forecast is more than 90% of annual target**				
£6m CIP has been delivered recurrently against the target of £7.8m.			**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.**	**The Trust is continuing to identify recurrent CIP schemes for 2024/25. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT are being used.**
75. Agency Ceiling **Target: Agency spend should not exceed 3.2% of total pay (ICS target)**				
The Trust Agency spend in month is 0.7% against a target of 3.2%.		**Assurance: The Trust consistently passes the target** **Variation: Special Cause Variation of an improving nature.**	**The national agency ceiling is 3.2% in 2024/25. Trust agency spend is still significantly below the target at 0.7%.**	**Agency spend continues to be monitored even though the target has been consistently achieved so that any actions can be taken if required. In addition, bank expenditure is now the focus of further scrutiny to control overall pay expenditure and ensure appropriate use.**

Appendix 3 – Trust IPR Indicator Overview

Indicator	KPI	Detail	Target	Additional Context
Quality				
Incidents		Number of incidents reported in month.		Nationally incidents are no longer referred to as SIs. This has been replaced by PSIIs in accordance with the nationally mandated Patient Safety Incident Response Framework.
	1	Number of incidents open over 40 days.	0	
		Total PSIIs recorded in month.		
		Number of PSII Actions Breached.		
		Number of never events reported in month.		
		Number of 'prevention of future death' orders.		
Duty of Candour		Duty of Candor (DoC) – Moderate Incidents		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 must be done within 10 working days.
	2	Duty of Candor – Serious Incidents	100%	
Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)	**3**	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.	Reduction from previous year	
	4	MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.		
	5	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.		
	6	Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.		
	7	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.		
	8	Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.		
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	**9**	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).		

VTE Assessment	**10**	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.	>= 95%	
Inpatient Falls & Harm Levels		Total number of falls which have occurred in month.		
		Falls per 1000 bed days in month.		
	11	Total number of inpatient falls which have occurred in month.	20% decrease from previous year	
		Levels of harm reported as a result of a fall in month.		
		Level of avoidable harm which has occurred in month.		
Pressure Ulcers		Pressure Ulcers (Categories 3 and 4)	10% reduction on previous year	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).
	12	Pressure Ulcers (Categories 2, 3 and 4)	10% reduction on previous year	
		Community Acquired Pressure Ulcers		
Medication Safety	**13**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
		Number of controlled drugs incidents.		
		Number medication incidents resulting in harm.		
Staffing Average Fill Levels	**14**	Staffing - Average Fill Rate - Day nurses/midwives		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.
		Staffing - Average Fill Rate - Day care staff		
		Staffing - Average Fill Rate - Night nurses/midwives		
		Staffing - Average Fill Rate - Night care staff		
Care Hours Per Patient Day (CHPPD)	**15**	Staffing - CHPPD Overall	>=7.9	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
		Staffing - CHPPD Benchmarking		
HSMR Mortality Ratio	**16**	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.	Plan	

SHMI Mortality Ratio	**17**	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.	Plan	
NICE Compliance	**18**	Trust NICE compliance	90%	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.
Complaints		Number of complaints received in month.		
		Number of complaints received in timeframe		
		Number of dissatisfied complaints in month.		
		Total number of open complaints in month.		
	19	Total number of cases over 6 months old in month.	0	
		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.		
Friends and Family Test (Inpatient & Day Cases)	**20**	Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?	95%	
		National, Regional, Cheshire & Mersey positive response rates for Benchmarking		
Friends and Family (ED and UCC)	**21**	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?	87%	
Mixed Sex Accommodation Breaches (ITU)	**22**	Number of MSA Breaches in month (ITU).	0	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.
Sepsis	**23**	Sepsis Emergency Patient Screening	>=90%	To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if
	24	Sepsis Inpatient Screening	>=90%	
	25	Sepsis Emergency Patient Antibiotics (within 1hr)	>=90%	

		Sepsis Emergency Patient Antibiotics (within 6hrs)		necessary administered anti-biotics within 1 hour.
	26	Sepsis Inpatient Screening (within 1hr)	>=90%	
		Sepsis Inpatient Screening (within 6hrs)		
Ward Moves Between 10pm and 6am	**27**	Ward Moves 10:00pm - 06:00am, for patients with an alert		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.
		Monthly out of hour (10pm-6am) ward moves		
		Average qty of Ward moves per patient with an alert		
Acute Kidney Injury	**28**	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than month in previous year	
		Number of community acquired Acute Kidney Injuries (AKI) in month.		
		Average Length of Stay (LoS) of patients within a AKI.		
Postpartum Haemorrhage >1500ml	**29**	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard.	<3.7%	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.
Fractured Neck of Femur	**30**	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.
		% of patients receiving surgery within 36hrs of admission		
MUST nutritional assessment completion	**31**	MUST Nutrition assessment completion	>85%	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

Diagnostic Waiting Times – 6 weeks	**32**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	
RTT Open Pathways and 52 & 65 week waits	**33**	Referral to open pathways	>92%	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for
	34	Number of patients waiting over 52 weeks.	0	

		Number of patients waiting over 65 weeks.	0	elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
		Number of patients waiting over 78 weeks.	0	
Under 4 hour A&E Wait time Target and ICS Trajectory (excluding WWIC)	**35**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>75%	
Under 4 hour A&E Wait time (including WWIC)	**76**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>75%	because of the pandemic, the commissioning changes didn't happen. As such, it has been confirmed that WHH's 4-hour position is to still benefit from the Widnes UTC 50% split. This gives WHH's "All Type 4 hour" position is to still a c5% positive increase. Now this has been confirmed, we have re-formatted the 4-hour performance reports to show an including and excluding Widnes UTC position.
Average Time in Department (ED)	**37**	How long on average a patient stays within the emergency department (ED).		
A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.	**36**	% of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.	<=2%	
Cancer 14 Days	**38**	Cancer 28 Day Faster Diagnostic Standard	>75%	All patients need to receive their first appointment for cancer within 14 days of urgent referral. 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. All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
		Cancer Appointment within 14 Days	>93%	
		Breast Symptoms appointment within 14 days	>93%	
Cancer 31 Day wait	**39**	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat.
Cancer 62 Day wait	**40**	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat.
Ambulance Handovers 15	**41**	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	
Ambulance Handovers 30–60 minutes	**42**	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	

Ambulance Handovers – more than 60 minutes	**43**	% of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).	100%	
Discharge Summaries – Sent within 24 hours	**44**	Discharge Summaries within 24 hrs	>95%	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.
Discharge Summaries – Not sent within 7 days	**45**	Discharge Summaries - NOT sent within 7 days	0	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.
Cancelled operations on the day for non-clinical reasons	**46**	% of operations cancelled on the day or after admission for non-clinical reasons.	<=2%	
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	**47**	Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	0	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.
Urgent Operations – Cancelled for a 2nd Time	**48**	Number of urgent operations which have been cancelled for a 2nd time.	0	
Super Stranded Patients		Stranded Patients are patients with a length of stay of 7 days or more.		
	49	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.		
No criteria to reside (NCTR)	**50**	Number of patients with no criteria to reside		
		Number of patients with right to reside		
		Superstranded - qty of NCTR vs CTR		
		Stranded - qty of NCTR vs CTR		
Elective Recovery Activity	**51**	% of Elective Activity (Inpatients)	month in previous year	
		% of Elective Activity (Day cases)	month in previous year	
Elective Recovery Diagnostics	**52**	% of Elective Diagnostic Activity - MRI	month in previous year	
		% of Elective Diagnostic Activity - Non-Obstetric Ultrasound	month in previous year	

		% of Elective Diagnostic Activity - CT scans	month in previous year	
		% of Elective Diagnostic Activity - Flexi Sigmoidoscopy	month in previous year	
		% of Elective Diagnostic Activity - Gastroscopy	month in previous year	
		% of Elective Diagnostic Activity - Colonoscopy	month in previous year	
Elective Recovery Outpatients	**53**	% of Elective Recovery Outpatient Activity	104%	
Fracture Clinic	**55**	Fracture Clinic - patients seen within 72 Hours	>95%	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
% Outpatient referred to long covid service within 15 weeks	**56**	% of Patients referred to Long COVID service not assessed within 15 weeks		
% of zero-day length of stay admissions (Type 5)	**57**	Type 5 activity		Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.
Reduction in Outpatient Follow Ups	**58**	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
% Patients discharged to their usual place of residence	**59**	% of patients who were discharged to their usual place of residence.		
Virtual Outpatient Appointments	**60**	Virtual Outpatient Appointments		
Theatre Utilisation (measured as productive operating time only)	**61**	Uncapped theatre utilisation	>85%	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
	62	Capped theatre utilisation	>85%	

				and providers to achieve 85% theatre touch time utilisation by 2024/25.

Workforce

Supporting Attendance	**63**	the monthly sickness absence % with the Trust Target (4.2%) previous year.	<4.2%	
Retention	**64**	ention rate % over the last 12 months.	>85%	
Turnover	**65**	of the turnover % over the last 12 months.	<13%	
Bank & Agency Reliance	**66**	reliance on bank/agency staff.	<9%	
Core/Mandatory Training	**67**	of the Core/Mandatory Training Compliance, this includes:	>85%	Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and most recently, safeguarding
Performance & Development Review (PDR)	**68**	of the PDR compliance rate.	>85%	

Finance

Trust Financial Position	**69**	Cumulative operating surplus or deficit compared to plan.	Plan	
		In month operating surplus or deficit compared to plan.	Plan	
Cash Balance	**70**	The cash balance at month end compared to plan.	Plan	
Capital Programme	**71**	Capital expenditure compared to plan.	Plan	
Better Payment Practice Code	**72**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	>95%	
Cost Improvement Programme – Plans in Progress in Year	**73**	Cost savings schemes in-year compared to plan.	>90% of annual target	
		CIP - In Year	plan	
Cost Improvement Programme – Recurrent	**74**	Cost savings schemes recurrent compared to plan.	>90% of annual target	
		Recurrent CIP - In Year	plan	
'Agency Ceiling'	**75**	At ICS level, agency spend should not exceed 3.7% of total pay.	>3.7%	

Appendix 4 - Statistical Process Control

1.0 What is SPC?

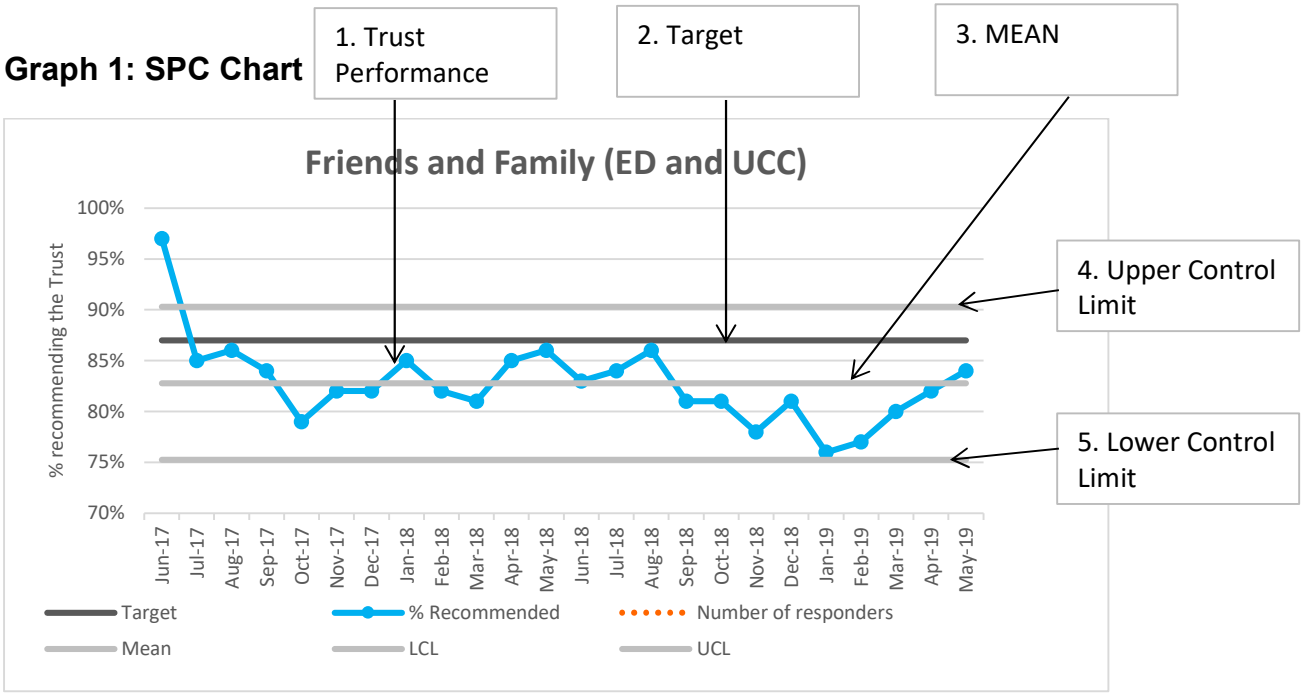
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

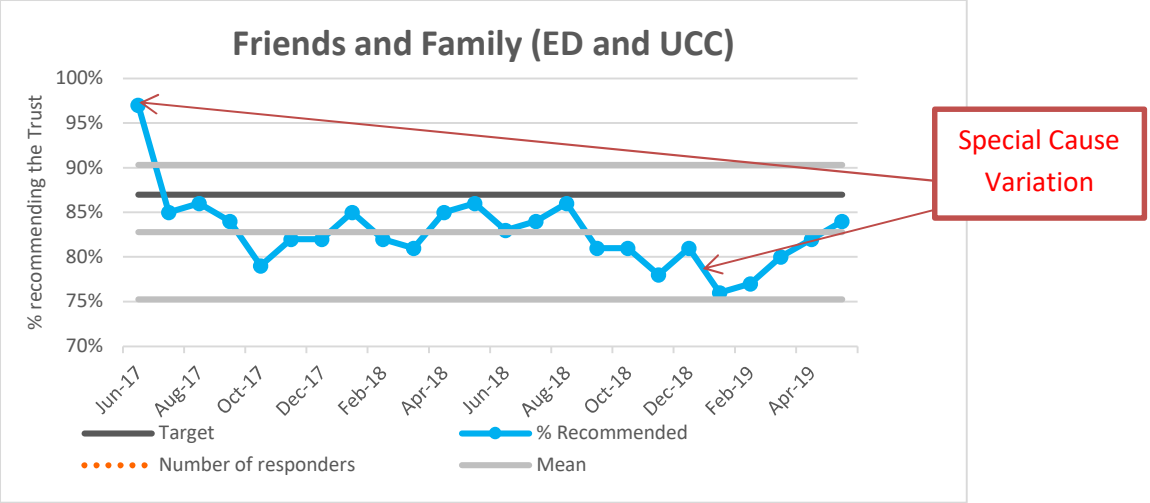


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

For 2022/23 the Trust has introduced the "Making Data Count" variation and assurance icons. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five

variation icons which is based solely on the data and the SPC rules. Ideally the assurance icon should be blue “P” icon which notes the indicator is consistently passing its target over the last 6 months. Again, ideally the variation icon should be either the grey “common cause variation” icon or a blue “H” or “L” icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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



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

Warrington & Halton Teaching Hospitals NHS Foundation Trust

Appendix 5

Income Statement at 31st October 2024

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	**341,561**	**33,941**	**33,920**	**-21**	**198,558**	**200,554**	**1,997**
Non NHS Clinical Income							
Private Patients	8	1	0	0	5	4	0
Non NHS Overseas Patients	71	6	4	-1	46	42	-4
Other non protected	670	62	44	-19	358	577	219
Sub total	**749**	**69**	**48**	**-20**	**409**	**624**	**215**
Other Operating Income							
Training & Education	9,541	782	942	161	5,632	5,935	303
Donations and Grants	50	5	-2	-7	25	43	18
Miscellaneous Income	14,681	1,223	1,459	235	8,385	10,556	2,170
Sub total	**24,272**	**2,010**	**2,399**	**389**	**14,043**	**16,534**	**2,491**
Total Operating Income	**366,582**	**36,019**	**36,367**	**348**	**213,009**	**217,712**	**4,703**
Operating Expenses							
Employee Benefit Expenses	-265,264	-26,857	-28,194	-1,337	-158,414	-163,322	-4,908
Drugs	-21,934	-1,802	-1,894	-92	-12,879	-13,412	-533
Clinical Supplies and Services	-23,849	-1,957	-2,150	-194	-13,991	-15,477	-1,486
Non Clinical Supplies	-46,875	-3,863	-2,962	901	-27,141	-26,459	682
Depreciation and Amortisation	-15,843	-1,320	-1,320	0	-9,242	-9,242	0
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	**-373,765**	**-35,799**	**-36,521**	**-722**	**-221,667**	**-227,912**	**-6,245**
Operating Surplus / (Deficit)	**-7,183**	**221**	**-154**	**-375**	**-8,658**	**-10,200**	**-1,542**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	13	13
Interest Income	393	19	122	103	295	820	525
Interest Expenses	-147	-12	-8	4	-83	-76	7
PDC Dividends	-4,834	-398	-398	0	-2,846	-2,846	0
Total Non Operating Income and Expenses	**-4,588**	**-391**	**-284**	**107**	**-2,634**	**-2,088**	**546**
Surplus / (Deficit) - as per Accounts	**-11,771**	**-170**	**-438**	**-268**	**-11,292**	**-12,288**	**-996**
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	-50	-5	2	7	-25	-43	-18
Add Depreciation on Donated & Granted Assets	487	41	41	0	284	284	0
Total Adjustments to Financial Performance	**437**	**36**	**43**	**7**	**259**	**240**	**-18**
Adjusted Surplus / (Deficit) as per NHSI Return	**-11,335**	**-135**	**-396**	**-261**	**-11,033**	**-12,048**	**-1,015**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR - August 2024 Detail
2nd October 2024

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There are **3 indicators that are both failing and have special cause variation of a concerning nature**, these are:

Quality:

- **5.** Healthcare Acquired Infections (CDI)

Access and Performance:

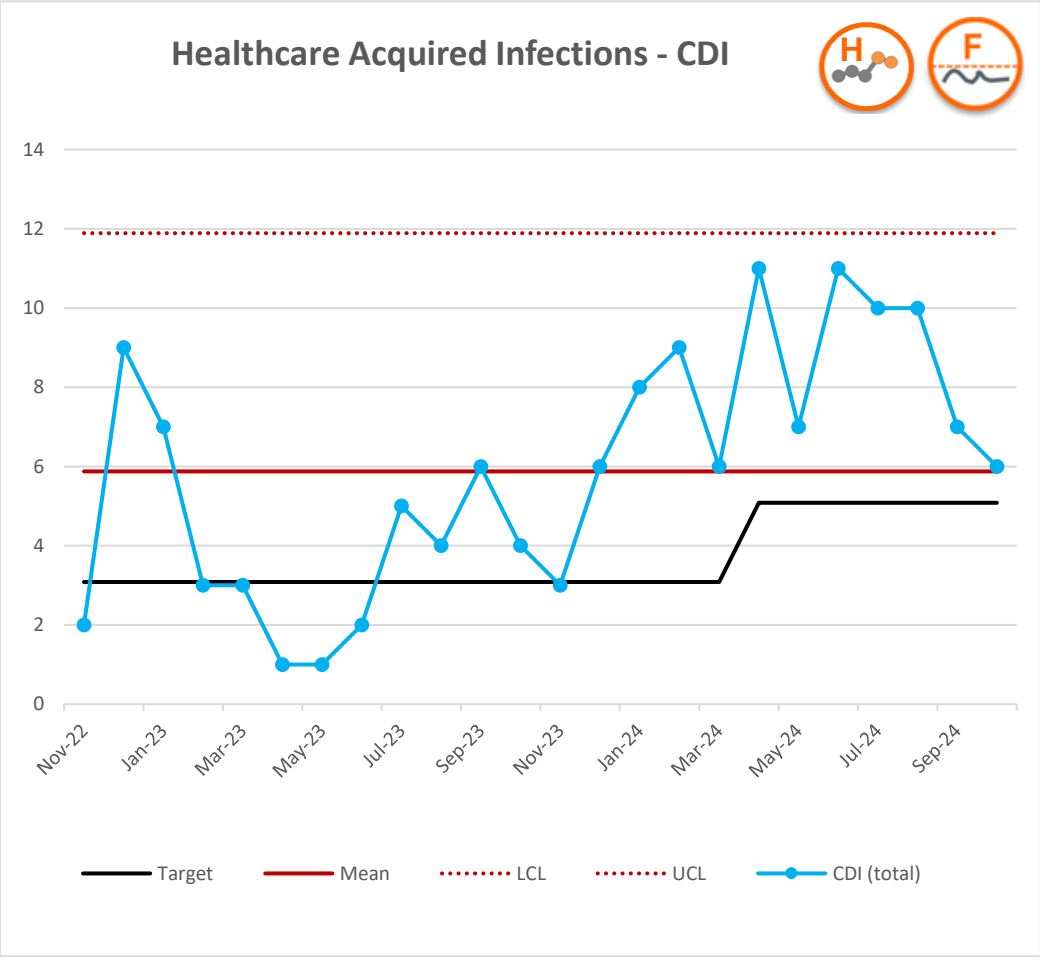
- **61.** Uncapped Theatre Utilisation

Finance and Sustainability:

- **72.** Better Payment Practice Code

5. Healthcare Acquired Infections (CDI)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

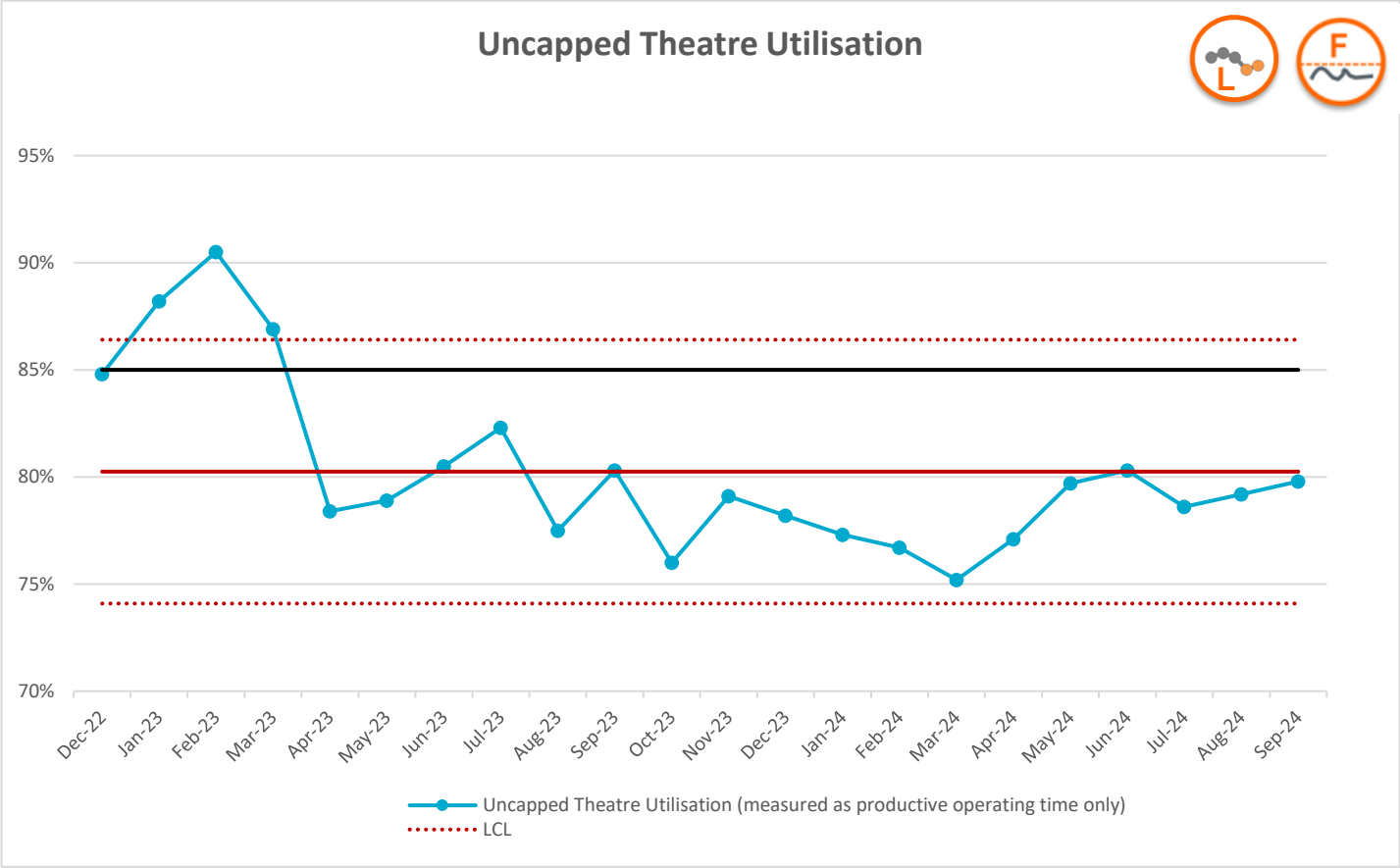


- National and regional increase in CDI cases
- WHH remains a low outlier compared to other NW Trusts
- Slight decrease in Antibiotic Point Prevalence Audit (85%) and IVOS CQUIN increase (38%*) being addressed by Consultant Microbiologists
- Trust-wide Deep Clean implemented
- Audit findings (2023/24 cases) learning shared and action plan implemented
- Annual plan of CDI training in progress
- Awareness raising events: IPC October and Antibiotics November

* Lower % is better

61. Uncapped Theatre Utilisation

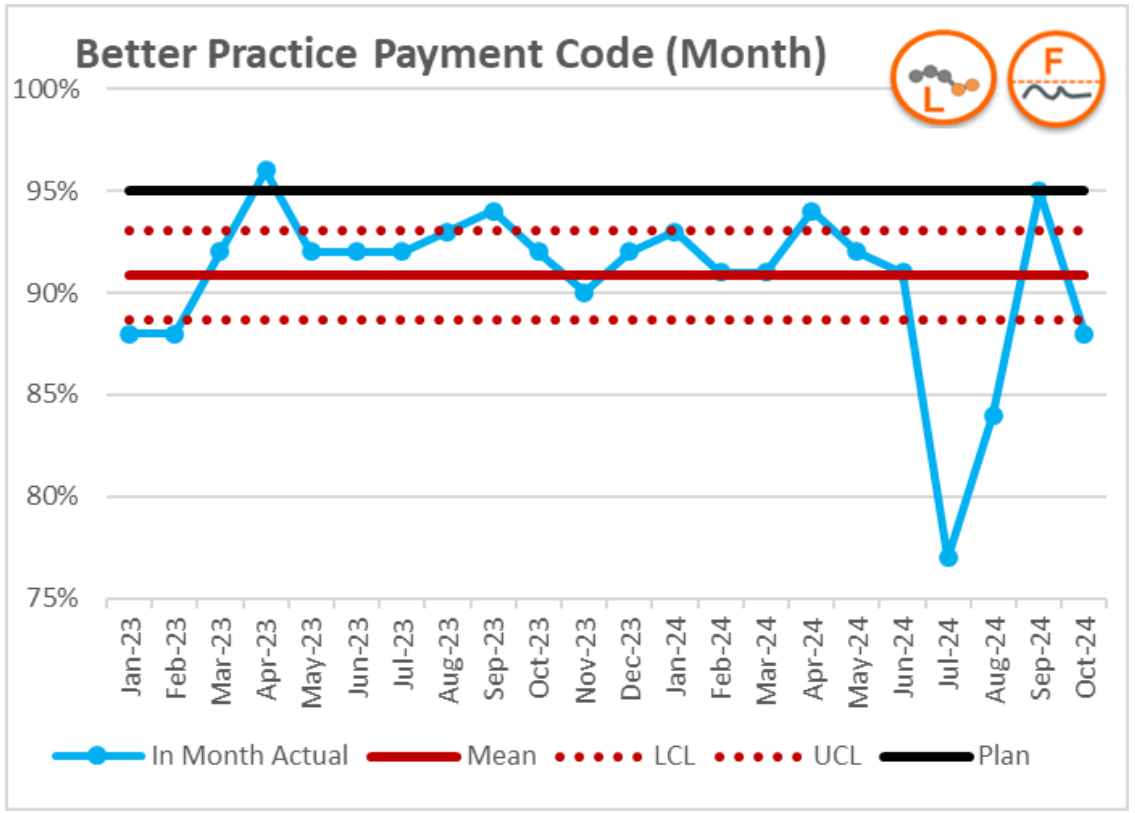
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



- Uncapped Utilisation is the total operating time and inclusive of any early starts or late finishes
- Achieved 79.2% in October against a target of 85%
- Moved from bottom quartile to a mid-position in model hospital benchmarking over the last 6 months
- Focus on start times and cases per list in worst performing specialties
- Focus on, on the day cancellations

72. Better Payment Practice Code

Warrington and Halton Teaching Hospitals NHS Foundation Trust



- BPPC for September was high due to timely processing of invoices compared to July and August when there was budget holder annual leave. October was lower again due to annual leave, around half term holidays.
- If an invoice is place on hold / in query this stops the clock with respect to BPPC.
- Guidance is routinely emailed to budget managers advising them of this.
- This guidance is to be re-enforced especially at times when higher annual leave is expected such as July / August and across the Christmas period.

Entity	BPPC Paid Period	Invoice Count	Invoice Count (Passed)	% Passed	BPPC Amount	Invoice Amount (Passed)	% Amount Passed
RWW	Apr-24	4,212	3,938	93.49%	15,556,883.31	13,767,479.00	88.50%
RWW	May-24	3,386	3,129	92.41%	10,926,139.58	10,261,733.77	93.92%
RWW	Jun-24	2,362	2,147	90.90%	8,231,309.05	7,577,539.25	92.06%
RWW	Jul-24	4,106	3,159	76.94%	10,207,767.22	8,297,908.22	81.29%
RWW	Aug-24	3,434	2,895	84.30%	8,687,704.51	8,128,969.07	93.57%
RWW	Sep-24	3,314	3,136	94.63%	7,612,385.93	7,180,799.64	94.33%
RWW	Oct-24	3,107	2,719	87.51%	8,965,554.90	8,673,532.12	96.74%

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 3 failing IPR indicators

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125a(i)	Meeting	Trust Board	Date Of Meeting	4 December 2024

Date of Meeting	8 October 2024
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/10/148	**Hot Topic- Quality Surveillance in Surgery following Great Ormond Street incident.**	The Committee received the Hot Topic in relation to the Quality Surveillance in Surgery following the Great Ormond Street incident. The presentation included- • Overview of quality surveillance mechanisms at WHH. Points of note include: • Multiple routes are available to raise concerns. • Governance processes offer ability to scrutinise. • External mechanisms available to offer additional assurance. • Medical Triangulation Meeting overseen by Medical Director monthly.	**Moderate** **Strong processes in place to provide surveillance of surgical cases.** **Conclude culture work in identified areas**	**Substantial:** **Monthly reporting with Executive oversight through Patient Safety and Clinical Effectiveness escalating to Quality Assurance Committee.**	**PSCESC October**
QAC/24/10/150	**Patient Safety and Clinical Effectiveness Report**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note • Stroke de-escalated as a Fragile Service – less than 10% patients now coming to WHH, SNAPP National Stroke Performance data now improved to B rating.	**Moderate:** **Backlog in Gynaecology waiting lists.**	**Substantial:** **Monthly reporting with Executive oversight through PSCESC**	**PSCEC October 2024** **Quality Committee Hot Topic - Cardiology November. Hot Topic Theatres**

		• Gynaecology deescalated from Fragile Service– sustained improvement in position. • Cardiology escalated to become a Fragile Service due to diagnostic delays/gaps in medical staffing. • ENT – waiting list position has improved due to insourcing although noted this is causing cost pressure.	**ENT backlog improved but needs further improvement.**	**Escalation processes in place to QAC**	**culture work – November.**
QAC/24/10/151	**Arbury Court Update.**	The Committee received an update on Arbury Court Noting - Background – previous concerns regarding number of incidents from 2021 triggering Place and ICB oversight. Noted reduction in incidents. Improved relationship – 6 weekly meetings ongoing. PLACE/ICB scrutiny stepped down.	**Moderate** **Further improvement with Screening Compliance required.**	**Substantial** **Quarterly oversight through QAC**	**Stepped down from QAC with option to escalate. Update to Board of Directors. Verbal update in November relating to previous peak in incidents.**
QAC/24/10/155	**ED Improvement Update**	The Committee received an update on the ED Improvement Programme and noted the following • ECIST Report received in month– action planning ongoing. • Behind trajectory for 4-hour standard. Actions in place to address. • Overall attendance lower, Ambulance attendance up (1.4% increase). • Improvement in 60-minute handover. • Reverse cohort in place to reduce corridor times that remains a challenge. • Deterioration in triage times- increased senior oversight introduced to address issues.	**Moderate** **12 hours in department times and triage times need to further improvement**	**Substantial** **Non-Executive and Executive oversight via Quality Assurance Committee**	**QAC November**

QAC/24/10/159	**Ward Accreditation Report**	The Committee received an update regarding Ward Accreditation noting • Ward accreditation updated to align to WHH Culture Plan and CQC Single Assessment Framework • Plan to develop specialist Accreditation for areas such as Theatres. • Levels of intervention clearly defined. • Panel of Subject Matter Experts being established as a Validation Panel for new programme.	**Moderate** **New Processes need embedding and evaluation**	**Substantive** **Oversight by Executives and Non-Executives at QAC**	**QAC Biannually**

The Committee also received the following items.
QAC/24/10/149 Deep Dive – Surveillance Programmes Backlogs & Position Update and Risk
QAC/24/10/152 Quality IPR Metrics
QAC/24/10/153 Cardiopulmonary Resuscitation (CPR) Decisions & Discussions (Adults) Position Report
QAC/24/10/154 Patient Experience Annual Report
QAC/24/10/156 Maternity Update
QAC/24/10/157 Quality Improvement update
QAC/24/10/158 Patient Equality, Diversity & Inclusion Sub-Committee Biannual report
QAC/24/10/160 Claims Report
QAC/24/10/162 High level enquiries/external inspections update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125a(ii)	Meeting	Trust Board	Date Of Meeting	4 December 2024

Date of Meeting	12 November 2024
Name of Meeting & Chair	Quality Assurance Committee, chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/11/169	**Hot Topic- Fragile services – Cardiology/ Cardiorespiratory**	The Committee received the Hot Topic in relation to Cardiology/Cardiorespiratory The presentation included- • Overview of current risks • Visibility of workforce pressures- recruitment ongoing • Overview of Harm profile Points of note include: • No moderate or severe harm noted in previous 2 years. • Action and recovery plans in place with plan to achieve trajectory by March 25 • Focus on high-risk patients	**Moderate** **Plans in place need to see outcomes of recruitment/ achievement of trajectories**	**Substantial:** **Monthly reporting with Executive oversight through Patient Safety and Clinical Effectiveness escalating to Quality Assurance Committee.**	**Patient Safety and Clinical Effectiveness Sub Committee (PSCESC) December 2024 Further information required to QAC regarding IPC incidents – December 2024**
QAC/24/11/170	**Deep Dive – Theatre safety Culture Survey and Culture Plan**	The Committee received presentation on Deep Dive in relation to Theatre Culture, Theatre Safety and Culture Plan The presentation included • Overview of findings from AQuA Culture Survey • Overview of Theatre Intervention Plan Points to note include	**Limited** **Actions presented however outputs not yet visible. Enhanced**	**Substantial:** **Monthly reporting with Executive oversight through PSCESC**	**PSCEC December 2024** **escalated to quarterly**

		• Several actions outlined within presentation • Need to consider how progress will be monitored and linked to QI	**monitoring required.**	**Escalated to quarterly reporting to QAC**	**reporting via QAC**
QAC/24/11/172	**Patient Safety and clinical Effectiveness Sub Committee Report.**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note • Electronic Blood Tracking/ED Blood Fridge Project timeframes were raised as a concern- increased Executive oversight in place • Discharge planning Audit Results – low compliance with documentation – Task and Finish Group launched to address areas of concern • Urology – challenge due to workforce – waiting list improving	**Moderate** **Assurance received – regarding fragile services – further improvements required** **ED Blood Fridge – limited assurance on timescales – increased executive oversight initiated**	**Substantial** **Monthly oversight through QAC** **Executive monthly oversight of Blood Tracking Project**	**February 2025**
QAC/24/11/178	**Medication Errors -Controlled Drugs**	The committee received an overview of • Incident themes and trends • Oversight of theft incident – covert cameras successfully utilised to identify multiple suspects – no further stock deficits noted since mid-September	**Moderate** Audits improving. Require further improvement. Need to see	**Substantive** Oversight by Executives and Non-Executives at QAC Strong oversight with	**QAC Biannually**

		Points to note • No moderate or above incidents reported • Actions and QI projects ongoing • Audit results improving, 100% coverage of all areas • Lower assurance in documentation audits and recording of balance transfers – targeted work ongoing	reduction in the number of incidents occurring.	scheduled Audits, quarterly monitoring via Medicines Governance and PSCESC	
QAC/24/11/179	Mental Health Update	The committee received an overview of • Regional and Local position • Overview of Incidents • Actions taken in past 12 Months • Update on Right Care Right Person The Committee noted • Assurance regarding the amount of improvement work ongoing • Increased reporting of Violence AND Aggression incidents- Priority work underway	**Moderate** Strong progress with workplan. Need to see Violence and Aggression plan conclude with reduced incidents reported.	**Substantive** Oversight by Executives and Non-Executives at QAC Strong oversight with scheduled Audits, quarterly monitoring via Mental Health Governance and PSCESC	

The Committee also received the following items.
QAC/24/11/171 Board Assurance framework
QAC/24/11/173 Sepsis high level update Q2
QAC/24/11/174 Dementia Strategy Biannual Report
QAC/24/11/175 Compliance Q2 Update
QAC/24/11/176 Medication Errors - Controlled Drugs
QAC/24/11/178 Maternity Update
QAC/24/11/180 Learning from Experience Q2
QAC/24/11/181 Infection Prevention and Control Q2

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Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125b (i)	Meeting	Trust Board	Date Of Meeting	4th December 2024

Date of Meeting	Wednesday 16th October 2024
Name of Meeting and Chair	Strategic People Committee, Chaired by Mike O'Connor
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPC/24/10/111	**Staff Story – Culture Champions**	**Adam Harrison-Moran, Head of Culture and Inclusion** Overview of the role of Culture Champions provided by the Culture and Inclusion team and the impact of the role on staff engagement. Currently c.100 Culture Champions across all staff groups. Culture Chmapions shared their positive experience of undertaking the role and how they are supported by the organisation with their role and are able to close feedback loops on issues that have been raised by staff. Also playing a key role in supporting staff to complete Staff Survey.	The Committee received **high assurance** of delivery of the role and impact.	The Committee received **high assurance** regarding the governance infrastructure to support the role.	N/A
SPC/24/10/112	**Hot Topic – PwC Report and Workforce**	**Carl Roberts, Associate Chief People Officer**	The Committee received **substantial**	The Committee received **high assurance**	As required

		Presentation focused on the PwC report and workforce issues, particularly the controls around pay. The following key points were highlighted: • Next steps from PWC • The completion of the Cost Improvement Programme (CIP) for non-pay variable pay on a substantive basis, which is done weekly • Daily changes to bank and agency staff • Summarised data submitted, with a focus on Key Lines of Enquiry (KLOE) The workforce CIP has been increased which requires a reduction in FTE. The organisation is currently off plan, with focus on fixed and variable pay to address.	**assurance** of delivery of the PwC actions.	regarding the governance infrastructure to support implementation.	
SOC/24/10/114	**Chief People Officer Report**	**Michelle Cloney, Chief People Officer** The Committee was informed that the national living wage had been revised in April 2024 and this had affected certain staff members who made payments for items such as lease cars or VivUp benefits through salary sacrifice. As a result, some employees' salaries fell below the minimum wage threshold. To address this, payments for these items were temporarily suspended from April to the present. Following approval from the Executive team, payments will now resume, and the Trust will reclaim the paused payments for the affected period. The majority of the repayments will be covered by the back pay scheduled for October 2024.	The Committee received **substantial assurance** of delivery of the actions to address the NLW.	The Committee received **substantial assurance** regarding the governance infrastructure to support PwC actions and decision making.	N/A
SPC/24/10/120	**GMC National Trainee Survey**	**Dr Paula Chattington, Director of Medical Education**	The Committee received **moderate assurance** of the	The Committee received **moderate assurance** that	N/A

		The Committee received an overview of the 2024 GMC National Trainee survey for the organisation. The organisation achieved a 90% participation rate, a significant improvement when compared with the previous year and above the national average. Significant improvements noted in Ophthalmology from negative to positive outlier which means that this will be removed from the Associate Dean review. The areas that have remained a consistently positive outlier are Anaesthetics and ICU. Biggest concerns focus on experience in achievement of out of hours rota and rota gaps in general. The Committee were keen to ensure that the voices of trainees were brought to greater prominence with discussion to take place aligned to quality governance route.	actions developed to respond to the survey.	there are robust governance routes in place to respond to trainee feedback on experience.	

Other reports received by the Committee:

- SPC/24/10/113 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPC/24/10/114 - Chief People Officer Report
- SPC/24/10/115 – WHH People Strategy: Bi-Annual Update
- SPC/24/10/116 – Monthly Safe Staffing Report Q2 incl Red Flags
- SPC/24/10/117 – Volunteer Update
- SPC/24/10/118 – We are WHH Culture Plan Bi-Annual Update
- SPC/24/10/119 – Bank Reduction Report Q2
- SPC/24/10/122 – Integration and Workforce Update
- SPC/24/10/124 – Committee Effectiveness Update on Actions

Chairs logs received by the Committee:

- SPC/24/10/122 – Workforce Inclusion and Culture Sub-Committee
- SPC/24/10/123 – Workforce Review Group

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

Governance Assurance: *Assurance in the internal controls in place*

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125b (ii)	Meeting	Trust Board	Date Of Meeting	4th December 2024

Date of Meeting	Wednesday 20th November 2024
Name of Meeting and Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPC/24/11/131	**Deep Dive – Fixed and Variable Pay Grip and Control**	**Carl Roberts, Associate Chief People Officer** Provided an update on various areas in relation to variable pay, and grip and control and these were outlined as follows: • FICC Key Lines of Enquiry • Workforce FTE increase • 2024/25 Pay CIP • Bank vs Agency Hourly Rates • PWR submission changes • PwC update In relation to the total spend on bank and agency, this would be mapped into vacancies and review of average costs which does seem higher. Findings would be included in future Pay Assurance reports to FSC.	The Committee received **substantial assurance** of delivery of the PwC actions.	The Committee received **substantial assurance** regarding the governance infrastructure to support implementation.	As required
SOC/24/11/136	**WHH Workforce Equality, Diversity and**	**Adam Harrison-Moran, Head of Culture and Inclusion**	The Committee received **substantial assurance** of	The Committee received **substantial assurance**	6 months

	Inclusion Strategy Update	The paper provided an update and assurance on the progress made in the delivery of the Workforce Equality, Diversity and Inclusion Strategy 2022-2025 which included: • Menopause guidance • Violence and aggression deep dive completed which reports through to Quality Assurance Committee, will be applying an EDI lens to the working group, aligned to risk 2103 • Initial review of ethnicity pay gap - initial findings would suggest there are not any disparities when reviewing through an ethnicity summary lens • achieved two charter marks • Sexual misconduct national policy framework • NHS EDI Improvement Plan	delivery of the actions to implement the strategy.	regarding the governance to support the strategy.	
SPC/24/11/137	**Health and Wellbeing Guardian Report**	**Jennie Dwerryhouse, Deputy Chief People Officer** An overview provided of the activity undertaken from April – September 2024 to provide assurance against the national Health and Wellbeing Guardian principles and refreshed responsibilities. The report detailed how the organisation is supporting the health and wellbeing of the workforce and the impact of interventions.	The Committee received **substantial assurance** of delivery of the actions to implement the strategy.	The Committee received **substantial assurance** regarding the governance to support the strategy.	6 months

Other reports received by the Committee:

- SPC/24/11/132 – Board Assurance Framework
- SPC/24/11/133 – Integration and Workforce Update
- SPC/24/11/134 - Chief People Officer Report
- SPC/24/11/135 – Workforce Integrated Performance Report (IPR)
- SPC/24/11/138 – Monthly Safe Staffing Report Q2
- SPC/24/11/139 – Midwifery Staffing Report Q2 Update
- SPC/24/11/140 - NHSE Self-Assessment Report for Education & Training
- SPC/24/11/141 – Guardian of Safe Working Q2 Update

Chairs Logs received by the Committee:

- SPC/24/11/142 – Operational People Committee
- SPC/24/11/143 – Workforce Review Group

Assurance Key:
Delivery Assurance: *Assurance in achieving outcomes*
Governance Assurance: *Assurance in the internal controls in place*

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed
Substantial	There is a good system of internal control designed to meet the system objectives, and that the controls are generally being applied consistently
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125c (i)	Meeting	Trust Board	Date Of Meeting	4 December 2024

Date of Meeting	28 October 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/10/138	**Hot Topic – PwC Forecast Update**	The Committee received the presentation noting:- • Financial Incident Command and Control (FICC) process now in place consisting of weekly returns and CEO meetings with PwC and the ICS • Movement in WTE compared to plan has been resubmitted based on a revised approach to submission • First meeting focussed on pay • Second meeting focussed on efficiencies and non-pay • Enhanced processes are being rolled out to increase grip and control • PwC focussing on three main areas (productivity, pay and non-pay grip and control and integration). UEC excluded as another review would not be beneficial at this time • Reduction from £7m gap to plan to £5.35m based on additional income from ERF and CDC and further offset of cost pressures	The Committee received **moderate** assurance based on delivery of the actions identified	The Committee **noted** and discussed the presentation receiving **moderate** assurance around process and procedures in place	**FSC November 2024**
FSC/24/10/139	**Deep Dive – Top 3 Cost Pressures**	The Committee received the presentation noting:- • Top three cost pressures from M5 were car parking / security, theatre consumables and ENT Medical Staffing • Car parking pressure forecast of £765k (reduction of £182k from M5) • Movement from 2019/20 due to reduction in income from patients / visitors, increased cost to Nexus as well as a reduction in number of staff paying for parking	The Committee received **moderate** assurance based on the continued overspend on cost pressures	The Committee **noted** and discussed the report receiving **moderate** assurance of the ongoing review	**FSC November 2024**

		• Theatre consumables cost pressure forecast of £365k (reduction of £57k from M5) • Cost per consumable more expensive this year compared to last year, explored bulk buying options which has reduced the cost • Increase in activity (with associated increase in income) has led to an increase in consumables for surgeries • ENT Medical staffing cost pressure forecast of £573k (increase of £188k from M5) • Main driver is consultant bank expenditure for on call costs to cover vacancies and maternity leave			
FSC/24/10/140	**Corporate Performance Report**	The Committee received the report noting:- • Number of 12 hour trolley waits has increased for the third consecutive month and is higher than this time last year • Continue to be behind trajectory for 4 hour performance and has deteriorated in month • Increase in Type 1 attendances	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the report receiving **substantial** assurance around level of detail reported	**FSC November 2024**
FSC/24/10/141	**Benefits Realisation ED Update**	The Committee received the report noting:- • Benefits of the investment include improved patient experience and improved turnover rates within nursing establishment • Assurance mechanisms in place to maximise utilisation of funding and only using bank and agency if absolutely have to maintain safety • Ongoing nursing cost pressure of £164k, full substantive recruitment expected by February 2026 as set out in the original revenue request • Number of patients on the corridors hasn't reduced, therefore unable to reduce funding at this stage, anticipated £0.5m in future	The Committee received **limited** assurance based on reduction in funding not yet seen	The Committee **noted** and discussed the presentation receiving **substantial** assurance around the management of the staffing levels in ED	
FSC/24/10/142	**Recovery Update**	The Committee received the report noting:- • 65 week position, 93 breaches remaining (only 8 due to capacity breaches), second in C&M Acute Providers	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC November 2024**

		• Max Fax, T&O and Pain are high risk for achieving the 52 week target • Forecast to spend between £3.5m to £3.6m based on straight line forecast of current spend	particularly in relation to 65 weeks		
FSC/24/10/143	**Monthly CIP Update**	The Committee received the report noting: • Month 6 CIP position is on plan £5.8m achieved – however stepped increase in the plan in the later part of the year • Fully identified £19.4m schemes of which £0.3m is high risk • £0.1m of £3m collaboration identified	The Committee received **moderate** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **substantial** assurance	**FSC November 2024**
FSC/24/10/144	**Monthly Productivity Improvement Update**	The Committee received the report noting:- Theatres • Ahead of trajectory for capped utilisation, improving late starts and procedures per session • On the day cancellations and theatre capacity to deliver job planned sessions deteriorated from last month • Underperforming on daycases due to delay in Endoscopy Hub opening which will be fully operational next month, increasing activity performance and income UEC • Reduction in amount of time patients spending on the corridor • Increase above target in patients accessing SDEC and UCR • Cost avoidance of £563k year to date however CIP not expected to materialise Outpatients improvement • Change of focus required to achieve DNA and clinic utilisation metrics given a plateau in achievement of the metrics • New approach with 3 workstreams (productivity / efficiency, pathway re-design and transactional / process / standardisation) • Additional work being undertaken around outpatient procedures to increase activity and related income	The Committee received **limited** assurance on the delivery of the improvement savings	The Committee **noted** and discussed the report receiving **substantial** assurance of the plans in place	
FSC/24/10/149	**Monthly Finance position – month 6**	The Committee received the report noting:- • Deficit support funding of £16.5m has been allocated to the Trust and the plan has been adjusted to reflect this (£27.8m reduced to £11.3m)	The Committee received **moderate** assurance due to	The Committee **noted** the paper receiving	**FSC November 2024**

		• At M6 the Trust is reporting a year to date £11.6m deficit (adverse variance of £0.7m due to Industrial Action only being partially funded) • Based on the current run rate the forecast would be £25m, based on current expectations the forecast is £20.6m inclusive of a risk adjusted forecast of £7m and a gap of £2.3m related to the pay award • Risks around cost pressures, CIP and collaboration target, risk of delivering the 104% income target and the impact of IA • Revenue requests supported by the Executive Team included	risks to the financial position.	**substantial** assurance	
FSC/24/10/150	**Capital Position Month 6**	The Committee received the report noting:- • Month 6 capital spend is £1.2m behind plan, expected to catch up later in the financial year • Movement in capital contingency was approved	The Committee received **moderate** assurance due to spend being behind plan.	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the contingency changes	**FSC November 2024**

Items for noting

FSC/24/10/145 Cost Pressures M6
FSC/24/10/146 Pay Assurance Report
FSC/24/10/147 Integration Update
FSC/24/10/148 Outline Business Case – Pathology Collaboration (approved to progress to Trust Board)
FSC/24/10/150 Schemes over £500k
FSC/24/10/151 Committee Effectiveness – Follow Up Report
FSC/24/10/152 Digital Strategy Group Update
FSC/24/10/153 Minutes Event Planning Group

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*
Governance Assurance: *Assurance in the internal controls in place*

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed
Substantial	There is a good system of internal control designed to meet the system objectives, and that the controls are generally being applied consistently

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No	There is an inadequate system of internal control as weaknesses in control, and/ or consistent non-compliance with controls should/ has resulted in failure to achieve the system objectives

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125c (ii)	Meeting	Trust Board	Date Of Meeting	4 December 2024

Date of Meeting	25 November 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/11/160	**Hot Topic – PwC Update & Forecast Update**	The Committee received the presentation noting:- • The mitigated financial forecast has been submitted to the ICS at £8.6m away from plan (revised deficit forecast of £19.9m), noting no formal feedback has been received • Key drivers of the revised deficit are high risk CIP, collaboration, the impact of Industrial Action and the unfunded pay award. • Run rate based on M7 is a £20.7m adjusted to £21.7m for phasing • Range from best (£18.5m) to worst case (£25.3m) with the likely case (£19.9m) being the submitted revised deficit forecast • The focus of FICC has been on starters and leavers, variable pay and spend on LLP, insourcing and outsourcing. • The Trust remains in mandated support	The Committee received **moderate** assurance based on consistent run rate	The Committee **noted** and discussed the presentation receiving **substantial** assurance around grip and control	**FSC December 2024**
FSC/24/11/161	**Deep Dive – EPCMS Lessons Learnt & Next Steps**	The Committee received the presentation noting:- • The recommendations from the lessons learnt from the failed procurement were discussed with some changes to be made, including one procurement advisor, a dedicated Programme Director, the ITT will be simplified and a reduced size of the evaluating panel • Phasing of FD funding profile has been revised by FD with capital and revenue funding being moved to next financial year (£2m to be spent in year). £1.4m of spend to be brought forward	The Committee received **moderate** assurance based on actions taken to date	The Committee **noted** and discussed the report receiving **moderate** assurance until the process is in place for the joint procurement	**FSC December 2024**

		to utilise the funding with funds to be ringfenced in later years for the project • Notification received that joint procurement is the only way to access FD funding therefore this is being explored			
FSC/24/11/163	**Corporate Performance Report**	The Committee received the report noting:- • Urgent Care as expected for this time of the year and improvement seen during November with the opening of A10 • Behind trajectory for 4 hour performance although in line with seasonal expectations • Formal notification received that the Trust is to come out of Tier 2 • Work is being undertaken to reduce the spend on elective recovery	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the report receiving **substantial** assurance around level of detail reported	**FSC December 2024**
FSC/24/11/164	**Recovery Update**	The Committee received the report noting:- • £1.9m spent year to date at month 7 against a forecast of £2.6m • Based on run rate this would equate to £3.3m by the end of the year therefore a review is underway to reduce spend whilst monitoring the number of patients expected to be waiting over 52 weeks by the end of the financial year as the planned spend is £2.6m	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC December 2024**
FSC/24/11/165	**Monthly CIP Update**	The Committee received the report noting: • Month 7 CIP position is on plan, £7.8m achieved (£6m is recurrent) • Fully identified £19.4m schemes of which £2.5m is high risk following an Executive review to re-assess the level of risk associated with the identified schemes. This is to be the focus of the deep dive next month • £3m collaboration target also deemed high risk • Improvement in PID completion percentage compared to last month	The Committee received **moderate** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **substantial** assurance	**FSC December 2024**
FSC/24/11/166	**Monthly Productivity Improvement Update**	The Committee received the report noting:- Theatres • Improvement in capped theatre utilisation, reduction of on the day cancellations and improvement in starting on time compared to prior month however still behind plan	The Committee received **limited** assurance on the delivery of the	The Committee **noted** and discussed the report receiving **substantial**	**FSC December 2024**

		• Significant risk identified on theatre utilisation / CIP delivery UEC • Improvement in Halton NCTR in October due to direct referrals for some pathways, this improvement hasn't continued into November • MWL are the lead provider of frailty virtual wards in Halton and are proposing to reduce the number of beds from 11 to 5 based on occupancy, this is being challenged • £713k cost avoidance year to date however CIP not expected to deliver in year Outpatients improvement • Deep dive is underway into outpatient opportunities to identify areas where additional income could be secured	improvement savings	assurance of the plans in place	
FSC/24/11/168	**Pay Assurance**	The Committee received the report noting:- • To achieve the WTE plan a reduction of 147 WTE bank staff is required • Bank is being used due to sickness, corridor care, opening A10, etc. • FICC process has focused on the bank rate compared to the agency rate as this has been found to be higher • Agency and bank are both managed by NHSP and when staff transferred from agency to bank, they were given an enhanced rate • The enhanced bank rate is being investigated; 45 days' notice required to decrease the bank rate on the NHSP contract	The Committee received **moderate** assurance due to review of bank rate requirements	The Committee **noted** the paper receiving **substantial** assurance around level of detail reported	**FSC December 2024**
FSC/24/11/175	**Decarbonisation Bid**	The Committee received the update noting:- • £1bn funding pot available for decarbonisation phase 4 • Funding to replace the boiler system at Warrington and CSTM • Windows and roofing costs have been included in the bid which are included in backlog maintenance in future years (2026/27 onwards) • £32.3m bid submitted along with £3.9m matched funding • Portal closed prior to bid submission – confirming with the company if the bid has been accepted	The Committee received **moderate** assurance whilst awaiting the outcome of the bid	The Committee **noted** the paper receiving **moderate** assurance around the detail of the bid	

FSC/24/11/177	**Monthly Finance position – month 7**	The Committee received the report noting:- • At M7 the Trust is reporting a year to date £12m deficit (adverse variance of £1m due to Industrial Action and pay award) • Cost pressures are currently being mitigated year to date • No further cash support is required for Quarter 3. • ERF variable activity has delivered 98.7% of plan • Revenue requests supported by the Executive Team included	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance	**FSC December 2024**
FSC/24/11/178	**Capital Position Month 7**	The Committee received the report noting:- • Month 7 capital spend is £1.4m behind plan, expected to catch up later in the financial year • Movement in capital contingency was approved • Development of 2025/26 draft capital plan underway and support given acknowledging it will be further refined • Support given for the use of FD funding on CDEL schemes with funding ringfenced for later years	The Committee received **moderate** assurance due to spend being behind plan.	The Committee **noted** the presentation receiving **substantial** assurance, **approved** the contingency changes and **supported** for Trust Board approval to use of FD funding on CDEL schemes	**Trust Board December 2024**

Items for noting

FSC/24/11/162 Board Assurance Report & Corporate Risk Register
FSC/24/11/167 Cost Pressures M7
FSC/24/11/169 Estates Strategy Progress Report
FSC/24/11/170 Integration Update
FSC/24/11/171 Sustainability Strategic Priorities Update – To be reported to Trust Board along with Quality and People Strategic Priorities
FSC/24/11/172 Medical Workforce Review Group Q2 Update
FSC/24/11/173 EPRR Core Assurance Update
FSC/24/11/174 Policies (Anti-Fraud, Bribery & Corruption and Overseas) – Policies supported to go to Audit Committee for ratification
FSC/24/11/176 Revenue Request – WLI – Supported to go to Trust Board for approval
FSC/24/11/178 Schemes over £500k
FSC/24/11/179 Digital Strategy Group Update

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*
Governance Assurance: *Assurance in the internal controls in place*

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/12/125(d)	Meeting	Trust Board	Date Of Meeting	4 December 2024

Date of Meeting	21 November 2024
Name of Meeting & Chair	Audit Committee, Chaired by Mike O'Connor
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
AC/24/11/73	**EPR Update**	The committee received an update in relation to the lessons learnt review which took place following the abandoned EPR process. The report outlined the review, its recommendations, emergent opportunities, emergent risks and next steps. Recommendations following the review were detailed and the committee received assurance around the lessons learned and mitigations now in place.	**Moderate –** the committee received evidence there is an adequate system of internal control; however, that there were some areas of weaknesses.	**Moderate –** the committee received evidence there is an adequate system of internal control; however, that there were some areas of weaknesses.	**A progress report to be presented to FSC in December**
AC/24/11/75	**Review of Quotation & Tender Waivers**	The committee received an update for the period 1 July to 30 September 2024, which showed an increase in the number of waivers, compared to the same period last year, however with a decreased total value. The committee were informed of the education programme in place to improve the position around retrospective waivers, in line with Trust Standing Orders and a Standing Financial Instructions, and noted the significant improvements in the Estates CBU.	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Moderate** - the committee received evidence There is an adequate system of internal control; however, that there were some areas of weaknesses	**Quarterly reporting to continue**

Other agenda items:
AC/24/11/66– Board Assurance Framework
AC/24/11/67- Committee Assurance update from Chairs of FSC, SPC, QAC
AC/24/11/68- Internal Audit Progress Report follow up actions (MIAA)
AC/24/11/69- Internal Audit Progress Report (MIAA)
AC/24/11/70 - Internal Audit Follow Up Report (MIAA)
AC/24/11/71- Anti-Fraud Progress Report (MIAA)
AC/24/11/72- Report and Updates from External Audit
AC/24/11/74 - Review Losses & Special Payments
AC/24/11/76 – Changes to SFIs

Assurance Key:
Delivery Assurance: *Assurance in achieving outcomes*

Governance Assurance: *Assurance in the internal controls in place*

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/126**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	4 December 2024	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper aims to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: Urology Orthopaedics – Fractured Neck of Femur ENT Cardiology and Cardiorespiratory Services Services de-escalated from Fragile Services oversight since last report: Theatres – procedural safety Services entering Fragile Services oversight since last report: None		
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision
RECOMMENDATION:	Trust board is asked to: • Note the current list of Fragile Services, associated clinical risk and high-level progress updates • Note progress towards stabilising the ENT staffing position with plans to the reduce the cost of these mitigating actions moving forwards through recruitment • Receive further Fragile Service Oversight reports		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/24/12/126

1. BACKGROUND/CONTEXT

Following recognition of a need for a systematic oversight mechanism for Fragile Services a formal process for oversight of Fragile Services has been incorporated into the PSCESC Agenda reporting to QAC and on to Trust Board since July 2023.

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

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

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

Theatres – Procedural Safety

- Update report received by October QAC
- No further never events (none for 9 months)
- 1 previous never event downgraded to no-harm incident by ICB following PSIRF PSII investigation
- 26% reduction in all-cause procedural incidents in last 3 months
- Recognised that while progress had been made, significant work is still required
- Recognised that the programme and its reporting would be more effective if held in the Care Group culture programme rather than Fragile Services
- Moving forwards the programme will report progress against plan and any further incidents bi-monthly to PSCESC and Quarterly to QAC

3. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

None

4. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

Summary

Improving overall waiting list position, however recent deterioration in P3 waiting list - service remains fragile from staffing and capacity/demand profile perspectives

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand
- Significant volume of high-risk patients on waiting lists confirmed by AI list validation

- P2 – waiting list static – however no longer growing
- P3 & P4 waiting lists show an overall positive reducing trend, although the P3 list has grown for 3 consecutive months
- Transperineal prostate biopsy position shows sustained improvement (>75% reduction in undated waiting list patients in year 120->30)
- Surveillance cystoscopy position very significantly improved from peak, with waiting list falling to fewer than 100 patients in November
- Decreased numbers of undated high risk follow up patients
- Ongoing risk of harm remains given P2/Stone, surveillance cystoscopy and emergent cancer performance risk
- Service exceeding clinical activity targets (>104% of 19/20 activity)

- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved and actioned
    - Additional middle grades recruited
    - Locum consultants commenced in post
    - Successful transfer of cystoscopy into UIU - UIU have increased cystoscopy case numbers per list.
    - Some weekend P3 outsourcing capacity diverted to deliver P2 activity in week

- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site
    - PCNL Stone patients transferred to Chester
    - Ongoing harm review process

- Ongoing improvement plan actions:
    - Urology Specialty Doctors require additional support to move to independent practice – plan in place
    - Specialist nurse delivered cystoscopy training plan now underway

- Follow up backlog plan requires further development – some insourcing capacity being diverted to service high risk follow up demand
- Plan to reintroduce PCNL at Warrington site as IR radiologist now in post – repatriation requires further planning, however no patients currently waiting for PCNL

Orthopaedics – Fractured Neck of Femur

Summary

Prompt surgery remains an unresolved quality and performance issue. Emergent risk around Orthogeriatric review capacity.

- Demand and capacity mismatch – driven predominantly by increased demand and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery is the remaining significant challenge
- Deterioration in orthogeriatric review performance given recent leavers in geriatrics
- Current mitigations:
  - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
  - Additional orthogeriatric consultant sessions funded & orthogeriatric fellow post at advert
  - Additional ad hoc fractured neck of femur lists utilising bank locum consultant
- Ongoing improvement plan actions:
  - Focused improvement plan to deliver 'prompt surgery' – revenue request in development to support extended trauma capacity
  - Further embed SOP to ensure that prolonged delays to theatre are escalated with escalation triggered by wait time as well as numbers waiting
  - MD supporting Medical and Surgical team in ensuring a sustainable model for medical support / orthogeriatrics is in place

Ear Nose and Throat Surgery

Summary

Waiting list position improved predominantly due to insourcing. Mitigations in place for medical staffing challenges, currently a significant cost pressure until recruited consultants commence.

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.

- Significant medical staffing challenges – deteriorating position now mitigated for with 2 consultant vacancies now recruited to
- No harm reported to date
- Additional capacity via LLP is supporting the reduction of patients awaiting 1st OPD appointments
- New OP waiting list has reduced significantly from >3500 to <1500.
- FU OP waiting lists remain a challenge but have improved in month
- High risk FU patients continue to be prioritised

- Completed Actions
    - Task and finish group established
    - Enrolled in phase one of GIRFT Further Faster program
    - Additional ENT stacker and scope in procurement for Warrington site

- Current mitigations
    - Outsourced sessions funded and underway
    - AI aided Harm Review process in place
    - 2 Trust F2 doctors to commence in post August 2024
    - 2 Consultants recruited – start Jan and April

- Ongoing improvement plan actions:
    - Ongoing strategic conversation with MWL and LUHFT regarding process to develop a sustainable ENT model for Mid and North Mersey
    - Incorporate Triage and clinical waiting list validation into job plans
    - Develop Local Anaesthesia biopsy service

Cardiology and Cardiorespiratory Services

Summary

Recently entered fragile services oversight. Demand and capacity mismatch driven by staffing issues and increasing demand.

- Cardiology pressures driven by consultant vacancies, consultant illness and a misalignment of activity in job plans resulting in excess capacity being directed towards cath-lab and elective work with a deficit in outpatient and inpatient capacity (Model Hospital data).
- Cardiorespiratory waits driven by demand / capacity gap and workforce issues
- No patient harm identified to date

- Completed Actions
    - Task and finish group established
    - Presented as hot topic to QAC
    - Consultant vacancy out to advert
    - Band 7 physiologist post recruited to

- Current mitigations
    - Locum Cardiologist supporting safe ward and acute care staffing
    - Successful recruitment into Assistant Technical Officer posts resulting in a reduction of 240 in the spirometry waiting list this month

- Ongoing improvement plan actions:
    - Medical Director, AMD and CD to undertake Consultant team job planning meeting to re-align job plan capacity with demand - December
    - Track progress for capital funding for ambulatory monitors
    - Complete scoping exercise to for ambulatory disposable patches
    - Monitor Spirometry Waiting Times following recruitment of ATOs
    - Pursue training support from Cheshire & Merseyside Physiologist Network for training support in Cardiorespiratory
    - Complete Cardiorespiratory Workforce Skill mix review

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note the de-escalation of Theatres (Procedural Safety) out of the Fragile Services oversight program into an alternative Quality Governance reporting structure
- Note the stabilised position with regards to ENT Medical Staffing, associated cost pressures and the positive consultant recruitment to reduce these
- Receive further Fragile Service Oversight reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12127**	
SUBJECT:	Compliance Update Q2 2024/25	
DATE OF MEETING:	Compliance Update Q2 2024/25	
AUTHOR(S):	Fliss Swift, Head of Compliance	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides compliance updates for Q2 of 2024/25. Items contained within this report have either been discussed at the Quality Compliance Oversight Group (QCOG), or at the Health and Safety Sub-Committee.

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the update		

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/24/11/175
	Date of meeting	12.11.2024

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

REPORT TO TRUST BOARD

SUBJECT	Compliance Update Q2 2024/25	AGENDA REF:	BM/24/12/127

1. BACKGROUND/CONTEXT

The CQC is the independent regulator of Health and Adult Social Care in England. Their role is to make sure both Health and Social Care Services provide people with safe, effective, compassionate, high-quality care and they encourage Care Services to improve. The CQC monitor, inspect and regulate services and publish findings. Where poor care is found, the CQC have powers to act, including implementing enforcement notices, if deemed appropriate. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) continues to make sure it provides people with safe, effective, caring, and responsive services and that it is well led.
To monitor performance in relation to Trust compliance obligations, a Quality Compliance Oversight Group (QCOG) was formed. The second meeting took place on 18 September 2024.

2. KEY ELEMENTS

Items reported to the QCOG Meeting, held on 18 September 2024, reflected the quality compliance work being undertaken during 2024/25, as well as outlining health and safety compliance visits from other agencies. The updates were as follows:

- CQC General Update - Engagement Pilot Schemes & Enforcement Update
- Single Assessment Framework progress
- Update on Must and Should Do's
- Risk Management – Potential hot spot areas that could provoke CQC interest.
- Positive Trust news/initiatives for CQC
- Mock Assessment Schedule
- CQC enquiries
- Health and Safety Inspections

2.1 ENGAGEMENT PILOT SCHEMES AND ENFORCEMENT UPDATE

Warrington and Halton NHS Trust (WHH) have been accustomed to regular CQC Engagement Meetings whereby the CQC Regional Management Team meets with the Trust Senior Team on a quarterly basis. With the introduction of the CQC's new Single Assessment Framework, Engagement Meetings of this nature no longer formed part of the process, however the Cheshire & Merseyside CQC Teams continued with this approach. Now, the benefits of these meetings have been recognised at a national level and a standard provider engagement template has been developed.

The process is that the CQC Operations Manager, inspector/assessor, and Regulatory Coordinator should meet ahead of the formal meeting with the Trust. This Pre-Engagement Preparation Meeting is an opportunity for the CQC Team to discuss any themes, trends, risks or concerns and areas of good practice identified from the review of intelligence. The finalised, tailored agenda for the Engagement Meeting from the preparation session is then sent to the Trust by the inspector/assessor.

The meeting agenda allows for discussion to include questions or concerns raised from data sets or Board of Directors papers, and review of Integrated Performance Reports. The sections of the Engagement Meetings are as follows:

Item	Themes	Additional information
CQC Update	Updates on CQC's work and transformation. National reviews and reports	
Quality Updates Safe	Update on previous or new: Safeguarding Concerns Patient Safety Incidents Other notifications Regulation 28 reports Staffing Mortality indicators and LEDER	*Acute Trusts to include:* Patient flow Discharges RTT Electives Cancer services Diagnostics UEC performance
Quality Updates Effective	Provider concerns from clinical audit, clinical outcomes. Update on outcome of local and national audits. Mandatory Training Supervision and Appraisal Mental Health Act Compliance	
Quality Updates Caring	Outcomes of Friends and Family Tests Patient satisfaction analysis Good news story	
Quality Updates Responsive	Access and waiting times. Complaints and Compliments Any changes to service provision (wards closed or moved, environmental changes, services in business continuity). CQC Enquiries	
Quality Updates Well-led	Risk Register: (any changes to current risk status with brief outline of mitigating actions taken by the board.), *to Include questions from reviewing board papers (BAF).* Staff engagement Board changes Areas of media interest	
Service Highlight Discussion	Section to discuss a core service at each meeting. What does the service provide? Service quality Risks, concerns, good practice.	WHH have used this as an opportunity t undertake informal visits to departments e.g. The CQC visited UED in August pri to the Engagement meeting
Other Matters of Concern		
Any other business		

The next CQC Engagement Meeting is due to take place on 13 November 2024 and preparation is underway. In addition to the standard agenda items, the CQC have added more specific topics to their agenda, under three of the five Quality Update sections. These are;

<u>Quality Updates – Safe</u>

- IPC: Discussion on the trust as a low outlier.

- Sepsis performance: Update on sepsis improvement plan.
- Patient flow: NCTR performance and discussion on how discharge is looked at in assessment
- VTE assessments: Discussion on VTE performance and top 5 wards.
- RTT: Discussion on 52-week waiters.
- UEC performance: Increase in handover times noticed, discussion on UEC performance and current demand.
- Theatre Utilisation: Discussion on new risk in utilisation noted in IPR.

Quality Updates – Effective

- Provider concerns from clinical audit, clinical outcomes: How is the trust responding to MUST compliance?
- Mandatory Training: Trust's consistent high performance in MT noted, discussion on what is considered mandatory training and how the trust is achieving sustained compliance.
- Supervision and Appraisal: Appraisal rates appear consistently below the trust's target. How does the trust monitor appraisals and when does the trust expect to achieve 85%?
- Mental Health Act Compliance: How does the trust monitor compliance of the mental health act and how does the trust monitor quality and performance in the psychiatric liaison services?

Quality Updates – Responsive

- Complaints and Compliments: Trust's consistent high-performance in complaints noted from review.

There is a section in the agenda called Service Highlight Discussion" and the focus on the last visit was UEC. The intention is to undertake an informal visit of 2 clinical areas yet to be determined, so the CQC can see the environment for themselves, hear about the quality initiatives being undertaken and initiate their own discussions directly with the staff. An update will be provided in due course.

CQC Enforcement Presentation

In Quarter 2 the CQC presented a special update, via Teams, to discuss enforcement powers.

Enforcement powers under the Health and Social Care Act 2008, as amended by the Care Act 2014, are there to improve Health and Adult Social Care Services and protect the health, safety and welfare of people who use them. The revised policy took effect from 21 November 2023 and replaced the previous Enforcement Policy.

CQC can prosecute for a breach in regulation or a breach of part of the regulation if a failure to meet the regulation results in avoidable harm to a person using the service or if a person using the service is exposed to significant risk of harm.

There are 4 stages for enforcement.

1. Initial assessment
2. Legal and evidential review
3. Is there a there a breach of a legal requirement? (Legal check)
4. Is the evidence sufficient, credible, and appropriately recorded, stored and retrievable? (Evidential check)
    - Selection of the appropriate enforcement action

- Seriousness of the breach
- Multiple or persistent breaches
- Criminal enforcement
- Final review

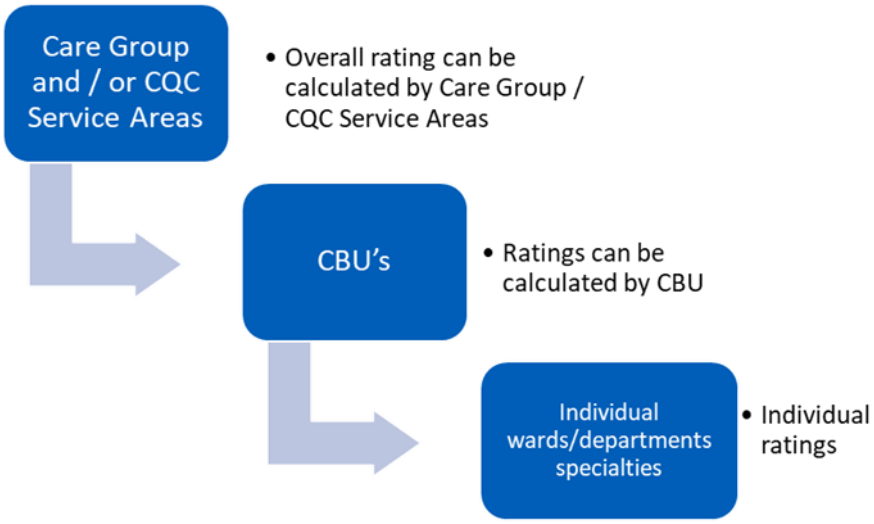
The Trust should always directly notify the CQC about potential significant harm incidents. The next issue is to assess if there is an ongoing risk of harm for others. If the CQC are not assured, this can lead to an inspection and potentially, a prosecution.

Prosecutions are rare. Over the last 10 years there have only been 10 NHS Trust prosecutions (and 3 were for one Trust). If a Trust is prosecuted, it is the *organisation* who faces action, and not any *individual*. If found guilty, the penalty is always financial. To reduce the change of a prosecution all Trusts need to undertake due diligence and take reasonable steps to minimise risk. Therefore, it is imperative the Trust makes sure that policies and processes are up to date and that mandatory training is also meeting compliance targets.

2.2 SINGLE ASSESSMEENT FRAMEWORK (SAF)

Work has been taking place with Care Groups. They were asked to evaluate their evidence and consider an appropriate score against each of the individual statements. This has provided an initial benchmark to work with. The challenges are to endeavour to score consistently across all units, and to recognise that this is a one-dimensional view. It gives an indication as to areas of both strength, and areas that might require improvement. However, there is still scope to factor in priority areas of work and ensure that emphasis is placed where the most significant gains can be achieved and are of most value.

Work being undertaken so far.

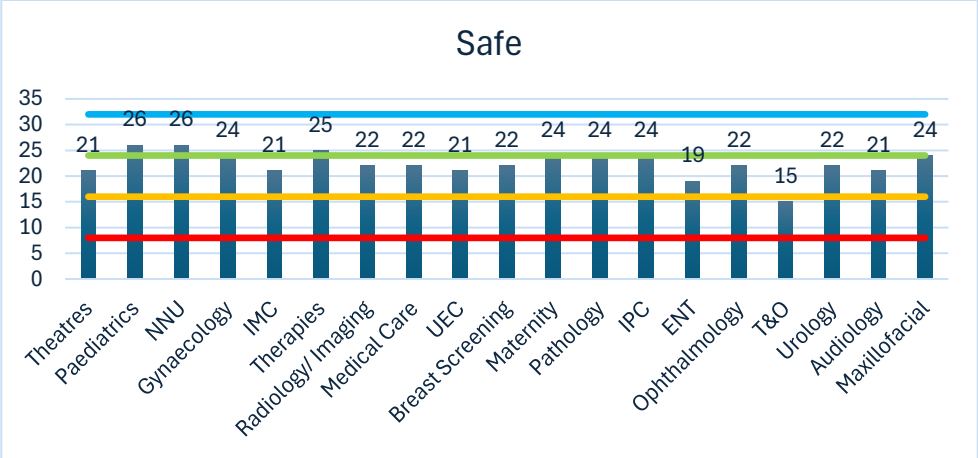


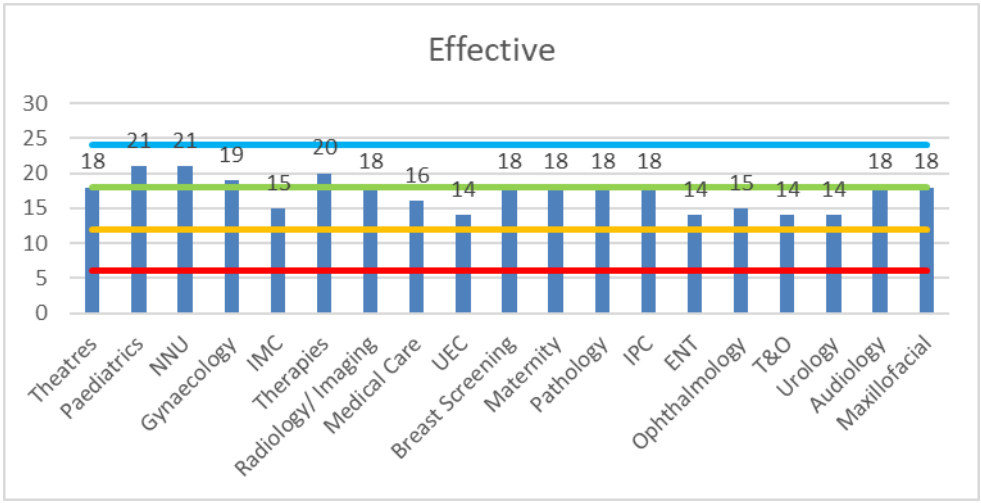
The scores have been broken down against each individual Quality Statement and then overall results for each of the five key the questions have also been evaluated. An initial progress update was shared at the Quality Compliance Oversight Group in September 2024 and an overview of the work was presented at the Executive Strategy Away Day, also held in September.

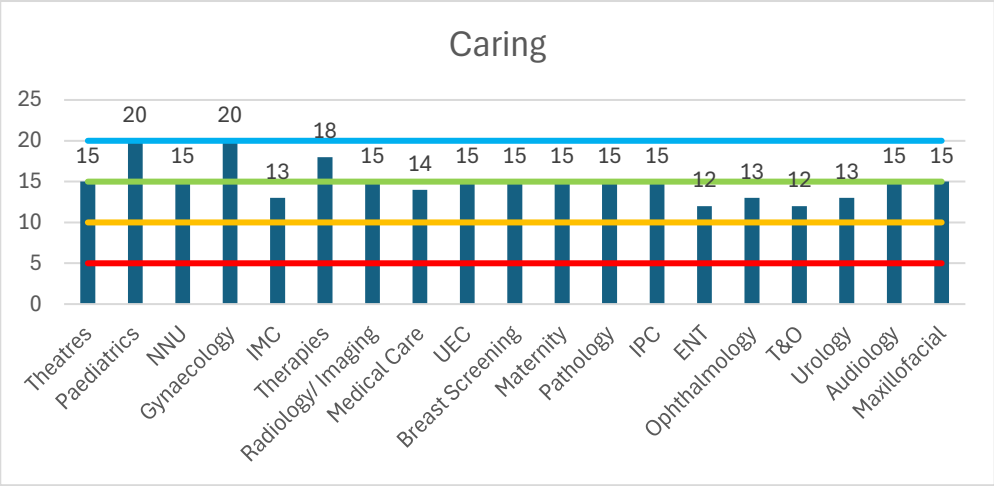
There are 34 Quality Statements in total, which replace over 300 Key lines of enquiry. A total between 1 and 4 points can be awarded to each statement, giving 136 as a maximum number of points achievable.

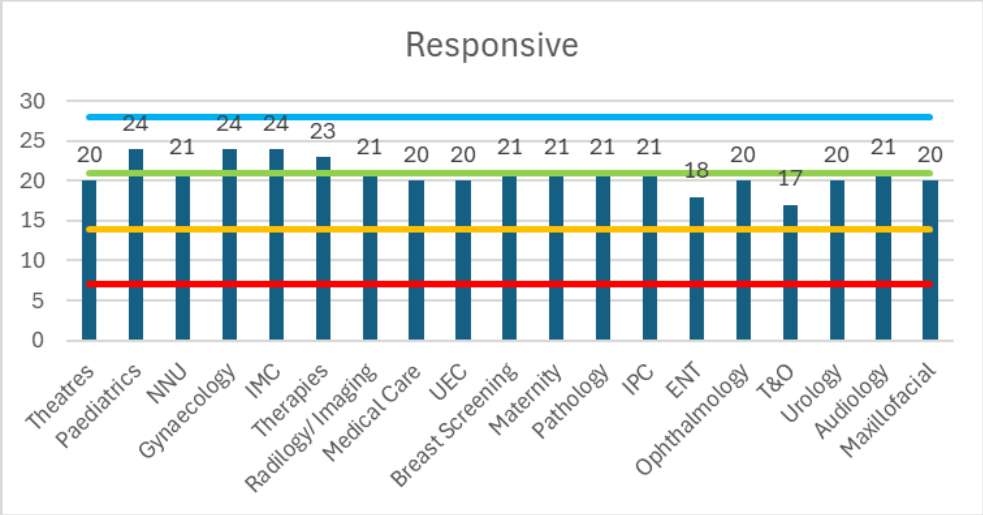
Safe	8 statements	32 points available	**25 to 38% (Inadequate)** **39 to 62% (Requires Improvement)** **63 to 87% (Good)** **Over 87% (Outstanding)**
Effective	6 statements	24 points available	
Caring	5 statements	20 points available	
Responsive	7 statements	28 points available	
Well-Led	8 statements	32 points available	

It is now possible to critically review and assess our evidence against each of the quality statements and for each of the CQC's 5 key questions. The minimum percentage lines for each of the achievement standard are colour coded, so it is easy to identify how each area is performing. This is a high-level view, and work continues to drill down by individual wards and departments within the CBU's for each Care Group.









the scores is currently being validated and scruitinised, and amendments to the initial scores are being undertaken where necessary. This will be reported via CQOG.

The final self-assessment information will then be used to influence the order of ongoing mock assessments from Quarter 4. This exercise is identifying key areas of focus where evidence may need to be strengthened. The ratings will then be routinely evaluated quarterly and adjusted accordingly.

Well led was also self-assessed for the Trust as a whole and was rated as a “strong good” (to achieve good, the percentage achievements for the Quality Statements need to be between 63% & 87%).

Department	SAF	• QS	Description	Points	Percentage
Well-Led	WELL-LED	QS-WELL1	Shared decision and culture	3	
	WELL-LED	QS-WELL2	Capable, compassionate and inclusive leaders	4	
	WELL-LED	QS-WELL3	Freedom to speak up	3	
	WELL-LED	QS-WELL4	Workforce equality, diversity and inclusion	3	
	WELL-LED	QS-WELL5	Governance, management and sustainability	4	
	WELL-LED	QS-WELL6	Partnership and communities	3	
	WELL-LED	QS-WELL7	Learning, improvement and innovation	3	
	WELL-LED	QS-WELL8	Environment sustainability	3	
			Total	26	81.25%

2.3 MUST DOs AND SHOULD DOs

There are 4 regulatory breaches still in place due to capacity and demand in the Emergency Department.

ED Inspection visit of 16 February 2019 and published on 15 April 2019		
	Must Do's	**Current position**
1	Crowding in the Emergency Department is reduced so that patients do not have to wait. on trolleys in corridors **Regulation 12(2)(b)**	Operational performance continues to be monitored by the Performance Review Group (PRG). • Electronic NEWS system reports audited by Deteriorating Patient Group and oversight from PSCE with escalation to QAC as required. • Manchester Triage System embedded • Waiting Room Nurse in place • "Call for Concern" in line with Martha's Rule Business Case approved for investment in additional nursing staff for the department – recruitment ongoing.
2	Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals **Regulation 12(2)(a)(b)**	
3	There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department **Regulation 18(1)**	
4	Information about the performance of the Service is accurate and properly analysed and reviewed by the Leadership Team. **Regulation 17(2)(a)**	
	Should Do's	**Current position**
1	Improve and monitor the speed of response from Senior Specialist Doctors when patients have been referred to them by the Emergency Department.	Review undertaken identified communication issues between clinicans. SOPs have been strengthened. Improvement are being monitored and reported vi the ED Improvement Group.
2	Implement hospital-wide measures to reduce delays in admitting patients from the Emergency Department.	WHH implemented a continuous flow model in October 2023 and have a robust boarding plan for base wards to support maintenance of safe occupancy within the Emergency Department. WHH has streaming processes in place.

CQC inspection & Well-led review 29 March - 2 May 2019 and published in 24/7/2019 **Should Do's**	
Area	**Status**
Trust-wide	9 completed and being monitored via QCOG/Care Group Governance
Warrington	15 completed and being monitored via QCOG/Care Group Governance
Halton	6 completed and being monitored via QCOG/Care Group Governance

Maternity Services at Warrington Hospital – published 17 January 2024 **Should Do's**		
	Should Do's	**Current position**
1.	Not all staff had completed the required mandatory training	Mandatory training compliance continuously monitored in Strategic People Committee, Workforce Review Group and Care Group Governance Meetings.
2.	Policies were not always in place or did not reflect current practice or provide sufficient guidance for staff.	Progress monitored monthly at specialty governance and delays escalated via CBU Governance.

		Guideline Review Group in place. Policy compliance monitored in Safety Oversight Meeting Weekly.
3.	Service should ensure that electronic patient records are integrated as far as is possible to avoid the risk of missed information.	Information pulled through to Badgernet. BadgerNet documents sent via EDT message to share to care and e-outcome. WHH and BadgerNet single pregnancy record.
4.	The service should continue to develop, communicate, and embed the transitional care provision.	Compliant with Saving Babies Lives Care Bundle V3 - external review by LMNS. Transitional Care Working Group in place. jointly led by Lead Nurse for Child Health and Deputy Director of Midwifery, Inpatient Matron, NNU and Maternity Ward Managers Robust action plan in place, monitored via CBU governance. TC service & NEWT2
5.	The Service should ensure that all staff complete regular Simulation Training/Skills and Drills training.	Programme of skills and drills in place in addition to those completed within Prompt and AIMS.

2.4 RISK MANAGEMENT

A discussion took place at QGOG around the Trust policy position. There is a revised governance plan in place this is monitored via the Safety Oversight Meeting with actions to address any policies that lapse. QGOG will continue to maintain oversight of the Trust policy position including work being done to address areas of deficit.

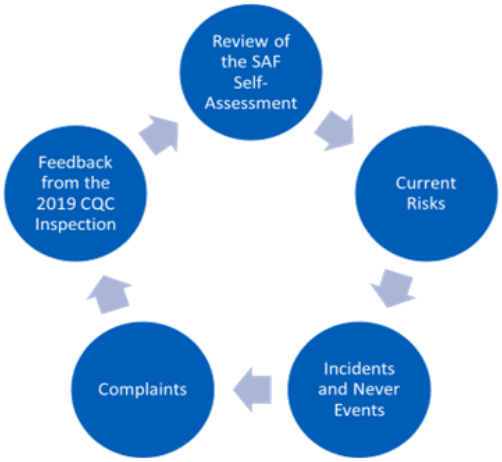
2.5 POSITIVE TRUST NEWS

National/Clinical Audits are showing excellent outcomes, and all targets are being met.

2.6 MOCK ASSESSMENTS

The Mock Assessment Programme commenced with an initial assessment of ED in June 2024. The next mock assessment was deliberately developed after the initial Single Assessment Framework self-assessments had been completed. The information gained for the self-assessment was used to inform and direct lines of enquiry for the mock. The aim is to undertake mock assessments bi-monthly, subject to operational pressures.

Theatres was also chosen as the next area of focus, due to recent known risks that caused Theatres to become a Fragile Service. The mock assessors visited the Theatres at Warrington over a week and at different times during each day. The visits took place between 16 and 20 September. However, it was not possible to assess Halton Theatres, as they were not in operation at the time of the assessment. A range of information was used to inform mock assessment questions and key themes of interest.



Information used to compile mock questions.

Overall, the assessment was extremely positive. The Theatre environment was clean, calm, and it felt safe and well managed. Staff were knowledgeable, thorough, and interacted well amongst themselves and with patients. The team culture was evident.

There were some general points that all areas of the Trust (not just Theatres) can learn from:

- Information displayed must be kept up to date and relevant
- Food must be in date and stored appropriately
- Training and Compliance must be monitored, and achievement targets reached and maintained
- Use of patient, carer and staff feedback – engagement is key
- Uniform Policy to be adhered to
- ID to be work/carried at all times and must accurately reflect job role

These points have already been shared at a recent Chief Nurse Check-in; they will be discussed at the next QCOG Meeting which is scheduled for 13 November 2024. A Communication Plan has been developed that identifies a variety of mediums for sharing messages from the compliance portfolio. These communications commenced from Quarter 3.

In addition, there were some considerations for Theatres specifically:

- 2 Datix incidents had to be reported during the assessment
- Ventilation issues. Revised schedule of work for Recovery with 3 air changes against a standard of 15 air changes must be a priority. (High risk) actions are in place to mitigate this/reschedule work
- Consideration to increase frequency of staff meetings and minute them
- Prompt starts for huddles is essential (to achieve full capacity on Theatre lists)
- The Assessment Team questioned if Theatres can be truly responsive to all demands, particularly whilst Halton theatres are closed, and Theatre 7 at WHH is now permanently used for training (not functional due to ventilation issues). Further work underway to address this issue and identify any associated risks

Finally, the Assessment Team found no safety issues that required immediate escalation that the Trust was not previously aware. A draft action plan has been developed and when finalised, it will be

monitored to ensure actions are adequately addressed. Updated action plan will be presented to next QCOG Meeting.

2.7 CQC ENGAGEMENT MEETNG 06 AUGUST 2024 AND ENQUIRIES

The last CQC Engagement Meeting took place on 6 August 2024, and it included an in formal visit to Urgent and Emergency Care. CQC colleagues gave verbal feedback at the end of the Engagement Meeting, and it was extremely positive.

Key topics of the August Engagement meeting were as follows.

- CQC updates
  - Transformation programme for CQC
  - Current challenges
  - Penny Dash review
  - 3 major work streams – SAF, systems and the provider portal
- WHH presented a Maternity update including *Mothers and Babies: Reducing Risk Through Audit and Confidential Enquiries.*
- WHH presented an overview of the excellent work being undertaken to address pressures around infection prevention and control
- The Trust Chief Pharmacist provided an update around current work streams, areas of concern and medicine reconciliation
- Specific service updates were presented for
  - Planned Care
  - Unplanned Care
  - Mental Health
  - Fragile Services

There was a total of 6 CQC enquiries in Q2, 4 of which were fully investigated and successfully closed. Two enquiries remain ongoing.

Closed Enquiries

Category	Query	Comments
Potential Serious Incident	Service user nearly fell form a 3rd floor window.	Window lock was in place, but patient managed to break it. For additional safety alternative window locks have been procured, and a schedule of works has been planned for phased installation. **Case closed on 09/08/24**
Whistleblower – Anonymous	Nurses lacking empathy. Concerns regarding care and pain relief.	All issues addressed and assurance was given. CQC satisfied with the response. Case closed on 09/09/2024
Anonymous Concerns re: staffing, care and medication	Concerns relating to Ward A2. Key areas of concern; • Patients being moved to different areas of the hospital out of hours. • Basic care concerns • Delays to care and treatment.	Likely to be linked to the enquiry above. All issues addressed and assurance was given. CQC satisfied with the response. Case closed on 11/09/2024

Concerns re: patient care	Concerns re: patient on oxygen and not being re-connected when transferred to AMU- no harm to patient.	Full investigation undertaken. Human error. Reflective practice. Reminder sent to all staff. All issues addressed and assurance was given. CQC satisfied with the response. Case closed 10/10/2024

Ongoing Enquiries from Q2

Category	Query	Comments
Concerns raised by a relative of a patient to the CQC	Concerns re: Delays for patients being cared for on the ED corridor impacting on level of support offered to patients.	Internal request for information sent out. **Target completion date 13 November 2024.**
Concern	Concerns about staffing for Trauma & Orthopaedics and a question about whether staff are suitably trained to deal with the level of acuity of patients.	Internal request for information sent out. **Target completion date 13 November 2024, as this case is to be added to the Engagement agenda for discussion.**

New Enquiries just logged in Q3

Category	Query	Datix No	Comments
Complaint – ISR	Concerns re: patient care in ED	196155 (2232/22151)	Currently awaiting review of PSII and when finalised send a copy to CQC – **Target date for completion is Jan 2025 (6months)**.
Monitor PSIRF Data – Severe Physical Harm	Review of 12 incidents. This was following inconsistencies between DATIX and LFPSE due to a technical issue that has now been resolved. CQC seeking assurance both systems now aligned for the individual incidents and due diligence has been applied.	**Awaiting Closure** – 193875 **Ongoing** – 193102, 193464, 195185, 192751, 192914, 194153, 195035, 195037 **Closed** – Ref.147805840 194891 195208	Initial information provided and then subsequent questions are still being have been raised and addressed.

2.8 HEALTH AND SAFETY INSPECTIONS

Trust Food Safety Consultants (Mercury Support)	Warrington Ward Kitchens - An external Contractor (Mercury Support) visited the Trust on 9 September 2024 to provide advice and support for the up-and-coming Environmental Health Inspection in October 24. Issues were identified and there will need to be some preparation work carried out throughout September 24. • Cereals, jams, sauces and butters were decanted from the original packets which meant use by dates were unavailable. • No allergen matrix was made available due to decanting. • Food brought in by patients' family were not labelled with use by dates which should be consumed within 24 hours. • Refrigerator temperatures were too high, and no records were available. • The hot water at hand basins was too hot. • Décor and furnishings were poor and dirty and single use cloths were not being disposed of • Damaged furnishings need replacing.

An action plan is in place and preparatory actions are ongoing in anticipation of the forthcoming Inspection.

3. NEXT STEPS

A comprehensive workplan has been developed to support the SAF and the changes in regulatory methods. If there are any further regulatory changes, or methods of working alter, the compliance work plan will be modified in line with latest guidance. The immediate objectives are as follows

- Self-assessment ratings for Safety Oversight Framework continues. The ratings and associated supporting evidence will determine the order of priority for assessments. Continue monitoring and progression for all 'must do's' and 'should do's'
- Scope all services that require accreditation and associated inspections and plan for peer review in preparation for inspections
- Progress IT solution plan including data collection and mapping against CQC evidence standards
- Work with the Associate Director of Nursing with a view to aligning elements of the CQC mock assessments with the established Ward Accreditation scheme
- Discharge planning. Safe, timely and effective discharge has been questioned in some recent enquiries. A new discharge work stream is starting, and Compliance have asked to be a part of this group
- Reduce the number of outdated policies, weekly reports to the Care Groups – full oversight via the Safety Oversight Meeting

4. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/128**	
SUBJECT:	Maternity & Neonatal Update	
DATE OF MEETING:	4 December 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
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 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. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		

	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an overview of activity, performance and quality within the maternity and neonatal services. The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 *(Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues)* alongside emerging local and regional matters. The paper provides a summary in relation to the following reports for oversight and discussion: • October Maternity Quality & Safety update – appendix 1a and 1b • November Maternity Quality & Safety update – appendix 2a and 2b • Maternity Incentive Scheme Year 5 and 6 – appendix 3a and 3b • ATAIN Q1 2024/25 – appendix 4 • Ockenden position – appendix 5 • PMRT Q2 2023/24 – appendix 6 • Biannual Maternity Self Assessment - appendix 7a and 7b • Review of harm events – appendix 8 • Q2 Midwifery Summary Safe Staffing Report – appendix 9a and 9b		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee and Strategic People Committee	
	Agenda Ref.	QAC/24/10/157 QAC/24/11/180 SPC/24/11/139	
	Date of meeting	8th October 2024 12th November 2024 20th November 2024	
	Summary of Outcome	Noted and approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update Summary Report	AGENDA REF:	BM/24/12/128

1. BACKGROUND/CONTEXT

This paper provides an overview of activity, performance and quality within the Maternity and Neonatal Services.

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

This paper provides a summary in relation to the following for oversight and discussion:

- October Maternity Quality & Safety update – appendix 1a and 1b
- November Maternity Quality & Safety update – appendix 2a and 2b
- Maternity Incentive Scheme Year 5 and 6 – appendix 3a and 3b
- ATAIN Q1 2024/25 – appendix 4
- Ockenden position – appendix 5
- PMRT Q2 2023/24 – appendix 6
- Biannual Maternity Self Assessment - appendix 7a and 7b
- Review of harm events – appendix 8
- Q2 Midwifery Summary Safe Staffing Report – appendix 9a and 9b

All papers have been shared and discussed at the appropriate committee meeting.

2. QUALITY & SAFETY MEASURES & METRICS

A review of quality and safety within the maternity and neonatal services is shared with Quality Assurance Committee (QAC) each month across a range of key themes and areas of national and local focus. These detailed reports are included in appendices 1a and 2a.

2.1 Patient Safety Events

In August and September 2024 themes from patient safety events were as follows:

- Admission of term babies admitted to Neonatal Unit
- PPH >1500ml
- PPH >1000ml
- Postnatal readmission

All patient safety events have received an internal review to identify urgent learning. Further details of the cases, learning identified and plans to improve are included in the detailed reports.

11 postnatal readmissions were reported in September 2024. The Q2 cluster review of postnatal readmission has also been completed. For the period 1st July 2024 - 30th September 2024, 24 women were readmitted to the maternity unit following 676 births. This

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provides a readmission rate of 3.55%. This is a reduction of 1.32% from Q1. There are no national maternity dashboards to benchmark postnatal readmissions, however, the National Maternal and Perinatal Audit reports an average of 3.3% readmission rate across England and Wales. This suggests WHH is not an outlier for postnatal readmissions.

Of the 24 postnatal readmissions, 11 of the readmissions were deemed avoidable (45%). This is an increase from 10% avoidable readmissions for Q1. Themes from the avoidable cases include blood pressure management not optimised prior to discharge home, lack of senior review of women experiencing hypertension prior to discharge home and community midwife not reviewing women following caesarean on day 5 visit.

Of the women readmitted, 50% were due to a wound infection (N=12) and 16% were due to hypertension (N=4). There were no women readmitted with retained products of conception, which accounted for the majority of women readmitted in Q1.

Actions have been identified as follows:

- Postnatal blood pressure proforma to be developed by C23 manager in consultation with the obstetric team
- MEWS2 roll out by March 2025
- All women following caesarean seen by registered midwife at home on day 5 to facilitate effective wound review

Specifically in response to an increase in postnatal readmissions due to wound infection the following actions are underway:

- A wound care surveillance working group is reviewing all women readmitted due to wound infection and has conducted a health surveillance survey for all women who have birthed via caesarean to develop actions to prevent reoccurrence
- Wound dressings are now removed at 48 hours as opposed to 24 hours
- Community midwives are seeing all women who birthed via caesarean on the primary visit and on day 5
- Work is ongoing with maternity theatres and the wider multidisciplinary team to ensure all women are given prophylactic antibiotics, the correct preparation is used, the abdomen is draped appropriately and theatre attire is adhered to.

2.2 Workforce metrics

Positive performance with regard to retention and vacancy rates are being sustained across the maternity and neonatal teams. Work remains ongoing to maintain compliance with mandatory training and improve metrics related to completion of staff appraisals. Improvement in relation to maternity specific training has improved and is now meeting all compliance targets as per the table below.

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Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	97.6%	91.6%	95.4%	96.2%	70%
Obstetric Consultants	100%	90%	90.9%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic Consultants	93.1%	n/a		n/a	n/a
Maternity Support Workers	96.5%	n/a		n/a	46.1%

*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track

A robust plan is in place with regard to achieving compliance targets for appraisals.

2.3 Service User Feedback

Service user feedback is collated and triangulated via a variety of sources. The midwifery team have recently met with a family to respond to a formal complaint. Within the complaint there was considerable feedback regarding the experience of the family. This included:

- Lack of awareness of how language and the tone of language used around women and families in an emergency situation can impact on their experience
- Feedback regarding the language used within the BadgerNet record when documenting the birth, in particular use of phrase “a lovely forceps delivery”
- Feedback regarding how discussions around consent were managed during intimate procedures
- Lack of compassion from staff and students
- No immediate debrief from intrapartum staff following the emergency
- Lack of handover of special circumstances (women had a documented history of PTSD)

As a result of this feedback a number of improvement actions have been instigated:

- Clinical simulation session to be developed which will include awareness of impact of human factors, environmental factors, communication, and consent including how the team communicate with the family during an emergency situation.
- Feedback to obstetric team in relation to language used in documentation
- Sharing of feedback with Specialist Midwife – Practice Education in relation to appropriate and sensitive conversations from students to families
- Family keen for experience to be shared with staff via a patient story
- Learning to be shared regarding provision of pain relief on transfer from Maternity Triage to Birth Suite during an emergency (Entonox should have been offered) and in relation to compassionate care
- Two day training course approved for 24 midwives to attend to become Birth Trauma Advocates to support women experiencing birth trauma and PTSD

The midwifery service continues to work in collaboration with the Maternity & Neonatal Voices Partnership (MNVP). A robust work plan has been developed to ensure co-

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production with service users is embedded within the maternity service. This work plan was shared with Quality Assurance Committee in October for approval and is included in appendix 1a for noting by Trust Board. As part of this workplan, a MNVP led 15 steps challenge took place on Friday 15th November 2024. Feedback from this will be shared to a future Trust Board.

Individual feedback from families is included the Quality and Safety report presented to Quality Assurance Committee in November 2024 (appendix 2a).

2.4 Staff feedback

A key objective within the Maternity & Neonatal Workforce Plan 2024 – 2025 was to implement measures which would ensure the service has a robust succession plan in place to develop our future leaders. To facilitate this, a band 6 midwifery development programme is to be implemented. This is being led by the Specialist Midwife – Retention.

To inform this piece of work an informal survey of midwives has been completed to gain further insight. The Specialist Midwife – Retention will now work with those who have responded to the survey to develop a programme working in coordination with colleagues from the Trust organisational development team to ensure the maternity service can take advantage of the wider Trust offer.

As part of the Perinatal Cultural leadership programme completed by the Quadrumvirate, Trust Board will be aware an action plan has been instigated to support the development of a positive workplace culture within the maternity and neonatal services. The updated action plan is included in appendix 2a for information.

As part of the action plan, a number of 'ideas sessions' are underway within the service focussing on the three key aspirations identified as part tof the learning from the Maternity & Neonatal SCORE survey and subsequent cultural conversations. These sessions are led by members of the Quadrumvirate and will continue through October to January across all clinical teams to provide as many colleagues as possible the opportunity to participate.

Those who have attended to date have engaged well with the sessions in a positive, proactive manner. Detailed feedback from the sessions and next steps will be shared with Trust Board once collated.

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2.5 Maternity Triage

In September 2024 556 triage attendances were recorded on the BadgerNet patient record system. This reflects the sustained increase in triage attendance since the beginning of 2024:

Triage attendances Dec 23 - Sept 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8
August	618	19.9
September	556	18.5

In September 2024 93.5% of attenders were seen within 15 minutes of arrival (best practice guidance) and meets the KPI of 90% review within 15 minutes. 98.74% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This also meets the KPI of 95% review within 30 minutes.

Following appropriate scrutiny and review, the revenue request has now been approved. The increase in establishment will be funded largely from within CBU - with a cost pressure of £6,259 in year 2024/25 and for financial year 2025/26 £25,036. However the full year funding of this proposal will be via non recurrent ringfenced funding from the Maternity Incentive Scheme rebate. Accordingly a piece of work is underway to identify how the new staffing model will be funded should an equivalent MIS rebate not be achieved in future years.

Recruitment into these new posts will commence shortly. To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways.

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

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2.6 Induction of Labour (IOL)

September data from the Local Maternity and Neonatal System (LMNS) shows WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers, in particular those providers of a similar size to WHH, albeit there has been some improvement compared to previous month:

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	57	169	94	67	125	83	107	702
Total Delayed	12	48	14	9	84	29	38	234
% of Total	21.05%	28.40%	14.89%	13.43%	67.20%	34.94%	35.51%	33.33%

Improvement work to improve IOL pathways has commenced and delays in IOL has also been added to the CBU risk register. Initial risk rating, 20, following mitigation, current risk rating 16. The WHH maternity service is also participating in an LMNS led improvement project related to IOL.

2.7 Maternity and Newborn Safety Investigation (MNSI) position

2.7.1 Background

To ensure Trust Board has oversight of the service's position with regard to cases being investigated by MNSI a monthly update is now provided to QAC. This ensures discussions regarding safety intelligence are taking place in line with the Maternity Incentive Scheme Safety action 9.

On receipt of a final report from MNSI, reports and associated actions are presented to the Trust Safety Oversight meeting (SOM). Once this has taken place, reports and learning are shared with QAC and Trust Board and to the maternity team.

A SOP is in development to formalise this process. This SOP will be presented to the Maternity Guideline Review Group in November and then progress through specialty and CBU governance processes in December.

2.7.2 Cases year to date

In the year to date 2024, MNSI have accepted five cases for investigation. Progress as at 29/10/2024 is as follows:

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
28/02/2024	MI-036897	HIE/Cooling	Complete	31/07/2024	10/09/2024	30/09/2024	N/A
10/03/2024	MI-036905	Stillbirth	Complete	25/06/2024	25/07/2024	17/09/2024	08/10/2024
04/02/2024	MI-037420	Stillbirth	In progress	29/08/2024	09/10/2024	04/11/2024	12/11/2024
05/02/2024	MI-037421	Stillbirth	In progress	23/09/2024	Awaiting	Awaiting	
25/08/2024	MI-038061	HIE/Cooling	Referred	Awaiting	Awaiting	Awaiting	

Two MNSI investigation reports were received in September and October 2024 (MNSI reference MI-037420 and MNSI reference MI-036905).

From these report there were five specific safety recommendations:

- The Trust to ensure a robust process for identification and referral of women with risk factors who require an obstetric consultant review in line with local guidance.
- The Trust to ensure staff are supported review risk factors and care plans at each antenatal contact to ensure that mothers receive care aligned with their risk factors
- MNSI recommends that Trust A (WHH) and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care
- MNSI recommends that the Trust supports Maternity Triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.
- MNSI recommends that the Trust actively review their telephone maternity triage service to ensure all telephone calls are answered, logged and actioned to provide safe clinical assessment of mothers and babies

Actions to meet these recommendations have been developed and are underway. A case on a page has also been developed for each case and shared with all maternity staff (included in appendix 1a and 2a). The full MNSI reports are included in appendices 1b and 2b for information.

2.8 Complaints

10 complaints were received in the CBU in September 2024. Six related to care within the maternity and neonatal services as follows:

Specialty	Description	Complaint Opened
Maternity	Patients concerns relate to the lack of support from staff during the birth of her son. Patient's wishes were not listened to and put the patient in a vulnerable position.	05/08/24
Maternity	Concerns relate to a delay in placing the patient on a hormone drip for induction, poor nursing care, lack of competent staff to perform an ultrasound, a delay in scan results being shared with the patient, and an over reliance of students staffing the ward.	15/08/24
Maternity	***Dissatisfied*** Patient attended Maternity Triage due to reduced fetal movements at 37 +6 and was dismissed by the Consultant. Following USS the following day, patient attended to triage again and was admitted for emergency c-section. Baby was found to have cord wrapped around neck 4 times and patient feels this could have been a different outcome had she not gone back to triage/pushed for USS	21/08/24
Maternity	Patient has multiple concerns relating to her maternity care and documentation within her medical records.	17/09/24

Maternity	There are multiple concerns relating to the failings to recognise and treat the patient's preeclampsia and postpartum preeclampsia. Patient was also prescribed the wrong dose of blood pressure medication.	04/09/24
Maternity	Patient disputes the information given following a post-mortem debrief. She also has concerns relating to the delay in being referred for genetic testing.	17/09/2024

Other cases received within the CBU related to care within the gynaecological service.

2.9 Progress against other workstreams

In June 2024 learning from a cluster review of all cases investigated via the PMRT process where maternal diabetes was identified as a contributory factor was shared. An improvement piece of work was instigated to respond to the themes identified. Good progress against the actions identified is being made with key priorities for the next quarter including:

- New clinic to be established for women with pre-existing diabetes, separating out women who are diagnosed with gestational diabetes (as recommended by Saving Babies Lives).
- Streamline referral pathways for diabetic pregnant women admitted to a non-maternity setting. Current referral to specialist midwife is via BadgerNet, however, not all departments/nursing staff have access to BadgerNet to make referral.
- In house education for midwives about gestational diabetes- including diagnosis, treatment, referral, escalation and postnatal follow up
- Diabetic nursing team to support PROMPT training for midwives and obstetricians, including recognition and management of DKA/complications of diabetes
- Patient information leaflets for gestational and pre-existing diabetic women. This will include care journey, i.e. members of the team, schedule of appointments, links to Diabetes UK resources, when to contact Maternity Triage, dietary advice, and other useful information.

2.10 Coroner Enquiries

No Regulation 28 enquiries have been received

3. MATERNITY INCENTIVE SCHEME (MIS)

Progress against the requirement of MIS year 6 is reported monthly to QAC.

Following the launch of MIS Year 6 on 29 April 2024, meetings with leads for all 10 Safety Actions took place to discuss the guidance and ensure processes were in place to meet the required specifications for each action. Informal meetings with action leads to track progress have continued.

The LMNS has a key role in reviewing provider evidence and obtaining assurance against the MIS Year 6 requirements. This assurance process has now commenced and the formal timetable has been received.. As part of this assurance process there are also key internal review dates. These key dates are included in appendix 3b for information.

4. Q1 2024/25 AVOIDING TERM ADMISSIONS TO THE NEONATAL UNIT

The Q1 2024/25 Avoiding Term Admission into Neonatal Unit (ATAIN) report was presented to Quality Assurance Committee in October 2024 and is included as appendix 4.
The report noted a Q1 2024/25 ATAIN rate of 6.8%. This is above both the national and NWNODN targets of 6% and 5.6% respectively and is a decrease of 0.1% on the last quarter.

However exploration of the data has identified WHH is the only Trust which reports babies that have been admitted to NNU for under six hours. In Q1 WHH had three babies who were admitted to NNU for less than six hours. If these babies were excluded from the ATAIN admissions the total number of term admissions as a % of live births would be 5.8%.The team are now exploring how to exclude admissions <6 hours from the WHH data submission whilst still being recorded to facilitate the ATAIN review process. This data issue has also been escalated to the LMNS who are working to ensure consistency of reporting across Cheshire & Mersey providers.

All term admissions in Q1 were reviewed and learning from these cases informs the ATAIN action plan. Good Practice was noted as follows:

- 30 minutes of peep project is ongoing and proving to be effective
- Excellent documentation from Obstetric Consultant & Midwives
- Excellent antenatal care enabled mum to make an informed decision about birth plan
- Fantastic collaborative working with other providers

Learning Points/Themes/Actions were captured as follows:

- QI project to be commenced in relation to obtaining and processing cord gas samples.
- Learning from ATAIN points for this quarter around the importance of accurate documentation
- Learning from ATAIN - setting up resuscitaire, and when to escalate deterioration
- Introduction of intermittent intelligent auscultation in the MLC setting.
- NLS training to be rolled out for all midwives attending births in the home environment.
- CTG workshops to recommence following commencement of lead consultant for fetal surveillance to support the MDT approach to this workstream.

In addition, individualised learning and facilitated reflection has taken place for specific intrapartum and postpartum care issues as appropriate with the support of colleagues/ supervisors.

5. OCKENDEN RECOMMENDATIONS UPDATE

The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates including those included as part of the Ockenden recommendations. To provide this assurance, the maternity service's position in relation to the Ockenden recommendations is reported QAC on a monthly basis.

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Following publication of the Ockenden report, three Ockenden action plans were developed, 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 most recent report to QAC noted the following:

- **Ockenden Part 1a**: WHH is 100% compliant.
- **Ockenden 1b**: WHH is 100% compliant.
- **Ockenden 2**: WHH is 100% compliant.

Accordingly, an overarching review of the Ockenden action plan has been completed by the Quadrumvirate who have agreed to formally close the Ockenden action plan.

6. PERINATAL MORTALITY REVIEW/AUDIT – Q1 2024/245

The Q2 2024/25 Perinatal Mortality Review was presented to Quality Assurance Committee in November 2024 and is included as appendix 6.

During Q2, WHH reported one baby to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This was the stillbirth of a baby born at 32+2 weeks

The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 3 2024/25 QAC following a PMRT review panel.

WHH stillbirth rate for Q2 2024/25 was 1.5 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning.

WHH stillbirth rate for rolling year Q3 2023/24-Q2 2024/25 rate is 3.19 per 1000 births, as noted the MBRRACE-UK national rate is 4.1 per 1000 births.

WHH Neonatal mortality rate during Q2 2024/2025 was 1.5 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

During Q2, WHH undertook two PMRT review panels one of a stillbirth (a baby born at 38+4 weeks) and one a late neonatal death of a baby born at 36+3 weeks. Parental perspective of the care they received were sought in all cases.

The panel review of the stillbirth case graded care as B.

The panel review of the late neonatal death graded care as C with issues with care identified for the mother and baby up to the point of the birth of the baby that may have made a difference to the outcome for the baby.

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Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Detailed findings and actions are included in appendix 6.

Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.

7. BIANNUAL MATERNITY SELF ASSESSMENT

The revised Maternity self-assessment tool is a national assurance tool introduced to maternity providers in response to the Kirkup Report (2015) and Ockenden Report (2020) and findings of outstanding Care Quality Commissioners (CQC) to support trusts to benchmark their services against national standards and best practice guidance. Evidence of completion of the tool is also required as part of the North West Region Maternity Performance Oversight Panel assurance process.

The Maternity self-assessment tool identifies 159 criteria. As at 31st October 2024, WHH is fully compliant with 124/159 criteria. This equates to 78% of the criteria, an improvement from 73.6% when the last assessment was completed. Actions are underway to achieve full compliance. It is anticipated all actions will be completed by the end of March 2025

This update was reported to QAC in November 2024 (appendix 7a), the detail of the self-assessment is included in appendix 7b.

8. REVIEW OF HARM EVENTS

A presentation was made to QAC in October which detailed the WHH position with regard to harm events which had occurred within the maternity service in the period September 2023-August 2024. The presentation is included in appendix 8 for discussion and noting. It has been agreed a further review of the position will be presented to QAC on a biannual basis.

9. MIDWIFERY SAFE STAFFING

9.1 Midwifery establishment

Midwifery safe staffing is reported quarterly to Strategic People Committee to provide assurance specifically in relation to midwifery staffing against national recommendations alongside triangulation against maternity red flag incidents.

The most recent paper to Strategic People Committee provided an overview of the staffing position at as 31st October 2024 and red flag position for the period July-September 2024 alongside other key workforce metrics. The paper is included as appendix 9a.

A full maternity workforce planning review using the nationally recognised Birthrate Plus® workforce planning tool was completed at the beginning of 2022. The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust at that time was 116.70wte, this included an additional 10% for non-clinical roles.

The maternity funded establishment at the 31st October 2024 is 128.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 31st October

2024 shows a further positive variance of 6.04wte. This further variance is the result of the addition of a number of new specialist midwifery roles to the midwifery establishment since January 2022 alongside an increase in WTE in some existing posts.

These changes have been made since the 2022 Birthrate Plus® assessment to meet the requirements of external reviews, national recommendations and frameworks including the Ockenden Report recommendations and the Maternity Incentive Scheme Years 4 and 5 (incorporating the Saving Babies Lives Care Bundle. All new posts have been funded within the service via reallocation of existing establishment or via external funding streams.

Review of the maternity workforce using the Birthrate Plus® workforce planning tool is required every three years in line with Maternity Incentive Scheme Year 6 - Safety Action 5. Therefore, a full review will be required at WHH by March 2025. This assessment is underway.

9.2 Midwifery red flags

Within the maternity service, staffing red flags across the maternity service are recorded within the SafeCare module of the health roster. As part of Maternity Incentive Scheme Year 6 - Safety Action 5 there is a requirement to closely monitor two key measures:

- Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.
- The provision of all women receiving one to one midwifery care in active labour

In the period 1st July-30th September 2024 2024 there is one episode recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary. This occurred at a time of high acuity and was for a short period of time while other clinical staff could be redeployed. There are no occasions where there was not a supernumerary Birth Suite Coordinator at the beginning of the shift.

In the period 1st July-30th September 2024 2024 there is one episode recorded in in SafeCare where a woman in active labour is **NOT** receiving one-to-one care In this case the Midwife was allocated to the Induction of Labour (IOL) suite. An IOL patient become established in labour. The midwife cared for this patient for a short time while transfer to Birth Suite for ongoing care was arranged. A red flag was incorrectly raised as this episode related to the short period while ongoing care was arranged.

Work is already ongoing to ensure the Birth Suite Coordinator remains supernumerary and that there are robust processes for ensuring women receive one to one care as soon as they are established in labour.

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This work is included in the action plan detailed below:

Action	Lead	Start date	Due Date	RAG rating
Complete recruitment processes to all midwifery vacancies	Tina Moors	1/7/2024	31/10/2024	
Submit revenue request to increase midwifery establishment to support triage staffing and release capacity elsewhere	Ailsa Gaskill-Jones	1/8/2024	31/10/2024	
Implement updated midwifery rotation processes to ensure staff are able to flex to all areas at time of high acuity	Ward Managers	1/9/2024	31/10/2024	
Clarify the responsibility of Specialist Midwives to be available to work clinically when required to do so	Tina Moors	1/10/2024	31/11/2024	
Work with team to clarify when red flags should be raised and ensure consistency of reporting	Kim Farrell	1/11/2024	30/11/2024	
Complete recruitment of additional staffing resource following approval of Triage establishment revenue request	Kim Farrell	1/11/2024	31/1/2025	

9.3 Workforce metrics

The vacancy rate for registered midwifery staff as at 31st October 2024 is 0.62%. This continues the significant improvement from the end of January 2023 when the vacancy rate was 18.29%.

There are a number of midwives who will be retiring during Q3 2024/25. Recruitment has been completed to backfill the majority of these vacancies with 8 newly qualified midwives commencing during November and December. Processes are underway to complete the remaining recruitment of band 6 experienced midwives to ensure the service can maintain appropriate skill mix.

Midwifery retention rates remain good with turnover at 7.96% at the end of October 2024. Midwifery vacancy rates below the Trust target have been maintained since December 2023.

9.4 Midwifery workforce deep dive

A midwifery workforce deep dive was presented to Strategic People Committee in November 2024. The deep dive was initiated to explore the underlying factors which have meant, despite a significantly improved midwifery retention position and a vacancy rate below the Trust target red and amber staffed shifts persist. A position which impacts on service provision.

The deep dive highlighted multifaceted reason which impact on midwifery staffing:

- Establishment uplift (headroom) not representative of absence.

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- Impact of maternity leave
- Impact of other workforce factors e.g., supernumerary, flexible working and restrictions on clinical duties
- National ask re implementation of Birmingham Symptom Specific Obstetric Triage system (BSOTs)
- Impact of measures to ensure retention of staff especially newly qualified
- Changes in service delivery including relocation of Maternity Triage, establishment of Nest MLU, increased caesarean section rates, longer length of stay
- Complexity of families receiving care has increased

The deep dive is attached for information in appendix 9b.

10. MONITORING/REPORTING ROUTES

The contents of this report are reported via the Women's Health Governance meeting. Items for escalation are monitored at W&C CBU Governance meeting monthly.

11. ASSURANCE COMMITTEE

The contents of this report has previously been noted and discussed at Quality Assurance Committees on 8th October 2024 and 12th November 2024 and at Strategic People Committee on the 20th November 2024.

12. RECOMMENDATIONS

The Trust Board is requested to note the content of this paper and its associated appendices for information.

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/129 appendix 1a**	
SUBJECT:	**Maternity & Neonatal Quality Review – August 2024**	
DATE OF MEETING:	4th December 2024	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		

Further Information:

	Yes	No	N/A
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		

Further Information:

	Yes	No	N/A
3. Foster good relations between people who share a protected characteristic and those who do not			✓

Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to maternity and neonatal care focussing attention on improving outcomes for this protected group.

EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update in relation to maternity and neonatal quality and provides Trust Board with oversight of key matters to provide assurance on

	maternity and neonatal safety and quality issues. This information is reported monthly to Quality Assurance Committee and Trust Board. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position There were two moderate harm and one severe harm events in the CBU in August 2024. Themes from maternity/neonatology patient safety events in August are as follows: • Admission of term babies admitted to Neonatal Unit (NNU) • Postpartum Haemorrhage (PPH) >1500ml • Postnatal readmission Work remains ongoing with regard to all of these themes. At the end of August compliance for Trust mandatory training across maternity and child health colleagues is above the Trust target. Compliance with PDR completion remains a challenge, a targeted piece of work is underway. Feedback and learning from a recent complaint is included for information. Work has commenced to develop a band 6 midwifery development programme. To inform this piece of work an informal survey of midwives has been completed to gain further insight. Emerging findings from the survey are included in this paper. In August 93% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes. 98.3% of attenders were seen within less

	than 30 minutes of arrival (NICE guidance). This is beyond the KPI of 95% review within 30 minutes. However, whilst meeting our KPIs, when compared to other providers across the LMNS, particularly those of a similar size, WHH does have more triage breaches as a proportion of births. Following investigation of two cases referred to the Maternity and Newborn Safety Investigations programme (MNSI) a meeting was held with MNSI on 6th September to discuss some emerging systems safety themes related to triage provision. In both cases this related to capacity within Maternity Triage and the impact acuity and activity can have on staff ability to complete holistic assessment for every mother as well as to effectively manage telephone triage. In both their cases there will be safety recommendations relating to Maternity Triage within the final MNSI reports. August data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour (IOL) activity when compared to other local providers. Improvement work to improve IOL pathways has commenced. It is anticipated this will become a formal quality improvement project. Delays in IOL has also been added to the CBU risk register. Initial risk rating, 20, following mitigation, current risk rating 16. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight by Trust Board. Four complaints were received in the CBU in August 2024. Three related to care within the maternity and neonatal services. In June 2024 learning from a cluster review of all cases investigated via the PMRT process where maternal diabetes was identified as a contributory factor was shared with QAC and subsequently with Trust Board. An update against the actions to improve is included for review.

	No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/10/157iii**	
	Date of meeting	**8 October 2024**	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Maternity & Neonatal Quality Review – August 2024	AGENDA REF:	BM/24/12/129 appendix 1a

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month August 2024.

The paper provides Trust Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 6 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

2. HARM EVENTS

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU in August 2024:

Severity	July 24	Aug 24
1 – No Harm	101	90
2 – Low Harm	39	33
3 – Moderate Harm	6	2
4 – Severe Harm	0	1
5 – Fatal	0	0
Total	146	126

There were two moderate harm and one severe harm events.

Details of the moderate harm events are as follows:

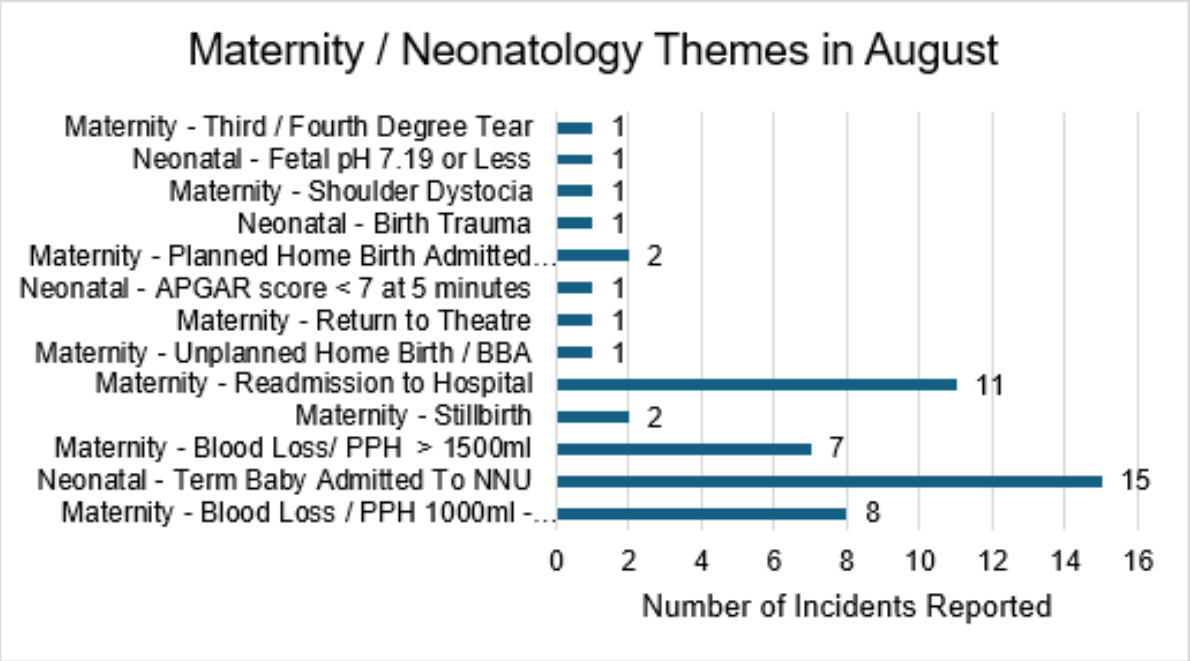
In one case a woman presented at 32/40 weeks gestation. The woman was not known to be pregnant by the maternity service and was not booked for maternity care. Sadly, an intrauterine death was identified at initial assessment. The case has been reviewed. There was no learning related to this event however failsafe processes with primary care have been established as this is the second event of this type for this family who are already known to social care and other primary care organisations.

The second case related to the birth of a preterm baby (30+3/40 weeks gestation) footling breech. The birth of the baby was a difficult extraction and resulted in a

neonatal injury (left humerus fracture). The event has been reviewed and there was no learning identified.

The severe harm event relates to the term admission of a neonate for cooling. An MDT review of the case has been completed with urgent actions identified. These actions have been formulated into a wider midwifery led care action plan. The case has also been referred to MNSI to facilitate an external investigation.

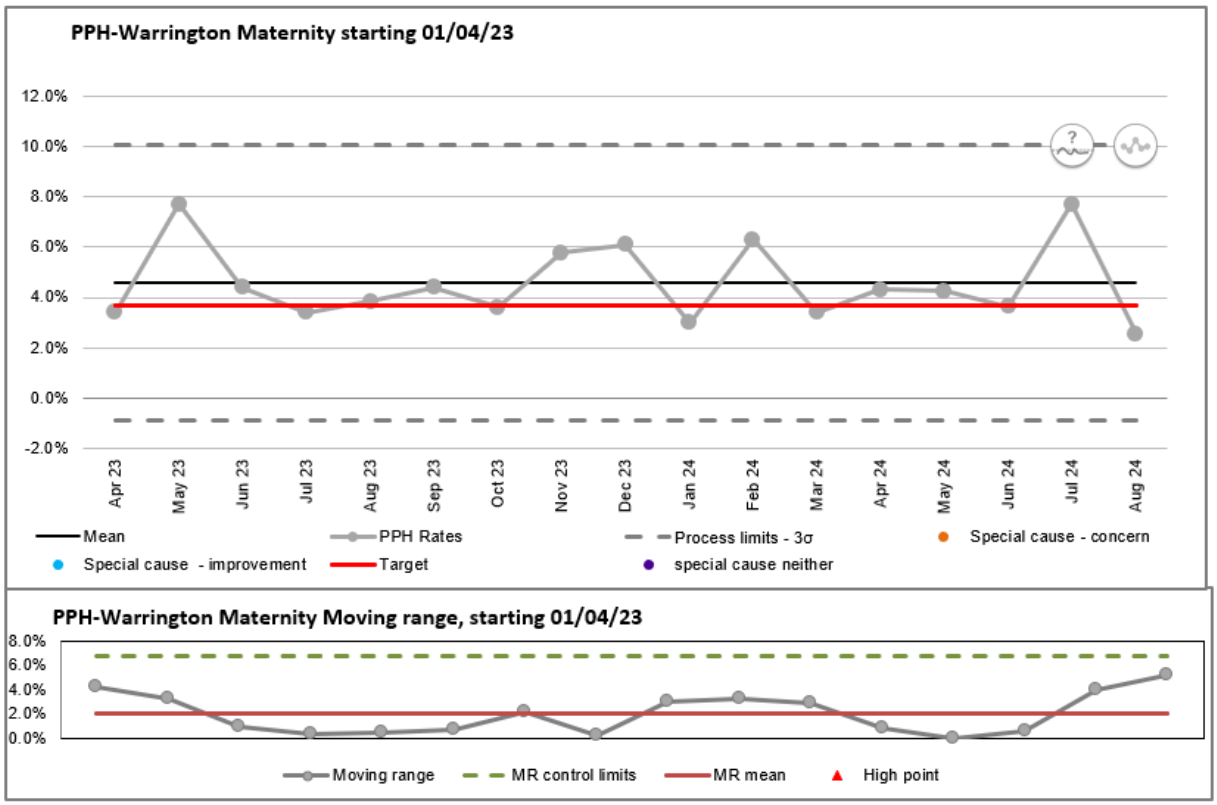
Themes from maternity/neonatology patient safety events in July 2024 are detailed in the table below:



- 15 term babies were admitted to the neonatal unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC and Board
- 11 postnatal readmissions were reported in August 2024. As advised previously, a quarterly cluster review of readmissions has been completed and a piece of improvement work in underway.
- There were 8 cases of PPH 1000ml-1500ml and 7 cases of PPH ≥1500mls in July 2024. The formal QI remains in progress.

The latest PPH QI position is included in appendix one for information.

The SPC chart for PPH ≥1500mls shows no trend at present, The SPC chart continues to show common cause variation.



Alongside the QI project, all cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group (IRG), learning shared and any urgent actions completed.

3. WORKFORCE METRICS & MEASURES

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

At the end of July compliance for Trust mandatory training across maternity and child health colleagues is 90.12% for Trust mandatory training (including safeguarding training), 88.22% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge. Rates in August (excluding those with a long term absence) for maternity and child health services is 72%. This is below the Trust target but a positive trajectory from 65.84% in July. This is being reviewed weekly.

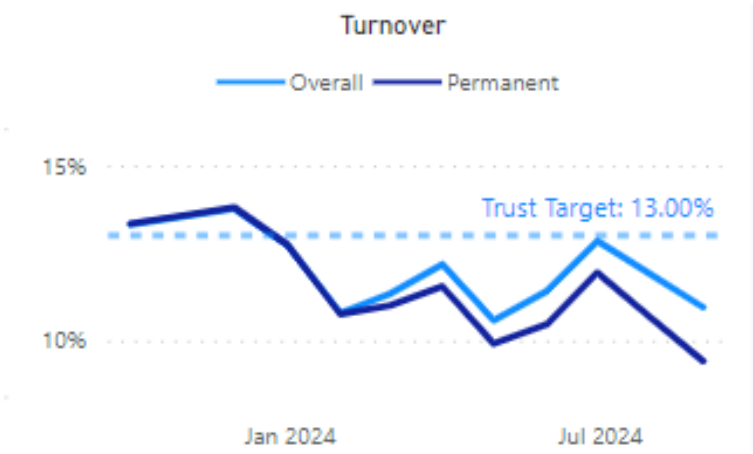
Compliance with maternity specific training remains good, this in monitored monthly to ensure progress is sustained. Where compliance has fallen below recommended levels robust plans are in place to achieve compliance in September and October.

Current position – Training compliance - maternity specific

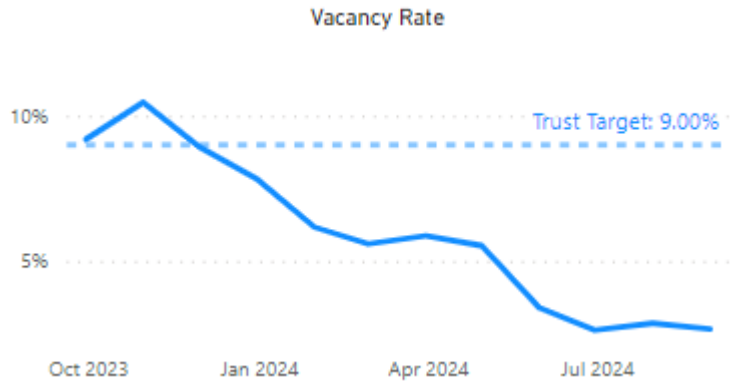
	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	99.2%	86.8%	95.4%	96.9%	64.1%
Obstetric Consultants	100%	72.7%	72.7%	n/a	n/a
Other Obstetric	100%	100%	80%	n/a	n/a
Obs Anaesthetic Consultants	93.1%	n/a		n/a	n/a
Maternity Support Workers	96.1%	n/a		n/a	36%

*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track
#Medical non-compliance relates to two medics – plan in place

Turnover for maternity and child health staff (permanent staff) has continued to decrease in August to 9.41% and is below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 2.66% in August 2024, significantly below the Trust target. This is illustrated in the graph below:



At the end of June 2024, the vacancy rate for registered midwives was 2.03%.

4. SERVICE USER FEEDBACK

The midwifery team have recently met with a family to respond to a formal complaint. Within the complaint there was considerable feedback regarding the experience of the family. This included:

- Lack of awareness of how language and the tone of language used around women and families in an emergency situation can impact on their experience
- Feedback regarding the language used within the BadgerNet record when documenting the birth, in particular use of phrase “a lovely forceps delivery”
- Feedback regarding how discussions around consent were managed during intimate procedures
- Lack of compassion from staff and students
- No immediate debrief from intrapartum staff following the emergency
- Lack of handover of special circumstances (women had a documented history of PTSD)

Actions and learning

- To complete a SIMS which will include human factors, environmental factors, communication, and consent including how the team communicate with the family during an emergency situation.
- Feedback to obstetric team in relation to language used in documentation
- Sharing of feedback with Specialist Midwife – Practice Education in relation to appropriate and sensitive conversations from students to families
- Family keen for experience to be shared with staff via a patient story
- Learning shared regarding provision of pain relief on transfer from Maternity Triage to Birth Suite during an emergency (Entonox should have been offered) and in relation to compassionate care
- Two day training course approved for 24 midwives to attend to become Birth Trauma Advocates. To support women with birth trauma and PTSD

The midwifery service continues to work in collaboration with the Maternity & Neonatal Voices Partnership with a robust workplan in place to ensure co-production with service users is embedded within the maternity service.

The 2024/25 MNVP workplan is included in appendix 2 for information.

5. STAFF FEEDBACK

A key objective within the Maternity & Neonatal Workforce Plan 2024 – 2025 was to implement measures which would ensure the service has a robust succession plan in place to develop our future leaders. To facilitate this, a band 6 midwifery development programme is to be implemented. This is being led by the Specialist Midwife – Retention.

To inform this piece of work an informal survey of midwives has been completed to gain further insight. Emerging findings from the survey are as follows:

- Those who responded were positive about the opportunities available to develop their career within the maternity service at WHH
- The majority of staff are keen to develop into specific roles or at least actively seek development towards this
- Many staff have not expressed their wish to develop to their line manager
- Many staff were not aware of the additional Trust resources available to them to support with career development

The Specialist Midwife – Retention will now work with those who have responded to the survey to develop a programme working in coordination with colleagues from the Trust organisational development team to ensure the maternity service can take advantage of the wider Trust offer.

6. MATERNITY TRIAGE

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

Current performance

In August 2024 618 triage attendances were recorded on the BadgerNet patient record system. This reflects the sustained increase in triage attendance since the beginning of 2024:

Triage attendances Dec 23 - July 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8
August	618	19.9

- 12.4% of attendees were seen immediately on arrival, a reduction from previous months
- The longest wait recorded for initial review was 53 minutes, this was due to high acuity
- 93% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes.
- 98.3% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is beyond the KPI of 95% review within 30 minutes.
- 0.2% of attendees were categorised as red on arrival. Appropriate ongoing care was provided in all cases.
- 17.9% of attendees were categorised orange on arrival, this is an increase from previous months.
- Whilst meeting our KPIs, when compared to other providers across the LMNS, particularly those of a similar size, WHH does have more breaches. In August 2024 6.89% of WHH triage attendances breached. Attendances at Countess of Chester breached on 2.04% occasions and Mid Cheshire 2.61%. Mersey and West Lancashire had no breaches in August 2024 on either site.

Following investigation of two cases referred to the Maternity and Newborn Safety Investigations programme (MNSI) a meeting was held with MNSI on 6th September to discuss some emerging systems safety themes they had identified as part of their enquiries.

In both cases this related to capacity within Maternity Triage and the impact acuity and activity can have on staff ability to complete holistic assessment for every mother as well as to effectively manage telephone triage. In both their cases there will be safety recommendations relating to Maternity Triage within the final MNSI reports.

In response to the issues highlighted by MNSI the following actions are in progress:

- All unfilled day telephone triage shifts have been allocated to NHSP bank
- Those undertaking telephone triage to be protected from redeployment where possible and the internal midwifery escalation process will be updated to reflect this.
- Appropriate contingency process to be in place to ensure at times of high acuity/escalation telephone triage is supported away from the clinical area.
- Telephone triage will be moved to the Nest office or the nursing station within the NEST – bleep holder paperwork to be updated to ensure this is monitored as part of the walkaround process
- Headsets to be provided for staff providing telephone triage
- All actions to be included/monitored as part of ongoing Triage Task & Finish group action plan
- Risk for the Maternity Triage service updated. Current risk rating 16.

Both MNSI reports will be shared with QAC and Trust Board once received in final form.

These actions are in addition to the existing action and activity in place to support a safe service:

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. This paper has been presented to Executive Team who have requested further information. An updated paper is in draft.
- To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways.

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

7. INDUCTION OF LABOUR (IOL)

August data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers, in particular those providers of a similar size to WHH:

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	49	145	80	36	115	105	55	585
Total Delayed	10	26	3	5	27	46	4	121
% of Total	20.41%	17.93%	3.75%	13.89%	23.48%	43.81%	7.27%	20.68%

43.81% of IOL at WHH were delayed in August 2024, this is a deteriorating position complared to previous months where delays ranged between 30 and 34%.

- The data below reports the **total number of delays by week by Provider** from **1st to 31st August.**

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
29/07/2024		4				13	1	18	14.88%
05/08/2024	1	1	1		2	12		17	14.05%
12/08/2024	3	2			4	8	1	18	14.88%
19/08/2024	6		2	4	8	6	2	28	23.14%
26/08/2024		19		1	13	7		40	33.06%
Grand Total	10	26	3	5	27	46	4	121	100.00%
% of Total	8.26%	21.49%	2.48%	4.13%	22.31%	38.02%	3.31%	100.00%	

38.02% of delayed IOL across Cheshire & Mersey in August 2024 were at WHH.

Improvement work to improve IOL pathways has commenced, the action plan is attached in appendix three for information. It is anticipated this will become a formal quality improvement project. Delays in IOL has also been added to the CBU risk register. Initial risk rating, 20, following mitigation, current risk rating 16.

8. MNSI POSITION AND REPORTS RECEIVED

8.1 Background

To ensure Trust Board has oversight of the sevice's position with regard to cases being investigated by MNSI an update will be provided each month with effect from October 2024.

8.2 Current position

Year to date 2024, MNSI have accepted five cases for investigation. Progress as at 25/9/2024 is as follows:

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
28/02/2024	MI-036897	HIE/Cooling	Awaiting SOM	31/07/2024	10/09/2024	30/09/2024	
10/03/2024	MI-036905	Stillbirth	Complete	25/06/2024	25/07/2024	17/09/2024	08/10/2024
04/02/2024	MI-037420	Stillbirth	In progress	29/08/2024	Awaiting	Awaiting	
05/02/2024	MI-037421	Stillbirth	In progress	23/09/2024	Awaiting	Awaiting	
25/08/2024	MI-038061	HIE/Cooling	Referred	Awaiting	Awaiting	Awaiting	

On receipt of the final report from MNSI, reports and associated actions are presented to the Trust Safety Ovesight meeting (SOM). Once this has taken place, reports and learning are cascaded within the maternity team. With effect from October 2024 reports will also be shared with QAC and Trust Board as part of this paper to ensure tdiscussions regarding safety intelligence are taking place in line with the Maternity Incentive Scheme Safety action 9.

A SOP is in development to formalise this process and will be shared to a future meeting of Trust Board once Trust governance processes are completed.

8.3 Reports received

One report has been received to date in 2024 (MNSI reference MI-036905).

This case related to a woman in her second pregnancy who followed a low-risk care pathway and attended Maternity Triage at 39+4 with pv bleed and changes to fetal movements. The woman subsequently attended for induction of labour at 39+6 weeks and was admitted to induction of labour bay on the materniity ward. IOL was commenced on that day at 16:05. When a repeat CTG was due the baby's heartbeat could not be heard. A bedside ultrasound was performed and it was confirmed the baby had died. A postmortem examination (PME) was performed, and the report described the cause of death as 'features of an acute asphyxia mode of death'.

There were two specific safety recommendations:

- The Trust to ensure a robust process for identification and referral of women with risk factors who require an obstetric consultant review in line with local guidance.
- The Trust to ensure staff are supported review risk factors and care plans at each antenatal contact to ensure that mothers receive care aligned with their risk factors

Actions to meet these recommendations have been developed and are underway. A case on a page has also been developed and shared with all maternity staff (appendix 4).

The final MNSI report is included in full in appendix 5 for information.

9. COMPLAINTS

Four complaints were received in the CBU in August 2024. Three related to care within the maternity and neonatal services as follows:

Specialty	Description	Complaint Opened
Maternity	Patients concerns relate to the lack of support from staff during the birth of her son. Patient's wishes were not listened to and put the patient in a vulnerable position.	05/08/24
Maternity	Concerns relate to a delay in placing the patient on a hormone drip for induction, poor nursing care, lack of competent staff to perform an ultrasound, a delay in scan results being shared with the patient, and an over reliance of students staffing the ward.	15/08/24
Maternity	*Dissatisfied* Patient attended Maternity Triage due to reduced fetal movements at 37 +6 and was dismissed by the Consultant. Following USS the following day, patient attended to triage again and was admitted for emergency c-section. Baby was found to have cord wrapped around neck 4 times and patient feels this could have been a different outcome had she not gone back to triage/pushed for USS	21/08/24

10. PROGRESS AGAINST OTHER WORKSTREAMS

In June 2024 learning from a cluster review of all cases investigated via the PMRT process where maternal diabetes was identified as a contributory factor was shared with QAC and Trust Board. An improvement piece of work was instigated to respond to the themes identified with progress as follows:

- Diabetes working group established, which includes representation from the diabetic nursing team, midwifery, dietitian and medical colleagues. The group aims to strengthen multi-professional working, help to define roles, and also to work on specific tasks, such as: patient information leaflets, education and referral pathways
- Diabetes action plan in place to support activity of working group
- The Specialist Midwife - Diabetes has worked closely with Antenatal Services Manager to streamline processes for women experiencing diabetes in pregnancy
- The system and process of teaching women how to self-monitor their blood sugar has been streamlined to reduce wait times
- Patient information leaflets have been updated
- Women with Diabetes now have access to the dietician for advice in relation to diet-controlled diabetes and carb counting
- Glucose tolerance tests (GTT) are now offered at the Halton site in addition to the Warrington site thus improving accessibility of this diagnostic for woman living within the Runcorn/Widnes area

Key priorities for the next quarter include:

- New clinic to be established for women with pre-existing diabetes, separating out women who are diagnosed with gestational diabetes (as recommended by Saving Babies Lives).
- Streamline referral pathways for diabetic pregnant women admitted to a non-maternity setting. Current referral to specialist midwife is via BadgerNet, however, not all departments/nursing staff have access to BadgerNet to make referral.
- In house education for midwives about gestational diabetes- including diagnosis, treatment, referral, escalation and postnatal follow up
- Diabetic nursing team to support PROMPT training for midwives and obstetricians, including recognition and management of DKA/complications of diabetes
- Patient information leaflets for gestational and pre-existing diabetic women. This will include care journey, i.e. members of the team, schedule of appointments, links to Diabetes UK resources, when to contact Maternity Triage, dietary advice, and other useful information.

A further update of progress will be provided to QAC in January 2025.

11. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received

12. RECOMMENDATIONS

Members of the Trust Board are requested to receive and note the findings of this paper for information.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix one – PPH QI Project Progress Plan

Quality Improvement Project Summary

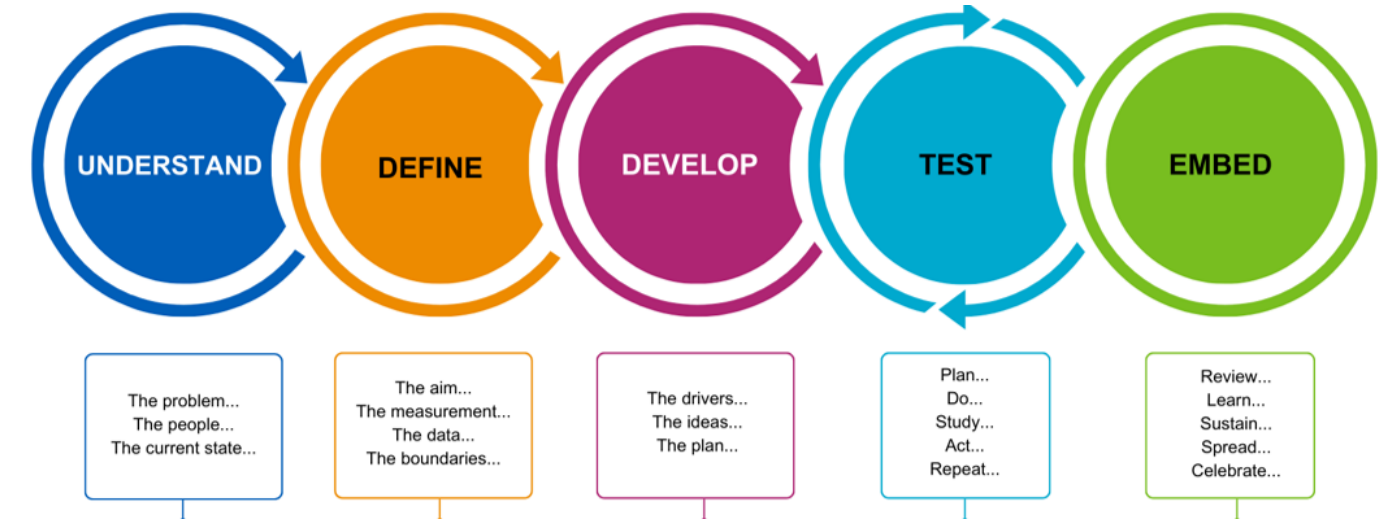
Last updated: 26/09/24

Project Title:	**Improving Post Partum Haemorrhage Rates**	**QIP Reference Number:**	WHHQIP0262
Project Lead:	Charlotte Hampson: Labour Ward Manager	**QI Coach:**	Sarah Delooze
Full project documentation can be found here.			
Overview (problem statement / aim):	In an 8-month review between March and October 2023, 61 patients had a PPH, a mean of 3.74%. Although not registering as a national outlier, at WHH it was found that the antenatal PPH checklist was completed in only 50.8% of cases (82% previous audit); blood loss for 52.5% of PPH was recorded retrospectively; and in 9/21 cases it was deemed the massive obstetric haemorrhage policy (MOH) should have been activated but was not, including 3 cases over 2L. Process and policy compliance is unsatisfactory and leaves the trust vulnerable to significant risk, and illustrative of a situation requiring significant improvement. The initial aim was *"To reduce the occurrence of PPH at WHH from 3.74 mean to 3.5 mean by October 2024."* This has now changed to reflect the findings from the SPC chart and a more realistic end date. *"To reduce the occurrence of PPH at WHH from mean of 5% of all births to a mean of 3.7% of all births by October 2025."*		
Last meeting date:	25/09/24	**Next meeting date:**	02/10/24
Updates / progress:	The project team is progressing well through the Five Essentials of CQI and the recommended methodology. Stakeholder mapping has been completed related to the interest and influence stakeholders. Process mapping for emergent and elective C sections and vaginal delivery have been completed, as has an incident 'walk and talk' through, with waste analysis completed as a result. Cause and effect analysis has been completed and revealed several avenues for tests of change. Family of measures have been agreed and the data collection plan has been established. An SPC chart is being compiled by Maria Banks from which the main outcome measure will be monitored. Additional data supporting the "understand" component of the Five Essentials is also being collated by Charlotte Hampson and Amelia Crowther. The project driver diagram has now begun. A meeting was held with the Transfusion Specialist and it was established that the team will complete a second 'walk and talk' through including the blood labs to identify more areas for waste analysis if applicable.		

Milestones and progress		
Stage	**QI tools / methodology**	**Status**
Understand	Problem statement	**Complete**
	Stakeholder mapping	**Complete**
	Fishbone analysis / 5why's	**Complete**
	Process mapping	**Complete**
Define	Aim statement	**Complete**
	Measures / data collection plan	**In progress**
Develop	Driver diagram	**In progress**
	Prioritisation matrix	
Test	PDSA testing	
	Implementing changes	
Embed	Sustainability plan	

Balance and Counter Measures	
No.	**Risk/consideration**
1.	Biweekly meeting has been moved to the weekly meeting to speed up the project.
2.	Project support from CQI Team will now be provided by SD.
3.	Discussions were held with the Rebecca Spiers, Transfusion Specialist, to discuss recent concerns aired re. blood product wastage in conjunction with the activation of the MOH pathway.

The Five Essentials of Continuous Quality Improvement: Project Timeline



17/01/24 Problem statement and stakeholder mapping: Constructing and evidencing the problem and team.

31/01/24 Process mapping session 1: Emergency C Section.

07/02/24: Theatre Simulation, Walk and Talk Through

21/02/24 Process mapping session 2: Elective C Section.

28/02/24 Process mapping session 3: Natural delivery.

13/03/24 Process mapping session 4: Review and confirm for all team members.

26/06/24: Defining measures and revised AIM statement.

03/07/24: Data plan meeting. Initial briefing.

10/07/24: Data plan meeting; Data capturing since Oct 23.

17/07/24: Cause and effect analysis, Fish bone diagram: updated with category medication.

24/07/24: Meeting stood down due to annual leave.

31/07/24: Data still being collated for baseline. Reviewed the measures.

18/09/24: Driver diagram continued.

25/09/2024: Meeting re. MOH policy and ordering blood product with Rebecca Spiers and project team.

Date.

Appendix two – MNVP Workplan

ACTION	LEAD	DUE DATE	RAG RATING
Revisit 15 Steps	Chair	30/12/2024	
Videos of who's who and tour of services that people may visit	Chair	Ongoing	
Monthly 'Ask the' ---- midwife, doctor... drop ins	Chair	Ongoing	
Review the offering for antenatal and postnatal education	Chair	Oct-24	
Explore possibilities of BadgerNet and use of tech to share information more widely without it being overwhelming	Chair	Ongoing	
Deliver succession plan following confirmation from Regional decisions (awaited)	Chair	31/01/2025	
Flyer to be redesigned and re-circulated	Chair	18/10/2024	
Working with those seeking asylum	Chair	30/12/2024	
Candle lit walk at Walton Gardens, Warrington on 9th October 2024, to coincide with the Wave of Light.	Consultant Midwife	09/10/2024	
Consultant Midwife to ask MVP to engage with a survey for feedback on birth reflections clinic - measure of satisfaction, offer to run a clinic at Halton.	Consultant Midwife	18/10/2024	
Continue to hear the voices of those working in the maternity system as well as those receiving care – celebrating the positive stories and sharing learning	Chair	Ongoing	TBC
Consultant Midwife led multidisciplinary working group to be established to focus on issues in relation to consent and communication. This group will work with staff, the Maternity Voices Partnership and women/birthing people to explore how matters of consent are discussed and to ensure we embed a positive communication culture across the services.	Consultant Midwife	Oct-24	
Staff listening events to include medical, neonatal as well as maternity based on feedback from triumvirate in January	Chair	2023/24	
Listening events via the sub groups and chair	Chair	2023/24	
Focusing on Stress Awareness Month linking with WHH social media	Chair	30/04/2022	
Supported in review of the action plan from National Maternity Survey	Chair	30/04/2022	
Quarterly MVP meeting	Chair	29/04/2022	
International Midwife Day	Chair	05/05/2022	

Maternal Mental Health Week Partnering with staff from the perinatal services at Hollins Park to hold an event at Warrington Hospital	Chair	06/05/2022	
Listening event - Thriving Families – Parents in Bloom (Warrington Market)	Chair	31/05/2022	
Park to hold an event at Warrington Hospital	Chair	31/05/2022	
Engagement with Halton CCG	Chair	17/06/2022	
Listening event - Brookvale Children's Centre - Parents in Mind (Halton)	Chair	30/06/2022	
Listening event - Brookvale Children's Centre - Team Sunlight Families (Halton)	Chair	30/06/2022	
Women's Health Launch (Aintree Racecourse)	Chair	07/07/2022	
15 Steps (whole maternity unit – 20 volunteers)	Chair	08/07/2022	
Quarterly MVP meeting	Chair	08/07/2022	
Disability Awareness Day (Walton Gardens)	Chair	17/07/2022	
Ockenden Insight Visit	Chair	29/07/2022	
Liverpool Pride	Chair	30/07/2022	
Co working with GM ICB	Chair	05/08/2022	
Compassion focused therapy for loss	Chair	11/08/2022	
Initial Review and actions from 15 Steps	Chair	31/08/2022	
Local Promotion of MVP	Chair	31/08/2022	
Engagement with partners;- *Greater Manchester Integrated Care *Silver Birch Hubs (Compassionate focussed therapy) *Homestart Warrington	Chair	31/08/2022	
Perinatal Pathways Review	Chair	23/09/2022	
National MVP call	Chair	26/09/2022	
Survey Monkey to capture voices not heard on 27th September 2022	Chair	04/10/2022	
Agreed actions from 15 Steps with consultant midwife for Quarterly MVP meeting	Chair	31/10/2022	
Initial feedback from staff listening event and survey	Chair	31/10/2022	
Listening event for staff within Maternity at Warrington	Chair	04/11/2022	
Quarterly MVP meeting	Chair	11/11/2022	
Overall feedback from listening events and survey	Chair	30/11/2022	
National MVP call	Chair	13/12/2022	
Review of feedback from listening events with SLT	Chair	30/12/2022	
Feedback from staff listening events shared with triumvirate	Chair	06/01/2023	
National MVP call	Chair	13/01/2023	
Feedback from staff listening events shared with CEO and Chief Nurse	Chair	13/01/2023	

Quarterly MVP meeting	Chair	13/01/2023	
Feedback from equality reporting	Chair	27/01/2023	
Toast and Tea rounds to explore how staff would like to receive feedback	Chair	31/01/2023	
Newborn sepsis study – co work (external)	Chair	31/01/2023	
Aqua Pilot Maternity and Neonatal Safety Champions Overview	Chair	10/02/2023	
Supported interviews for Consultant Midwife	Chair	24/02/2023	
Created document to present feedback for SLT to review and add to for onward sharing	Chair	28/02/2023	
Smoking in pregnancy co work and pregnancy research study support - as and when Sarah 's team request	Chair	28/02/2023	
Supported meet and greet with Claire Mathews and Michelle Waterfall	Chair	02/03/2023	
Sub Group Meeting	Chair	03/03/2023	
Aqua Pilot Maternity and Neonatal Safety Champions Workshops	Chair	16/03/2023	
Sub Group Meeting	Chair	17/03/2023	
Set MVP QR Code on all PCN screens to raise awareness of MVP	Chair	Mar-24	
Listening event for staff within Maternity at Warrington	Chair	27/09/2022	
Support with the redesign of maternity/neonatal unit - i.e.. any planned changes to design and layout, DoM engages with MNVP for feedback at each stage of the plan	Chair	Feb-24	
Agree 2024/25 workplan	Chair	Apr-24	

Appendix three - Induction of Labour Action Plan

IOL Task & Finish Group Ongoing Action Log				
Agenda Date	**Action**	**Owner**	**Update**	**RAG status**
16.10.23	IOL SROM- Review latest evidence in delays/medical review	Chris Bentham	13.11.23- CB discussed SROM patients should be augmented immediately. The team discussed MDT reviews twice daily at each medical ward round. CB to feedback at next meeting to benchmark standards across other units within the LMNS as to what is set out in their guidelines. CB to discuss twice daily reviews with the obstetric team. 11.12.23- To discuss with Rita as to when the regional guidelines are due before we implement any change to our own current guidelines. Senor staff meeting has reported that a face-to-face ward round will take place daily of each patient, but not necessarily face to face x2. All patients will be reviewed morning and evening.	
16.10.23	IOL inpatient CTG monitoring – review monitoring whilst inpatient	Kim/Julie	16.10.23-Sarah David had previously put actions in place- will review. 13.11.23- Change of practice request 6hrly CTG monitoring put in place by previous FS lead midwife. Team have agreed to move forward with this. KF to circulate to group ahead of governance/guidelines. 11.12.23- Now attached to guideline as an appendix. Comms sent out to staff. FS lead midwife will support roll out.	
16.10.23	To Update on estate start date	Kim Farrell	13.11.23 Work commenced.	
16.10.23	IOL leaflet promotion	Kerry Jones	13.11.23- Unable to push leaflet out. Kerry has submitted a change request. 11.12.23- Kerry not in attendance to meeting. 4.3.24- Leaflet is now pushed out. Leaflet updated with the NHS IOL leaflet. WHH out of date.	
16.10.23	IOL bookings to become available on BN- SOP to be produced, old booking system to be switched off	Kerry Jones	16.10.23-Slots will require monitoring- to be included in SOP. 13.11.23-User guides have been created x3 for MDT. IT supporting movement of patient clinics from Lorenzo to BN. BN live bookings from 4th Dec 11.12.23- Bookings now live	
13.11.23	To review licencing of 2nd propess administration. Team agreed that if evidence supports, midwives are to administer 2nd propess if prescribed by medics to reduce delays.	Kim Farrell	11.12.23- Not yet actioned to feedback at next meeting 4.3.24-Update- Awaiting meeting set up with pharmacy for px of second process. 29.7.24 PGD reviewed – Process to remain due to licencing of propess.	
13.11.23	To review the process of outpatient IOL. Charlotte and Kim to meet separately and to feedback at the next meeting.	Kim/Charlotte	11.12.23- CH/KF have met and discussed outpatient IOLs to attend triage AM and NEST Staff/triage staff will complete. Await correct model of staffing and works completion before implementation 4.3.24- Update- CH/KF have met and discussed. Comms to go out when staffing model correct on triage and opening of IOL 29.7.24- Meeting with Kerry and Despina to be set up to arrange a separate outpatient appointment in BN. To discuss NEST/Triage staff to possibly support OP IOLS	30/9/24

Agenda Date	Action	Owner	Update	RAG status
11.12.23	Fetal surveillance lead to review all IOL equipment to ensure change in practice can be facilitated.	Julie Rowlinson	4.3.24- Action complete	
4.3.24	Kerry to ensure leaflets are removed from clinic and only printed out for women that do not have access to BN	Kerry	To liaise with Jo ANS to ensure no leaflets are in the waiting area	
29.7.24	CH to introduce flow charts for processes of ongoing IOLS/ Commencement of IOLS/accelerations of Inductions. Areas to consider movement of patients. Escalation and acuity to be considered	Charlotte	9.9.24-No update	30/9/24
29.7.24	MG to develop audit tool	Maria	Completed	30/8/24
29.7.24	Dilapan Rep visit tba	Rita	29.7.24- Arranged for the 30th September with Kim/Rita/Charlotte	30/9/24
29.7.24	Meeting with LWH IOL lead midwife	Kim	Meeting arranged for the 5th Aug 9.9.24- Meeting complete. Discussed LWH pathways. IOL lead has sent information in relation to QI and pathways. To meet with the senior team to disseminate	30/8/24
29.7.24	Laminate indications of IOL NICE/SBL standards	Charlotte	9.9.24-Completed and shared with staff	30/8/24
9.9.24	Spot check audit-last 3months – Outpatient IOLS	Charlotte		30/9/24
9.9.24	?introduce red flags for overspill inductions	Kim		30/9/24

IOL Task & Finish group

Minutes: 9.9.24

Attendance: Kim Farrell, Intrapartum Matron. Sarah Nuttie, Consultant Midwife. Amelia Crowther, Theatre Co-ordinator	**Meeting Apologies:**

Items discussed	Minutes
• **Updated all actions.** • **Overspill of IOLS** • **Outpatient IOLS** • **Aromatherapy service**	SN requested a review of overspill of IOLS into other areas. From the 12th August C23 have supported x10 IOLS. KF has asked for an ongoing audit. AC requested it to be raised as a red flag. This could be impacting bed blocking/diverts/patient experience. Overspill should remain on BS as per SN request to support patient experience SN has requested a spot check 3monthly audit of how many outpatients we are currently facilitating KF discussed ongoing working group to introduce postdates clinic to support reduction of IOL.

Appendix four – Learning from investigations – case MI-036905

MNSI Maternity & Newborn Safety Investigations

Learning from Investigations

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

The Case

A 24yr old woman in her second pregnancy. She followed a low-risk care pathway with a plan to birth in the Nest. She was a smoker and serial growth scan were indicated. Testing for GDM was also indicated as she had a raised BMI. She was not referred for growth USS or GTT.
Growth USS was performed at 38+6 as SFH was raised however the USS was within the expected range and the mother remained on the low-risk pathway.
The mother attended triage at 39+4 with pv bleed and changes to fetal movements. CTG was normal and a plan for IOL at the next available opportunity. Liqour and doppler studies were undertaken and normal. IOL was for two days later with a plan for CTG next day.
Attendance for CTG next day was normal and the mother returned home.
IOL commenced at 39+6 weeks at 16:05 hours.
When a repeat CTG was due at 05:04 hours (40+0 weeks) the Baby's heartbeat could not be
heard. A bedside USS was performed at 05:40 hours and it was confirmed that the Baby had
died. The Mother's labour was augmented, and the Baby was stillborn at 16:44 hours. At birth
the Baby weighed 3,480 grams which was on the 29th customised growth centile.
A postmortem examination (PME) was performed, and the report described the cause of death as 'features of an acute asphyxia mode of death'.

MNSI Findings

The Mother's pregnancy referral was received at 14+1 weeks. Due to her pregnancy being greater than 12 weeks a telephone booking was performed as a matter of urgency at 15+1 weeks and arrangements were made for prompt dating via ultrasound assessment. Due to the after-scan appointment being partially completed the Mother was not booked for an oral glucose tolerance test or obstetric consultant review which were indicated in local guidance. Not having a consultant review led to the Mother not being offered serial growth ultrasound scans, the impact of this for the Baby is unknown

The Mother was a smoker when she became pregnant, when she stopped smoking her smoking status was removed from her electronic patient record. This meant that her smoking status at booking was not consistently considered as a risk factor on her care pathway. Referral to stop smoking support services and carbon monoxide testing was in line with guidance. The Mother independently reduced her smoking and stopped antenatally.

The electronic patient record system did not pull through the correct management plan for growth assessment of the Baby at the time of the Mother's pregnancy booking. The data then pulled through at 17+2 weeks indicating that serial growth scans were required. As the Mother reported she had stopped smoking, the management plan was then edited, and her risk changed from 'intermediate' to 'low'.

The Mother did not receive ongoing risk assessment during her pregnancy, this meant that previously missed risk factors were not highlighted, and elements of her management plan was not aligned with her risks.

The Mother received two ultrasound scans in the third trimester; growth at 38+6 weeks and amniotic fluid volume and umbilical artery Doppler at 39+4 weeks. The absence of ultrasound assessment before 38+6 weeks means that, when the calcification of the placenta occurred is unknown. Additionally, as this was an isolated assessment and as serial growth ultrasound scans had not been performed; it is unknown if the Baby's growth was within an expected growth trajectory.

Assessment of the Mother's and Baby's well-being was indicated at 39+3 weeks when the Mother contacted the antenatal day unit with red vaginal blood 'spotting'. There was no documentation of this telephone contact which was not in line with guidance. It is unlikely that this had an impact on the outcome for the Baby.

Induction of labour was offered and accepted in line with guidance for 2 days' time when the Mother had reduced fetal movements at 39+4 weeks. Further monitoring was arranged for 39+5 weeks, and the Mother continued to be concerned that her Baby was not moving in their usual pattern. Due to clinicians being reassured that a computerised cardiotocograph (CTG) met criteria at 10 minutes and not considering that the reduced fetal movements were ongoing, no escalation of concerns with the movement of the Baby occurred.

The Mother was admitted for induction of labour at 39+6 weeks and had a slightly elevated heart rate. Maternal observations were not performed in line with local guidance due to workload pressures in the induction of labour bay. It is unlikely that this had an impact on the outcome for the Baby. CTG was repeated 6 hours following induction of labour. The baseline heart rate of the Baby was difficult to interpret when the CTG was discontinued at 23:05 hours. Continuation of the CTG may have supported a more accurate interpretation of the Baby's wellbeing.

The family were provided with bereavement care and given memory making opportunities with their Baby whilst in hospital. Building works impacted the availability of a bespoke private and quiet environment. Cleaning had not been performed effectively which caused distress when the family returned to visit their Baby following discharge.

MNSI Safety Recommendation	Trust actions and learning
The Trust to ensure a robust process for identification and referral of women with risk factors who require an obstetric consultant review in line with local guidance.	• BadgerNet digital system includes recommendations following a risk assessment, i.e. if risk factors for FGR, recommendation would be for serial growth scans and consultant review. These risk assessments should be reviewed at every contact. • The antenatal care guideline and booking guideline is being updated by the antenatal clinic manager and community manager to highlight the importance of risk assessment at every contact- including how this should be recorded digitally. • Practice development midwife to be involved in the guideline process and to be responsible for circulating any key changes and updates to local guidance for all staff. • Staff training MAMU-2 update includes: 'actual management plan' can be populated by staff member, as well as BadgerNet auto input. SBL training to include importance of ongoing risk assessment and updates to local guidance. • Bookings to be audited to provide assurance that risk assessment is taking place, correct risk is assigned and women are referred to an obstetrician appropriately.
The Trust to ensure staff are supported review risk factors and care plans at each antenatal contact to ensure that mothers receive care aligned with their risk factors	• Risk assessments should be reviewed at every contact. The antenatal care guideline and booking guideline is being updated by the antenatal clinic manager and community manager to highlight the importance of this. • Audit to be completed for assurance that risk assessments are reviewed and completed at every contact in antenatal services and community. • Staff focus groups to explore barriers to completing risk assessments on BadgerNet • Digital midwife to review the booking and antenatal care guidelines, along with other local guidance, i.e. reduced fetal movements, to ensure that the BadgerNet recommendations are correct and inline with guidance.

Lisa Davies Jan 2023

Maternity Investigation

MI-036905

Independent report by the Maternity & Newborn Safety Investigations (MNSI)

Final report July 2024

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Section 1. MNSI investigations

1.1 How MNSI decides what to investigate

MNSI will undertake maternity investigations in accordance with Care Quality Commission (Maternity and Newborn Safety Investigation programme) Directions 2023.

In accordance with these defined criteria, eligible babies include all term babies (at least 37+0 weeks of gestation) born following labour, who have one of the following outcomes:

Intrapartum stillbirth: when a baby was thought to be alive at the start of labour and was born with no signs of life.

Early neonatal death: when a baby dies within the first week of life (0-6 days) of any cause.

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

- was therapeutically cooled (active cooling only), or
- has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following:
  a. hypotonia;
  b. abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck;
  c. clinical seizures.

* ‘severe brain injury’ means a brain magnetic resonance imaging scan showing hypoxic damage (a type of brain injury that occurs when there is a disruption in supply of oxygen to the brain) or the baby demonstrating ongoing neurological signs or symptoms.

Under CQC legislation MNSI will also continue to investigate cases where a family or Trust has concerns about the care provided but the baby is found not to have a severe brain injury (and therefore does not fall under one of the categories of “eligible babies” within the definition of a “qualifying maternity case” in the Directions).

The defined criteria for maternal death investigations are:

Maternal death: death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.

- Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.
- Indirect: deaths from previous existing disease or disease that developed during pregnancy, and which was not the result of direct obstetric causes, and which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

*Includes giving birth, ectopic pregnancy, miscarriage or termination of pregnancy.

1.2 MNSI investigation approach

It is the role of MNSI to investigate safety incidents without attributing blame or liability. The focus is to identify opportunities to learn and to improve patient safety across the healthcare system.

The MNSI programme is part of a national strategy to improve maternity safety across the NHS in England. MNSI's maternity investigations replace any local incident investigations conducted by the healthcare organisation in which the mother and baby received care.

All NHS trusts are required to tell us about certain patient safety incidents that happen in maternity care. This is so that we can carry out an independent investigation and where relevant, make safety recommendations to improve services at local level and across the whole maternity healthcare system in England.

Throughout investigations we work closely with the families, NHS trusts and staff involved. We do not place blame on individuals or investigate individual members of NHS staff. Our programme was established in 2018 as part of the Healthcare Safety Investigation Branch and is now hosted by the Care Quality Commission.

MNSI investigations are independent, it does not investigate on behalf of families, staff, organisations or regulators. Where safety recommendations are made, these are directed to a specific organisation, and to other organisations or bodies who can influence and support change.

Findings and safety recommendations

On completion of the investigation, the report will contain **findings** which reflect information that was discovered through analysis of the evidence collected during the investigation. **Safety recommendations** are made to organisations when the findings identified during an investigation are considered to be contributory to the outcome.

Not all reports will contain **safety recommendations** and organisations are guided to use the findings to support learning and change.

Section 2. Referral, investigation and terms of reference

2.1 Referral of the case

The Trust contacted the Maternity & Newborn Safety Investigations (MNSI) about the incident, which met the criteria for MNSI to conduct a maternity investigation.

2.2 Investigation process and methodology

MNSI uses a standard process in all its maternity programme investigations:

- Gather all relevant evidence
- Establish the factual circumstances leading up to the incident
- Analyse the evidence
- Identify the most significant safety factors and safety issues that contributed to the incident being investigated
- Formulate safety recommendations and findings.

This process is supported by the following:

2.2.1 Review of medical records

After consent is obtained from the family to access the appropriate medical records, these are uploaded by the trust and MNSI can commence the review/investigation.

Records accessed can include (and are not limited to), hospital records, GP records or ambulance service records and transcripts.

All relevant trust policies, procedures and practices are reviewed. Additionally, investigators may undertake a walk-through of a mother's and baby's journey within the maternity service.

2.2.2 Family interviews

Introductory and supplemental interviews are held with the family to understand their recollection of events, hear their concerns and understand key questions they may have. Involvement of families in the investigation process is a fundamental part of MNSI's work, adding value to the evidence gathered and the learning outcomes.

2.2.3 Subject matter review panels

The panels during this investigation were attended by experienced subject matter advisors in obstetrics and midwifery who provided advice and guidance. This guidance includes signposting to evidence, national guidance and current best practice. The panel assists in formulating the investigation's terms of reference and key lines of enquiry. The investigators also have access to human factors specialists throughout the investigation process.

2.2.4 Staff interviews

Face to face or virtual interviews are conducted with key participants of the incident, who are able to provide a depth of information in addition to the medical records. MNSI may also request interviews with other members of a trust who may be able to provide further background information to support the investigation. Where individuals may be able to provide small pieces of information relevant to the investigation, investigators may conduct telephone or email enquiries.

2.2.5 Analysis

A range of resources assist in understanding factors that may contribute to an incident occurring. MNSI promotes use of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) as one way to help understand why incidents occur. Our maternity investigations aspire to utilise SEIPS to consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, national policies, and professional guidance, which contribute to how incidents occur.

Once analysis is complete MNSI may form findings and safety recommendations based on the relevant factors of the case, aimed at reducing the chance of reoccurrence and optimising learning for all members of trust staff.

Findings and safety recommendations from individual reports are analysed and may be used nationally to share wider thematic learning.

2.2.6 Communication during investigations

Throughout the investigation process, MNSI maintains regular contact with both families and trusts. The frequency of this may vary according to need. If a serious safety concern is identified this will be escalated back to a trust as soon as is practicable. This ensures an opportunity for a trust to address safety issues in a timely manner.

2.2.7 Quality assurance

Following evidence collection and analysis a report is produced which is reviewed by a second subject matter review panel. Our aim is to ensure that the advisors are different to those on the first panel in order to ensure a fresh perspective. Following internal quality assurance, external quality assurance is undertaken with both the trust and the family before a report is finalised and shared with the trust and the family. The definitions and standard wording used within MNSI reports are written and quality assured by MNSI clinical advisors in their relevant field and updated as needed.

2.2.8 Post-mortem examination

In cases which have been referred to His Majesty's Coroner and a post-mortem examination (PME) has been completed, the MNSI report will reflect the cause of death as stated in the PME. In cases where an inquest is planned to take place, the cause of death will not be confirmed until the inquest is concluded. On occasion the wording in relation to the cause of death may be changed or added to as part of the inquest process, this may occur after the MNSI report has been completed.

2.2.9 His Majesty's Coroner information

MNSI acknowledges it is possible that there is other information, available to the family or His Majesty's Coroner, which could have been relevant to the information MNSI considered during this investigation. For clarity, our final report was produced by accessing and reviewing all evidence that was available to us at the time of the investigation. Our findings and safety recommendations were made on that basis and all evidence used for this investigation is listed in the appendices at the end of our report. If our findings differ to those from later investigations, such as by His Majesty's Coroner, the reasons for this may be due to the different evidence available to different investigations.

2.3 Terms of reference

- Investigate all aspects of maternity care from the pregnancy booking to confirmation that the Baby had died with a focus on risk assessment.
- Consider how the infrastructure and resources available within the organisation and the structure of maternity services within the Trust.
- Ensure that the perception of events from the family, the Trust and staff directly involved in the care of the Mother and the Baby are captured.

A note of acknowledgement

We are grateful and give our thanks to the family whose experience is written about in this report. The family gave generously their time and shared openly their thoughts with us. We would also like to thank the Trust and members of staff who participated in this investigation process and openly shared their perceptions of the incident and maternity services with us as well as expressing their empathy for the family involved. To preserve anonymity, the family are referred to as the Mother and the Father throughout. The baby is referred to as the Fetus, fetal or the Baby until the birth and is referred to as the Baby after the birth.

Section 3. Summary report

A 24-year-old White British mother was booked for midwife led care at 15 weeks and 1 day gestation (15+1 weeks) in her second pregnancy. The Mother's medical, obstetric and social history was obtained and she followed a low-risk antenatal care pathway, with a plan to give birth on the co-located birth centre.

The Mother was a smoker and serial growth ultrasound scans of the Baby were indicated as her pregnancy was moderate risk for fetal growth restriction. Testing for gestational diabetes was also indicated as she had a raised body mass index. The Mother was not referred for serial growth ultrasound scans or diabetes screening.

A growth ultrasound scan (USS) was performed at 38+6 weeks as the Mother's symphysis fundal height measurement was above the expected range. The Baby's growth was assessed by USS as being within the expected range and the Mother remained on a low-risk care pathway.

The Mother attended the maternity triage at 39+4 weeks with a history of vaginal bleeding and a change in the usual pattern of her baby's movements. A cardiotocograph (CTG) was performed which was 'normal' and no bleeding was seen. A plan was made to induce the Mother's labour 2 days later due to the change in the Baby's movements. An USS was performed which showed the blood flow through the umbilical cord and amniotic fluid volume were both in the expected range.

A planned CTG was performed on maternity triage at 39+5 weeks. The movements of the Baby remained changed from their usual pattern, the CTG was 'normal' and the Mother returned home.

Induction of labour was started via a prostaglandin pessary at 39+6 weeks at 16:05 hours. When a repeat CTG was due at 05:04 hours (40+0 weeks) the Baby's heartbeat could not be heard. A bedside USS was performed at 05:40 hours and it was confirmed that the Baby had died. The Mother's labour was augmented and the Baby was stillborn at 16:44 hours. At birth the Baby weighed 3,480 grams which was on the 29th customised growth centile.

A postmortem examination (PME) was performed and the report described the cause of death as 'features of an acute asphyxia mode of death'. The placenta was sent for histology (examination under a microscope) and the report stated that 'findings of delayed villous maturation and high grade fetal vascular malperfusion were contributory to fetal death'.

Section 4. Facts of the case

4.1 Incident criteria: intrapartum stillbirth

When a baby was thought to be alive at the start of labour and was born with no signs of life; this includes when:

- labour was diagnosed by a health professional; this includes the latent phase of labour, i.e. less than 4cm dilatation
- a mother called the unit to report any concerns of being in labour, for example (and not limited to) abdominal pains, contractions or suspected ruptured membranes
- a baby was thought to be alive at induction of labour
- a baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes

4.2 The incident

A 24-year-old White British mother was booked for midwife led care at 15 weeks and 1 day gestation (15+1 weeks) in her second pregnancy.

The Mother's medical, obstetric and social history was obtained and she followed a low-risk antenatal care pathway, with a plan to give birth on the co-located birth centre. Antenatal care was provided by a continuity of carer team.

Continuity of carer
Continuity of carer is an approach within maternity care describing consistency in the midwifery or clinical team providing care for a mother and her baby throughout her pregnancy labour and postnatal period. Continuity of carer has been shown to improve clinical outcomes for both mothers and babies, as well as improving maternal satisfaction with care. (MNSI)

The Mother was a smoker and a risk assessment identified that she was at a 'moderate risk' of fetal growth restriction during her pregnancy. Serial growth ultrasound scans were indicated 4 weekly from 32 weeks which were not performed.

Small for gestational age, intrauterine growth restriction and fetal growth restriction
The curved lines on a baby's growth chart represent the range of growth that is expected. Most babies will continue to grow along the same curve.
Small-for-gestational age (SGA) refers to a baby born with a birth weight (BW), which is smaller than most babies born at the same number of weeks of the pregnancy. A baby's

estimated weight as calculated by ultrasound scans, can be plotted on these charts, to identify SGA babies. The birth weight also can be plotted on the chart.
Intrauterine growth restriction (IUGR) (also known as fetal growth restriction, FGR) is a condition where a baby's growth slows or stops during the pregnancy.
IUGR babies are more likely to find the stress of labour difficult.
Further information from: RCOG - having a small baby

The Mother had a body mass index of 34.7kg/m^2, which was above the expected range, a referral appointment for an oral glucose tolerance test was not sent.

Body mass index in pregnancy

BMI is a measure for indicating nutritional status in adults. It is defined as a person's weight in kilograms divided by the square of the person's height in metres (kg/m^2) (WHO). The World Health Organisation (WHO) classifies BMI as follows:

BMI	Nutritional status
Below 18.5	Underweight
18.5 - 24.9	Normal weight
25. 0 - 29.9	Pre-obesity
30.0 - 34.9	Obesity class I
35.0 - 39.9	Obesity class II
Above 40	Obesity class III

Obesity in pregnancy is associated with an increased risk of several serious adverse outcomes, including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. Fetal heart rate monitoring can be a challenge, and closer surveillance is required, with recourse to fetal scalp electrode or ultrasound assessment of the fetal heart if necessary. (RCOG 2018)

Oral glucose tolerance test

An oral glucose tolerance test is a medical test in which an initial fasting blood test is taken, then a glucose solution or sugary drink is given by mouth. A further blood sample is taken two hours later. The test determines how quickly the glucose is cleared from the blood in order to diagnose gestational diabetes. Further information from: Diabetes UK - testing for diabetes

Gestational diabetes mellitus (GDM)

Gestational diabetes is a form of diabetes that may affect a mother in the second half of the pregnancy. It is usually diagnosed through a blood test at 24–28 weeks of pregnancy. The hormones produced during pregnancy make it more difficult for the body to use glucose properly for energy, so the glucose remains in the blood and the levels rise, leading to gestational diabetes. Mothers who are overweight, come from certain ethnic backgrounds, have a family history of diabetes, have previously had a baby over 4500g or had gestational diabetes in a previous pregnancy are at increased risk of developing gestational diabetes.

Further information from: Diabetes UK - gestational diabetes and NHS - gestational diabetes

The growth of the Baby was monitored by plotting symphysis fundal height measurements on a customised growth chart from 29+3 weeks.

Symphysis-fundal height

Symphysis fundal height (SFH) is a measurement of the size of a mother's uterus which is used to assess a baby's growth during pregnancy. It is measured from the top of a mother's uterus to her pubic bone. (MNSI)

Customised growth chart

One method of monitoring the growth of a baby is to consider relevant features of a mother (such as height, weight, ethnicity and number of previous babies). These features assist in making an individual projected growth chart for that baby. Two measurements can be plotted on the same chart:

- Measurements taken of a mother's uterus (symphysis-fundal height, SFH)
- Expected weight of a baby (estimated fetal weight, EFW) at the time of an ultrasound scan

Measurements plotted on an individualised graph through a pregnancy, can assist clinicians in detecting any slowing of growth in a baby. (MNSI)

As the Mother's pregnancy booking occurred after 12+0 weeks this was considered 'late' and a dating ultrasound scan was arranged for the following day which confirmed the pregnancy as 15+2 weeks and no abnormalities were identified. Screening for chromosomal abnormalities was offered and the Mother chose to not have screening. Routine booking blood testing for blood born viruses, group and screen (a test to determine a mother's blood group and presence of red cell antibodies) and full blood count (FBC) was performed and the Mother's

haemoglobin was on the borderline of the expected range at 110 grams per litre (g/L). All other results were within the expected range.

Haemoglobin
Haemoglobin is the protein in red blood cells that carries oxygen to the body's organs and tissues. If a blood test reveals that haemoglobin levels are lower than normal this is known as anaemia. (MNSI)

Referral to the stop smoking support service occurred at 15+3 weeks and contact was made with the Mother via telephone, text and letter. Carbon monoxide breath testing was performed routinely during the Mother's antenatal care with results between 1-5 parts per million (ppm) (the expected range was less than 4ppm). The risks of smoking were discussed, the Mother chose to not receive stop smoking support and reduced her smoking independently.

As the Mother's haemoglobin was borderline at booking, blood was obtained at her next routine community midwifery appointment at 17+2 weeks, for an 'iron profile'. The results were within the expected range and a prescription was arranged for ferrous sulphate (iron medicine) 200 milligrams (mg) once a day. The care records stated the Mother reported she had managed to stop smoking and leucocytes 1+ were found on routine testing of her urine. As there were no symptoms of an infection, a plan was made to send a further urine sample 'should symptoms develop'.

Leucocytes
Leucocytes are white blood cells that fight infection in a mother's body. They are commonly identified in the urine of pregnant mothers. Whilst the presence of leucocytes can mean an infection is present, this is usually not the case. (MNSI)

The routine anomaly ultrasound scan was performed at 19+5 weeks and reported as 'incomplete' as not all views of the Baby could be seen. The ultrasound scan was rebooked for 22+2 weeks.

Mid pregnancy anomaly ultrasound scan
The mid-pregnancy anomaly ultrasound scan (USS) looks for some physical abnormalities in a baby. The USS only looks for these problems and can't find everything that might be wrong. It looks in detail at a baby's bones, heart, brain, skin covering the spinal cord, face, kidneys and abdomen. It allows the sonographer or doctor to look specifically for 11 conditions, some of which are very rare. Further information from: NHS - anomaly scan

The Mother attended a routine community midwifery appointment at 20+4 weeks and reported that she was experiencing migraines. All maternal observations were within the expected range and the Mother was given advice on the signs of pre-eclampsia.

Pre-eclampsia

Pre-eclampsia is a condition that typically occurs after 20 weeks. It is a disease that is detected with a combination of raised blood pressure (hypertension) and one or more new-onset conditions including protein in the urine (proteinuria), abnormalities in liver, kidney or blood clotting function, severe headache, persistent vision problems or evidence of reduced placental function such as reduced growth of a baby. There may be no symptoms. The exact cause of pre-eclampsia is not understood. Pre-eclampsia is common, affecting between four and 16 in 200 mothers during pregnancy. It is usually mild and normally has very little effect in pregnancy. In a small number of cases, it can develop into a more serious illness. Severe pre-eclampsia (which around one in 200 mothers, develop during pregnancy) can be life-threatening for both mother and baby. (Adapted from RCOG, 2012)

Further information from: NHS - pre-eclampsia

The routine anomaly ultrasound scan was completed at 22+2 weeks and no abnormalities were identified.

The Mother did not attend a routine community midwifery appointment at 28+4 weeks as she was not aware this appointment had been made. Contact was made via telephone and the appointment was rearranged for 6 days later.

At 29+3 weeks the Mother attended the rearranged midwifery appointment and reported her frustrations that she was unsure who her named midwife was, as she had seen a number of different midwives and received antenatal care in differing locations. A plan was made for future appointments to provide midwifery continuity of carer at a consistent location. Maternal and fetal (baby) observations were within the expected range and repeat testing of the Mother's haemoglobin showed it had increased to 112g/L, within the expected range. It was documented that the Mother had reduced her smoking to 1 to 2 cigarettes a day. Stop smoking support was offered and the Mother chose not to be referred.

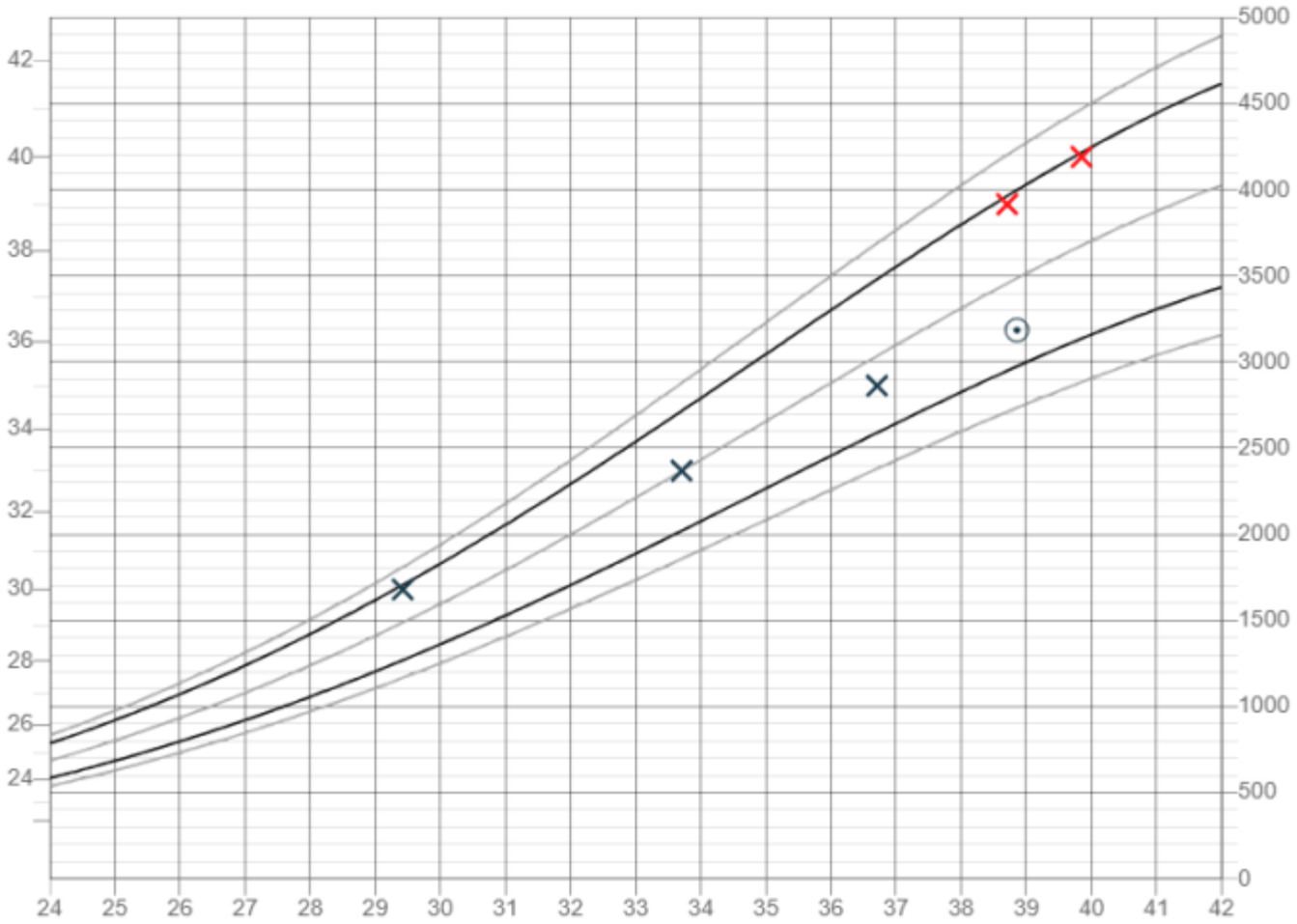
The Mother did not attend a routine community midwifery appointment at 32+2 weeks as her first child was unwell. The appointment was rearranged for 10 days later.

At 33+5 weeks and 36+5 weeks routine community midwifery appointments were attended by the Mother and all maternal and fetal observations were within the expected range. A birth plan

was discussed and it was planned that the Mother would birth on the co-located birth centre at the hospital as the Mother recalled being repeatedly told she was a “low risk pregnancy”.

A routine community midwifery appointment at 38+5 weeks found the growth of the Baby to be above the expected range on symphysis fundal height measurement and a growth ultrasound scan was arranged for the following day. The movements of the Baby were documented to be in their normal pattern. All maternal observations were within the expected range and induction of labour was arranged for 40+7 weeks if the Mother did not go into labour before.

Table 1. Customised growth chart



Symphysis fundal height measurements are plotted using ‘**X**’ and estimated fetal weights on ultrasound scan by ‘**ʘ**’.

Induction of labour

Induction of labour (IOL) is the process of artificially starting labour using a variety of medications and techniques. Usually, the first stage is to soften and prepare a mother’s cervix by using prostaglandin tablets, pessaries or gels. Sometimes her cervix will be prepared using a mechanical method, such as a balloon. The next stage is to artificially

break the waters (artificial rupture of membranes (ARM)). If contractions are still not strong or regular enough the drug oxytocin is given. This is one of the hormones produced naturally by mothers in labour and assists in increasing the frequency of contractions. Oxytocin is given through a drip, and the timing of the subsequent contractions are monitored closely. If the contractions are too sparse, or become too frequent, the amount of oxytocin given via the drip will be altered.
Further information from: NICE - induction of labour

The growth ultrasound scan at 38+6 weeks found the estimated weight of the Baby plotted on the 22nd customised growth centile with the umbilical artery Doppler and amniotic fluid level 'normal'. It was documented that calcifications (calcium deposits which occur naturally closer to the end of pregnancy) were seen 'throughout' the placenta. The Mother recalled being anxious before this ultrasound scan, she was then reassured once the growth of the Baby was confirmed to be within an expected range.

Growth ultrasound scan
This is an ultrasound scan performed to check the overall wellbeing of a baby. It involves some combination of assessing a baby's size, the amount of fluid around a baby and the measurement of blood flow to the placenta and within a baby using Doppler ultrasound. (MNSI)

Umbilical artery Dopplers
Umbilical artery Doppler measurements, to check the blood flow from the baby back to the placenta, may be performed during an ultrasound scan (USS) to assess a baby's wellbeing. When indicated, umbilical artery Doppler measurements are usually performed from 26-28 weeks onwards. Measurements outside the expected range suggest that the baby has an increased chance of being small for gestational age (SGA) at birth.
Further information from: RCOG - Management of small for gestational age babies

Following the ultrasound scan the Mother was seen on the maternity triage unit. A midwifery clinician reviewed the ultrasound report and the Mother was advised to contact the maternity triage if there were 'any concerns regarding herself or baby' before being discharged home.

The Mother received a membrane sweep at 39+2 weeks during a routine community midwifery appointment. The Mother's cervix was documented to be 1-2 centimetres (cm) dilated. The Baby's heart rate was heard before and after the membrane sweep and was within the expected range.

Membrane sweep

A membrane, or cervical sweep, involves having a vaginal (internal) examination that separates the membranes of the amniotic sac surrounding a baby from the cervix (neck of the womb). This separation releases hormones (prostaglandins) that may trigger natural labour. It is not uncommon to experience some discomfort or slight bleeding afterwards. Further information from: NHS - induction of labour

The Mother contacted the antenatal day unit at 12:35 hours at 39+3 weeks and reported red vaginal blood loss. The Mother recalled being told to “bed rest” by a clinician on the telephone. There was no documentation of this telephone call from Trust records. Review of the Mother’s telephone records showed the call was placed to the antenatal day unit and lasted for 1 minute.

A further telephone call was made to the maternity triage at 11:04 hours at 39+4 weeks as the Mother was concerned that the Baby’s usual pattern of movement was reduced and she had noticed further vaginal blood loss. The Mother was advised to go to maternity triage for assessment, she arrived at 11:20 hours, her observations were all within the expected range and her modified early obstetric warning score (MEOWS) score was zero.

Modified early obstetric warning score (MEOWS)

The modified early obstetric warning score (MEOWS) is a tool to detect and respond to mothers who are at risk of their condition worsening. Vital signs such as temperature, blood pressure, heart rate, respiration rate etc. are recorded and scored on an observation chart. The resulting total score indicates the appropriate action to take. (MNSI)

A computerised cardiotocograph (CTG) was started at 11:35 hours which met criteria and was discontinued at 12:05 hours.

Computerised cardiotocography analysis

Cardiotocography (CTG) is an electronic means of recording a baby's heart rate pattern, to assess their wellbeing. Sometimes in the antenatal period (before labour or induction of labour), this can be analysed by a computer. A CTG from a healthy baby would be expected to meet the computerised CTG analysis criteria. The antenatal use of computerised CTG analysis is recommended in national guidance due to its potential to reduce the chance of human error (NHS England, 2019). (MNSI)

An ultrasound scan to measure the blood flow through the umbilical cord and amniotic fluid volume was indicated in local fetal movement guidance and this was requested.

A member of the obstetric team saw the Mother at 12:25 hours and a speculum examination (instrument to visualise a mother's cervix) was performed to look for a cause of the Mother's bleeding. No signs of bleeding could be seen. Induction of labour was discussed and the Mother recalled the reason for the offer of induction of labour being explained as "the movement (of the Baby) was dropping, there was a chance of stillbirth". The Mother accepted induction of labour and this was arranged for the next available vacancy in 2 days' time (39+6 weeks).

A repeat membrane sweep was offered before the Mother returned home and she chose for this to not be repeated.

When the Mother returned home, she received a telephone call asking her to re-attend the hospital for the ultrasound scan that afternoon at 16:00 hours. The blood flow through the umbilical cord and amniotic fluid volume were both in the expected range. The Mother recalled that she was informed the level of amniotic fluid was "borderline". The ultrasound scan report stated that the placenta 'contains some calcifications throughout'. The Mother was seen by another member of the obstetric team following the ultrasound scan and she remained concerned that her Baby's movements were reduced. In view of the ongoing reduced movements of the Baby, the electronic induction of labour booking system was checked and she was informed there remained no capacity to bring her induction forward. There was no internal escalation or decision for admission and a "safety net" appointment was made for the Mother to reattend the antenatal day unit the following day for a repeat computerised CTG.

The Mother attended the antenatal day unit at 39+5 weeks and was seen by a midwifery clinician. A computerised CTG was started at 09:16 hours which met criteria after 10 minutes and was discontinued. It was documented that the Mother was advised to contact maternity triage if she was 'concerned regarding fetal movements'. The Mother remained concerned about her Baby's movements and reported to staff that her Baby was still less active than normal. The Mother recalled being told she had "no reason to panic" and that she "would be meeting [her] baby tomorrow" before she then returned home. The Mother recalled feeling as though her concerns were "dismissed". Staff on the antenatal day unit did not recall the Mother remaining concerned about her Baby's movements at the time of this contact.

The Mother attended for induction of labour at 14:15 hours at 39+6 weeks and was admitted to the 'induction of labour bay'. The MEOWS score was one, due to her heart rate being above the expected range at 115 beats per minute (bpm). The electronic patient record showed that MEOWS were recommended to be performed '2-4 hourly' in view of the raised heart rate. The

Mother recalled being asked more than once if it was usual for her heart rate to be raised and she reported that it was not, although she was “feeling anxious”.

Expected ranges of maternal observations

During pregnancy, labour and in the postnatal period a mother’s temperature, heart rate, blood pressure, respiratory (breathing) rate and oxygen saturation in the blood may be measured. Most mothers will have observations in the following ranges.

- **Temperature** 36C to 37.9C
- **Heart rate** 50-99 beats per minute (bpm)
- **Blood pressure systolic** (top number) 100-150mmHg, diastolic (bottom number) 50-90mmHg
- **Respiratory rate** 11-20 respirations per minute (rpm)
- **Oxygen saturation** 95%-100%

A computerised CTG was started at 14:25 hours which met criteria after 17 minutes. The CTG continued, and maintaining contact with the Baby’s heartbeat was difficult. Staff tried holding the CTG transducer in place and changing the monitoring equipment, these attempts were unsuccessful in gaining effective contact with the Baby’s heartbeat. The family recalled that during the CTG monitoring the Mother was asked to hold the transducer in place and change her position. An alarm on the monitoring equipment sounded on four occasions to alert staff that the Baby’s heartbeat was not being detected. The family found this concerning as the Baby was not active and so asked if it was possible to have an ultrasound scan. Reassurance was given that “everything was ok” and they were informed that an ultrasound scan was not possible. The family recalled that they did not feel as though staff were listening to their concerns that the Baby remained less active and that it felt as though staff were relying solely on the CTG monitoring.

A plan was made, in discussion with a senior member of the midwifery team, to examine the Mother’s cervix to see if her waters could be broken. Once this information was gained a further management plan would then be made.

The Mother’s cervix was not dilated enough for staff to break her waters. The CTG was re-started at 15:43 hours and a prostaglandin pessary was given at 16:05 hours. The CTG was discontinued at 16:35 hours as it was categorised as ‘normal’. The Mother’s heart rate was monitored throughout the CTG and was above the expected range at 110-120bpm.

Prostaglandins for induction of labour

There are several medicines which can be considered for induction of labour. They are designed to prepare the cervix (neck of the womb) for labour and are often the first stage of an induction of labour process. The medication is given in a vaginal pessary, gel or tablet preparation which is inserted into the top of the vagina.

Further information from: NICE - induction of labour

At 4 hours and 32 minutes following the Mother's previous MEOWS, her observations were repeated. The score remained one as her heart rate was slightly above the expected range at 104bpm. The electronic patient record showed that MEOWS was recommended to be performed '2-4 hourly' in view of the raised heart rate.

A further CTG was started at 22:26 hours. The Mother recalled this CTG being delayed (due at 22:05 hours) this was due to other women undergoing induction of labour also needing care. The CTG was discontinued at 23:05 hours and was categorised as 'normal'. The Mother's MEOWS score was one. This was incorrectly documented as zero in the Mother's record. The electronic patient record again showed that the MEOWS was recommended to be performed '2-4 hourly' in view of the raised heart rate.

Due to acuity on the birth suite the midwifery clinician, caring for the Mother and other women in the induction bay, was reallocated to work on the birth suite at 03:45 hours (40+0 weeks). A midwifery clinician, who was working on the postnatal ward, took over the care of the women in the induction bay. No verbal handover was received, the details of the mothers in the induction bay and care they required was documented on a clipboard which was "up to date".

The Mother's MEOWS score was zero at 05:04 hours and attempts were made to locate the Baby's heartbeat with a view to starting a CTG. A midwifery clinician was unable to find the Baby's heartbeat using a CTG transducer and a student clinician brought a handheld Doppler. Attempts with the handheld Doppler were also unsuccessful and the midwifery clinician asked the student clinician to also try in case it was her technique. The Mother recalled asking if a doctor could help as she was uncomfortable that the task of locating the Baby's heartbeat had been passed to a student clinician and her anxiety was increasing the longer her Baby's heartbeat was unheard. The Mother remembered being told her baby was "a wriggly little thing" by staff before another midwifery clinician came to support and continued to try to locate the Baby's heartbeat. The care giving midwifery clinician went to the birth suite at approximately 05:35 hours and asked a senior member of the obstetric team to attend. A bedside ultrasound scan was performed by the obstetric clinician at 05:40 hours (36 minutes from the first attempt) and the Baby's heartbeat could not be seen. The Mother reported that

when she recalls the length of time spent confirming the Baby had died, she felt distressed that a doctor was not called sooner. The Mother was walked to a room on the birth suite before a call was made asking her husband to attend immediately. The on call obstetric consultant was telephoned at 05:50 hours and asked to attend. A repeat bedside ultrasound scan was performed by the on call obstetric consultant at 06:10 hours which confirmed that the Baby had died.

The Mother's labour was augmented later that day and the Baby was stillborn at 16:44 hours.

Augmentation of labour

Augmentation of labour is the process of stimulating the uterus to increase the frequency, duration and intensity of contractions after the onset of spontaneous labour. If uterine contractions are not strong or regular enough the drug oxytocin may be given. Oxytocin is one of the hormones naturally produced by mothers in labour and assists in increasing the frequency of uterine contractions. Oxytocin is given through a drip and the timing, of the subsequent uterine contractions, are monitored closely. The amount of oxytocin given via the drip can be altered if uterine contractions are too sparse, or become too frequent. (MNSI)

At birth the Baby weighed 3,480 grams which was on the 29th customised growth centile.

A postmortem examination (PME) was performed and the report described the cause of death as 'features of an acute asphyxia mode of death'.

The placenta was sent for histology (examination under a microscope) and the report stated, 'findings of delayed villous maturation and high grade fetal vascular malperfusion were contributory'.

Delayed villous maturation

This might be seen when the placenta is examined under a microscope. Part of the microscopic structure of the placenta are called villi. In delayed villous maturation these structures are less well developed than would be expected for the number of weeks of pregnancy. This means the placenta was not able to work in the best way during the pregnancy. This finding may be associated with gestational diabetes. (MNSI)

Fetal vascular malperfusion

Unusually structured blood vessels in the placenta indicating reduced or absent blood flow, most commonly caused by umbilical cord obstruction. (MNSI)

Section 5. Investigation findings and analysis

5.1 Ethnicity and health inequalities

While this had no impact during this episode of care, MNSI is committed to working with other system partners to understand and further reduce the factors behind health inequalities faced by mothers, babies and families from Black, Asian or minority ethnic backgrounds.

Health inequalities

Health inequalities are avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions (The Office for Health Improvement and Disparities, 2022).

Ethnicity

'We refer to ethnicity and not race. This is because surveys usually ask people for their ethnicity and not their race. Using consistent terms helps people to understand our data' (Race Disparity Unit, 2021).

According to the Office of National Statistics (ONS), there is 'no true consensus on what defines an ethnic group, as identification to these is self-defined and subjectively meaningful to the individual. Ethnicity can include a variety of elements such as ancestry, culture, identity, religion, language, and physical appearance. However, it is generally accepted that ethnicity includes all of these aspects, and others, in combination. Under the Equality Act 2010, ethnicity includes colour, nationality and ethnic or national origins' (NHS Digital, 2022).

Ethnic minorities

'Ethnic minorities' refer to all ethnic groups except the White British group. Ethnic minorities include White minorities, such as Gypsy, Roma and Irish Traveller groups (Race Disparity Unit, 2021).

MNSI acknowledges that maternity care requires system level changes to make the navigation of maternity services safer for Black mothers who are 3.7x and Asian mothers who are 1.8x more likely to die than White mothers (MBRRACE-UK, 2022a).

The 2022 MBRRACE-UK perinatal surveillance report (MBRRACE-UK, 2022b) informs us of the effects ethnicity and deprivation have on perinatal mortality:

1. Stillbirth and neonatal mortality rates increased with deprivation across all ethnic groups.

2. Stillbirth and neonatal mortality rates were lowest for babies of White ethnicity from the least deprived areas (2.78 stillbirths per 1,000 total births and 1.26 neonatal deaths per 1,000 live births).
3. The multiple impact of ethnicity and deprivation is highlighted by a stillbirth rate of 8.10 and 7.96 per 1,000 total births for babies of Black African and Black Caribbean ethnicity respectively from the most deprived areas.
4. Neonatal mortality rates were over 3 per 1,000 live births for babies of Pakistani and Black African ethnicity from the most deprived areas.
5. Due to considerably higher proportions of babies of Black African, Black Caribbean, Pakistani and Bangladeshi ethnicity being from more deprived areas, they are disproportionately affected by the higher rates of stillbirth and neonatal death associated with deprivation'.

MNSI aims to raise the awareness and gather further data to share the understanding of these inequalities with all stakeholders within maternity care in the UK. MNSI supports proactive change and challenge to further reduce all health inequalities which lead to better health outcomes for mothers, babies and families from Black, Asian or minority ethnic backgrounds.

MNSI considers there was no evidence that ethnicity or health inequalities impacted on the care or outcome in this case. The family did not feel ethnicity or health inequalities impacted on their care.

5.2 Antenatal care

The Mother completed a new pregnancy referral online at 14+3 weeks as she had just found out she was pregnant and the booking appointment was completed at 15+1 weeks. If it is thought a mother is greater than 12 weeks at the time of referral, local booking guidance (v7.4) aims to complete the pregnancy booking appointment within 7 days. Booking appointments are usually face to face. The Mother's booking was completed via telephone in order to complete as a matter of urgency and arrangements were made for the pregnancy dating ultrasound scan to be performed the following day to confirm the gestation of the pregnancy. The Mother's records and a handwritten note were left in the antenatal clinic for the face-to-face components of the pregnancy booking to be completed the following day when she attended the dating scan. The dating scan was completed the following day at 15+2 weeks and she attended a face-to-face appointment in the antenatal clinic.

MNSI considers arrangement of the pregnancy booking appointment via telephone was reasonable and the dating ultrasound being performed promptly to confirm the pregnancy's gestation was good practice.

5.2.1 Smoking in pregnancy

The Mother was a smoker at the time of pregnancy booking, she reduced her smoking and the investigation learnt she did not smoke after 22 weeks of pregnancy. The investigation found that her smoking status from booking was not consistently considered a risk factor during her pregnancy, with her status as a smoker being removed from her electronic patient record (EPR) at 17+2 weeks (see section 5.2.3).

'Stopping smoking in pregnancy is important for the health of both the woman and her baby' (National Institute for Health and Care Excellence (NICE), 2023) and 'reducing smoking in pregnancy reduces the likelihood of stillbirth, fetal growth restriction (FGR), intrapartum complications, placental abruption and preterm birth'. Carbon monoxide (CO) testing 'should be offered to all pregnant women at the antenatal booking appointment' and 'additional monitoring should also be considered at each antenatal appointment for women who smoke or were recorded as recent/ex-smoker at booking' with 'referral for those with elevated levels (4ppm [parts per million] or above) for support from a trained stop smoking specialist'. (NHS England (NHSE), 2023). Local risk assessment guidance (v8) is in line with NHS England.

The Mother reported at her booking appointment that she smoked less than five cigarettes a day. Her CO level was recorded at 0ppm and a referral to the stop smoking service was completed in line with local and national guidance (NICE, 2021; NHSE 2023). The Mother was contacted by the stopping smoking service and offered support on four occasions during her pregnancy by text, telephone and letter. The Mother chose not to receive support from the stopping smoking service, she independently reduced her smoking and stopped. CO monitoring was performed at each antenatal contact during her pregnancy and was in the expected range on seven out of eight occasions.

MNSI considers the risk of smoking was not consistently considered as part of the Mother's care pathway with her status being removed from her EPR at 17+2 weeks. MNSI further considers the Mother was provided with information surrounding the risks of smoking for herself and her baby and offers of referral to 'stop smoking' services were provided. The conversations held were in line with local guidance and the Mother was able to make informed choices. MNSI considers that monitoring of CO levels was undertaken as recommended in national guidance.

5.2.2 Antenatal care pathway and risk assessments

The Mother followed a midwifery led antenatal care pathway. Local antenatal risk assessment guidance (v8) supports an obstetric led care pathway for smoking mothers. The investigation learned that some members of staff were aware of the local guidance whilst others felt that mothers can follow a smoking pathway and still have midwifery led care, whilst the growth of their baby is on an expected trajectory on serial growth ultrasound scans. National guidance (NICE, 2023) does not require mothers who smoke to follow an obstetric led pathway.

A number of risk assessments were completed at the initial booking in line with local guidance. The Mother was a smoker which is a risk factor for fetal growth restriction (FGR) (NHS England (NHSE), Saving Babies' Lives (SBL) v3, 2023). Risk assessment for FGR was completed and the Mother was scored as 'moderate risk' which indicated that growth assessment of the Baby was required via ultrasound scan assessment every 4 weeks from 32 weeks until the birth of the Baby. The Mother did not receive these growth ultrasound scans.

The Mother was also assessed for her risk of developing gestational diabetes and as her body mass index (BMI) was above the expected range she was at an increased risk. Local gestational diabetes guidance requires testing to be performed via an oral glucose tolerance test between 24 weeks to 28 weeks. An oral glucose tolerance test was not performed during the Mother's pregnancy.

The investigation learned that all mothers attend an "after scan appointment" in the antenatal clinic immediately following their dating ultrasound scan. The purpose of this appointment is for a midwifery review to ensure follow up arrangements are in place, consultant referrals are completed for women with risk factors, oral glucose tolerance tests are booked, growth charts are generated and booking blood tests are reviewed. The Mother attended the after-scan appointment and her booking bloods were taken and body mass index calculated. No further details of the after-scan contact were documented.

The Trust mostly use electronic patient records (EPR) while a paper proforma is completed during the after-scan appointment as there is no such appointment on the EPR. The investigation was not able to review a completed paper proforma from the Mother's after scan appointment. It was unclear whether one had been misplaced or if it was not completed. The consultant referral was not completed and an oral glucose tolerance test not requested. The investigation noted that smoking status at booking is not included on the proforma to prompt the obstetric consultant referral.

The investigation learnt that the usual process for arranging serial growth ultrasound scans for smoking mothers is via an obstetric consultant review appointment. The Mother not receiving the consultant review contributed to the serial growth ultrasound scans not being arranged.

MNSI considers the Mother not being referred to an obstetric consultant led clinic contributed to serial growth ultrasound scans not being arranged, the impact of this for the Baby is unknown.

MNSI safety recommendation

The Trust to ensure a robust process for identification and referral of women with risk factors who require an obstetric consultant review in line with local guidance.

5.2.3 Electronic patient record system

The electronic patient record system (EPR) contains risk assessments where data is inputted into mandatory fields. The EPR generates the overall risk by “pulling through” risk factor data and the required management for the mother is auto generated and displayed in the ‘recommended management plan’.

The investigation found that, at the time of the Mother’s booking appointment, the Mother’s EPR displayed the management plan for growth surveillance of the Baby incorrectly as ‘fundal height measurement at 26-28 weeks gestation’. The investigation has been unable to understand why the EPR generated the incorrect management plan at booking, when the risk assessment appears to have been completed correctly. The investigation further found that the ‘recommended management plan’ for growth surveillance of the Baby changed at the Mother’s 17+2 weeks appointment to ‘Saving Babies’ Lives Moderate Risk’ which indicates the need for serial growth scans in line with national NHS guidance. The investigation learnt that the Trust are exploring with the provider of their EPR to understand why the management plan did not pull through the appropriate plan for the Mother from booking.

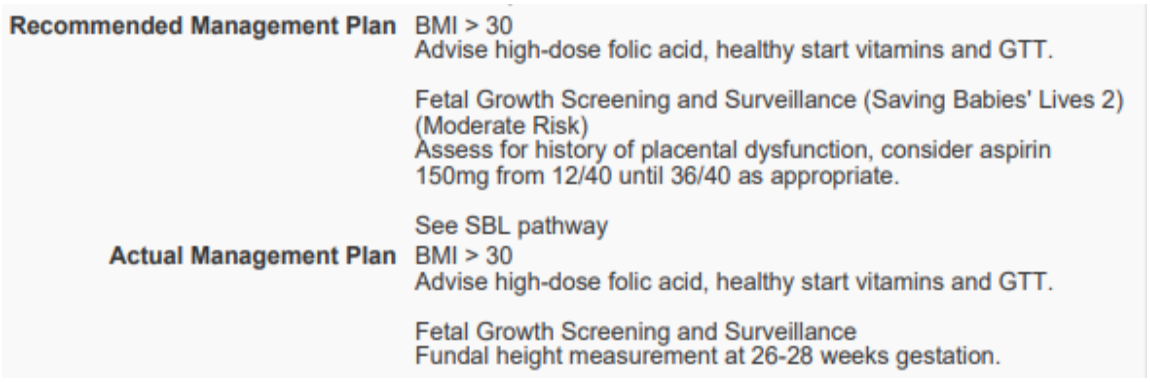
The EPR has two management plans ‘recommended’ and ‘actual’. The ‘recommended management’ is auto generated and the ‘actual management’ is editable. The reason for the ‘actual management plan’ being editable is that, as a mothers pregnancy progresses, actions which have been completed and therefore are no longer relevant can be removed.

The care records show that at 17+2 weeks the Mother reported she had stopped smoking and her smoking status was updated in the EPR. The EPR has two options which can be selected for smoking mothers; ‘smoking over 20 per day’ or ‘smoking less than or equal to 20 per day’. As the Mother had stopped smoking, the previously selected ‘smoking less than or equal to 20 per day’ was unchecked. At the same time a paper copy of the previous (out of date) version of

national guidance (NHSE, SBL v2, 2019) was referred to and the smoking risk factor which indicates the need for serial growth scans was worded as ‘current smoker’ rather than ‘smoker at booking’. The EPR does not have an option for ‘smoker at booking’ to alert staff to this risk factor, the Mother’s overall risk status was changed from ‘intermediate’ to ‘low’ and the ‘actual management plan’ reflected the same.

Serial growth scans remain indicated for mothers who are smokers at booking, even if they later stop smoking (Saving Babies’ Lives (SBL) v3, 2023). As the Mother was a smoker at booking, serial growth scans remained indicated in line with guidance. The auto-generated ‘recommended management plan’ in the EPR remained unchanged from 17+2 weeks to the Baby’s birth, and indicated serial growth scans were required. The investigation was informed, by various staff, that the ‘actual management plan’ is the one they refer to, they consider it to be more accurate as it is usually “up to date and less wordy”.

Figure 1. Management plans as shown in the Mother’s EPR



Staff referring to the actual management plan which had been changed when the Mother reported she had stopped smoking, may have contributed to not identifying that serial growth scans were needed.

The investigation learnt that the need for an oral glucose tolerance test appears in the EPR ‘recommended management plan’, in the same way as it does for fetal growth surveillance. The investigation found the Mother’s BMI data did pull through to both the ‘recommended’ and ‘actual’ management plans to generate the alert that an oral glucose tolerance test was required. The alert remained present in the management plans from the booking appointment and continued until the end of the Mother’s care. The glucose tolerance test was not arranged at the after-scan appointment and this was not detected by clinicians who provided antenatal care.

Local guidance refers to risk assessment as an ongoing process for ‘all professionals providing care’ and this should be performed at each visit. This is supported by the Ockenden Report’s

final findings (2022) which recommend antenatal risk assessment at each contact as an essential action.

National guidance (NICE, 2021) requires that a risk assessment is completed at each antenatal appointment in order to:

- ‘Review and assess the plan of care for the pregnancy
- Identify women who need additional care’.

The investigation learnt that the management plans are always visible on a mother’s EPR antenatal summary page and any clinician who has an antenatal contact with a mother can see them. It is likely that the plans were not read in full by clinicians who had contact with the Mother antenatally as the Mother did not recall being asked by any clinician whether she had serial growth ultrasound scans or an oral glucose tolerance test arranged. The Mother recalled that she had serial growth ultrasound scans in her first pregnancy and she assumed she did not need them in her second as her previous pregnancy had been uncomplicated and she was repeatedly told she was ‘low risk’ this time. The investigation was unable to determine why ongoing risk assessment and review of the Mother’s management plan did not occur at her antenatal contacts.

The Mother was booked on a continuity of carer team for her antenatal care and saw five different midwifery clinicians on the team which included her named midwife on one occasion (20+4 weeks). The investigation was informed that the usual process is that the clinician who will be the named midwife ideally books a mother and this supports “follow up” to ensure additional appointments that a mother may need are booked. The investigation learnt that the Mother was not sure who her named midwife was. The Mother recalled feeling as though her appointments “were slotted in wherever there was availability” and she did not feel as though she received the same level of continuity or care as in her first pregnancy. The investigation learnt that her named midwife “has the biggest caseload” and does not have availability to see all women they are allocated, this led to the Mother being seen in other midwifery clinician’s clinics and not knowing her named midwife. The investigation learned that due to time constraints, it is considered difficult for staff to review a full antenatal history during clinic appointments when they see a mother who is not on their caseload.

MNSI considers the EPR generated an incorrect recommended management plan at the pregnancy booking appointment, for women who are smokers at booking. MNSI further considers the data input options when the Mother had stopped smoking at 17+2 weeks did not support staff to recognise that serial scans were still indicated. The Mother did not receive

continuity of carer which may have contributed to losing oversight of the need for serial growth ultrasound scans and an oral glucose tolerance test.

MNSI considers that the Mother did not receive ongoing risk assessment during her pregnancy, this meant that previously missed risk factors were not highlighted and her management plan was not aligned with her risks.

MNSI safety recommendation

The Trust to ensure staff are supported review risk factors and care plans at each antenatal contact to ensure that mothers receive care aligned with their risk factors.

5.2.4 Ultrasound scans

The growth of the Baby was monitored through symphysis-fundal height (SFH) measurements from 29+3 weeks. Local fetal growth restriction guidance (v3) is that SFH measurements are taken at each antenatal appointment (no more frequently than every 2 weeks) from 26 weeks to 28 weeks. The Mother did not have an antenatal appointment between 22+2 weeks and 29+3 weeks due to her not being aware of an appointment at 28+4 weeks which was why SFH measuring started later than guidance.

It was identified at a routine appointment at 38+5 weeks that the SFH measurement plotted on the customised growth chart as a large increase from the previous measurement. A growth ultrasound scan was arranged for the following day which showed the measurements of the blood flow through the umbilical cord and amniotic fluid volume were within the expected ranges. The estimated weight of the Baby was on the 22nd customised growth centile.

A further ultrasound scan was performed at 39+4 weeks after the Mother attended the maternity triage unit with a reduction in her Baby's movements. The growth of the Baby was not repeated as it had been less than 2 weeks since the last ultrasound growth assessment and so, in line with guidance was not indicated. The measurements of the blood flow through the umbilical cord and amniotic fluid volume were within the expected ranges.

Both ultrasound scan reports mentioned that calcifications were seen 'throughout' the placenta. MNSI has reviewed these images and the calcifications are within expected limits for the pregnancy gestation at the time of both assessments. The absence of ultrasound assessment before 38+6 weeks means that, when the calcification of the placenta occurred is unknown. There is some correlation with stillbirth and preterm calcification (Jamal et al, 2017). MNSI noted that the blood flow through the umbilical cord and the amniotic fluid volume measurements were within the expected ranges at the time of both ultrasound scans.

MNSI considers both ultrasound scans in the third trimester were timely when concerns were identified and both the growth centile on ultrasound scan and birth centile of the Baby were within the expected range. MNSI further considers that the growth of the Baby at 38+6 weeks is an isolated assessment of the Baby's growth and a drop in growth or possible growth restriction was not identifiable from one ultrasound scan assessment. As serial growth ultrasound scans had not been performed, it is unknown if the Baby's growth was within an expected growth trajectory or when the calcification of the placenta started.

5.2.5 Telephone contact with the maternity triage unit

Advice was given to the Mother by the community midwifery team to contact the maternity triage unit if she had any pregnancy related concerns. A telephone call was made by the Mother at 39+3 weeks due to her experiencing some red vaginal blood 'spotting'. The investigation could not find any documentation in the care records of this telephone call. Review of the Mother's mobile telephone records showed the call was placed at 12:35 hours and went through to the antenatal day unit. In line with local induction of labour guidance (v7), a membrane sweep had been offered and accepted by the Mother the previous day in the community midwifery clinic at 14:00 hours. The Mother recalled being given reassurance over the telephone that the blood loss was 'normal' following a membrane sweep and advised to 'rest'.

Local triage guidance (v4) and national guidance (Royal College of Obstetricians and Gynaecologists (RCOG), 2011) support a clinical assessment of a mother when any vaginal bleeding is reported as 'it is important to establish if the bleeding is an APH [antepartum haemorrhage] or blood stained 'show''.

Antepartum haemorrhage

Antepartum haemorrhage (APH) is bleeding from the vagina, occurring after 24 weeks of pregnancy, and before the birth of a baby. This occurs in 3-5% of pregnancies and is associated with an increased risk of fetal hypoxia (a lack of oxygen to a baby), slow growth of a baby in the womb, premature birth and stillbirth.

Further information from: RCOG - bleeding in pregnancy guideline

The Code (Nursing and Midwifery Council (NMC), 2015) sets out professional standards of practice for nurses and midwives. Standard 10 states that professionals should 'keep clear and accurate records'. The usual process for documenting telephone contacts with the maternity triage is within a 'communication' tab on the EPR which includes completion of mandatory fields and a free text box to record advice given. The investigation found that the call the Mother placed, was made to the antenatal day unit and not answered by the maternity triage,

this may have contributed to why the Mother's telephone contact was not documented on the EPR.

MNSI considers an assessment of the Mother and Baby was indicated when she reported vaginal blood loss, in line with local and national guidance. The documentation of her contact with the antenatal day unit was not in line with national guidance. It is unlikely that this had an impact on the outcome for the Baby.

5.2.6 Management of reduced fetal movements

National guidance (NHSE SBL, 2023) aims to raise awareness amongst pregnant women of the importance of recognising and reporting reduced fetal movements. Discussions regarding fetal movements were documented at each of the Mother's antenatal contacts and access to an electronic copy of the NHS Tommy's leaflet was given through the Trust's antenatal application on the Mother's mobile telephone. These conversations and sharing of information were in line with local reduced fetal movements (v4.1) and national guidance. The investigation learnt that some staff within the Trust considered the electronic leaflet to not be as effective as paper copies which were previously given to women. Staff reported their concerns that electronic leaflets require mothers to remember how to navigate the application and are not as accessible to other family members as the sharing of paper leaflets. The antenatal records application was considered by staff to be mainly used as an electronic reminder for women of their appointments. Review of the Mother's application showed that none of the electronic information leaflets had been accessed and she did not recall being shown these. The transition to paperless records is part of the national maternity transformation programme's digital technology workstream (NHSE, 2017).

The Mother had no concerns regarding her Baby's movements until she was over 39 weeks. When the Mother presented at the maternity triage unit at 39+4 weeks, she had experienced some further vaginal blood loss as 'spotting' and felt the Baby had not been as active as usual for the previous 24 hours. Assessment of the Mother and Baby provided reassurance to staff as the computerised cardiotocograph (CTG) met criteria and was categorised as 'normal'. No cause for the blood loss was seen and induction of labour was offered and accepted in line with National (NHSE SBL, 2023) and local induction guidance (v7).

The investigation learnt that the electronic diary for inductions of labour showed that there was no capacity to induce the Mother until 39+6 weeks and this was due to ongoing inductions of labour within the maternity unit as well as mothers already booked to attend. The investigation further learnt that this was not unusual and induction of labour for reduced fetal movements is considered an urgent rather than an emergency procedure. 48 hours is considered within the

Trust, as an appropriate timeframe. Local and national guidance do not offer a timeframe in which induction of labour should be performed after an episode of reduced fetal movements at over 39 weeks of pregnancy. National guidance recognises that the 'decision to offer birth should consider the timing as to whether this can be achieved within the safe capacity of the unit.'

An ultrasound scan was performed later the same day (39+4 weeks) to review the blood flow through the Baby's cord and the amniotic fluid volume in line with local and national guidance (NHSE, SBL, 2023). The Mother was reviewed by a senior member of the obstetric team following the ultrasound scan and the findings were within the expected range. The Mother reported the movements of her Baby had remained reduced that afternoon, the electronic diary was rechecked and there remained no capacity to induce the Mother's labour sooner than 39+6 weeks. A plan was made to give the Mother an appointment for CTG monitoring the following morning (39+5 weeks) but to attend sooner if concerned.

When the Mother attended the antenatal day assessment unit (39+5 weeks) for the computerised CTG, it met criteria at 10 minutes and was discontinued. The investigation learnt that the Mother told staff she was still concerned that her Baby was not moving in their usual pattern and recalled being told she had "no reason to panic" and that she would be meeting her Baby the "following day". The Mother reported that she felt as though her questions were "dismissed" and "brushed off" and staff were pre-occupied with the CTG monitoring and not her concerns. The investigation learnt that clinicians on the antenatal day assessment unit did not recall any ongoing concerns with reduced fetal movements and this was considered as the reason why no escalation conversations were held to try to bring the Mother's induction of labour forward or to offer overnight admission for additional monitoring. The investigation has been unable to reconcile these differences.

MNSI considers that when the Mother originally presented with reduced fetal movements at 39+4 weeks, arrangements for her induction of labour for 2 days' time with further monitoring at 39+5 weeks was reasonable.

MNSI further considers the USS and CTG monitoring findings were both within expected ranges. It is unknown if closer monitoring of the Mother and Baby would have had an impact on the outcome.

5.2.7 Acuity and capacity in the maternity unit

The Mother attended with reduced fetal movements at 39+4 weeks and induction of labour was arranged for 39+6 weeks. The investigation reviewed the acuity and capacity in the maternity unit from 39+4 weeks to 39+6 weeks of the Mother's pregnancy. Four inpatient

inductions of labour were planned for each day at 39+4 and 39+5 weeks, which is the maximum number the maternity unit has capacity for each day. In addition, the maternity unit had been busy for a number of days which meant there were mothers, who had undergone induction of labour, whose transfer to the labour ward had been delayed, in some cases by 24 hours. The investigation learnt there were a total of five women being cared for by the midwife responsible for the induction of labour bay when the Mother was admitted.

The investigation learnt that on the day the Mother first presented with reduced fetal movements the Trust had escalated their capacity issues in line with regional guidance (v3) and 'mutual aid' from neighbouring maternity units had been requested and granted for two ongoing inpatient inductions of labour. This enabled the Trust to admit new inductions that were waiting at home. The investigation further learnt that when the Mother was admitted for induction of labour at 39+6 weeks, she was the only mother in the diary whose induction of labour went ahead as the capacity and acuity issues were ongoing and the other women in the diary were delayed until the following day.

MNSI considers that, at the time of the Mother's presentation with reduced fetal movements, the maternity service was experiencing increased capacity and acuity levels which were escalated in line with regional guidance. There was evidence of a supportive regional system in place for managing capacity and acuity.

5.3 Care during induction of labour

The Mother was admitted for induction of labour at 14:15 hours at 39+6 weeks. The reason for and process of induction was discussed with the Mother and Father. On admission there was difficulty in obtaining a "good quality trace" of the Baby's heartbeat and monitoring equipment was swapped. This has caused concern for the Mother and Father as they remained concerned that the Baby was less active and felt staff were focussed with the CTG monitoring. The investigation learnt that there are two different types of CTG monitoring equipment in the induction of labour bay. One monitor is the computerised CTG to obtain an analysis before induction starts which is required by local guidance (v4), the other available is a previous model which does not perform the computerised analysis. The reason the monitor was swapped to the previous model the investigation learnt was because the visual printout of the heart rate tracing is different and so swapping the monitors was thought might support continuous assessment for 1 hour following the prostaglandin pessary.

MNSI has reviewed the CTG monitoring prior to the prostaglandin pessary and the initial computerised CTG met criteria at 16 minutes and appears normal. The loss of contact which followed would have made assessment of the Baby's wellbeing challenging following the prostaglandin pessary and MNSI considers the change in monitoring equipment was reasonable. The CTG following the prostaglandin pessary at 16:05 hours was normal.

The Mother's heart rate was above the expected range of 100 beats per minute (bpm) throughout her time on the induction of labour bay ranging from 102-120bpm. Local guidance is that the fetal heart is heard and maternal observations are completed 4 hourly during induction of labour. There was a prompt on the Mother's EPR to increase the frequency of observations to 2-4 hourly when her heart rate was above 100bpm. The Mother's observations were mainly performed in line with guidance with two sets outside of guidance;

- 18:47 hours (39+6 weeks) 4 hours and 22 minutes
- 05:04 hours (40+0 weeks) 5 hours 59 minutes

The investigation learnt that with one member of staff caring for the induction mothers it can be challenging to meet the local guidance target of 4 hourly due to having to prioritise some women's needs over observations that may be due.

MNSI considers the Mother's observations were mainly in line with guidance. It is unlikely that her raised heart rate had an impact on the outcome for the Baby.

Local guidance is that fetal heart rates are listened to 4 hourly and CTG monitorings are performed 6 hourly when women are undergoing induction of labour, irrespective of the reason for induction. If concerns arise then CTG monitoring is performed more frequently. The investigation learnt that this was a recent change in local practice due to some cases of CTG monitorings being pathological on repeat after intervals of 12 hours.

The last CTG performed was at 22:26 hours and discontinued at 23:05 hours. The CTG was categorised as 'normal'. MNSI has reviewed the CTG and considers it was difficult to interpret the baseline heart rate of the Baby at 23:05 hours. The baseline heart rate of the Baby was difficult to determine without a 10-minute period of stable baseline, continuation of the CTG at this time may have supported a more accurate interpretation of the Baby's wellbeing.

5.4 Bereavement care

The family were provided with bereavement support whilst in hospital and provided with opportunities for memory making with their Baby. They reported to the investigation that elements of their care during this time caused increased distress to them and wider family

members. The area was undergoing significant building works and a bespoke environment was not available. They could hear other women in labour and babies crying and the Mother felt “this was the last place you should have to be” after your baby has died. When returning to visit their Baby the day after being discharged home they were taken to the same room in which their Baby was born. The area was unclean with blood and vomit still in the bathroom which was cleaned once staff were informed.

MNSI considers that the Trust did not meet all nine of the bereavement standards outlined in the National Bereavement care Pathway (NBCP, 2022). The standards are in place to support consistency in approach and quality for the provision of bereavement care. When a trust does not meet all these standards, a mother and father’s experience of bereavement care may be suboptimal. MNSI considers that trusts benefit from auditing their provision of bereavement care against these standards aiming to improve the bereavement care they offer, where gaps are identified. MNSI acknowledges that the building works at the time of the Family’s care may have had an impact on care provision.

5.5 Placenta and postmortem findings

A postmortem examination (PME) was offered to the parents and they accepted. The report described the cause of death as ‘features of an acute asphyxia mode of death’.

The placenta was sent for histological examination (studying cells using a microscope) following the Baby’s stillbirth. The Royal College of Pathologists (Evans et al 2022) recommend that ‘as a minimum, all placentas from stillbirth (antepartum or intrapartum) receive a histological examination (The Royal College of Pathologists, Evans et al 2022).

The placenta’s histological examination report stated: ‘findings of delayed villous maturation and high grade fetal vascular malperfusion were contributory’.

Delayed villous maturation is more common in diabetic mothers. The Mother was not tested for diabetes during her pregnancy when it was indicated. Testing was performed postnatally; the findings were normal and there was no evidence of glucose in the Mother’s urine antenatally. Delayed villous maturation in non-diabetic pregnancies has been associated with an increased risk of stillbirth near term in normally grown babies (Jaiman et al, 2020).

The placenta also showed features indicating fetal vascular malperfusion (FVM) which may cause inefficient transfer of blood between the fetus and placenta. The feature of FVM cannot be detected antenatally.

MNSI considers the placental histology findings align with the clinical findings of the Baby's postmortem and may inform future antenatal care.

Section 6. MNSI findings and safety recommendations

6.1 Findings

1. The Mother was from a White British background. There was no evidence that ethnicity or health inequalities impacted on the care of the Mother or the outcome for the Baby.
2. The Mother's pregnancy referral was received at 14+1 weeks. Due to her pregnancy being greater than 12 weeks a telephone booking was performed as a matter of urgency at 15+1 weeks and arrangements were made for prompt dating via ultrasound assessment.
3. The Mother was a smoker when she became pregnant, when she stopped smoking her smoking status was removed from her electronic patient record. This meant that her smoking status at booking was not consistently considered as a risk factor on her care pathway. Referral to stop smoking support services and carbon monoxide testing was in line with guidance. The Mother independently reduced her smoking and stopped antenatally. Carbon monoxide levels were within the expected range on seven out of eight occasions.
4. Due to the after-scan appointment being partially completed the Mother was not booked for an oral glucose tolerance test or obstetric consultant review which were indicated in local guidance. Not having a consultant review led to the Mother not being offered serial growth ultrasound scans, the impact of this for the Baby is unknown.
5. The electronic patient record system did not pull through the correct management plan for growth assessment of the Baby at the time of the Mother's pregnancy booking. The data then pulled through at 17+2 weeks indicating that serial growth scans were required. As the Mother reported she had stopped smoking, the management plan was then edited and her risk changed from 'intermediate' to 'low'.
6. The Mother did not receive ongoing risk assessment during her pregnancy, this meant that previously missed risk factors were not highlighted and elements of her management plan was not aligned with her risks.
7. The Mother received two ultrasound scans in the third trimester; growth at 38+6 weeks and amniotic fluid volume and umbilical artery Doppler at 39+4 weeks. The absence of ultrasound assessment before 38+6 weeks means that, when the calcification of the placenta occurred is unknown. Additionally, as this was an isolated assessment and as serial growth ultrasound scans had not been performed, it is unknown if the Baby's growth was within an expected growth trajectory.
8. Assessment of the Mother's and Baby's well-being was indicated at 39+3 weeks when the Mother contacted the antenatal day unit with red vaginal blood 'spotting'. There was

no documentation of this telephone contact which was not in line with guidance. It is unlikely that this had an impact on the outcome for the Baby.

9. Induction of labour was offered and accepted in line with guidance for 2 days' time when the Mother had reduced fetal movements at 39+4 weeks. Further monitoring was arranged for 39+5 weeks and the Mother continued to be concerned that her Baby was not moving in their usual pattern. Due to clinicians being reassured that a computerised cardiotocograph (CTG) met criteria at 10 minutes and not considering that the reduced fetal movements were ongoing, no escalation of concerns with the movement of the Baby occurred.
10. Mutual aid was gained from neighbouring trusts when the Trust were experiencing capacity and acuity issues at the time of the Mother's induction of labour. The management and escalation were in line with regional guidance.
11. The Mother was admitted for induction of labour at 39+6 weeks and had a slightly elevated heart rate. Maternal observations were not performed in line with local guidance due to workload pressures in the induction of labour bay. It is unlikely that this had an impact on the outcome for the Baby.
12. A CTG was repeated 6 hours following induction of labour. The baseline heart rate of the Baby was difficult to interpret when the CTG was discontinued at 23:05 hours. Continuation of the CTG may have supported a more accurate interpretation of the Baby's wellbeing.
13. The family were provided with bereavement care and given memory making opportunities with their Baby whilst in hospital. Building works impacted the availability of a bespoke private and quiet environment. Cleaning had not been performed effectively which caused distress when the family returned to visit their Baby following discharge.
14. The Baby underwent a postmortem examination which cited the probable cause of death as acute asphyxia.
15. The placenta was sent for histological examination and the findings of delayed villous maturation and high grade fetal vascular malperfusion are in keeping with the clinical findings of the postmortem. These findings may inform future antenatal care.

6.2 Safety recommendations

It is recommended that:

1. The Trust to ensure a robust process for identification and referral of women with risk factors who require an obstetric consultant review in line with local guidance.

2. The Trust to ensure staff are supported review risk factors and care plans at each antenatal contact to ensure that mothers receive care aligned with their risk factors.

Appendices

Appendix 1: Evidence log

Appendix 2: Reference list

Appendix 1. Evidence log

Clinical records

- Antenatal records
- Intrapartum records
- Ultrasound scan images

Family records

- Mobile telephone records
- Timeline of events

Trust guidelines

- Booking Pregnant Women v7.4
- Induction of Labour v7
- Management of Gestational Diabetes v13
- Reduced Fetal Movements v4.1
- Risk Assessment in the Antenatal Period v8
- SGA/FGR Detection and Management Guideline v3
- Triage v4
- Maternity Escalation Policy & Operational Pressures Escalation Levels Framework v3

National guidelines

- NICE (2021). Antenatal Care
- NICE (2023) Tobacco: preventing uptake, promoting quitting and treating dependence
- NHS Digital (2022). Ethnicity
- NHS England (2017). Maternity Transformation Programme
- NHS England (2023). Saving Babies' Lives: version 3
- NBCP (2022). Stillbirth Bereavement Care Pathway
- RCOG (2011). Antepartum Haemorrhage
- RCP (2022). Histological Examination of the Placenta

Investigation evidence

- Family meeting
- Two subject matter review panels
- Ten staff interviews
- Report panel

Appendix 2. Reference list

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/129 – appendix 2a**			
SUBJECT:	**Maternity & Neonatal Quality Review – September 2024**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
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)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to maternity and neonatal care focussing attention on improving outcomes for this protected group.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update in relation to maternity and neonatal quality and provides Trust Board with			

	oversight of key matters to provide assurance on maternity and neonatal safety and quality issues. This information is reported monthly to Quality Assurance Committee and Trust Board. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position There were seven moderate harm events in September 2024. There were no severe or fatal harm events. Themes from maternity/neonatology patient safety events in September are as follows: • Admission of term babies admitted to Neonatal Unit (NNU) • Postpartum Haemorrhage (PPH) 1000ml-1500ml • Postpartum Haemorrhage (PPH) >1500ml • Postnatal readmission Work remains ongoing with regard to all of these themes. At the end of September compliance for Trust mandatory training across maternity and child health colleagues is above the Trust target. Compliance with PDR completion remains a challenge, a targeted piece of work is underway. A Maternity & Neonatal Voices Partnership (MNVP) led 15 steps challenge will take place on Friday 15th November 2024. Feedback from this will be shared to a future Quality Assurance Committee. Individual feedback from families is included in appendix one for information.

	As part of the Perinatal Cultural leadership programme completed by the Quadrumvirate and the associated action plan, a number of 'ideas sessions' are underway within the service. These sessions are focussing on the three key aspirations identified as part of the learning from the Maternity & Neonatal SCORE survey and cultural conversations. These sessions will continue through October to January. Detailed feedback from the sessions and next steps will be shared with Trust Board once collated. In September 93.5% of attenders to Maternity Triage were seen within 15 minutes of arrival. 98.74% of attenders were seen within less than 30 minutes of arrival. This achieves the service's KPIs. However, whilst meeting the Trust KPIs, when compared to other providers across the LMNS, particularly those of a similar size, WHH does have more triage breaches as a proportion of attendances. September data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour (IOL) activity when compared to other local providers albeit with some improvement in the position. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight by Trust Board. Six complaints were received in the CBU in September 2024. Three related to care within the maternity and neonatal services. The remaining complaints related to care within the gynaecological service. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/11/180iv**	
	Date of meeting	**12th November 2024**	

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

REPORT TO TRUST BOARD

SUBJECT	Maternity & Neonatal Quality Review – September 2024	AGENDA REF:	BM/24/12/129 – appendix 2a

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month September 2024.

The paper provides Trust Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 6 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

2. HARM EVENTS

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU in September 2024:

Severity	Aug 24	Sept 24
1 – No Harm	92	115
2 – Low Harm	34	49
3 – Moderate Harm	3	7
4 – Severe Harm	1	0
5 – Fatal	0	0
Total	130	171

There were seven moderate harm events in September 2024. There were no severe or fatal harm events.

Six of the moderate harm events related to third degree tears, all were reviewed by the Intrapartum Review Group (IRG). Learning was identified in two cases. In one case there was a delay in transfer from home for review following a suspected 3rd degree tear. In the second case the IRG review highlighted retrospective documentation which had not been recorded as such. In both cases actions have been allocated to the Midwifery Led Care working group to share appropriate learning.,

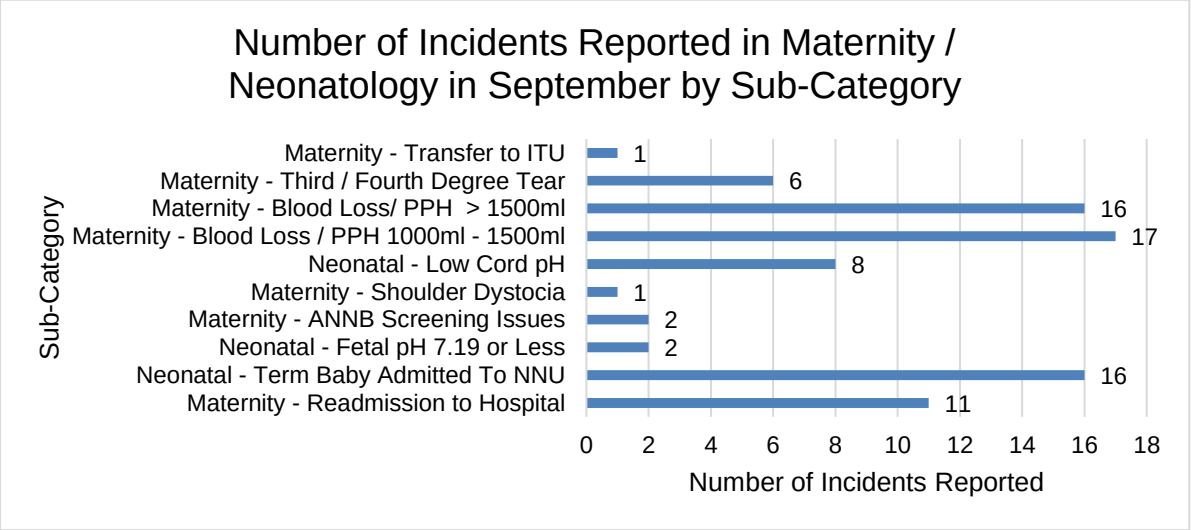
In the year October 2023 - September 2024, 36 women experienced 3rd/4th degree tears at WHH, this equates to 14.4 per 1000 births. As a comparison, across Cheshire

& Mersey most recent data notes a rate of 24.2 per 1000 births and across England 29 per 1000 births.

The seventh moderate harm event relates to a woman admitted with severe pre-eclampsia/ HELLP syndrome who deteriorated in the postnatal period and was admitted to ITU. An Initial Safety Review (ISR) was completed. Learning was identified in relation to the services critical care learning provision. This is not related to shortcomings in care but rather to ensure we optimise care provision to women in this situation and reduce the need for women to be admitted to ITU.

In total there were five ISRs undertaken in September. Two After-Action Reviews (AAR) were declared for Maternity Diverts. The formal AAR reports have not yet been completed, however initial review suggests the diverts were as a result of challenges with patient flow, in particular capacity on the maternity ward. This resulted in post-natal women being cared for on Birth suite and as subsequently impacted on the ability to maintain the supernumerary status of the Birth Suite coordinator.

Themes from maternity/neonatology in September 2024 are detailed in the table below:



16 term babies were admitted to the neonatal unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC and Trust Board.

11 postnatal readmissions were reported in September 2024. The Q2 cluster review of postnatal readmission has been completed. For the period 1st July 2024 - 30th September 2024, 24 women were readmitted to the maternity unit following 676 births. This provides a readmission rate of 3.55%. This is a reduction of 1.32% from Q1. There are no national maternity dashboards to benchmark postnatal readmissions, however, the National Maternal and Perinatal Audit reports an average of 3.3% readmission rate across England and Wales. This suggests WHH is not an outlier for postnatal readmissions.

Of the 24 postnatal readmissions, 11 of the readmissions were deemed avoidable (45%). This is an increase from 10% avoidable readmissions for Q1.

Themes from the avoidable cases include blood pressure management not optimised prior to discharge home, lack of senior review of women experiencing hypertension prior to discharge home and community midwife not reviewing women following caesarean on day 5 visit. Actions have been identified and are underway as follows:

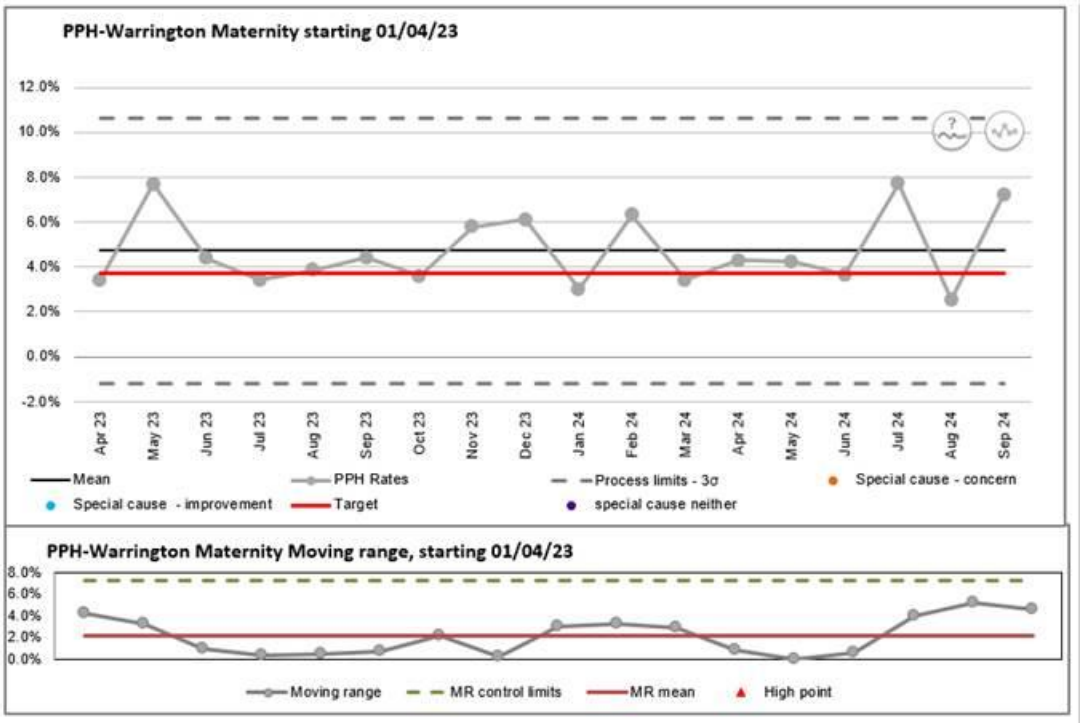
- Postnatal blood pressure proforma to be developed by C23 manager in consultation with the obstetric team
- MEWS2 roll out by March 2025
- All women following caesarean seen by registered midwife to facilitate effective wound review

Of the women readmitted, 50% were due to a wound infection (N=12) and 16% were due to hypertension (N=4). There were no women readmitted with retained products of conception, which accounted for the majority of women readmitted in Q1.

In response to an increase in postnatal readmissions due to wound infection:

- A wound care surveillance working group is reviewing all women readmitted due to wound infection and has conducted a health surveillance survey for all women who have birthed via caesarean to develop actions to prevent reoccurrence
- Wound dressings are now removed at 48 hours as opposed to 24 hours
- Community midwives are seeing all women who birthed via CS on the primary visit and on day 5
- Work is ongoing with maternity theatres and the wider multidisciplinary team to ensure all women are given prophylactic antibiotics, the correct preparation is used, the abdomen is draped appropriately and theatre attire is adhered to

There were 17 cases of PPH 1000ml-1500ml and 16 cases of PPH ≥1500mls in September 2024.



The SPC chart for PPH ≥1500mls shows no trend at present, The SPC chart continues to show common cause variation. However metrics from across the LMNS have highlighted a higher rate of PPH ≥1500mls at WHH, with a rate of 48.7 cases per 1000 births (rolling year to end of September 2024). As a comparison, across Cheshire & Mersey most recent data notes a rate of 34.4 cases per 1000 births and across England 30 cases per 1000 births.

The formal QI remains in progress with specific change ideas being finalised. These will be shared to December QAC and then to Trust Board.

It should be noted, local data suggests WHH has higher rates of emergency caesarean section and of women having an elective caesarean section in a first pregnancy than other providers within the LMNS. Caesarean birth is a known risk factor for PPH. It is therefore likely this is contributing to rates of PPH at WHH. A piece of work will be commenced to understand potential reasons for these higher rates.

In addition to the QI project, all cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group (IRG), learning shared and any urgent actions completed.

3. WORKFORCE METRICS & MEASURES

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

At the end of September compliance for mandatory training across maternity and child health colleagues is 89.14% for Trust mandatory training (including safeguarding

training), 87.8% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge. Rates in September (excluding those with a long term absence) for maternity and child health services is 72%. This is being reviewed weekly and all managers are aware outstanding PDRs need to be completed by 30th November 2024. Confirmed dates for all outstanding PDRs are to be advised to the Director of Midwifery by 7th November 2024.

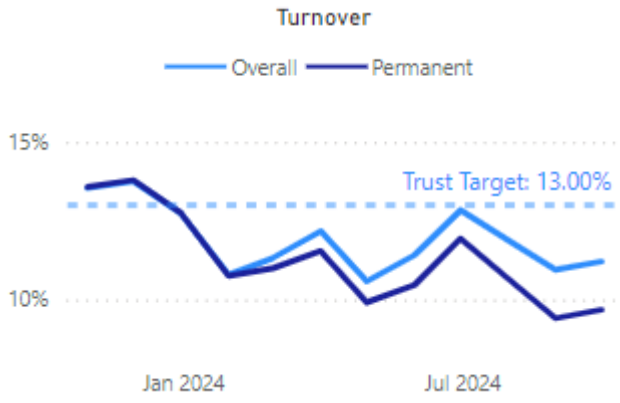
Compliance with maternity specific training has improved and is now meeting all compliance targets.

Current position – Training compliance - maternity specific

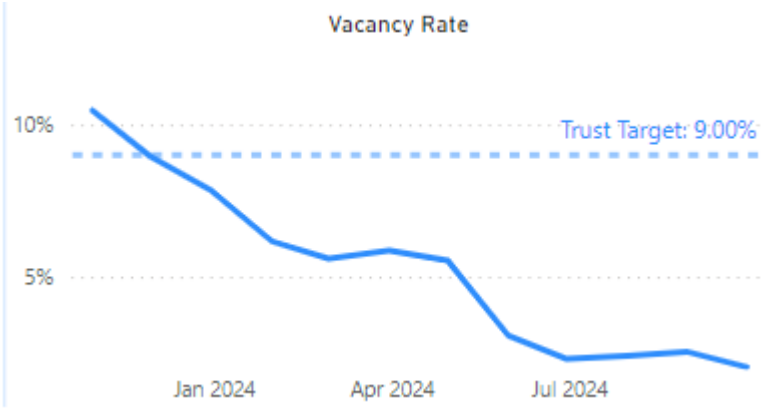
	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	97.6%	91.6%	95.4%	96.2%	70%
Obstetric Consultants	100%	90%	90.9%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic Consultants	93.1%	n/a		n/a	n/a
Maternity Support Workers	96.5%	n/a		n/a	46.1%

*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track

Turnover for maternity and child health staff (permanent staff) in September was 9.68% and is below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 2.03% in September 2024, significantly below the Trust target. This is illustrated in the graph below:



At the end of September 2024, the vacancy rate for registered midwives was 0.96%, a further reduction from August 2024 when the rate was 2.03%.

4. SERVICE USER FEEDBACK

The midwifery service continues to work in collaboration with the Maternity & Neonatal Voices Partnership (MNVP) with a robust workplan in place to ensure co-production with service users is embedded within the maternity service. As part of this workplan a MNVP led 15 steps challenge will take place on Friday 15th November 2024. Feedback from this will be shared to a future Quality Assurance Committee.

Individual feedback from families is included in appendix one for information.

5. STAFF FEEDBACK

As part of the Perinatal Cultural leadership programme completed by the Quadrumvirate, the committee will be aware an action plan has been instigated to support the development of a positive workplace culture within the maternity and neonatal services. The updated action plan is included in appendix two for information.

As part of the action plan, a number of 'ideas sessions' are underway within the service focussing on the three key aspirations identified as part tof the learning from the Maternity & Neonatal SCORE survey and subsequent cultural conversations:

- Focus on kindness through building relationships, trust and understanding each other's roles, responsibilities and pressures which will also support shared decision making.
- Increase collaboration through improved teamwork across teams and specialisms.
- Increase communication to gather ideas, help staff rise to the challenge, deal with change and foster inter role relationships.

These sessions are led by members of the Quadrumvirate and to date have been held with colleagues from Maternity Triage and the Birth Suite coordinator cohort. The focus

has been on what is going well, what do we need to improve and how do we achieve this. These sessions will continue through October to January across all clinical teams to provide as many colleagues as possible the opportunity to participate.

Those who have attended to date have engaged well with the sessions in a positive, proactive manner. The sessions have provided valuable insight, feedback and ideas as to how to continue to develop the maternity and neonatal services and how to improve workplace culture. Detailed feedback from the sessions and next steps will be shared with Trust Board once collated.

6. MATERNITY TRIAGE

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

Current performance

In September 2024 556 triage attendances were recorded on the BadgerNet patient record system. This reflects the sustained increase in triage attendance since the beginning of 2024:

Triage attendances Dec 23 - Sept 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8
August	618	19.9
September	556	18.5

- 8.6% of attendees were seen immediately on arrival, a reduction from previous months
- The longest wait recorded for initial review was 45 minutes.
- 93.5% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes.
- 98.74% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is beyond the KPI of 95% review within 30 minutes.
- 1.4% of attendees were categorised as red on arrival. All were seen within five minutes and appropriate ongoing care was provided in all cases.

- 18.34% of attendees were categorised orange on arrival, this is an increase from previous months.
- Whilst meeting our KPIs, when compared to other providers across the LMNS, particularly those of a similar size, WHH does have more breaches. In September 2024 6.6% of WHH triage attendances breached. Attendances at Countess of Chester breached on 1.71% occasions and Mid Cheshire 5.48%. Mersey and West Lancashire had no breaches in September 2024 at the Ormskirk site and only 1.62% on the Whiston site.

A new staffing model has been agreed with the clinical team which considered acuity audits and best practice guidance. The initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model and revenue request was prepared which would require a reduced annual recurrent investment of £285,161. This investment would increase the band 6 midwifery establishment by 3.0 WTE and Band 3 Midwifery Support Worker establishment by 2.69 WTE from 2024/25.

Following appropriate scrutiny and review, the revenue request has now been approved. The increase in establishment will be funded largely from within CBU - with a cost pressure of £6,259 in year 2024/25 and for financial year 2025/26 £25,036. However the full year funding of this proposal will be via non recurrent ringfenced funding from the Maternity Incentive Scheme rebate. Accordingly a piece of work is underway to identify how the new staffing model will be funded should an equivalent MIS rebate not be achieved in future years.

Recruitment into these new posts will commence shortly. To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways.

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

7. INDUCATION OF LABOUR (IOL)

September data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers, in particular those providers of a similar size to WHH albeit there has been some improvement compared to previous month:

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	57	169	94	67	125	83	107	702
Total Delayed	12	48	14	9	84	29	38	234
% of Total	21.05%	28.40%	14.89%	13.43%	67.20%	34.94%	35.51%	33.33%

Improvement work to improve IOL pathways has commenced and delays in IOL has also been added to the CBU risk register. Initial risk rating, 20, following mitigation, current risk rating 16. The WHH maternity service is also participating in an LMNS led improvement project related to IOL.

8. MNSI POSITION AND REPORTS RECEIVED

8.1 Background

To ensure Trust Board has oversight of the sevice's position with regard to cases being investigated by MNSI an update will provided each month with effect from October 2024.

8.2 Current Position

Year to date 2024, MNSI have accepted five cases for investigation. Progress as at 29/10/2024 is as follows:

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
28/02/2024	MI-036897	HIE/Cooling	Complete	31/07/2024	10/09/2024	30/09/2024	N/A
10/03/2024	MI-036905	Stillbirth	Complete	25/06/2024	25/07/2024	17/09/2024	08/10/2024
04/02/2024	MI-037420	Stillbirth	In progress	29/08/2024	09/10/2024	04/11/2024	12/11/2024
05/02/2024	MI-037421	Stillbirth	In progress	23/09/2024	Awaiting	Awaiting	
25/08/2024	MI-038061	HIE/Cooling	Referred	Awaiting	Awaiting	Awaiting	

On receipt of the final report from MNSI, reports and associated actions are presented to the Trust Safety Oversight meeting (SOM). Once this has taken place, reports and learning are cascaded within the maternity team. With effect from October 2024 reports are also shared with QAC and Trust Board as part of this paper to ensure discussions regarding safety intelligence are taking place in line with the Maternity Incentive Scheme Safety action 9.

A SOP is in development to formalise this process.This will be presented to the Maternity Guideline Review Group in November and then progress through specialty and CBU governance processes in December. The SOP will be shared to Trust Board once governance processes are completed.

8.3 Reports received

One new report has been received in October 2024 (MNSI reference MI-037420).

This case related to a woman in her first pregnancy who was receiving shared care between WHH and another local provider (Trust B). During her pregnancy testing for gestational diabetes (oral glucose tolerance test – GTT) was completed at WHH and was found to be outside of the expected range in pregnancy. This was incorrectly identified as 'normal' during routine testing. As a result the women was not placed on the correct antenatal pathway and therefore did not receive care appropriate to a woman with a diagnosis of gestational diabetes.

At 31+3 weeks the Mother attended the Maternity Triage unit with a yeast infection and her urine was tested. This showed glucose (3+) and a further GTT appointment to test for diabetes was made. Routine urine testing in the community did not show any glucose in urine, the woman felt reassured by this, and she did not attend for an additional GTT appointment. She was not contacted when she did not attend a second GTT appointment and her community care with Trust B continued.

Between 40+2 weeks gestation and 40+4 weeks gestation, the woman contacted and attended Maternity Triage at WHH on a number of occasions.

On attending to Maternity Triage at 40+4 weeks the woman was assessed and the baby's heartbeat could not be detected. The baby was born the following day. The family agreed that they did not want a post-mortem but the placenta was sent for histopathology examination and reported 'Fetal vascular malperfusion with over-coiled umbilical cord.

Following invstigation by MNSI, there were three specific safety recommendations:

- MNSI recommends that Trust A (WHH) and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care
- MNSI recommends that the Trust supports Maternity Triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.
- MNSI recommends that the Trust actively review their telephone maternity triage service to ensure all telephone calls are answered, logged and actioned to provide safe clinical assessment of mothers and babies

Actions to meet these recommendations have been developed and are underway. A case on a page has also been developed and shared with all maternity staff (appendix 3).

The final MNSI report is included in full in appendix 4 for information.

9. COMPLAINTS

Six complaints were received in the CBU in September 2024. Three related to care within the maternity and neonatal services as follows:

Specialty	Description	Complaint Opened
Maternity	Patient has multiple concerns relating to her maternity care and documentation within her medical records.	17/09/2024
Maternity	There are multiple concerns relating to the failings to recognise and treat the patient's preeclampsia and postpartum preeclampsia. Patient was also prescribed the wrong dose of blood pressure medication.	04/09/2024
Maternity	Patient disputes the information given following a post-mortem debrief. She also has concerns relating to the delay in being referred for genetic testing.	17/09/2024

Other cases received within the CBU related to care within the gynaecological service.

10. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received

11. RECOMMENDATIONS

Members of the Trust Board are requested to receive and note the findings of this paper for information.

Appendix one - Service user feedback:

Care received by LN

On 4/10/24 my daughter experienced a traumatic forceps delivery. Her son Jasper was a very big boy. After the birth they were taken to ward 23.

I went to visit on Saturday afternoon whilst her husband went home to get some rest. Whilst I was there Jasper was in his crib at the side of my daughter's bed. He was examined by a junior Dr and a nurse, who I now know to be Jackie (Richards?) Jackie seemed to be a very experienced, professional midwife. She was highlighting potential health concerns with Jasper to the junior doctor. She took immediate action and took `Jasper to the neonatal unit for observations. She clearly communicated with us why this was happening, she was reassuring and explained what she felt the concerns were. Her professional demeanour and confidence led me to believe that we could trust her judgement. This whole situation was extremely distressing for us as a family. Jackie was empathetic, calm and supportive.

The whole team on duty over the weekend have been amazing. The neonatal staff have facilitated visits , reassured and supported Lucy and Myles. The Dr on duty came to see my daughter when she was too weak to attend and see Jasper. He answered her questions and explained in detail what tests were being done and why.

As a first time parents and grandparent , this is not the start in life we would have wanted for Jasper. It has been extremely challenging and worrying for us as a family. This horrible, time has been made bearable due to the diligence of amazing midwives, doctors and care staff. The wrap around support has been exceptional. I cannot thank them all enough.

Jasper is now improving and we look forward to having him home soon. Please pass on my feedback to all concerned.

Care received by CP

I just wanted to reach out and say a huge thank you to the whole of the Maternity Unit at Warrington hospital for helping me bring my second daughter into this world on Monday 23rd September weighing 7.6lbs.

The care and true professionalism shown on Triage, Birth Suite/Labour Ward, and Ward C23 was and is truly amazing. This pregnancy although (thankfully) no real issues I was constantly reassured, supported and inspired by all the staff that I encountered.

To name just a few:

- Lucia Linares - Triage
- Charlotte Mahoney - Triage

- Lauren Davenport - Birth Suite
- Clare Bracewell - Ward C23

And I cannot fail to mention the two absolute incredible students, one of whom I had the pleasure of giving her, her 40th and final birth, so she can officially qualify was Danniella. I believe she has secured a job at Warrington, and she is truly outstanding. The other student was Karleen she is in her first year and again, is amazing.

The students covering across the Trust in these maternity areas are an absolute asset and will be perfect midwives in the future. It is clear to see the impact you and the team leaders have made to create and build such a great, solid maternity team across WHH.

I am truly grateful to you all and if I only I was young again, I'd train to be a midwife myself because of the impact they had on me.

Appendix two – Perinatal Cultural Leadership action tracker

PCLP Culture workplan

RAG	
Red	not started
Amber	work underway/on track
Green	Complete - evidence not yet received
Blue	Full compliance - evidence received

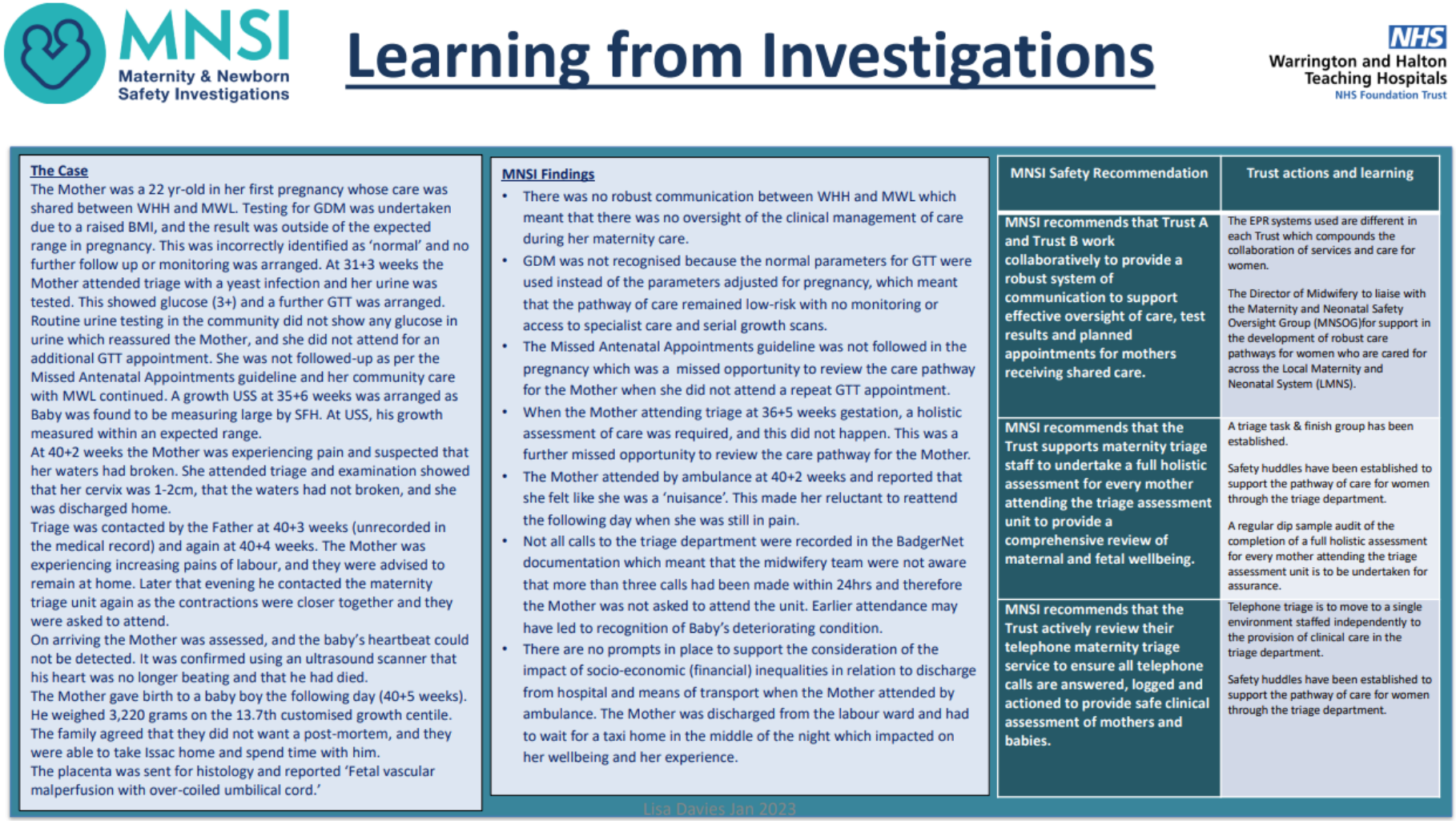
No	Action Required	Lead	Progress	Initial due date	RAG status
PCLP1	Roll out the day in the life framework offering shadowing opportunities to promote cross role and area awareness. This will be spotlighted bi-monthly in weekly newsletters and shared on digital platforms for the next 12 months.	Quad/Emma Bentham		31st October 2024	
PCLP2	Creation of a Women's & Children's Facebook group specifically to share updates and celebrate good news stories. This will be updated at least weekly using teams to collaborate and generate ideas with implementation in the next 2 months.	Quad/Emma Bentham	Facebook group created - to upload content and share with CBU team to join.	31st August 2024	
PCLP3	Implementation of a meet the team proforma which specifically asks questions not related to work. This will be shared on the newly founded Facebook group with a nomination system to be ongoing until the next staff survey.	Quad/Emma Bentham		31st October 2024	
PCLP4	Development of a programme of "Meet the Quad" Teams sessions to share key updates	Quad/Emma Bentham		31st October 2024	

PCLP5	Series of ideas events to be completed to focus on team working and to further explore barriers to effective team working and how we can ensure the team feel involved in decision-making	AGJ/LJ/TM	• Maternity Triage – completed x 3 sessions October 2024 • Birth Suite Co-ordinators - 4 dates across November • Community team leaders – 4 dates across November • Antenatal Services – 2 dates November • Maternity Ward – 3 dates across November (TBC) • Birth suite staff – 2 dates December/2 dates January (TBC) • Specialist Midwives – 3 dates December (TBC) • Community Midwives – 3 dates January (TBC) Separate sessions will be done with neonatal colleagues and medical staff.	31st October 2024	
PCLP6	Maternity & Neonatal Working group to be established focus on wellbeing, emotional recovery and burnout	LJ		31st October 2024	
PCLP7	Communication to be completed to clarify leadership structure	AGJ - DOM		30th November 2024	
PCLP8	To utilise the "You said, we did" feedback tool quarterly to demonstrate progress against actions from the culture workstreams (from Q3 2024)	Quad/Emma Bentham		31st December 2024	
PCLP9	To engage fully with the Trust culture plan and communicate this to the maternity and neonatal team	All		31st December 2024	

PCLP10	To implement system to capture/triangulate staff satisfaction/culture related learning and ensure oversight via the Quad and Maternity & Neonatal Safety Champions	AGJ - DOM		31st December 2024	
PCLP11	To ensure feedback from exit interviews is captured and used to support improvement activity	Tina Moors - Dep DoM		31st October 2024	
PCLP13	To complete regular temperature check surveys with the team to support triangulation of data from other sources (e.g. informal feedback, learning from complaints, exit interviews) and identify improvement activity	Matrons	Ward managers collating feedback from monthly ward meetings, informal feedback and from temperature check surveys with teams to share with maternity matrons. Matrons to collate data and identify areas for improvement. RCM application for 6 RM for Team Development Course completed.	31st December 2024	
PCLP14	To implement programme of development opportunities (shadowing, mentoring, formal training) to support staff in career development and retention	Sarah Nuttie/Pam Aldred - Retention Midwife		31st March 2025	
PCLP15	To review PCLP action plan as part of Quad/NED meetings	Quad/Emma Bentham	Agenda item for Quad meet 5/11/2024	5th November 2024	
PCLP16	To report progress against PCLP quarterly to QAC (next update Nov QAC)	AGJ		12th November 2024	

PCLP17	To meet with Trust colleagues to align activity with wider Trust culture plan	AGJ	Meeting held 17/10/2024.	Complete	
PCLP18	Feedback from ideas events to be collated, shared with Quad and actions identified	AGJ		31st January 2025	
PCLP19	Quad to meet with Health Innovation NW to identify plan for ongoing support	Quad	Meeting held 9/10/2024.	Complete	

Appendix three - Learning from investigations – case MI- 037420



Maternity Investigation
MI-037420

Independent report by the
Maternity and Newborn Safety Investigations (MNSI) programme.

Maternity investigation report October 2024

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About the MNSI programme

The Maternity and Newborn Safety Investigation programme (MNSI) is hosted within the Care Quality Commission (CQC). MNSI is responsible for patient safety investigations of NHS maternity care in England which meet the criteria outlined in the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions (2023). Details of our criteria can be found in appendix 1, and on our website: What we investigate (mnsi.org.uk)

MNSI investigations replace the local investigation carried out by the healthcare organisation. We work closely with those who received care, their families and healthcare staff affected by patient safety incidents, and we do not attribute blame or liability.

We acknowledge the health inequalities that impact some mothers, pregnant persons and their babies. MNSI is committed to working with relevant organisations to understand the factors behind these health inequalities and to inform changes that support safer maternity care. The information we collect during our investigations will be used to support wider work regarding addressing the known disparities in maternal, fetal and neonatal outcomes for people from certain ethnic or socio-economic backgrounds.

MNSI's investigation approach

Most harm in healthcare results from problems within the systems and processes that influence how care is delivered. Our investigations seek to identify the contributory factors that have led to harm, or the potential for harm. Safety recommendations for healthcare organisations and safety prompts identified within our reports aim to improve healthcare systems and processes, reduce risk, and improve safety.

Findings, safety recommendations and safety prompts

This report contains **findings** from our analysis of the evidence gathered during our investigation. The report may also contain **safety recommendations** and **safety prompts.**

Safety recommendations are made to an NHS organisation when the evidence indicates a change is needed to make care safer.

Safety prompts describe an action that may help to improve safety at a local level and where there was insufficient evidence to support a safety recommendation. This could be because the issue fell outside the direct scope of the investigation.

Not all reports will contain **safety recommendations** or **safety prompts**. On these occasions, maternity services are encouraged to use the findings within the report to promote and support learning.

A note of acknowledgement

We would like to thank the Mother whose experience is central to this investigation and detailed in this report. The Mother and Father generously gave their time and shared their thoughts openly with the investigation. Information shared helped to inform the investigation and provided valuable insight into the impact of such events.

We would also like to thank the healthcare staff involved in the investigation. MNSI acknowledges staff involved in safety events may be adversely affected and require additional support. The investigation found the healthcare staff were open and willing to support improvements.

To preserve anonymity, the family is referred to as the Mother and Father throughout. In accordance with their wishes, their baby Issac is referred to by name throughout this report.

Executive summary

Issac was stillborn at 40 weeks and 5 days, after the Mother attended the maternity unit with signs of labour. The maternity and newborn safety investigation programme was informed about his birth 3 months later due to misinterpretation of the MNSI referral criteria at the time of his birth. An independent review of care by the Trust in the weeks after his birth determined that the case should be referred.

Incident overview

The Mother was confirmed to be 'moderate' risk during her pregnancy due to a raised body mass index (BMI), and her care was shared between Trust A where she wished to give birth to Issac, and Trust B where she received routine antenatal community midwifery care.

Testing for gestational diabetes (oral glucose tolerance test – GTT) was outside of the expected range in pregnancy. This was incorrectly identified as 'normal' during routine testing at 24+6 weeks and no further follow up or monitoring was arranged. At 31+3 weeks the Mother attended the maternity triage unit with a yeast infection and her urine was tested. This showed glucose (3+) and a further GTT appointment to test for diabetes was made.

Routine urine testing in the community did not show any glucose in urine, the Mother felt reassured by this, and she did not attend for an additional GTT appointment. She was not contacted when she did not attend a second GTT appointment and her community care with Trust B continued. A growth ultrasound scan (USS) at 35+6 weeks was arranged as Issac was found to be growing above the 97th customised growth centile (by external measurement of the Mother's abdomen). At USS his growth measured within an expected range.

At 40+2 weeks the Mother was experiencing pain and suspected that her waters had broken. An ambulance was called as she was distressed and in pain. She was taken to Trust A where she was assessed. Examination showed that her cervix was 1-2cm, that the waters had not broken, and she was discharged home.

The maternity triage unit was contacted by the Father at 40+3 weeks (unrecorded in the medical record) and again at 40+4 weeks. The Mother was experiencing increasing pains of labour and they were advised to remain at home. Later that evening he contacted the maternity triage unit again as the contractions were closer together and they were asked to come in.

On arriving (40+4 weeks) the Mother was assessed and Issac's heartbeat could not be detected. It was confirmed using an ultrasound scanner that his heart was no longer beating and that he had died.

The Mother gave birth to Issac the following day (40+5 weeks). He weighed 3,220 grams on the 13.7th customised growth centile. The family agreed that they did not want a post-mortem and they were able to take Issac home and spend time with him.

The placenta was sent for histopathology examination and reported 'Fetal vascular malperfusion with over-coiled umbilical cord.'

Findings

1. When care was shared between Trust A and Trust B, there was no single, robust system in place to communicate and provide up to date information about a mother's clinical management during her maternity care. This meant that there was no oversight of the Mother's urine and blood test results, which suggested the possibility of gestational diabetes.
2. When the Mother's blood test was suggestive of gestational diabetes at 24+6 weeks this was not recognised. This meant that the Mother remained on a low risk pathway of care. A diagnosis of diabetes involves closer monitoring on a high-risk obstetric led pathway with access to a diabetes specialist midwife, serial growth ultrasound scans and induction of labour from 37+0 weeks.
3. The local Trust guideline for when mothers do not attend antenatal appointments was not followed when a repeat glucose tolerance test was arranged at 31+3 weeks. This meant that the Mother was not counselled regarding the need for the test and had no further opportunity to attend.
4. When the Mother attended the triage assessment unit at 36+5 weeks with suspected broken waters, a holistic assessment of her care was required and did not happen. This meant that no further action was taken to further investigate the glucose (3+) found in her urine. This meant that the Mother continued in her pregnancy with no additional monitoring for diabetes.
5. Issac was born on the 13.7th customised growth centile weighing 3,220 grams (g) which was significantly less than estimated from ultrasound growth assessment carried out at 36+0 weeks. There was no written record of growth monitoring by abdominal

measurement after 36+0 weeks and this meant that any changes in growth may not have been recognised.

6. During periods of high activity staff can be working in a challenging, busy environment on the labour ward and caring for more than one mother. This can impact on the time and capacity for understanding provided to mothers in the early stages of labour, as well as to the wellbeing of staff. This meant that when the Mother attended by ambulance at 40+2 weeks she was informed that this was unnecessary and she felt she was a 'nuisance'. This made her reluctant to attend the unit the following day when she was in pain.
7. Not all telephone calls made by the Mother and Father to the maternity triage unit were recorded into the Mother's medical records from 40+2 weeks to 40+4 weeks. This meant that the midwifery team were not aware that more than three calls had been made within 24 hours, and as a consequence the Mother was not asked attend the unit. An earlier attendance may have led to recognition of Issac's deteriorating condition.
8. There are no prompts or processes in place for maternity staff to consider the impact of socio-economic (financial) inequalities in relation to discharge from hospital and means of transport. The Mother was discharged from the labour ward and had to wait for a taxi home in the middle of the night which impacted on her wellbeing and her experience.

Safety recommendations and safety prompts

Safety recommendations

1. MNSI recommends that Trust A and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care.

2. MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.

3. MNSI recommends that the Trust actively review their telephone maternity triage service to ensure all telephone calls are answered, logged and actioned to provide safe clinical assessment of mothers and babies.

Safety prompts

1. The investigation found that Trust guidelines were not embedded in practice in all areas of the maternity service.
    - How are guidelines and policies implemented to all staff grades and departments?
    - How easy is it for staff to access policies and guidelines?

2. The investigation found that the Mother's urine tested positive for glucose when she attended the maternity triage assessment unit and no further action was taken. During triage assessment:
    - How do staff know that all abnormal results have been recognised and actioned appropriately when care has been handed over to another clinician?

3. The investigation found that during a busy antenatal clinic at Trust B, the Mother's abdominal measurement was not documented due to the number of tasks requiring completion during antenatal appointments of a standard, set length.
    - During midwifery antenatal clinic appointments, how are staff facilitated to record multiple measurements and observations whilst continuing to carry out other tasks?
    - When there are additional tasks required for mothers having shared care how is this reflected in the length of the appointment time?

4. The investigation found that the time and capacity for understanding provided during communication with the Mother was impacted by the high activity levels in the maternity unit.
    - During periods of high activity and stress on the maternity unit, what support systems are available to the team that allows them to:
        - Take regular breaks, including meals away from the unit
        - Talk to other colleagues
        - Care for themselves
    - How are staff supported to feedback information to families in a supportive and compassionate manner?

5. When a mother requests a baby's heart rate be assessed:
    - How are staff supported to listen and respond to a mother's care needs and preferences?

6. The investigation found that due to the pressure of the unit activity there was no assessment of the financial and emotional impact of sending the Mother home in the middle of the night after she had arrived by ambulance.
    - What prompts and tools are available for staff to consider health inequalities when planning care?
    - Is there a pathway for discharges during unsociable hours, including assessing the impact this may have on families emotional and financial wellbeing?

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1. Investigation approach

1.1 Summary of investigation process

The Trust contacted MNSI to inform them of Issac's stillbirth 3 months after he was born due to misinterpretation of the MNSI referral criteria. The event met the criteria for MNSI to carry out an independent investigation (The Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions 2023).

During the investigation, advice was provided by experienced and senior clinicians in relevant specialities. Following evidence collection and analysis, the findings were written in a draft report. This was reviewed by senior members of the MNSI programme. The draft report was then shared with Trust A, Trust B and the family for their review and comment before being finalised.

The healthcare organisations Trust A and Trust B are responsible for acting on any safety recommendations and safety prompts directed to them.

1.2 Terms of reference

The terms of reference were shared with, and informed by, those affected by the event. For the purposes of the investigation the clinical record for The Mother was reviewed. Following this, the terms of reference (the key areas to be explored) for investigation were agreed. Ethnicity and other health inequalities will be explored as part of the following terms of reference.

The terms of reference for this investigation were:

1. Investigate all aspects of maternity care from the antenatal care to when the Mother arrived in labour and the Baby was found to have died in utero, with a particular emphasis on:

    a. Shared care between maternity service providers

    b. Management of abnormal blood results and gestational diabetes mellitus

    c. Care in the latent phase of labour

2. Consider how the infrastructure and resources available within the organisation and the structure of maternity services within the Trust impacted on the care provided to the Mother and the Baby.

3. Ensure that the perception of events from the family, the Trust and staff directly involved in the care of the Mother and the Baby are captured.

1.3 Information gathering

The investigation used different sources of evidence to help understand the circumstances surrounding the Mother's care, and any factors that may have contributed to Issac's stillbirth. Consideration was given to ethnicity and other health inequalities, the environment, equipment, tasks, policies, and processes to understand how these may have influenced staff decisions and actions. This allowed the investigation to form an understanding of the healthcare systems involved and how they contributed to care and the outcome.

Information sources included:

- a meeting and telephone conversations with the Mother and the Father
- a review of relevant guidance
- a review of the Mother's clinical records
- reviews with advisors with a specialist knowledge in obstetrics and midwifery,
- interviews with staff who provided clinical care to the Mother
- meetings with staff working at the trusts to understand the healthcare systems and processes which impacted on the care that the Mother received.

The investigation was not able to confirm that all telephone calls described by the Mother and Father were logged and recorded.

The evidence gathered was analysed to identify learning. These informed the identification of themes and the development of safety recommendations and safety prompts.

Further details about the MNSI programme's criteria and approach to information gathering can be found in appendix 1.

2. Background and context

2.1 MNSI referral criteria: stillbirth

When a baby was thought to be alive at the start of labour and was born with no signs of life; this includes when:

- labour was diagnosed by a health professional; this includes the latent phase of labour, i.e. less than 4cm dilatation
- a mother called the unit to report any concerns of being in labour, for example (and not limited to) abdominal pains, contractions or suspected ruptured membranes
- a baby was thought to be alive at induction of labour
- a baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes

2.2 Ethnicity and health inequalities

Maternity and Newborn Safety Investigation programme (MNSI) acknowledges that that maternity care requires system level changes to make the navigation of maternity services safer for Black and Asian mothers who are more likely to die than White mothers (MBRRACE-UK, 2022a).

In our reports, we refer to ethnicity and not race. Under the Equality Act 2010, ethnicity includes ‘colour, nationality and ethnic or national origins’ (NHS Digital, 2022).

Health inequalities are avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions (The Office for Health Improvement and Disparities, 2022). ‘Ethnic minorities’ refer to all ethnic groups except the White British group. The term ‘ethnic minorities’ includes White minorities, such as Gypsy, Roma and Irish Traveller groups (Race Disparity Unit, 2021).

NHS England describes health inequalities as the conditions in where someone is born, grow, live, work and age can impact health and wellbeing. For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population. These groups are also

more likely to experience challenges in accessing care. The reasons for this are complex and may include:

- the availability of services in their local area
- service opening times
- access to transport
- access to childcare
- language (spoken and written)
- literacy
- poor experiences in the past
- misinformation
- fear

MNSI aims to raise awareness of health inequalities and ethnicity in maternity care and supports changing the current system to reduce health inequalities leading to better outcomes for mothers, babies and families from Black, Asian or minority ethnic backgrounds.

MNSI will share findings and recommendations with all hospitals and organisations working with maternity care services across England.

The 2022 MBRRACE-UK perinatal surveillance report (MBRRACE-UK, 2022b) explains the effects ethnicity and deprivation have on perinatal and maternal mortality:

- Black mothers are 3.7x more likely to die than White mothers (MBRRACE-UK, 2022a).
- Asian mothers are 1.8x more likely to die than White mothers (MBRRACE-UK, 2022a).

The 2022 MBRRACE-UK perinatal surveillance report (MBRRACE-UK, 2022b) explains the effects ethnicity and deprivation have on perinatal mortality:

- Stillbirth and neonatal mortality rates increased with deprivation across all ethnic groups.

- Stillbirth and neonatal mortality rates were lowest for babies of White ethnicity from the least deprived areas (2.78 stillbirths per 1,000 total births and 1.26 neonatal deaths per 1,000 live births).
- The impact of ethnicity and deprivation is highlighted by a stillbirth rate of 8.10 and 7.96 per 1,000 total births for babies of Black African and Black Caribbean ethnicity respectively from the most deprived areas.
- Rate of neonatal death were over 3 per1,000 live births for babies of Pakistani and Black African ethnicity from the most deprived areas.
- More babies of Black African, Black Caribbean, Pakistani and Bangladeshi ethnicities are from deprived areas, they are disproportionately affected by the higher rates of stillbirth and neonatal death associated with deprivation'.

2.3 Sharing information between healthcare providers

There are a number of electronic patient record software systems (both maternity and non-maternity) in use across the NHS in England and the challenges in sharing patient records is a recognised risk to safe health and maternity care.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 states that 'where responsibility for the care and treatment of service users [mothers] is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.'

This means that when care is shared between two or more providers or where there are integrated services, there should be arrangements made to share relevant information promptly and in line with current legislation and guidance, and to plan and deliver care in partnership.

2.4 Gestational diabetes mellitus (GDM)

Any mother can develop GDM during pregnancy. Mothers can be at an increased risk if they have a high body mass index (BMI, have had a previously large baby, had GDM previously, if family members have diabetes or if they are of an ethnicity with a high prevalence of diabetes. If any of these risk factors are present, screening for GDM should be offered during pregnancy (National Institute of Health and Care Excellence (NICE), 2020; NICE, 2021).

Body mass index in pregnancy

BMI is a measure for indicating nutritional status in adults. It is defined as a person's weight in kilograms divided by the square of the person's height in metres (kg/m^2) (WHO). The World Health Organisation (WHO) classifies BMI as follows:

BMI	Nutritional status
Below 18.5	Underweight
18.5 - 24.9	Normal weight
25. 0 - 29.9	Pre-obesity
30.0 - 34.9	Obesity class I
35.0 - 39.9	Obesity class II
Above 40	Obesity class III

Obesity in pregnancy is associated with an increased risk of several serious adverse outcomes, including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. Fetal heart rate monitoring can be a challenge, and closer surveillance is required, with recourse to fetal scalp electrode or ultrasound assessment of the fetal heart if necessary. (RCOG 2018)

Gestational diabetes mellitus (GDM)

Gestational diabetes is a form of diabetes that may affect a mother in the second half of the pregnancy. It is usually diagnosed through a blood test at 24–28 weeks of pregnancy. The hormones produced during pregnancy make it more difficult for the body to use glucose properly for energy, so the glucose remains in the blood and the levels rise, leading to gestational diabetes. Mothers who are overweight, come from certain ethnic backgrounds, have a family history of diabetes, have previously had a baby over 4,500g or had gestational diabetes in a previous pregnancy are at increased risk of developing gestational diabetes. Further information from: Diabetes UK - gestational diabetes and NHS - gestational diabetes

GDM can cause problems including a baby growing larger than normal, polyhydramnios (too much fluid in the uterus), premature birth, pre-eclampsia, stillbirth or a baby developing low blood sugar or jaundice after birth (Tommy's, 2020).

National guidance on diabetes in pregnancy states, GDM should be monitored during pregnancy (NICE, 2020). Guidance advises that treatment should be diet and exercise management where possible, with metformin (oral medication to lower blood sugar levels) offered if glucose targets are not met. If adequate control is still not achieved, insulin can be offered.

2.5 Monitoring the growth of a baby

Babies that are small for gestational age (SGA) are known to be at significantly increased risk of poor outcomes (Gardosi et al, 2018). Some women have risk factors for having a small baby. When abdominal measurement is not a suitable tool for monitoring a baby's growth, serial growth ultrasound scans are recommended. Dependent on whether moderate or high-risk factors are present, additional uterine artery Doppler ultrasound (measures blood flow to the placenta) may be performed, in which case the recommended schedule of growth ultrasound scans may alter (Robson et al, 2013).

Small for gestational age, intrauterine growth restriction and fetal growth restriction

The curved lines on a baby's growth chart represent the range of growth that is expected. Most babies will continue to grow along the same curve.

Small-for-gestational age (SGA) refers to a baby born with a birth weight (BW), which is smaller than most babies born at the same number of weeks of the pregnancy. A baby's estimated weight as calculated by ultrasound scans, can be plotted on these charts, to identify SGA babies. The birth weight also can be plotted on the chart.

Intrauterine growth restriction (IUGR) (also known as fetal growth restriction, FGR) is a condition where a baby's growth slows or stops during the pregnancy.

IUGR babies are more likely to find the stress of labour difficult.

Further information from: RCOG - having a small baby

Growth ultrasound scan

This is an ultrasound scan performed to check the overall wellbeing of a baby. It involves some combination of assessing a baby's size, the amount of fluid around a baby and the measurement of blood flow to the placenta and within a baby using Doppler ultrasound. (MNSI)

A number of antenatal pathways have been developed with the aim of detecting small babies prior to labour and birth. Regardless of the package used approximately half of SGA babies are not detected prior to birth (Williams et al, 2018 and Vieira et al 2022).

Fetal growth restriction (FGR) was found to be the largest category of SGA babies accounting for over half of all normally formed stillbirths (Williams et al, 2018). Occasionally, a baby that is suspected to be FGR, may not be small for gestational age (Robson et al, 2013). Antenatal detection of SGA or FGR babies enables a management plan to be implemented which reduces the risk of stillbirth and perinatal morbidity.

National guidance on the management and timing of birth are specific to an individual baby and whether they are SGA, FGR or have additional complications present (NHS England, 2019).

The local Trust guideline for measuring and monitoring growth of a baby states that women who are on a low risk midwifery led care pathway should have abdominal measurements to monitor their baby's growth from 26-28 weeks gestation. This is in line with national guidance (National Institute of Clinical Excellence (NICE) 2023).

2.6 Latent phase of labour

National guidance (NICE, 2017) defines the latent phase of labour as:

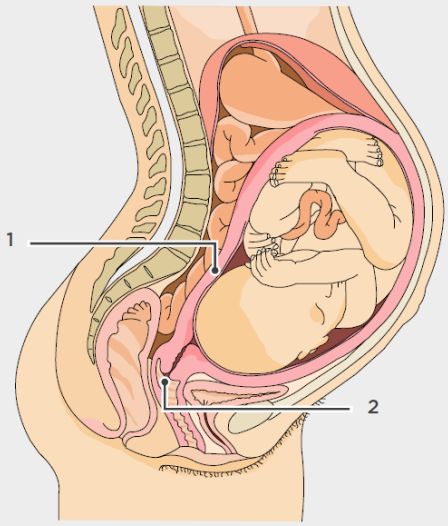
- A period of time, not necessarily continuous, when there are painful contractions; and
- There is some cervical change, including thinning out and dilatation up to 4cm.

Local guidance on care in the latent phase of labour outlines the expectations of a contact. This should include an assessment of a mother's level of pain, including her wishes for coping with labour along with the range of pain relief options available.

The local Trust A guideline states, if a mother is unable, reluctant to go home or requires pain relief in the latent phase she should be admitted.

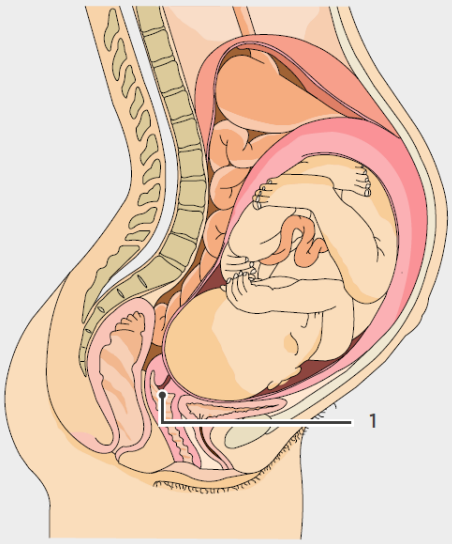
First stage of labour

The first stage of labour can be divided into two parts:



1. Uterus
2. Cervix

1. The first part is referred to as the latent phase, when there are painful contractions and there is some cervical change, including thinning out and opening of the cervix.



1. 1cm dilated

2. The second part is referred to as the established first stage of labour, when there are regular painful contractions and there is ongoing opening of the fully thinned out cervix.

2.7 Emergency ambulance service

Emergency 999 calls to UK ambulance services are processed by trained non-clinical emergency call handlers using algorithmic decision support and triage software called the advanced medical priority dispatch system (AMPDS). AMPDS uses key questions to categorise and determine the required level of response. This may range from a patient reported to be 'not breathing' to less time-critical conditions, such as 'back pain'.

Ambulance response time requirements are based on the 'Ambulance Response Programme (ARP) Standards' (NHS England, 2017). The average response target time for a category '1' emergency call is 7 minutes, with 90% of these calls responded to within 15 minutes (NHS England, 2017).

The regional ambulance service guidance (in use at the Trust) for maternity units on 'divert' status explains that this will not affect an emergency transfer into the unit. When a mother is identified as an obstetric emergency, they will be transported to the nearest appropriate maternity service with a pre-alert (red telephone) call.

2.8 Maternity triage

Maternity triage is for pregnant women or new mothers who need to be seen outside of their scheduled maternity appointments because of urgent pregnancy related concerns or unexpected complications. The service should be available at all times. Advice on when and how to contact maternity triage should be discussed at scheduled appointments and in information available from the woman's handheld patient records (Royal College of Obstetricians and Gynaecologists (RCOG), 2023).

National recommendations advise using a standardised assessment and clinical prioritisation process rather than seeing women in the order in which they arrive. This is to ensure those who have urgent issues are seen ahead of those with less urgent concerns and helps guide treatment according to their clinical need (RCOG, 2023).

2.8.1 Birmingham symptoms specific obstetric triage system (BSOTS) in use at Trust A

Trust A uses the Birmingham symptoms specific obstetric triage system (BSOTS) algorithm designed for triage of telephone calls (in line with national guidance from RCOG, 2023). The member of staff is prompted to record the 'primary reason' a mother has called triage from

eight options available. Once an option is selected, prescribed questions lead the staff member through the algorithm based on the mother's answers.

The Trust use BSOTS in their face-to-face triage of mothers. This is the recommended triage tool of pregnant women within the UK. It includes a standardised initial assessment of all women and their babies within 15 minutes of arrival and the use of symptom-specific algorithms to determine the clinical urgency of further investigations and seniority of review. With this initial assessment the mother is allocated a 'traffic light' colour code which reflects the clinical need and urgency of when a full clinical assessment is needed and the timeframe for first review from arrival:

- Red = Immediate
- Amber = 15 minutes
- Yellow = 1 hour
- Green = 4 hours

The maternity triage team includes staff who are specifically trained to assess pregnant and postnatal women both over the telephone and in person. This should be their main responsibility and focus, with appropriate staffing levels maintained to ensure best care can be given (RCOG, 2023). All midwives who work in triage at the hospital have had specific training in BSOTS.

2.8.2 Triage staffing

The Royal College of Obstetricians and Gynaecologists (RCOG), recommends the minimal staffing levels for maternity triage with the Trust's current birth rate is one midwife and one maternity support worker at all times and to consider one additional midwife for peak time workload which is typically 13:00 hours to 21:00 hours. In addition to this there should be an appropriately trained midwife familiar with maternity triage whose role is to solely answer a dedicated triage telephone line available 24 hours per day in a protected and quiet space located outside the clinical area. Calls should ideally be audio recorded with consent.

3. The safety event that affected the Mother and Issac

This section summarises the Mother's pregnancy, labour and Issac's birth based on the recollections of family, staff and the medical records.

3.1 Antenatal care

The Mother was 22 years old, White British and English speaking. This was her second pregnancy following a miscarriage 1 year before. She attended a face-to-face antenatal booking appointment at Trust A when she was 9 weeks and 5 days' gestation (9+5 weeks). Due to a raised body mass index (BMI) of 34.11kg/m2, she was referred for a test for gestational diabetes between 24 and 26 weeks in her pregnancy.

The antenatal handheld notes were provided to the Mother and she was able to access test results and other leaflets on an app on her smartphone.

Community midwifery care was provided by Trust B at the Mother's local GP practice and she attended all scheduled appointments.

The gestational diabetes blood test, known as an oral glucose tolerance test (GTT) took place at 24+6 weeks at Trust A's antenatal clinic. The results reported fasting glucose as 5.8 millimoles/litre (mmol/L). This was reported as 'normal. Using BDA [British Diabetic Association] criteria', with no treatment or additional monitoring needed.

Oral glucose tolerance test

An oral glucose tolerance test is a medical test in which an initial fasting blood test is taken, then a glucose solution or sugary drink is given by mouth. A further blood sample is taken two hours later. The test determines how quickly the glucose is cleared from the blood in order to diagnose gestational diabetes.

Further information from: Diabetes UK - testing for diabetes

When the Mother was 31+3 weeks she attended the maternity triage assessment unit at Trust A with vaginal discharge. A vaginal swab as taken during a speculum examination and a urine test showed blood 1+, glucose 3+, ketones 2+, and protein 1+. A urine sample was sent for microbiology tests and a repeat GTT for gestational diabetes was arranged. A likely diagnosis of a yeast infection was discussed with the Mother and she was discharged home.

The community midwifery team assessed the Mother at 31+6 weeks (urinalysis not recorded). The triage attendance was discussed together with the GTT appointment that had been made for a further diabetes test.

The Mother told the investigation that she did not attend the diabetes test appointment at 32+6 weeks as she felt well and reassured that there were no concerns. A week later at 33+6 weeks her urine was tested during a community antenatal appointment and showed there was no glucose present. External measurement of the Mother's uterus was measured and plotted onto the customised growth chart and showed an expected rate of growth.

Trust A had recognised that the Mother had not attended for a repeat GTT appointment. She was sent a second appointment by letter for 34+0 weeks. The Mother did not recall receiving a letter and did not attend.

A growth ultrasound scan was requested at 35+6 weeks during a community antenatal appointment as Issac's growth was more than expected by the SFH measurement, which plotted above the 97th customised centile. The ultrasound scan took place the following day at 36+0 weeks and reported Issac's growth to be in the expected range (on the 71st customised centile).

The Mother contacted the maternity triage assessment unit at 21:58 hours when she was 36+5 weeks as she had felt a 'popping sensation' and passed some clear fluid, which she thought may have been her waters breaking. She was advised to attend the unit and arrived at 22:35 hours. She was assessed and explained that she had noticed some mild bleeding on wiping when going to the toilet on the unit. It was documented that Issac was moving as normal, and that the Mother was not experiencing uterine contractions. Urinalysis showed glucose 3+, blood 2+ and ketones 1+. The gestational diabetes test result from 24+6 weeks was checked and a 'normal' result noted. The obstetric team were asked to review and she was seen by a senior obstetric doctor at 00:50 hours. The Mother recalled to the investigation that she was unsure of Issac's movements.

An assessment including a speculum examination (instrument to visualise a mother's cervix) found no watery loss and her cervix was closed. A bedside test for amniotic fluid (waters) was negative, meaning that the waters had not broken. Issac's heart rate was listened to and was within the expected range. A vaginal swab was taken and sent to be tested for any infection. This reported positive for candida (thrush). The Mother was reassured and discharged home. Treatment was provided by her GP.

Candida albicans

Candida albicans (sometimes called thrush) is a common yeast infection that may affect a mother/father/baby. It is usually harmless, may be uncomfortable and may return if not treated. If one partner has thrush you may treat both to stop it being transmitted back and forth. Further information from: NHS - Thrush

Community midwifery care continued as scheduled and at 39+6 weeks the Mother was offered a membrane sweep (to stretch the opening of the cervix). During the procedure her cervix was assessed to be 1cm dilated. Urinalysis did not show any glucose or signs of infection. Trust A was contacted, and induction of labour was arranged for 41+1 weeks if she had not already given birth.

3.2 Triage calls and attendances from 40+3 weeks

The Mother began to experience uterine contraction pains at home when she was 40+2 weeks in the early evening. The pain became 'very strong' and another family member called 999 at 20:38 hours requesting an ambulance. Information and support was provided by the call handler as there was some uncertainty as to whether Issac's head could be seen. The Grandmother and Father were instructed to prepare for the possibility of an imminent birth. The Mother was heard to be increasingly distressed during the call.

The ambulance team arrived at 20:45 hours and made an assessment. The Mother's pulse was fast at 118 beats per minute (bpm) and her blood pressure was 133/89 millimetres of mercury (mmHg) (slightly higher than expected). Issac's head could not be seen and there was no bleeding or discharge vaginally. It was not known if the waters had broken. Uterine contractions were recorded as 1 minute and 15 seconds apart and lasting for up to 2 minutes. Gas and air was given to the Mother for pain relief and the ambulance left the house to transfer her to the labour ward at Trust A.

'Gas and Air'

'Gas and air' is a gas made up of 50% nitrous oxide and 50% oxygen that is used for pain relief during birth. It is administered through a mask or mouthpiece. It is simple and quick to act and wears off in minutes.

Further information from: NHS - gas and air

On contacting the Trust to alert them to their arrival, the ambulance was informed that the maternity unit was experiencing very high activity levels and was not able to admit the Mother. They were asked to take her to a different hospital (Trust C) and the ambulance changed direction. Shortly after, the ambulance was informed that Trust A was the nearest hospital and in line with regional guidance, the ambulance re-routed arriving onto the labour ward at Trust A at 21:20 hours.

The Mother was assessed on arrival and she recalled being told soon after arriving that they should not have called an ambulance and that this was not an emergency.

All observations of the Mother and Issac were as expected. She explained to staff that at 14:00 hours that afternoon she had noticed clear fluid after passing urine, with no more since. It was documented that Issac was moving as normal, and her uterine contractions were 1 in every 5 to 6 minutes (1:5-6). (The Mother recalled to the investigation that she was uncertain of Issac's movements due to the pain she had been experiencing.) She was examined at 22:07 hours using a speculum (instrument to visualise the cervix). It was not possible to view her cervix and no fluid (waters) could be seen. A bedside test was used to check if the waters had broken and this was negative. A vaginal examination was then undertaken at 22:15 hours to assess the dilation of the cervix and it was found to be 1-2cm dilated. Issac's heart rate was noted as being listened to before and after the procedure and was within the expected range. The Mother was concerned that his heart rate had not been checked following the procedure and asked for this to happen. It was explained to her that this was not necessary.

The Mother recalled that she visited the toilet following the examination and noted a yellowy/green discharge. She showed this to staff and was reassured. A few minutes later a further solid whitish discharge was seen and the Father alerted the midwifery team. They were reassured again that there were no concerns.

Pain relief was discussed, and codeine was offered. At this time the Mother preferred to take only paracetamol and this was provided at 22:36 hours. Contractions were described as 'tightenings' 1-2:10, lasting 30 seconds, 'mild on palpation'. The Mother remained on the labour ward to allow for further observation. At 23:29 hours there was no change in the contractions and the early phase of labour was discussed with her. She was advised to go home, to try taking a bath and to contact the unit again if she had any concerns.

The following day (40+3 weeks) the Mother described feeling unwell with vomiting. She used the bath for pain relief and noticed some 'greenish' particles in the water. The Father contacted

the maternity triage unit by telephone on three occasions during the day for advice and was advised for the Mother to remain at home and use a bath for pain relief. He recalled being asked about Issac's movements and explained that they were unsure because of the pain. There was no documentation of the telephone calls made to the triage unit at 40+3 weeks. The investigation requested Trust telephone call logs which were not available at the time of writing the report.

The Mother's pain increased and the Father called the maternity triage unit the following day when the Mother was 40+4 weeks at 13:21 hours; he explained during the call that there was more 'green' discharge with a smell. This was noted as a 'mucus plug' with no vaginal loss. The call lasted for 5 minutes, and the Mother and Father recalled being advised to continue to stay at home. Staff tried to speak to the Mother (this was not documented) and the Father described that she was struggling to talk due to the pain. They remained at home and called the maternity triage unit again at 20:03 hours. The Mother was described as 'upset and uncomfortable', reporting contractions for the previous 2 hours occurring 3-4:10, that she was happy with Issac's movements and described a mucus vaginal loss with no bleeding. She was advised to come to the triage assessment unit for assessment.

The Mother explained to the investigation that she was uncertain of Issac's movements during this time as she was in pain.

3.3 Triage attendance at 40+4 weeks

The Mother and Father arrived on the triage assessment unit at 20:50 hours. During the assessment it was not possible to find Issac's heartbeat with the handheld Doppler device. The consultant obstetrician was bleeped to attend at 21:00 hours and they arrived at 21:15 hours. They confirmed with an ultrasound scan that no heartbeat could be seen, and that Issac had died. The Mother and Father were comforted by staff and care was given to provide pain relief.

3.4 Care during labour and postnatal care

Labour continued with the Mother being provided morphine for additional pain relief. The waters were broken at 04:15 hours and there was significant meconium (a baby's first bowel movement). The Mother had a higher-than-expected heart rate throughout her labour. Blood samples and a vaginal swab were taken to check for infection (sepsis) and antibiotics were given. Blood cultures taken were negative for infection.

Issac was born the following day (40+5 weeks) at 13:59 hours weighing 3,220 grams on the 13.7th centile. The Mother and Father along with their family were able to spend time with him and were supported by the bereavement team to take him home and make memories before the funeral.

After the birth the Mother was found to test positive for gestational diabetes mellitus.

The placenta was sent for further histopathology analysis (under a microscope) and reported:

‘Fetal vascular malperfusion. Overcoiled umbilical cord (single umbilical artery). Comment: Fetal vascular malperfusion in this scenario downstream of chorionic and system vessel thrombi is most likely due to intermittent cord compression in an over-coiled cord. FVM can precipitate profound reduction in fetoplacental perfusion and is the most likely cause for IUGR [intra-uterine growth restriction] and stillbirth at 41gw.’

Fetal vascular malformation

Unusually structured blood vessels in the placenta indicating reduced or absent blood flow, most commonly caused by umbilical cord obstruction. (MNSI)

Hypercoiled (overcoiled) umbilical cord

If there are more than 3 coils per 10cm of umbilical cord it is said to be hypercoiled. The blood vessels in a hypercoiled umbilical cord are more likely to be compressed, which can affect the blood and oxygen supply to a baby. (MNSI investigation team)

4. Investigation analysis and findings

This section described the findings of the investigation into the Mother's and Issac's care. It focuses on the factors that affected and influenced decisions and actions of clinicians at that time. The report gives attention to factors and themes which emerged from analysis of the evidence:

- Processes for identifying gestational diabetes mellitus
- Communication and information sharing processes between Trust A and Trust B
- Care provided to the Mother during the early stages of her labour

4.1 Communication and planning of the Mother's care between trusts

The investigation found that when care is shared between Trust A and Trust B, there was no single, robust system in place to communicate and provide up to date information about a mother's clinical management during her maternity care. The investigation found that the Mother's handheld records were not a full and complete record of the her antenatal care. The following were either not always recorded or not recorded at all:

- Ultrasound scan reports
- Blood test results
- Antenatal midwifery assessments
- Maternity triage unit assessments

The Mother's choice was to give birth at Trust A. Antenatal community midwifery care was provided by Trust B due to the location of her GP practice. The investigation learnt that this is not unusual as the GP practice is located midway between both trust hospital locations.

The antenatal booking appointment, ultrasound scans and blood tests were arranged and provided by Trust A. Routine community antenatal midwifery appointments were provided by Trust B. The investigation learnt that Trust A provides mothers access to their antenatal medical records on an app that can be downloaded onto a smartphone. This is linked to the Trust A electronic maternity records and includes information such as results of tests, appointments, information leaflets and contact telephone numbers. In addition, mothers whose care is shared with another trust are provided with hand-held paper records by Trust A. The Mother kept these safely at home and took them with her when she attended appointments.

The investigation was told that the midwifery team (Trust B) working at GP practices cannot access the electronic maternity records of Trust A. They rely on the handheld paper record and a mother sharing results or records on their smartphone. They described that there was a poor mobile telephone signal inside the building and that often the app could not be used during a consultation. This meant that staff relied on information being given to them verbally by mothers if they did not have their paper records with them. The investigation found that the GP practice midwives completed their records onto Trust B's electronic maternity record which was then duplicated and copied into the handheld record. Staff explained that during a 20-minute routine antenatal appointment this meant additional time was spent attempting to locate previous records or results and inputting information from the assessment into two places, reducing the amount of time providing care to mothers and often causing appointments to overrun.

MNSI safety recommendation.

1. MNSI recommends that Trust A and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care.

4.2 Screening for gestational diabetes

The investigation found that the Mother tested positive for gestational diabetes at 24+6 weeks and this was not recognised. This meant that the Mother remained on a low risk pathway of care. A diagnosis of diabetes involves closer monitoring on a high-risk obstetric led pathway with access to a diabetes specialist midwife, serial growth ultrasound scans and induction of labour from 37+0 weeks.

The investigation learnt that Mother's test result had been interpreted as 'normal'. The electronic referral system to the pathology laboratory did not make it mandatory to select if the patient was pregnant or not. This meant that the laboratory used values for a non-pregnant patient and this gave a 'normal' result. The investigation learnt that the reference values used in pregnancy are recommended by the National Institute for Health and Care Excellence (Diabetes in pregnancy, 2020). For non-pregnant patients a different set of values are recommended by the British Dietetic Association (BDA).

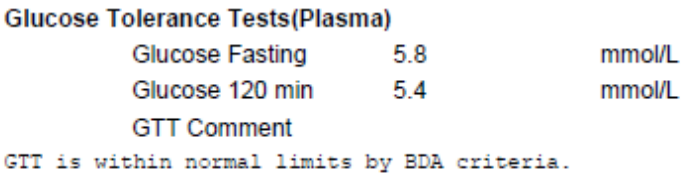
Table 1: Comparison of standard values for plasma glucose

	Normal fasting plasma glucose	**The Mother's result**
NICE	Below 5.6 mmol/l	5.8 mmol/l (abnormal)
BDA	3.0 to 5.9 mmol/l	5.8 mmol/l (normal)

The investigation found that antenatal diabetes blood tests (GTT) and the checking of results was carried out by midwifery support staff at Trust A in order to provide support to the midwifery team.

This meant that 'normal limits' was read from the report, and the result (shown below) was not clinically interpreted by a registered healthcare professional.

Image 1: The Mother's glucose tolerance (diabetes) test result



The community midwifery team at Trust B were not provided with a copy of the result, copies were not requested as blood tests and checking of results was normally the responsibility of Trust A.

As a result of Trust A's initial investigation into the Mother's care, which occurred prior to referral to MNSI, changes have now been made:

- A new mandatory field has been added to the pathology laboratory electronic referral system; when requesting a diabetes test the clinician must enter if the patient is pregnant or not pregnant. This will mean the correct criteria is used to measure the result against.
- All returned results are now checked in the antenatal clinic by a registered midwife.

The investigation was informed that the Trust recognised that other mothers may have been affected in a similar way. All diabetes test results from the previous 12 months were reviewed and additional follow up was made in a small number of cases.

MNSI safety recommendation

1. MNSI recommends that Trust A and Trust B work collaboratively to provide a robust system of communication to support effective oversight of care, test results and planned appointments for mothers receiving shared care.

4.2.1 Follow up after non-attendance for GTT test

The investigation found that the local Trust guideline for when mothers do not attend antenatal appointments was not followed when a repeat GTT was arranged at 31+3 weeks as the use of this guidance was not embedded in practice in this clinical area. As there was no single, robust system in place to communicate appointments for mothers receiving shared care, the community midwifery team at Trust B were not aware of the Mother's missed GTT. This meant that the Mother was not counselled regarding the need for the GTT test and had no further opportunity to attend.

The non-attendance was noted by the GTT clinic team at Trust A and a second appointment was sent out by letter. The follow up did not include a telephone call to the Mother. The investigation learnt that she did not recall receiving the letter for the second appointment and so did not attend. There was no further follow up by Trust A and the community midwifery team (Trust B) were not kept informed. This meant that they were not able to counsel the Mother about gestational diabetes and support her to arrange a further appointment.

The investigation learnt that following review of the Mother's care, the use of the Trust non-attendance guideline was introduced in the GTT clinic.

MNSI safety prompt.

1. The investigation found that Trust guidelines were not embedded in practice in all areas of the maternity service.
   a. How are guidelines and policies implemented to all staff grades and departments?
   b. How easy is for staff to access policies and guidelines?

4.3 Holistic obstetric assessment of mothers

The investigation found that when the Mother attended the triage assessment unit at 36+5 weeks with suspected broken waters, a holistic assessment of her care was required and did not happen. This meant that no further action was taken to further investigate the glucose (3+) found in her urine and gestational diabetes remained undiagnosed. The investigation has been unable to fully understand the systems factors that impacted this part of the Mother's care due to staff sickness and the passage of time since the assessment, due to the delay in referral to MNSI.

Some members of the team had no recall of the events that took place during the Mother's attendance due to the length of time that had passed. The normal working practices were discussed, and the investigation was told that after 34+0 weeks a finding of glucose in urine would be normally be followed up and assessed with regular home blood glucose monitoring arranged. The investigation learnt that the focus of care was on identifying whether the Mother's waters had broken, which was her main reason for attending.

There was a handover of care between clinicians and the investigation could find no evidence of direct and purposeful communication to discuss and follow up the finding of glucose (3+) in her urine sample.

MNSI safety recommendation.

2. MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.

MNSI safety prompt.

2. The investigation found that the Mother's urine tested positive for glucose when she attended the maternity triage assessment unit and no further action was taken. During triage assessment:

a. How do staff know that all abnormal results have been recognised and actioned appropriately when care has been handed over to another clinician?

4.4 Monitoring Issac's growth

The investigation found that Issac was born on the 13.7th customised growth centile weighing 3,220 grams (g) which is significantly less than estimated from ultrasound growth assessment carried out at 36+0 weeks. There was no written record of growth monitoring by symphysis fundal height measurements after 36+0 weeks, which the investigation learned was impacted by the number of tasks required in the time allocated for the Mother's antenatal appointments, with these being a set length.

There was no further documentation relating to Issac's growth monitoring after 36+0 weeks. The investigation learned that the Mother's abdomen was measured and found to be in the expected range for gestation at 39+0 weeks, this measurement was not documented. At this same appointment an offer for a membrane sweep was accepted and completed. This procedure requires additional time, extending the antenatal appointment due to it being an additional task and requiring additional time. The investigation learned that there was no facility for staff to increase the time allotted for each mother and the allocated appointment time was set. The investigation found that as a consequence of the numerous tasks undertaken, including the additional documentation required for both trusts, there was an oversight and the measurement was not recorded.

The investigation acknowledges that Trust B has now increased the length of the appointment time for community antenatal appointments. This was as a result of review of the appointment times and not as a result of investigation into the Mother's care.

MNSI safety prompt.

3. The investigation found that during a busy antenatal clinic at Trust B, the Mother's abdominal measurement was not documented due to the number of tasks requiring completion during antenatal appointments of a standard, set length.

a. During midwifery antenatal clinic appointments, how are staff facilitated to record multiple measurements and observations whilst continuing to carry out other tasks?

b. When there are additional tasks required for mothers having shared care how is this reflected in the length of the appointment time?

4.5 Care on labour ward at 40+2 weeks

The investigation found that during periods of high activity, staff can be working in a challenging and busy environment, caring for more than one mother. This can impact on the time and capacity for understanding provided to mothers in the early stages of labour, as well as to the wellbeing of staff. This meant that when the Mother attended by ambulance at 40+2 weeks she was informed that this was unnecessary and she felt she was a 'nuisance'. This made her reluctant to attend the unit the following day when she was in pain.

The investigation learned the activity levels on the maternity unit were unusually high on the evening that the Mother attended by ambulance with contractions and suspected ruptured membranes. This had been escalated to the Trust executive team at Trust A resulting in the unit being on a 'deflect' status. This means that mothers calling into the triage assessment would be advised to attend another trust's maternity unit to maintain patient safety. The investigation learned that mothers arriving by ambulance would still be accepted. The paramedic team were asked to attend another trust hospital in anticipation of the unit being on divert status imminently, prior to the 'deflect' status being in place.

On arrival to the labour ward by ambulance, the Mother and Father were informed by hospital staff that they should not have called an ambulance to get to the maternity unit as it was not an emergency. The Mother and Father explained to the investigation how this made them feel and how this affected their actions in the days following. They were told that a 999 call was unnecessary, as she was not in established labour, that their situation was not an emergency and that there is a considerable cost to call an ambulance. They felt they were "told off", were 'a nuisance' and that their concerns were not listened to.

The investigation learned that the maternity team were aware of the Mother's early labour and recalled that two telephone calls had been made to the triage unit earlier that day. No record of these calls were logged in the Mother's records. The team understood that the Father had been advised that an ambulance was not needed for transport to the hospital in early labour.

The investigation spoke to staff to understand more about what happens when mothers arrive by ambulance. The investigation learned that previously a mother had arrived by ambulance requiring emergency care and had been taken to the triage assessment unit. This had led to delays in treatment and a poor outcome. The procedure was changed, and all mothers arriving by ambulance are required to be taken directly to the labour ward for assessment. This means

that mothers may arrive onto the labour ward by ambulance during periods of high activity, not requiring urgent one to one care.

Due to the high levels of activity on the maternity unit that evening, the midwifery triage team remained on shift to complete the care for mothers being assessed. The oncoming triage team for the night shift were redeployed to the labour ward. A plan was in place that any emergency cases arriving to triage would be assessed on the labour ward. It was during this period of very high activity that the Mother arrived by ambulance with signs of early labour. The Mother's uterine contraction pain and frequency had begun to reduce, and the team were not aware of the level of pain and concern she had been experiencing earlier. There was an assumption that the family had called an ambulance for a non-emergency.

The Mother was assessed to check if her waters had broken, and the investigation learned that she asked if Issac's heartbeat could be listened to again after the procedure had been completed. She recalled being told that this was not needed and no explanation as to why was given to her. The investigation learned that listening in to a baby's heart rate takes approximately 2 minutes to complete. When a mother requests this from a midwife it is a simple procedure to perform and provides reassurance. National Institute for Health and Care Excellence (2021) Antenatal care for uncomplicated pregnancies states that 'when caring for a pregnant woman, listen to her and be responsive to her needs and preferences.' The Mother described not feeling reassured or heard.

Following discharge from the labour ward the Mother and Father described waiting outside the unit for a taxi to take them home, this was around 12:30 hours. The following day the Mother felt exhausted and ill. The investigation found no record of enquiry to the family as to how they would get home in the middle of the night.

The investigation acknowledges that this was a challenging shift for the maternity team. Midwives were undertaking multiple tasks and were caring for more than one mother, some requiring high levels of clinical care. This meant that time available to listen and provide supportive/pastoral care was very limited and this impacted on the way the Mother's attendance was treated.

MNSI safety prompts

4. The investigation found that the time and capacity for understanding provided during communication with the Mother was impacted by the high activity levels in the maternity unit.
    a. During periods of high activity and stress on the maternity unit, what support systems are available to the team that allows them to:
    - Take regular breaks, including meals away from the unit
    - Talk to other colleagues
    - Care for themselves
    b. How are staff supported to feedback information to families in a supportive and compassionate manner?

5. When a mother requests a baby's heart rate be assessed:
    a. How are staff supported to listen and respond to a mother's care needs and preferences?

4.6 Management of maternity triage assessment telephone calls

The investigation found that not all telephone calls made by the Mother and Father to the maternity triage unit were logged and recorded into the Mother's medical record between 40+2 weeks and 40+4 weeks. This meant that the midwifery team were not aware that more than three calls had been made within 24 hours, and as a consequence the Mother was not asked to attend the unit earlier. Earlier attendance and assessment may have led to recognition of Issac's deteriorating condition.

Trust A uses the BSOTS triage system as recommended by the Royal College of Obstetricians and Gynaecologists (2023). This recommends that the telephone triage line is answered by a dedicated midwife. All calls should be taken outside the clinical area in a dedicated and protected quiet space. The investigation learned that this does not always happen at Trust A.

The investigation learned that staffing for the maternity triage unit does not include a dedicated telephone triage midwife. Efforts are made to provide a dedicated specialist midwife to carry out this role when staffing will allow (09:00 hours to 17:00 hours, Monday to Friday). The investigation was told that this is not always possible, and then the triage midwife will answer calls. This is in addition to caring for mothers attending the unit. The investigation also learnt

that calls can be taken by obstetric doctors, students or midwifery support workers who will take messages and refer to the midwife in the unit.

Due to workload pressures, it was explained that when the unit is busy, not all calls are always recorded into a mother's electronic records. This may be due to task overload or lack of computer system availability. It should be noted that the calls the Mother and Father made at 40+4 weeks were over the weekend when there is no specialist midwife available to take telephone calls.

Observation of the maternity triage area during the investigation showed that a dedicated quiet office is available when a specialist midwife answer calls into the triage unit. When calls are answered by the triage midwife, these are taken in the triage office area. This is a busy space, used by other team members and is the main area for completing records and documentation, making it difficult for staff to fully concentrate on calls due to these potential distractions. This means that it may be possible not all calls are being recorded into the electronic maternity records.

BSOTS recommends that mothers making three telephone calls to the maternity triage unit within 24 hours should be asked to attend for assessment. The investigation found it is likely that not all calls were logged, and that this information was not available to the triage team. As a result the Mother was not invited to attend until she was 40+4 weeks when Issac's heartbeat could no longer be detected and it was confirmed that he had died.

MNSI safety recommendation.

3. MNSI recommends that the Trust actively review their telephone maternity triage service to ensure all telephone calls are answered, logged and actioned to provide safe clinical assessment of mothers and babies.

4.7 The impact of socio-economic inequalities on wellbeing

The investigation found that some socio-economic inequalities may have impacted on the Mother's care. The investigation learned that there are no prompts or processes in place for maternity staff to consider the impact of social financial inequalities in relation to discharge from hospital and means of transport. The Mother was discharged from the labour ward and had to wait for a taxi home in the middle of the night, which impacted on her wellbeing and her experience.

The investigation found that the Mother and Father did not have access to their own vehicle and this made it more difficult for them to travel to the hospital. At a time of already stretched finances when planning for their first baby, they often used taxis and this would also be a barrier for going into the hospital in early labour, as they were concerned they would be sent home again.

Birth companions statement (November 2023) to the Women and Equalities Committee's Inquiry noted that essential transport costs was an additional concern for some women 'impeding their access to services and adding further strain on their finances.'

Waiting outside the unit for a taxi in the middle of the night left the Mother who was in early labour, feeling exhausted and ill. There was no consideration or understanding of their situation and this has added to their negative memories of the experience of Issac's stillbirth.

MNSI safety prompt.

6. The investigation found that due to the pressure of the unit activity there was no assessment of the financial and emotional impact of sending the Mother home in the middle of the night after she had arrived by ambulance.
    a. What prompts and tools are available for staff to consider health inequalities when planning care?
    b. Is there a pathway for discharges during unsociable hours, including assessing the impact this may have on families emotional and financial wellbeing?

Appendices

Appendix 1: Additional information about the MNSI programme

Appendix 2: References

Appendix 1: Additional information about the Maternity and Newborn Safety Investigation programme (MNSI)

MNSI investigates in line with the criteria outlined in the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions (2023). Eligible babies include all term babies (at least 37+0 weeks of gestation) born following labour, who have one of the following outcomes –

(a) **Intrapartum stillbirth:** when a baby was thought to be alive at the start of labour and was born with no signs of life,

(b) **Early neonatal death:** when a baby died within the first week of life (i.e. days 0–6) of any cause.

(c) **Severe brain injury:** diagnosed as occurring in the first 7 days of life, when the baby—

(i) was therapeutically cooled (active cooling only), or

(ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following:

- low tone (hypotonia);
- abnormal reflexes including oculomotor or pupillary abnormalities;
- absent or weak suck;
- clinical seizures.

The defined criteria for maternal death investigations are:

Maternal death: death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.

Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.

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

*Includes giving birth, treatment of an ectopic pregnancy, miscarriage or termination of pregnancy

Further information about the MNSI programme's approach to gathering information

Review of information

After consent is obtained from the family to access the relevant clinical records, these are uploaded by the healthcare organisations and MNSI starts the investigation.

Records that can be used include, (and are not limited to), hospital records, GP records, ambulance service records and transcripts, and relevant trust guidelines and procedures. Information reviewed may also include an assessment of tools used to monitor staffing levels (acuity), and staff working patterns.

Investigators may undertake a walk-through of a mother's, pregnant person's or birthing parent's and baby's journey within the maternity service and observe the clinical environment.

Family interviews

Interviews and telephone conversations are held with the family to listen to their recollection of events and any concerns they may have. Families' involvement in the investigation process is central to an MNSI investigation.

Specialist review panels

Advisors with a specialist knowledge provided advice and guidance during the investigation process: signposting to evidence, including national guidance and expected practice. They assisted in formulating the investigation's terms of reference and key lines of enquiry.

Staff interviews

Face to face or video interviews are held with staff involved in a mother's, pregnant person's or birthing parent's or baby's care to understand what influenced their decision making and the care provided. Interviews may also be held with other staff members who can provide further information to support the investigation.

Communication during investigations

Throughout the investigation process, the investigator provides regular updates with families and healthcare organisations. If a safety concern that needs immediate action is identified, this is escalated to the healthcare organisation during the investigation. This helps ensures that there is an opportunity for a healthcare organisation to address safety issues in a timely manner.

Post-mortem examination

In cases which have been referred to His Majesty's Coroner and a post-mortem examination (PME) has been completed, the MNSI report will reflect the cause of death as stated in the PME. In cases where an inquest is planned to take place, the cause of death will not be confirmed until the inquest is concluded. On occasion the wording in relation to the cause of death may by changed or added to as part of the inquest process, this may occur after the MNSI report has been completed.

His Majesty's Coroner information

MNSI acknowledges it is possible that there is other information, available to the family or His Majesty's Coroner, which could have been relevant to the information MNSI considered during this investigation. For clarity, our final report was produced by accessing and reviewing all evidence that was available to us at the time of the investigation. Our recommendations were made on that basis and all evidence used for this investigation is listed within our report. If our findings differ to those from later investigations, such as by HM Coroner, the reasons for this may be due to the different evidence available to different investigations.

Analysis

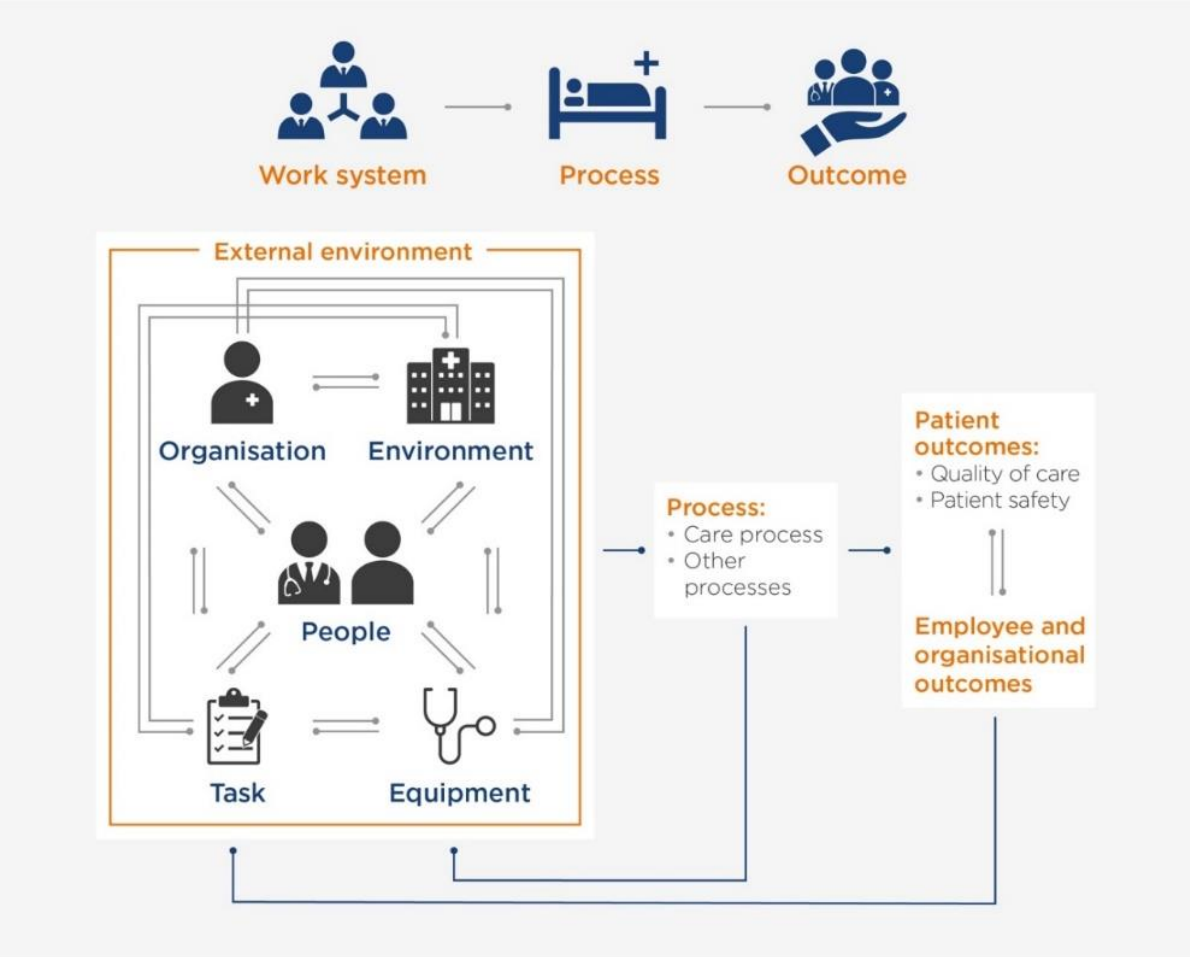
The investigator can access a range of resources to help understand what contributed to care.

MNSI promotes use of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) as one way to help understand why incidents occur. The investigators consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, and national policies and professional guidance, that contribute to how incidents occur.

Once analysis is complete MNSI may develop safety recommendations, safety prompts and findings. This is aimed at supporting the immediate and sustainable improvement of care and service provision locally and across the wider NHS.

Learning from individual reports are analysed and are used nationally to share wider thematic learning.

Image 1. Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013)



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Women and Equalities Committee inquiry into the impact of the rising cost of living on women (Birth Companions submission, November 2023).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/159 appendix 6**			
SUBJECT:	**Quarter 2 2024-25 Perinatal Mortality Review/Audit**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery, Lisa Davies – Governance Lead – Women's and Children's			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and focusses attention on improving outcomes for this protected group			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025.			

	The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 6) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports. This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 2 (Q2) PMRT report for the period covering 01/07/2024 – 30/09/2024. During Q2, WHH reported one baby to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): **One stillbirth:** • One baby born at 32+2 weeks The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 3 2024/25 QAC following a PMRT review panel. WHH stillbirth rate for Q2 2024/25 was 1.5 per 1000 births. WHH annual mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births. WHH Neonatal mortality rate during Q2 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births. During Q2, WHH undertook two PMRT review panels one of a stillbirth (a baby born at 38+4 weeks) and one a late neonatal death of a baby born at 36+3 weeks. Parental perspective of the care they received were sought in all cases. The panel review of the stillbirth case graded care as B. The panel review of the late neonatal death graded care as C with issues with care identified for the mother and baby up to the point of the birth of the baby that may have made a difference to the outcome for the baby.

	In both cases, there were issues with care identified for the mother and baby up to the point that the baby was confirmed to have died that would have made no difference to the outcome for the baby. In both cases, there were issues identified with the care of the mother following confirmation of the death of her baby that would not have made a difference to the outcome for the mother. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note** ✓	**Decision** ✓
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/11/180i**	
	Date of meeting	**12 November 2024**	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Quarter 2 2024-25 Perinatal Mortality Review/Audit	AGENDA REF:	BM/24/12/159 appendix 6

1. BACKGROUND/CONTEXT

The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) UK confidential enquiries, reported that 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 6 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 2 PMRT audit data for 2024/2025 and highlights good practice and lessons learned identified through the mortality reviews completed during the period.

Definitions:

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

2. QUARTER 2 2023/24 STILLBIRTHS & NEONATAL MORTALITY

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

During Q2 reporting period one case was reported to MBRRACE-UK:

One Stillbirth:
One baby born at 32+2 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 4 November 2024 and will be included in the Q3 2024/25 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 2. WHH Stillbirth Rate:

- WHH Q2 stillbirth rate for 2024/2025 is 1.5 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH current annual stillbirth rate for Q3-Q4 2023/24 is 3.71 per 1000 births. Rolling year Q3 2023/24-Q2 2024/25 rate is 3.19 per 1000 births. The MBRRACE-UK national rate is 4.1 per 1000 births.

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

Metric	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	12-month total
Number of live births	627	591	615	676	2509
Total number of stillbirths >24 weeks	1	5	1	1	8
Total Stillbirth Rate >24 weeks (per 1000 births)	**1.59**	**8.50**	**1.60**	**1.50**	**3.19**
Number of intrapartum still birth rate	0	1	0	0	1
Number of stillbirths >37 weeks	0	2	1	0	3

2.2 Q2. WHH Neonatal Mortality Rate:

- WHH neonatal mortality rate during Q2 2024/2024 was 1.5 per 1000 live births.
- The MBRRACE-UK national rate is 2.7/1000 live births.

3. QUARTER 2 2023/24 PMRT REVIEW FINDINGS

3.1 Quarter 2 PMRT Review Panel Key Findings

Synopsis of Findings

One baby born at 38+4 weeks gestation was a stillbirth. The cause of death was confirmed as fetal vascular malperfusion.

One baby born at 36+3 weeks gestation was a late neonatal death. This baby was born at WHH and died at Alder Hey Children's Hospital. The cause of death identified at post-mortem was determined to be Tetralogy of Fallot.

Surveillance Findings:

- Both babies were of a singleton pregnancy.
- Both women were aged between 30-37 years.
- Both women were identified as white ethnicity and spoke English as their first language.
- Neither woman had any communication problems because of learning difficulties/hearing problems.
- Both women had a BMI of greater than 30 (associated with an increased risk of complications in pregnancy).
- One woman was a non-smoker and had a carbon monoxide (CO) level below 3 parts per million (PPM).
  One woman was a smoker who declined smoking cessation support in the pregnancy.
- Neither of the women booked late in the pregnancy.
- In all cases there were no issues identified with the care provided in relation to safeguarding.

3.2 PMRT Grading of Care

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

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

3.2.1 PMRT Grading of Care – Late Fetal Loss/Stillbirth

During Q2 one PMRT review panel took place. Parental perspective of the care they received were sought. In this case, care was graded B. There were no issues with care identified for the mother and baby up to the point of the birth of the baby that would have made a difference to the outcome for the baby. In this case there were issues with care identified for the mother and baby up to the point that the baby was confirmed to have died that would have made no difference to the outcome for the baby. In this case there were issues identified with the care of the mother following confirmation of the death of her baby that would not have made a difference to the outcome for the mother.

Table 3: Q2 WHH Grading of Care following a Late Fetal Loss/Stillbirth.

PMRT grading	Care up to the point the baby was confirmed as having died	Care following confirmation of the death of her baby
PMRT grade A The review group concluded that there were no issues with care identified	-	-
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	1	1
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	-	-
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-
Not Graded		
Total Cases	One case	One case

3.2.2 PMRT Grading of Care – Neonatal Death

During Q2 one PMRT review panel took place. Parental perspective of the care they received were sought.

In this case care up to the point that the baby was confirmed as having died was graded as C. This cause of death for this baby was identified at post-mortem was determined to be Tetralogy of Fallot (ToF). This was not identified through antenatal ultrasound scan. Whilst ToF is not always diagnosed through scan, had it been identified there may have been a difference in outcome.

In this case there were issues with care identified for the mother and baby up to the point that the baby was confirmed to have died that would have made no difference to the outcome for the baby. In this case there were issues identified with the care of the mother following confirmation of the death of her baby that would not have made a difference to the outcome for the mother.

Table 4: Q2 WHH Grading of Care Following Neonatal Death

PMRT grading	Care up to the point that the baby was confirmed as having died	Care to the baby from birth to the point that the baby was confirmed as having died	Care to the mother following confirmation of the death of her baby
PMRT grade A The review group concluded that there were no issues with care identified	-	-	-
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	-	1	1
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	1	-	-
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-	-
Not Graded	-	-	-
Total cases	One case	One case	One case

3.2.3 PMRT reporting for Saving Babies Lives Care Bundle v3- Q2 2024/25:

As part of the Saving Babies Live Care Bundle version three, there is also a requirement to consider whether fetal growth restriction (FGR) identification and management, reduced fetal movement (RFM) management and/or intrapartum

monitoring were a contributory factor to perinatal mortality. Table 5 details the outcome of the PMRT reviews completed in Q2 assessed against these interventions:

Table 5 – Saving Babies Lives interventions.

Intervention		**%**
Intervention 2.8	Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue	0.0%
Intervention 3.2	Percentage of stillbirths which had issues associated with RFM management identified	0.0%
Intervention 4.3	Percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	0.0%
Intervention 5.2	Percentage of late second trimester singleton births and preterm births (using PMRT) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared, and percentage of late second trimester singleton births and preterm births	0.0%

3.3 WHH PMRT Panel Attendance

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

Table 6: Q2 WHH PMRT Panel Attendance

Number of participants involved in PMRT reviews. Total number of reviews from 01/07/2024 – 30/09/2024 = 2			
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	1	1	2
Admin/Clerical	0	0	0
Bereavement Midwife	1	1	2
External Rep	1	1	2
Management Team	1	1	2
Midwife	1	1	2
Neonatal Nurse	0	0	0
Neonatologist/Paediatrician	0	1	1
Obstetrician	1	1	2
Other	0	0	0
Governance Manager	1	1	2
Safety Champion	0	0	0

3.4 Maternity Incentive Scheme Year 5 Compliance

WHH is compliant with all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 6 as per table 7.

Table 7: PMRT MIS Safety Action 1 Compliance

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Standard Required		**Compliant Y/N**
a)	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days for deaths from 8 December 2023 to 30 November 2024.	Assessed as compliant
b)	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 8 December 2023.	Assessed as compliant
c)	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed within six months.	Assessed as compliant
d)	Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Assessed as compliant

3.5 Learning and Good Practice

- It was identified that the confirmation of the death of the baby was not prioritised in one of the cases which meant that the mother was waiting without a definitive diagnosis, and this caused unnecessary additional emotional upset.
- The bereavement support for women who have experienced neonatal loss and whose care had been provided by more than one organisation can be fractured.
- Parental involvement was sought in all cases as part of PMRT panel review.
- The one case of stillbirth which occurred in the quarter has been notified to MBRRACE and surveillance completed within the required timescale.

3.6 Action Plan Summary

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

There were five actions recorded from the Q2 2024/25 PMRT review panels and three actions remain in progress:

Table 8: PMRT Action Plan

Action	Lead	Start date	Due Date	RAG rating
Share the learning from this case through bereavement training updates.	Hannah Parker, Bereavement Midwife	16/09/24	31/12/24	
Importance of urgency to confirming fetal demise by USS to be shared across the obstetric colleagues through a case on a page.	Rita Arya, Consultant Obstetrician & Gynaecologist	16/09/24	31/12/24	
Consider the earlier use of Prostin in the newborn, with a differential diagnosis.	Narayana Vayyeti, Consultant Paediatrician	16/09/24	31/12/24	
Clarify with Connect Northwest the pathway for transport discussions when transfer is required.	Narayana Vayyeti, Consultant Paediatrician	16/09/24	31/12/24	
Clarify the responsibility of bereavement care with the LMNS, when care crosses organisations to prevent care becoming disjointed.	Rita Arya, Consultant Obstetrician and Gynaecologist	16/09/24	31/12/24	

4. SUMMARY

WHH Q2 PMRT audit recorded one baby reported to MBRRACE who was born between 01/07/2024 and 30/09/2024.

- The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 3 2024/25 QAC report following the PMRT review panels due to be held on 4 November 2024.
- WHH stillbirth rate for Q2 2024/25 was 1.50 per 1000 births. WHH annual Mean stillbirth rate is 2.71 per 1000 births which is below the 2022 MBRRACE-UK national rate 4.1 per 1000 births.
- WHH Neonatal mortality rate during Q1 2024/2025 was 1.50 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- Two PMRT review panels were held in Q2 which were attended by multidisciplinary internal and external panel members. PMRT reviews are all graded as either A B C or D as per outcome incurred. One related to a case of stillbirth, one to a case of neonatal death.
- In the case of neonatal death, care was graded C with issues identified for the mother and baby up to the point of the birth of the baby that may have made a difference to the outcome for the baby.
- Parental perspective of the care they received were sought in all cases.

- Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee and two of five Q2 PMRT actions are complete.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

5. MONITORING/REPORTING ROUTES

This Report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting in November 2024.

6. RECOMMENDATIONS

The Trust Board is asked to note the findings of this paper as per MIS Year 6 recommendations.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/129 appendix 3a**			
SUBJECT:	**Maternity Incentive Scheme Year 6 Update - October**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and			

	perinatal care by driving compliance with ten Safety Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. NHSR is now operating Year six of the Clinical Negligence Scheme for Trusts (CNST) MIS following publication of guidance on 2 April 2024. Conditions of eligibility for payment under the Scheme are set out in the guidance and a completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025. Progress against MIS year 6 requirements is ongoing and regularly reviewed. Regular assurance meetings are held with the LMNS to review progress against the actions, in particular to monitor progress against Saving Babies Lives Care Bundle v.3 (SBLCBv3). The latest review took place on 4 September 2024. Feedback confirmed 96% compliance overall for the 6 elements. Four out of the six elements are 100% compliant. The next LMNS quarterly review meeting is scheduled for 4 December 2024.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/10/157iv**	
	Date of meeting	8 October 2024	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Maternity Incentive Scheme Year 6 Update - October	AGENDA REF:	BM/24/12/129 appendix 3a

1. BACKGROUND/CONTEXT

NHS Resolution has now commenced year six of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2024. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2025.

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

2. CURRENT POSITION

2.1 Overall position

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024 and circulated to all providers of maternity services.

Following the launch of MIS Year 6 on 29 April 2024, meetings with leads for all 10 Safety Actions took place to discuss the guidance and ensure processes were in place to meet the required specifications for each action. Informal meetings with action leads to track progress have continued.

An overarching review took place with the LMNS at the quarterly meeting with the Trust on 4 September. No concerns were raised by the LMNS at this meeting.

Formal review meetings led by the Director of Midwifery to assess progress against all MIS year 6 requirements will be held with each action lead during week commencing 30 September 2024.

2.2 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the SBLCBv.3.

Progress against SBLCBv.3 continues to be reviewed and monitored by LMNS on a quarterly basis. The latest review took place on 4 September 2024. Feedback confirmed 96% compliance overall for the 6 elements. Four out of the six elements are 100% compliant.

The remaining two elements not yet achieved are as follows: -

Element 1: Smoking in pregnancy – 80% compliant (8/10 interventions fully implemented.

- Intervention 1.3 - Smoking status at:
  - 36/40 weeks – required compliance 85%, achieved 54% in July 2024
  - every AN appointment - required compliance 60%, achieved 56% in July 2024

- Intervention 1.6 : required compliance 0-60%
  - Smokers verified as non-smokers at 4 weeks and 36 weeks. Compliance achieved for July 2024 of 0% and 17% respectively. Focus required on non-smokers at 4 weeks.

Element 2: Fetal Growth restriction – 95% compliant (19/20 interventions full implemented.

- Intervention 2.2 : required compliance 95%
  - Number of women booked who are recommended vitamin D supplementation at booking. At time of review, compliance for July 2024 of 92% was achieved.

Action plans are in place for each of the three above interventions.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	40%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	25%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Not implemented	0%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Not implemented	0%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	4%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Not implemented	0%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	14%	Partially implemented	96%	CNST Met

The next LMNS quarterly review meeting is scheduled for 4 December 2024.

3. MONITORING / REPORTING ROUTES

Progress with the remaining aspect of MIS Year 5 (SBLCBv3), and MIS Year 6 is shared and discussed at CBU Governance meetings.

The content of this report will be shared at Women's Health Governance in October 2024.

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/129 appendix 3b**			
SUBJECT:	**Maternity Incentive Scheme Year 6 Update - November**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and			

	perinatal care by driving compliance with ten Safety Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. NHSR is now operating Year six of the Clinical Negligence Scheme for Trusts (CNST) MIS following publication of guidance on 2 April 2024. Conditions of eligibility for payment under the Scheme are set out in the guidance. Progress against MIS year 6 requirements is ongoing and regularly reviewed. Regular assurance meetings are held with the LMNS to review progress against the actions, in particular to monitor progress against Saving Babies Lives Care Bundle v.3 (SBLCBv3). The latest review of SBLCBv3 took place on 4 September 2024. Feedback from the LMNS confirmed 96% compliance overall for the 6 elements. Four out of the six elements are 100% compliant. Progress is being made against the remaining two elements. The next LMNS quarterly review meeting is scheduled for 4 December 2024. The LMNS has a key role in reviewing provider evidence and obtaining assurance against the MIS Year 6 requirements. The timeline for the LMNS assurance process has now been received. A completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/11/180ii**	
	Date of meeting	12 November 2024	

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

REPORT TO TRUST BOARD

SUBJECT	Maternity Incentive Scheme Year 6 Update - November	AGENDA REF:	BM/24/12/129 appendix 3b

1. BACKGROUND/CONTEXT

NHS Resolution has now commenced year six of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2024. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2025.

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

2. CURRENT POSITION

1.1 Overall position

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024 and circulated to all providers of maternity services.

Following the launch of MIS Year 6 on 29 April 2024, meetings with leads for all 10 Safety Actions took place to discuss the guidance and ensure processes were in place to meet the required specifications for each action. Informal meetings with action leads to track progress have continued.

Formal review meetings led by the Director of Midwifery to assess progress against all MIS year 6 requirements were completed during week of 30 September 2024. Actions to ensure compliance with MIS year 6 were all underway and on track.

2.2 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the SBLCBv.3.

Progress against SBLCBv.3 continues to be reviewed and monitored by LMNS on a quarterly basis. The latest review took place on 4 September 2024. At that meeting it was confirmed four our out of the six elements were 100% compliant. Two elements were ongoing there were two elements not achieved :

- Element 1: Smoking in pregnancy (80% compliant)
- Element 2: Fetal Growth restriction (95% compliant)

The latest position in relation to these two elements is as follows: -

Element 1: Smoking in pregnancy – 80% compliant (8/10 interventions fully implemented.

- Intervention 1.3 - Smoking status at:
  - 36/40 weeks – required compliance 85%, achieved 54% in July 2024
  - every AN appointment - required compliance 60%, achieved 56% in July 2024

Latest data for September is 64% compliance with October data pending. Smoking status has been made a mandatory field at every antenatal contact from the end of October. Accordingly improvement will be seen from November data which will allow WHH to achieve standard

- Intervention 1.6 : required compliance 0-60%
  - Smokers verified as non-smokers at 4 weeks and 36 weeks. Compliance achieved for July 2024 of 0% and 17% respectively. Focus required on non-smokers at 4 weeks.

Latest data for September shows non-smokers at 36 weeks is 29% and at 4 weeks 40%. There are some ongoing issues with data quality as a result of the use of multiple recording systems but these are being resolved by the team.

Element 2: Fetal Growth restriction – 95% compliant (19/20 interventions full implemented.

- Intervention 2.2 : required compliance 95%
  - Number of women booked who are recommended vitamin D supplementation at booking. At time of review, compliance for July 2024 of 92% was achieved.
  - October data shows WHH now meeting compliance with 96% of records meeting the recommendations. The BadgerNet system has been updated to make documentation of advice regarding vitamin D supplementation a mandatory field.

Action plans are in place for each of the three above interventions.

The next LMNS quarterly review meeting of SBLCBv3 is scheduled for 4 December 2024.

3. MONITORING/REPORTING ROUTES

Progress with the remaining aspect of MIS Year 5 (SBLCBv3), and MIS Year 6 is shared and discussed at CBU Governance meetings. The content of this report will be shared at Women's Health Governance in November 2024.

The LMNS has a key role in reviewing provider evidence and obtaining assurance against the MIS Year 6 requirements. This assurance process has now commenced and the formal timetable has been received. This is provided in appendix one for

information. As part of this assurance process there are also key internal review dates. These are also detailed in appendix one.

4. RECOMMENDATIONS

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

Appendix one - MIS Year 6 assurance process

LMNS Asssurance Timetable

Date	Actions
5th July 2024	LMNS Assurance Board- MIS SA 7 MNVP Action Plan
13 Sept 2024	LMNS Assurance Board- MIS SA 7 MNVP updated Action Plans and confirmation of all requirements of SA 7
15th Nov 2024	• LMNS Assurance Board-sign off SA 7 (if not submitted in time for September Assurance Board) • SBLv3 Q3 evidence submission deadline
18th Nov-29th Nov 2024	LMNS reviewing SBLv3 Q3 evidence on NHS Futures platform
w/c 2nd Dec 2024	LMNS reviewing MIS evidence on NHS Futures platform (SA 3,4,5,6,7,8,9)
w/c 2nd Dec 2024	LMNS have scheduled 1:1 MIS/SBL Provider assurance meetings to feedback on SBL v3 evidence only
w/c 2nd Jan 2025	• LMNS clinical team feedback on final review of MIS evidence on NHS Futures platform • SBLv3 Q3 final position implementation tool to be shared with Providers
17th Jan 2025	LMNS Assurance Board to sign off evidence. LMNS will send LMNS Assurance Board Minutes to Providers as evidence
20th Jan 2025 – 20th Feb 2025	• Providers present evidence to Quality Boards and Trust Boards. • LMNS to be invited to attend the part where MIS Year 6 evidence is being presented and agreed. • LMNS informs the ICB of progress / evidence.
21st Feb 2025	Trust submission form signed by Trust CEO to be sent to CEO of ICS.
24th – 28th Feb 2025	• Integrated Care System CEO signs declaration and form and it is returned to Providers from ICB. • Providers to submit the signed form to NHSR
3rd March 2025	**Trust final submission to NHS Resolution by 12.00 noon**
April 2025	LMNS to receive all Board minutes outlining MIS year 6 position, evidence and action plans where required

WHH internal assurance timetable

Date	Action	Name
8th January 2025 (latest)	Review with Chief Nurse / Deputy Chief Executive	Ali Kennah/Dan Moore
8th January 2025 (latest)	Review and sign off with Chief Executive	Nikhil Khashu
14 Jan 2025	Presentation to Quality Assurance Committee	Ailsa Gaskill-Jones
5th Feb 2025	Present MIS Evidence and presentation to Trust Board	Ailsa Gaskill-Jones
5th Feb 2025	Final sign off by Chief Executive (Board Notification Form)	Nikhil Khashu

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/159 appendix 4**			
SUBJECT:	**2024-2025 Quarter 1 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery, Annabel Grossmith – Consultant Obstetrician & Gyneacologist, Shannon Osbaldeston – Assistant CBU Manager for Paediatrics & Neonatal			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving the principles within ATAIN will have a positive impact on this group.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	• Q1 2024/25 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 6.8%, which is			

	above both the national and NWNODN targets of 6% and 5.6% respectively and is a decrease of 0.1% on the last quarter. • WHH is the only Trust which reports babies that have been admitted to NNU for under six hours; in Q1 WHH had three babies who were admitted to NNU for less than six hours. If these babies were also excluded from the ATAIN admissions the total number of term admissions as a % of live births would be 5.8%. • The team are now exploring how to exclude admissions <6 hours from the WHH data submission whilst still being recorded to facilitate the ATAIN review process. • All term admissions in Q1 were reviewed and learning from these cases informs the ATAIN action plan. • The ATAIN action plan is monitored via WCH Governance. • A quality improvement project is currently underway to put in place a further enhanced transitional care offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/10/157ii**	
	Date of meeting	8th October 2024	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	2024/2025 Quarter 1 Avoiding Term Admission into Neonatal Unit (ATAIN)	AGENDA REF:	BM/24/12/159 appendix 4

1. BACKGROUND/CONTEXT

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

The ATAIN objective is to reduce the number of unexpected term admission of infants ≥37+0 weeks gestation 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 6 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 6 specify the ATAIN action plan should be shared with Trust Board, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meetings.

2. KEY ELEMENTS

WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies that were admitted to the Neonatal Unit (NNU) during the Q1 reporting period from 1st April 2024 to 30th June 2024.

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

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

Summary of unexpected term admissions to NNU

The Q1 ATAIN Rate was 6.8% and higher than the national and NWNODN targets with a slight decrease of 0.1% on last quarter. Whilst we have identified significant themes on review of ATAIN admissions following low risk care, we have not been identifying persistent themes amongst high risk care maternity patients to account for our position as an outlier in the region.

Of the 42 term admissions, three did not require review as part of the ATAIN process as the babies were well and admitted for social reasons, having explored all other available options for care. If these three admissions were not included, this would reduce the ATAIN rate for Q4 to 6.37%.

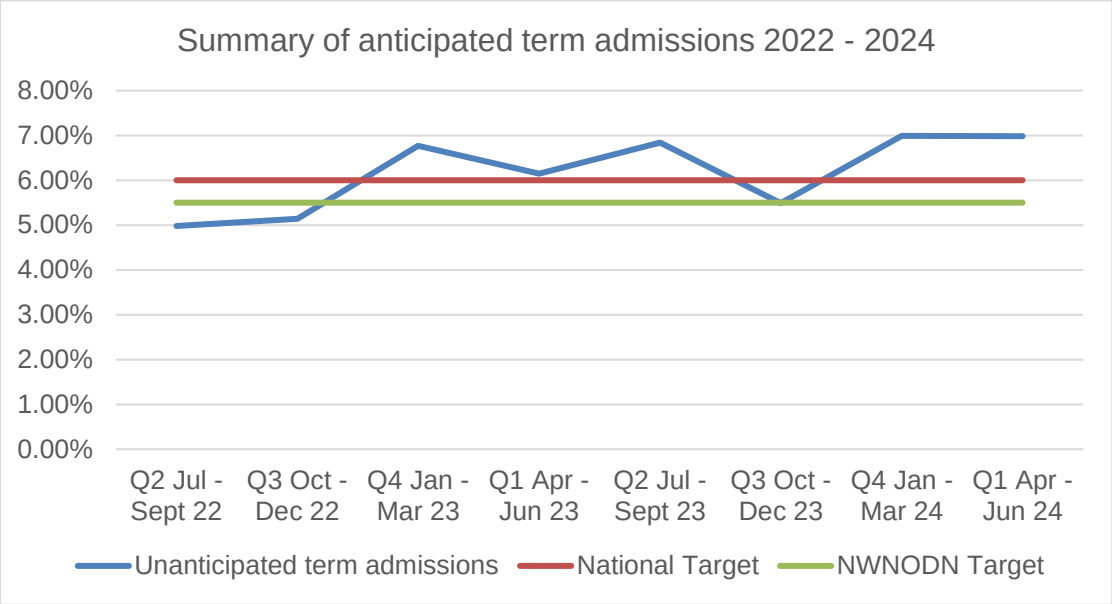
It has also been identified WHH is the only Trust which reports babies that have been admitted to NNU for under six hours; in Q1 WHH had three babies who were admitted to NNU for less than six hours. If these babies were also excluded from the ATAIN admissions the total number of term admissions as a % of live births would be 5.8%.

The QI Lead Nurse for the NWNODN has confirmed that all other Trusts exclude term admissions of <6 hours duration from their data (and from review), which has helped explain the WHH position.

The ATAIN review team strongly feel these cases, which still involve separation of mothers and babies, should be reviewed. Accordingly, the team are now exploring how to exclude this data from impacting our position nationally and regionally whilst still being recorded to facilitate the review process. In the interim, the focus and drive on addressing learning themes using QI projects and individual case learning continues to be the WHH strategy to promote improvements in care.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	National target 6%	NWNODN Target 5.6%
Q2 Jul – Sept 2022	682	34	4.98%		
Q3 Oct – Dec 2022	642	33	5.14%		
Q4 Jan – Mar 2023	635	43	6.77%		
Q1 Apr – Jun 2023	602	37	6.15%		
Q2 Jul – Sept 2023	599	41	6.84%		
Q3 Oct – Dec 2023	619	34	5.49%		
Q4 Jan – Mar 2024	586	41	6.99%		
Q1 Apr – Jun 2024	612	42	6.86%		

Below is a summary of unanticipated term admissions to Neonatal Unit from July 2022 – June 2024.

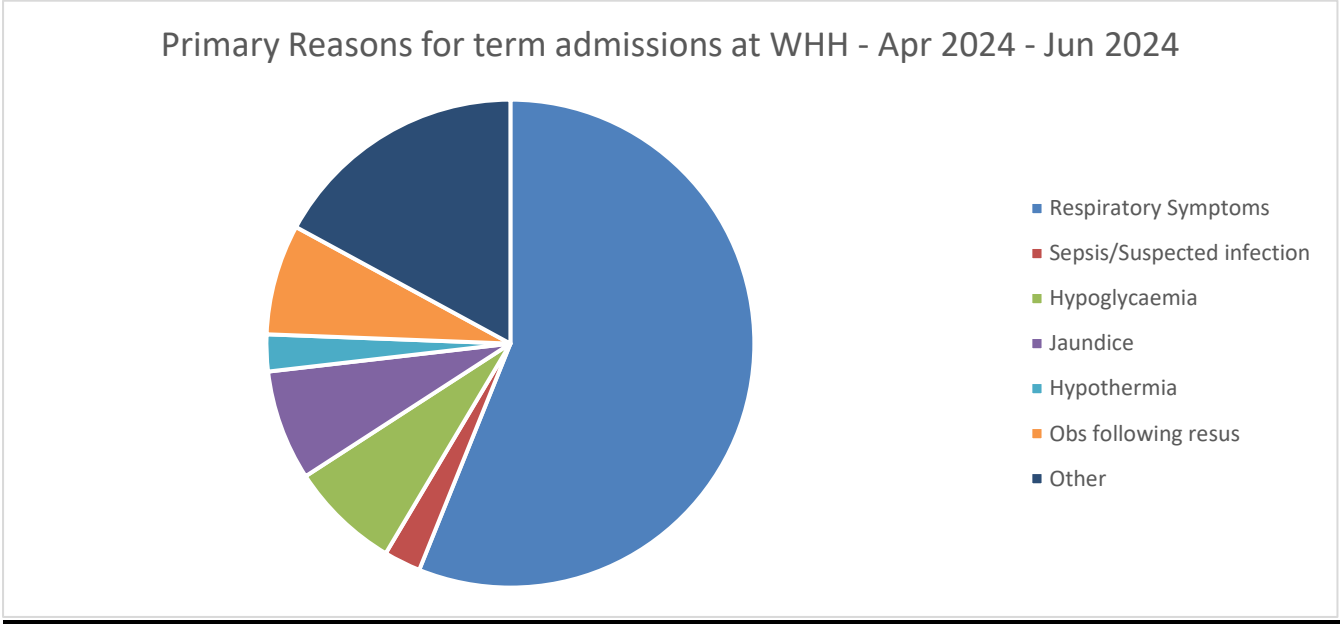


Reasons for term admissions

(recorded on BadgerNet by ATAIN admission criteria)

WHH Number Live Births 2022-2023		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions
Q4 Jan-Mar 2023	635	43	6.77%	19	47.5%	3	7.5%	4	10%	2	5%	1	2.5%
Q1 Apr-Jun 2023	602	37	6.15%	26	70.3%	1	2.7%	1	2.7%	0	0%	3	8.1%
Q2 Jul-Sep 2023	599	41	6.84%	26	63.4%	1	2.4%	0	0%	3	7.3%	2	4.9%
Q3 Oct-Dec 2023	619	34	5.49%	17	50%	0	0%	3	8.8%	2	5.9%	2	5.9%
Q4 Jan-Mar 2024	586	41	6.99%	23	56%	1	2.4%	3	7.3%	3	7.3	1	2.4%
Q1 Apr-June 2024	612	42	6.86%	29	69%	2	4.7%	2	4.7%	1	2.35 %	0	0%

Below is a table of primary reasons for term admissions at WHH:



Over 65% (29) 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). Only 7 of these cases were deemed avoidable if care had been optimal.

Themes and Learning: Outcomes of ATAIN review

WHH Oct 2022 - Mar 2024	Number of Term Admissions	Outcome of ATAIN review		
		Avoidable Admissions	Unavoidable Admissions	% avoidable
Q3 Oct – Dec 2022	33	5	28	15.2%
Q4 Jan – Mar 2023	43	7	32	16.3%
Q1 Apr – Jun 2023	37	7	29	18.9%
Q2 Jul – Sep 2023	41	11	30	26.8%
Q3 Oct – Dec 2023	34	12	22	35.2%
Q4 Jan – Mar 2024	41	13	28	31.7%
Q1 Apr – Jun 2024	42	15	27	35.7%

Reasons for categorising term admissions as avoidable included:

- Caesarean section should have been performed more urgently
- Poor management in intrapartum care of baby
- Hypoglycaemia pathway not followed.

Good Practice:

- 30 minutes of peep project is ongoing and proving to be effective
- Excellent documentation from Obstetric Consultant & Midwives
- Excellent antenatal care enabled mum to make an informed decision about birth plan
- Fantastic collaborative working with other providers

Learning Points/Themes/Actions:

- QI project to be commenced in relation to obtaining and processing cord gas samples.
- Learning from ATAIN points for this quarter around the importance of accurate documentation
- Learning from ATAIN - setting up resuscitaire, and when to escalate deterioration
- Introduction of intermittent intelligent auscultation in the MLC setting.
- NLS training to be rolled out for all midwives attending births in the home environment.
- CTG workshops to commence as we now have consultant and band 6 midwife in post to support fetal surveillance.

Individualised learning and facilitated reflection has taken place for specific intrapartum and postpartum care issues as appropriate with the support of colleagues/supervisors.

Recommendations:

- Continuation of targeted support for staff as required from cases requiring individualised learning.
- Continue regular ATAIN meetings including the introduction of Junior Doctors to the ATAIN meeting to discuss cases and actions/progress with involvement from the wider team.
- Shared learning from ATAIN to continue to be disseminated to all midwifery, paediatric, neonatal and obstetric staff.
- Regular review of ATAIN actions to ensure timely completion.
- Senior midwifery review of all babies to be facilitated on Birth Suite and C23 in order to support early identification of deteriorating babies to allow actions to prevent admission.

3. MONITORING / REPORTING ROUTES

The ATAIN action plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This report will be shared at the March Women's and Children's Clinical Business Unit Governance meeting.

4. RECOMMENDATIONS

Members of the Trust Board are requested to receive and note the findings of this paper for information as per Safety Action 3 of MIS Year 6 recommendations.

COMPLETED ATAIN ACTION PLAN

	Action	Owner	Next Review Date	Target Completion Date	Update	RAG
1	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 Coordinator / Birth Suite Manager / Infant Feeding Co-ordinator	29/09/2023	Completed	Skin-to-skin in theatre has been facilitated and has been added to the theatre safety huddle. Decision made to continue weighing babies in theatre as no cases of admission have been due to hypothermia in theatre this is reviewed on a quarterly basis. This will continue to be under review Wool blankets are in use	
2	Appointment of fetal monitoring lead consultant and fetal monitoring lead midwife as per Ockenden requirements.	Associate Clinical Director / CBU Manager / Director of Midwifery	29/09/23	Completed	03/09/24: currently recruiting to fetal monitoring lead	
3	Audit to take place of all aspects of ATAIN parameters (asphyxia, temperature, jaundice, hypoglycaemia and respiration).	Birth Suite Manager, C23 Manager, Maternity Theatre Co-ordinator	30/04/24	Completed	4/6/24 – Commenced with input from the wider midwifery management team. 25/09/2024 – Ongoing monthly with support from maternity managers.	
4	Improve compliance on Birth Suite to ensure hourly peer reviews of CTG's – this work is currently ongoing and in January we saw a considerable improvement.	Birth Suite Manager Audit and Assurance Midwife	30/04/24	Completed	4/6/24: QI project is ongoing. Compliance had exceeded 90% and continues to be audited monthly. Co-ordinators now peer review every other CTG to ensure oversight and an escalation process is being implemented at present to ensure staff are aware of who to escalate to and when.	
ONGOING ATAIN ACTIONS						

	Action	Owner	Next Review Date	Target Completion Date	Update	RAG
6	NEWTT audit every month to ensure compliance with neonatal observations	Ward Managers	30/04/2024	Ongoing	To be implemented once NEWTT2 has been implemented. 25/09/2024 – Awaiting implementation of NEWTT2, prior to commencement of audit as this will provide clear parameters for staff.	
7	Development of Transitional Care offering to further reduce term admissions and separation of mothers and babies.	Clinical Director	31/03/2024	Ongoing	4/6/2024: TC service has now been implemented however business cases are being developed to increase staffing establishment. MDT meeting held 22/09/2023 to plan funding/staffing/logistics for this. 29/2/24: TC is being provided, but need update as to whether this is consistently staffed yet. 01/03/24: Commenced TC working group. Admission criteria has been simplified and disseminated. Plan made to cover the service 24hrs from NNU and postnatal ward staff. Admissions are being audited and business plan being developed for long term sustainability. All babies admitted to NNU are being audited to see if they could have been cared for on TC to identify any areas of improvement to increase TC offering.	
8	Recommend senior midwifery review of all babies on Birth Suite before transfer to Ward area in order to identify signs of early deterioration to address before admission required	LW	30/04/24	Ongoing	23/08/2024 – Discussion ongoing around staffing model on C23 to look at implementation of supernumerary shift leader on C23.	
9	QI project to give 30 min PEEP in theatre prior to admission to NNU to reduce admission rate	Neonatal CD, ANNPs	1/3/24	Ongoing	QI Project of 30 min of peep is going well and proving to be effective.	
10	Quarterly fresh eyes review group to be established to complete thematic reviews of ATAIN ensure actions are	Assistant CBU Manager,	04/06/2024	Ongoing	As a result of the annual leave period this first meeting is to take place at the end of October when new Assistant CBU Manager is in post.	

	implemented and share learning and good practice	Governance Lead & Maternity Matron				
11	Introduction of IIA across the NEST and homebirth service	Consultant Midwife, Maternity Matrons		Ongoing	23/07/2024 – Email sent to all SLT recommending implementation of IIA in all MLC settings. 04/09/2024 – First session of IIA training completed 11/09/2024 – Continue to capture staff	
12	Alternative cord gas syringes to be procured to support with the ongoing issues around obtaining cord gases. Cord gas QI project to be commenced.	Birth Suite Manager & Maternity Theatre Co-ordinator		Ongoing	24/09/2024 – Birth Suite manager liaising with POC team regarding alternative cord gas syringes, however POC unable to support with alternative, therefore plan to register QI project	
13	CTG workshop to be recommenced, to share weekly learning on the shop floor in relation to fetal surveillance.	Fetal Surveillance Consultant & Fetal Surveillance Midwife		Ongoing		

	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/24/12/159 appendix 5**	
SUBJECT:	**Maternity Update Ockenden Report**	
DATE OF MEETING:	4th December 2024	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		

Further Information:

	Yes	No	N/A
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		

Further Information:

	Yes	No	N/A
3. Foster good relations between people who share a protected characteristic and those who do not			✓

Further Information:
The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.

EXECUTIVE SUMMARY *(KEY ISSUES):*	The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight

	of maternity safety updates. This paper provides the Quality Assurance Committee (QAC) oversight of the update with regards to Ockenden recommendations, and the report will also be noted at Trust Board. In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second report. The WHH Ockenden update as of 31st July 2024 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 100% compliant. • **Ockenden 2**: WHH is 100% compliant. The remaining one outstanding action has been completed. A review of the Ockenden action plan has been completed the Quadrumvirate have agreed to close the Ockenden action plan.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/09/157i**	
	Date of meeting	8 October 2024	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/24/12/159 appendix 5

1. BACKGROUND/CONTEXT

The report will update the Trust Board of the Ockenden report's 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

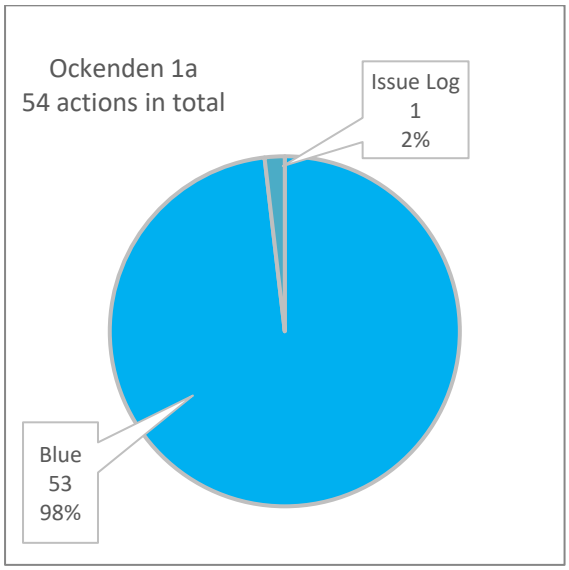
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

2.1.1 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance

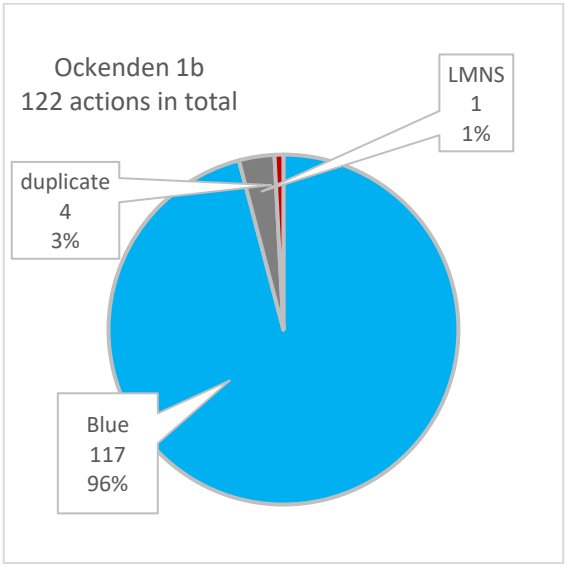


Excluding the LMNS action, Ockenden Part 1a action plan is 100% compliant. This action plan closed following agreement at Moving to Outstanding in February 2022.

2.1.2 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

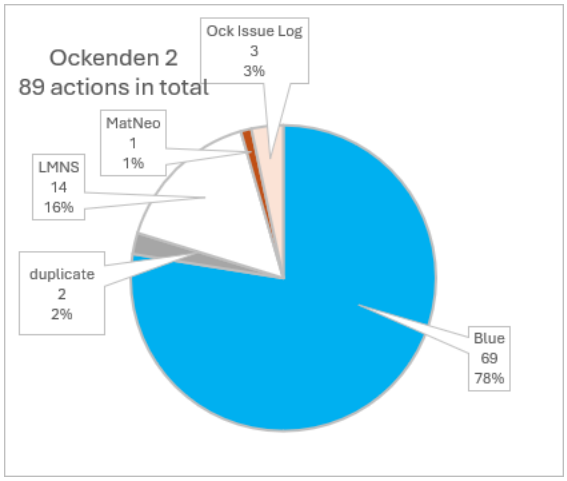


Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is 100% compliant.

2.1.3 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



Excluding the following 20 actions from the initial 89:

- 14 LMNS
- 2 duplicate actions
- 4 (including 1 MatNeo) transferred to an Ockenden Issues Log. These actions require further monitoring and some analysis of audit, and it was agreed to close on the action plan and transfer to an Ockenden Issues Log so that they remain under scrutiny.

The Ockenden 2 action plan is 100% compliant.

WHH Risks for Escalation

- None

a. Ockenden Summary

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

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

A review of the Ockenden action plan has been completed the Quadrumvirate have agreed to close the Ockenden action plan.

3. MONITORING / REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting in October 2024.

4. RECOMMENDATIONS

Members of the Trust Board are requested to receive and discuss the findings of this paper for information.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/159 appendix 7a**			
SUBJECT:	**Maternity Self-Assessment Tool**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information: This paper provides findings following completion of the NHS Maternity self-assessment tool, self-assess whether their operational service delivery meets national standards, guidance and regulatory requirements to ensure a safe, effective maternity service. The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the self-assessment tool are to ensure			

	safer care for this cohort. Achieving the principles within the tool will have a positive impact on this group.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The revised Maternity self-assessment tool is a national assurance tool introduced to maternity providers in response to the Kirkup Report (2015) and Ockenden Report (2020) and findings of outstanding Care Quality Commissioners (CQC) to support trusts to benchmark their services against national standards and best practice guidance. Evidence of completion of the tool is also required as part of the North West Region Maternity Performance Oversight Panel assurance process. The WHH benchmarking update in this report aligns to the key themes identified within the recommended tool: • Directorate infrastructure and leadership • Multidisciplinary team dynamics • Governance infrastructure and ward-to-board accountability • Application of national standards and guidance • Safety culture across the Care Group and Trust • Comprehension of business and impact on quality The Maternity self-assessment tool identifies 159 criteria. As at 31st October 2024, WHH is fully compliant with 124/159 criteria. This equates to 78% of the criteria, an improvement from 73.6% when the last assessment was completed. Actions are underway achieve full compliance. It is anticipated all actions will be completed by the end of March 2025 The detail of the self-assessment is included in appendix 7b. This paper is asked to be noted for information

PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note** ✓	**Decision** ✓
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/11/180iii**	

	Date of meeting	**12 November 2024**
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO TRUST BOARD

SUBJECT	Maternity self-assessment tool	AGENDA REF:	BM/24/12/159 appendix 7a

1. BACKGROUND/CONTEXT

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

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

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

2. KEY ELEMENTS

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

- Directorate infrastructure and leadership
- Multidisciplinary team dynamics
- Governance infrastructure and ward-to-board accountability
- Application of national standards and guidance
- Safety culture across the division and trust
- Comprehension of business and impact on quality

3. MEASUREMENTS/EVALUATIONS

The Maternity self-assessment tool identifies 159 criteria to be evidenced against. As at 31st October 2024, WHH is fully compliant with 124, which equates to 78% of all actions. This is an improvement from the position when the assessment was last completed when compliance was noted against 73.6% of the criteria.

The 159 criteria have been RAG rated as follows:-

- Red 9 (6%)
- Amber 26 (16%)
- Green 124 (78%)

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

- Establishment of a formal maternity safety improvement plan – this is underway as part the development of a quality improvement plan for the maternity service
- Collaborative multiprofessional input to service development and improvement
- Trust wide Schwarz rounds
- Development of a business plan for 12 months prospectively

Activity is underway in relation to all red and amber actions with completion planned as part of the 2024/25 workplan.

The detail of the self-assessment is included in appendix 7b.

4. MONITORING/REPORTING ROUTES

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

Best practice requires the self-assessment tool be completed every six months with a report to Quality Assurance Committee for discussion and for the report to then be shared with the Trust Board. Accordingly a reviewed position will be taken to Quality Assurance Committee in May 2025 and then to Trust Board.

5. CONCLUSION

The Maternity self-assessment tool has been undertaken and the 159 criteria have been RAG rated. 124/159 of the criteria are compliant, which equates to 78% of all actions. Actions are in place to achieve full compliance. This has been developed in conjunction with the wider maternity strategy and transformation action plan, the North West Region Maternity Performance Oversight action plan, the workforce strategy and service equity and equality plans.

6. RECOMMENDATIONS

The Trust Board is asked to note this report for information.

Maternity Self-Assessment tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups	G	Trust/CBU organograms updated July 2023 to demonstrate CBU staffing structures and clinical leadership. Women's and Child Health CBU organogram to be updated to reflect recent changes to CBU Business Manager and Matrons.
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	Quadrumvirate in place comprising CBU Business Manager, Director of Midwifery, Lead Nurse for Gynaecological and Paediatric Services and Clinical Director. All share responsibility for attending specialty, operational and governance meetings within the CBU and Trust wide.
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined	G	Director of Midwifery job description clearly defines the professional accountability for midwifery.
		Agenda for change banded at 8D or 9	G	Position currently filled
		In post	G	Position currently filled
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	In place
		Clinical director to executive medical director	G	In place
		DoM to executive director of nursing	G	In place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		General manager to executive chief operating officer	G	In place
		Maternity services standing item on trust board agenda as a minimum three- monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, ATAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockenden learning actions	G	Monthly Quality & Safety report provided for Quality Assurance Committee for:- • Governance Overview (including Complaints, Patient Safety events) • Maternity Safety & Experience (including Safety Champion themes, FFT, MVP Feedback • MNSI cases • Key safety risks and workplans e.g. Maternity Triage • Workforce metrics and training compliance • Coroner Regulation 28 position Quarterly report: • Transitional care • PMRT • ATAIN Monthly report provided for Quality Assurance Committee for:- • MIS including SBLCB progress Quarterly Staffing Paper provided to Strategic People Committee including NICE red flags audit, workforce metrics All papers are also taken to Trust Board
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	DoM presents to Board at each Board meeting as per Perinatal quality surveillance model as per above

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		There should be a minimum of three PAs allocated to clinical director to execute their role	G	In place. 2 PAs for Clinical Director role, 1 PA for Assoc Clinical Director role.
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	G	Yes.
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	G	HR Business Partner for W&C CBU is Jo-Ann Murphy Matron/Ward Manager 1:1 meetings in place to monitor recruitment, retention, sickness, vacancy and maternity leave. HR support as per Sickness and Absence Policy.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	Senior Business Accountant for W&C CBU is Denise Dugdale.
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	G	Monthly meetings in place with Finance.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	G	Senior operational support in place: Planned Care Group triumvirate consisting of Associate Medical Director, Associate Director and Associate Chief Nurse

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	G	Monthly Women's Health and CBU Governance meeting. Meetings consist of multiprofessional groups to discuss and agree collaboratively on all clinical decisions. Other regular MDT meetings where governance and safety matters are discussed and decisions made: • Intrapartum Review Group • ATAIN Review group • Guideline Review group • Audit meetings
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly	G	• Incident Reporting Group, Audit, PMRT are all multidisciplinary and have identified Chairs. • Ward Manager & Specialist Midwives meeting is chaired by Matrons.
		Leadership culture reflects the principles of the '7 Features of Safety'. **7 features of safety in maternity units** 1. commitment to safety and improvement at all levels, with everyone involved; 2. technical competence, supported by formal training and informal learning; 3. teamwork, cooperation and positive working relationships; 4. constant reinforcing of safe, ethical and respectful behaviours; 5. multiple problem-sensing systems, used as basis of action; 6. systems and processes designed for safety, and regularly reviewed and optimised; 7. effective coordination and ability to mobilise quickly.	A	In place but evidence to be collated to move to green

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Leadership development opportunities	Trust-wide leadership and development team in place	G	Senior leaders are visible to frontline staff. Listening opportunities are provided to staff from both the Quadrumvirate Team and also the Chief Nurse and Non Exec Safety Champion.
		Inhouse or externally supported clinical leadership development programme in place	A	Ward Managers attend monthly Trust Ward Managers Meeting, and also attend a Maternity Managers and Specialist Midwives Meeting facilitated by Maternity Matrons. Matrons attend Trust Nursing and Midwifery Forum. Matron opportunities to attend ad hoc leadership and development training days. Opportunities to complete external leadership educational programmes. RCM Band 7 development programme in train for 2025 Formal leadership programme for aspiring managers band 6 and below or those in senior leadership positions in process of being developed Development of Deputy Manager Band 6 roles for aspiring Band 7.
		Leadership and development programme for potential future talent (talent pipeline programme)	A	Formal leadership programme for aspiring managers band 6 and below or those in senior leadership positions in process of being developed
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	G	Coaching and mentoring are available on an individual needs basis. Service supportive of leadership programmes such as masters level study, nominations to the Florence Nightingale programmes.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	G	Trust/CBU organograms in place to demonstrate lines of accountability.
		Organisational vision and values in place and known by all staff	G	Trust values are published and well understood by staff. Values merit badges are awarded to staff who have demonstrated a high standard for an individual Trust value. Trust wide vision and values strategy is in place. Ward Accreditation programme is used to monitor staff understanding of the Trust vision and values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	Contractual Code of Conduct HR Policies and Process in place. HR full support for advice and escalation where needed.
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years	G	In place
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	G	In place
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	G	Maternity and neonatal strategy was developed with input from staff, MNVP and experts by experience.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	G	MNVP in place. Meets quarterly with rep from Midwifery SLT at each meeting. Consultant Midwife works closely with MNVP on key projects MNVP workplan in place which includes regular 15 Steps challenge. From October 2024 MNVP invited to following: • Monthly Safety Champions Walkaround • Quarterly NED/Quad Meeting • Guideline Review Group • LMNS MNSOG
		Maternity strategy aligned with trust board LMNS and MVP's strategies	G	Complete
		Strategy shared with wider community, LMNS and all key stakeholders	G	Complete
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	G	Jayne Downey is the nominated Non Executive Maternity Safety Champion
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	G	Director of Midwifery and Neonatal Safety Champion participate in the Safety Champions walk arounds. Director of Midwifery and Obstetric Safety Champions attend WH Governance Meetings.
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	G	Programme of 15 Steps Challenge in place Monthly Safety champion walkaround sin place which now include MNVP co-chairs
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	Maternity Safety Champion (Director of Midwifery) attends QAC. Agenda item to present Maternity update report of achievements and challenges. Discussion and actions are recorded in the QAC minutes.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	A	Pathway in place but not formalised
		Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans	A	Quarterly audit days, Obs & Gynae away days and other senior maternity meetings all in place.
	Multiprofessional training programme	Record of attendance by professional group and individual	G	In place and reported monthly to Quality Assurance Committee
		Recorded in every staff member's electronic learning and development record	G	In place
		Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	G	In place
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	G	In place.
		All staff given time to undertake mandatory and job essential training as part of working hours	G	Yes
		Full record of staff attendance for last three years	G	Yes
		Record of planned staff attendance in current year	G	Yes
		Clear policy for training needs analysis in place and in date for all staff groups	G	Yes

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent	G	Yes – recorded in ESR. Compliance for training not accessible in ESR is monitored by the Practice Development Midwife.
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	Yes, Exception Report provided for CBU Governance meeting and discussed at management meetings.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	G	Yes – PROMPT training. Skills and Drills. MAMU 2 (CTG training).
	Clearly defined appraisal and professional revalidation plan for staff	Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	G	Training meets all current NMC revalidation requirements and supports GMC educational requirements.
		All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	Trust standard job descriptions and role profiles in place.
		Compliance with annual appraisal for every individual	A	Trust standard in place for all staff to have annual appraisal. PDR compliance is reviewed by Line Managers and levels of compliance monitored at CBU Management meetings. Current compliance is below 85% threshold. PDR trajectory to achieve full compliance in place.
		Professional validation of all relevant staff supported by internal system and email alerts	G	HR process in place to support monitoring of compliance and notification when professional registration has lapsed or validation is overdue.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	G	HR guidelines in place to support monitoring of capability and performance in the workplace. Staff supported to identify opportunities for professional education and development as part of PDR process. Senior Managers and Leaders accessible at clinical level for staff to discuss training and development opportunities. Rotational midwifery posts support maintenance of midwifery clinical skills
	Multiprofessional clinical forums	Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Dates set annually for GRG, PMRT, WHGG, WACHGG, Departmental Audit
	Multiprofessional inclusion for recruitment and HR processes	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	G	Interviews for senior leadership posts are conducted with an MDT interview panel
		Organisational values-based recruitment in place	G	All job descriptions and interview processes follow values based principles
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	G	Investigation panels have an MDT review process for incident claims and complaints. External representation requested as appropriate. Families are included in investigations where there has been a suspected poor outcome.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	A	No SOP however staff have access to support from Health and Wellbeing Department, Mental Health First Aiders and Counselling Services. Senior Managers and Clinicians offer debriefing opportunities for staff in group settings or on an individual basis following incidents and complaints. Develop local guidance on multiprofessional debriefing of staff. Provide debriefing training for senior leaders and managers who lead formal debriefing sessions.
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	G	Process in place as part of implementation of PSIRF framework
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Schedule of attendance from multiprofessional group members available	G	In place and evidence available
		Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	G	In place and evidence available
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	A	MNVP and service users have been consulted on development of relocation of Triage and IOL. CQC Maternity Service Survey report shared with MNVP and actions/next steps discussed
	Collaborative multiprofessional input to service development and improvement	Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	A	In progress, completion by end of December 2024.
		Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility	A	In progress, completion by end of December 2024
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	A	In progress, completion by end of December 2024

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	A	In progress, completion by end of December 2024
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	G	Trust Knowledge & Evidence Service in place. Includes quarterly Maternity, Obstetrics & Gynaecology Evidence Update Bulletin - October 2024
		Clear communication and engagement strategy for sharing with key staff groups	R	Not in place
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	A	In progress, completion by end of December 2024.
	Multiprofessional approach to positive safety culture	Weekly/monthly scheduled multiprofessional safety incident review meetings	G	Initial Safety Review and Intrapartum review group meetings take place weekly led by Trust Governance and includes CBU Ward Managers, Senior Managers, Clinical Staff – Midwifery, Gynaecology and Neonatal.
		Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	A	Quarterly Trust shared learning forum in place. Maternity included on agenda. Maternity also standing agenda item at Patient Safety & Experience Committee. LMNS to be invited to future shared learning sessions.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Positive and constructive feedback communication in varying forms	G	SCORE Survey completed and Perinatal Cultural Leadership action plan in place. Trust Values badges awarded for exemplary behaviour. Safety Huddle Meeting highlights areas of good practice to be shared trust wide. Weekly Safety Brief provided to staff via Ward Managers. DOM monthly update provided to all staff. Ward Managers and Senior Leaders provide written and verbal feedback to individuals. Case on a page tool used to share feedback along with patient stories
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	G	All incident reviews have the opportunity to identify good practice. This is fedback to staff at the time of the review.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience.	G	Line managers and Matrons will link in with more junior colleagues following complex cases.
	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	G	
		Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	A	In place. Need to capture evidence
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they do not become normalised.	A	In place. Need to capture evidence

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	All policies and procedures align with the trust's board assurance framework (BAF)	G	Yes
		Governance framework in place that supports and promotes proactive risk management and good governance	G	Dedicated Governance Lead for Women's and Children's Health Department . Obstetrics and Gynaecology Governance Leads in place. Trust wide governance strategy in place. Governance activities and outcomes at speciality and CBU level meetings.
		Staff across services can articulate the key principles (golden thread) of learning and safety	G	Monthly newsletter circulated to staff with maternity lessons learned. Single point lessons developed to support ad hoc learning for incidents. Action plans are developed in response to lessons learned from incidents claims and complaints. Action plans are monitored through departmental governance meetings. Our Wise Learning (OWL) and learning from MNSI case on a page shared with staff.
		Staff describe a positive, supportive, safe learning culture	G	CQC report provided positive evidence of this. Feedback from Safety Champion walkaround would further support this..
	Maternity governance structure within the directorate	Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	G	Corporate Governance Team in place with identified WCH Governance Leads. Corporate governance systems and practices are followed at Departmental level.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support	G	• Integrated Governance Lead in post (current RM with NMC pin) • Consultant Obstetrician governance lead in post • Specialist Midwife - Audit & Assurance in post • Specialist Midwife - Practice Development in post • Specialist Midwife Retention in post (supporting preceptorship programme) • Specialist Midwife - Practice education in post • MDT Intrapartum group in place to lead and review clinical incidents • Maternity risk manager - not in post however management of risk by the Deputy DoM and DoM (both NMC registrants)
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	G	Governance responsibilities are clearly described in Job Plans. Individuals are allocated as leads in maternity specific improvement initiatives such as MIS, SBL, ATAIN.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales	G	CBU and Corporate Governance monitoring systems in place to monitor compliance with deadlines and authorise extensions as required.
	Maternity-specific risk management strategy	In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	A	Maternity Risk Management Strategy is included in the Trust Risk Management Strategy.
		Clearly defined in date trust wide BAF	G	Yes

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	G	Reporting templates are available for all trust wide meetings. Work plan in place to highlight when specific reports are required for meeting agendas.
	Proactive shared learning across directorate	Mechanism in place for trust-wide learning to improve communications	G	Learning shared via daily safety meeting and safety brief to all staff. Various meeting forums to share learning and good practice. .
		Mechanism in place for specific maternity and neonatal learning to improve communication	G	**Various tools used:** • SEE Boards • Our Wise learning • Single point Lessons • Training Train • Area specific safety briefs? • MNSI Case on a page • Face to face listening and learning sessions held following adverse events
		Governance communication boards	G	Safe, Effective, Experience (SEE) boards provided in all clinical areas by Integrated Governance Lead – sharing all information and learning relating to Governance.
		Publicly visible quality and safety board's outside each clinical area	G	All wards have quality safety boards visible.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Learning shared across local maternity system and regional networks	G	DoM, Dep DoM and other members of the senior team will attend a variety of LMNS/regional quality/improvement meetings including: • LMNS Maternity and Neonatal safety Group with shared learning key aspect of meeting • WHAM operational group
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	Maternity Service has participated in safety collaborative initiatives and learning events. Staff attend LMNS learning events and safety initiatives
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	R	Not in place
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Multi-agency input evident in the development of the maternity specification	G	ICB engagement meetings in place to discuss maternity performance and quality outcomes.
		Approved through relevant governance process	G	In place
		In date and reflective of local maternity system plan	G	In place
	Application of CNST 10 safety actions	Full compliance with all current 10 standards submitted	G	Achieved full MIS Year 5 compliance in 2024
		A SMART action plan in place if not fully compliant that is appropriately financially resourced.	N/A	
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	Yes
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines	G	Guideline Review Group in place with guidelines circulated for MDT comment prior to approval

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.	G	Multiprofessional meetings in place. Schedule available.
		All guidance NICE complaint where appropriate for commissioned services	G	Compliance is monitored as a governance function and reported through governance meetings. Where no compliance is reported a risk assessment and action plan to achieve compliance is developed.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	G	Compliance is monitored as a governance function and reported through governance meetings. Where no compliance is reported a risk assessment and action plan to achieve compliance is developed
	Saving Babies Lives care bundle implemented	All five elements implemented in line with most updated version	A	Saving Babies Lives Care Bundle v.3 (SBLCBv3 implemented
		SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	G	The latest external review took place of Saving Babies Lives Care Bundle v.3 on 4 September 2024. Feedback confirmed 96% compliance overall for the 6 elements. Four out of the six elements are 100% compliant. Action plans in place for remaining aspects.
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan	G	Trajectory for improvement in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Application of the four key action points to reduce inequality for BAME women and families	All four key actions in place and consistently embedded	G	Local maternity systems are asked to increase support for at-risk pregnant women (Covid) – complete Reach out and reassure pregnant BAME women with tailored communications (Covid) - complete Minimise the risk of Vitamin D insufficiency – in place and monitored as part of Saving Babies Lives Care Bundle v.3 Make sure you are gathering the correct data – data collection completed via BadgerNet
		Application of equity strategy recommendations and identified within local equity strategy	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan.
	Implementation of 7 essential learning actions from the Ockenden first report	All actions implemented, embedded and sustainable	G	Action Plan for the 7 essential learning actions from Ockenden first report complete.
		Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	Fetal Surveillance midwife post well established. Previous post holder resigned August 2024, new postholder appointed (0.6fte), start date December 2024
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	G	In place
	A-EQUIP implemented	Plan in place for implementation and roll out of A-EQUIP	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. Design of 2025 workplan underway
		Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. Design of 2025 workplan underway

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. Design of 2025 workplan underway
	Maternity bereavement services and support available	Service provision and guidance aligned to national bereavement pathway and standards	G	Regional Pathway in place.
		Bereavement midwife in post	G	7 day service in place
		Information and support available 24/7	G	Bereavement Champions have received training from Bereavement Midwife to ensure 24 hour support for staff and families.
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	G	Dedicated Family Rooms available.
	Quality improvement structure applied	Quality improvement leads in place	G	Deputy Dom is lead within the Maternity service. Maternity team also work closely with the Trust Quality Academy.
		Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	A	Monthly Maternity Innovation meetings established led by the Maternity Matron. Support provided from the Quality Academy. Formal plan underway. Completion by 31/12/2024
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	Safety Collaborative focussed on QI methodology and some staff have attended the trust wide QI training sessions provided by the Quality Academy, utilising recognised and approved quality improvement tools and frameworks.
		Established quality improvement hub, virtual or otherwise	G	Trust wide Quality Academy in place, plus monthly Maternity QI meetings established.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	MatNeoSip embedded in service delivery	Listening into action or similar concept implemented across the trust	G	Trust engages with varied MatNeoSip project. NHSE Perinatal Cultural Leadership programme completed with included SCORE survey and implementation of action plan to support improved culture.
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	G	NHSE Perinatal Cultural Leadership programme completed with included SCORE survey and implementation of action plan to support improved culture.
	Maternity transformation programme (MTP) in place	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	A	QIP underway. Completion by 31/12/2024
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	A	Will be included as part of QIP underway. Completion by 31/12/2024
		Standing agenda item on key directorate meetings and trust committees	A	Once QIP in place will report quarterly to speciality governance and Quality Assurance Committee/Board. Completion by 31/12/2024
		Human factors training lead in post	A	External provider identified and training scheduled.
	Freedom to Speak Up (FTSU) guardians in post	FTSU guardian in post, with time dedicated to the role	G	Trust wide guardians in post with identifiable lanyards. Guardians receive time to support role Anonymous reporting system in place.
	Human factors training available	Human factors training part of trust essential training requirements	A	Human factors training programme is being implemented as part of the PSIRF implementation
		Human factors training a key component of clinical skills drills	G	Human factors included as part of Prompt training
		Human factors a key area of focus in clinical investigations and formal complaint responses	G	Key aspect within PSIRF. Work to do to embed

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas e.g., antenatal/postnatal ward/triage.	G	SOP in place, regular audits undertaken
		Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	G	In place
	Safety huddles	A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	G	In place
		Guideline or standard operating procedure describing process and frequency in place and in date	G	Need evidence to support
		Audit of compliance against above	A	In place, evidence to be collated
	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	R	Not yet in place
		Multiprofessional attendance recorded and supported as part of working time	R	As above

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Broad range of specialties leading sessions	R	As above
	Trust-wide safety and learning events	Trust-wide weekly patient safety summit led by medical director or executive chief nurse	G	Weekly safety Oversight meeting in place
		Robust process for reporting back to divisions from safety summit	G	Weekly meetings between Governance lead for Women's & Children's CBU and director of Midwifery including reporting back
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	G	Quarterly Trust wide Shared Learning Forum in place
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	G	In place
Comprehension of business/ contingency plans impact on quality. **(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	In date business plan in place	R	Formal plan will be developed for 2025
		Meets annual planning guidance	R	Formal plan will be developed for 2025
		Business plan supports and drives quality improvement and safety as key priority	R	Formal plan will be developed for 2025
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	A	Formal plan being developed for 2025 but measures to ensure workforce needs are met and safe staffing is in place are included with the Maternity & Neonatal Workforce Strategy, reported to QAC and Strategic People Committee and included in assurance related to the Maternity Incentive Scheme.
		Consultant job plans in place and meet service needs in relation to capacity and demand	G	Yes, monitored by CBU Business Manager
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	Yes, monitored by CBU Business Manager

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Business plans ensures all developments and improvements meet national standards and guidance	G	Yes, monitored by CBU Business Manager/quadrumvirate
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	R	Formal plan will be developed for 2025
		Business plans include dedicated time for clinicians leading on innovation, QI and Research	R	Formal plan will be developed for 2025
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	G	Included as part of Maternity & Neonatal Strategy 2024-26
		Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan including key workstreams related to pelvic health, infant feeding, smoking and enhanced provision for BME women and women in the most deprived deciles.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

Maternity Service - Review of harm events – September 2023-August 2024

Ailsa Gaskill-Jones – Director of Midwifery

Lisa Davies – Governance Lead Midwife

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Grading of harm – Context

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Changes in the way providers record patient safety through guidance published in August 2023 as part of the implementation of the learning from patient safety events framework (LFPSE)
- This includes assessing the degree of harm which relates to the actual impact on a patient from the particular incident being reported.
- This builds on the previous assessment guidance in the National Reporting and Learning System (NRLS) and maintains the principle.
- Patient safety incident harm definitions should always be applied based on the best information about the actual impact of the incident at the time of recording.
- The new addition in the policy guidance in relation to patient safety incident data in the LFPSE service relates to specific capture of information on psychological harm.
- Previously in the NHS, harm grading included psychological harm as well as physical harm within one measure, in the new guidance and reporting these are now split out into two separate measures.

New physical harm grades	New psychological harm grades
No physical harm	No psychological harm
Low physical harm	Low psychological harm
Moderate physical harm	Moderate psychological harm
Severe physical harm	Severe psychological harm
Fatal	n/a

Grading of physical harm

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

No physical harm
No physical harm

Low physical harm is when **all of the following** apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment.
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit.
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication.
- did not or is unlikely to affect that patient's independence.
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm is when **at least one** of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe harm is when **at least one** of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

- You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Grading of psychological harm

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

No psychological harm

- No specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm is when **at least one** of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

WHH harm events Sept 23-Aug 24

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Harm	LFPSE grading	WHH position	Assurance pathway
Neonatal mortality (refers to the number of babies which have died within the first 28 days of life)	Fatal	➢ WHH Neonatal mortality rate during Q1 2024/2025 was 0.0 per 1000 live births. ➢ The MBRRACE-UK national neonatal rate is 1.64/1000 live births.	➢ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper ➢ All cases reported to MBRRACE ➢ Select criteria referred to MNSI for investigation (>37weeks following labour and died within the first 7 days) ➢ Comparator rates and learning from cases reported via quarterly PMRT to QAC and Board
Intrauterine death (>24 weeks gestation)	Moderate	➢ WHH stillbirth rate for Q1 2024/25 was 1.60 per 1000 births. ➢ WHH annual Mean stillbirth rate (2023/24) is 2.71 per 1000 births. ➢ The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ All cases reported to MBRRACE ➢ Intrapartum Term stillbirths referred to MNSI for investigation ➢ Comparator rates and learning from cases reported via quarterly PMRT to QAC and Board
3rd & 4th degree tears	Moderate	➢ 36 cases Sept 23-Aug 24 ➢ 1.49% of births	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ Not noted as an outlier in regional metrics
PPH >1500mls	Low – occasionally moderate	➢ 97 cases Sept 23- Aug 24 ➢ 93 low harm, 4 moderate harm ➢ 4% all births ➢ Awaiting updated regional data	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ PPH workstream standing item within monthly QAC Quality & Safety paper

WHH harm events Sept 23-Aug 24

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Harm	LFPSE grading	WHH position	Assurance pathway
Babies transferred for cooling	Moderate	➢ 5 cases Sept 23-Aug 24 ➢ 0.2% all births	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ Intrapartum cases referred to MNSI for investigation ➢ Overview of MNSI referrals/investigations to be shared quarterly to QAC and Board from October 2024
Gynaecological interventions	Case dependent	➢ 1 case Sept 23-Aug 24	➢ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper
Dropped baby	Case dependent	➢ 1 case Sept 23- August 24 - low harm	➢ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper
Term admission to Neonatal Unit	Unavoidable - No harm Avoidable – Low harm	➢ July 23-June 24 (most recent data) – 6.53%	➢ Not meeting national/regional targets – query re data under discussion as per Q1 2024/25 ATAIN paper ➢ Quarterly reporting of position to QAC ➢ Action plan in place
Neonatal birth trauma	Case dependent	➢ Two cases Sept 23- Aug 24 ➢ 1 low harm, 1 moderate harm ➢ 0.08% of all births	➢ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper

WHH harm events Sept 23-Aug 24

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Harm	LFPSE grading	WHH position	Assurance pathway
Maternal VTE	Low – occasionally moderate	➢ Two cases Sept 23- Aug 24 ➢ 1 low harm, 1 moderate harm ➢ 0.06% of all women booked	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper
Pressure Ulcer	Case dependent	➢ 5 cases Sept 23- August 24 - all low harm ➢ 0.2% all births	➢ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/159 appendix 9a**			
SUBJECT:	**Midwifery Summary Safe Staffing Report**			
DATE OF MEETING:	4th December 2024			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of staffing matters to ensure a safe service. The paper also relates to workforce measures, in a majority female workforce. In ensuring safe staffing this will support the service in maintaining staff wellbeing in this group.			

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The purpose of this paper is to provide assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents. This paper provides an overview of the staffing position at as 31st October 2024 and red flag position for the period July-September 2024 alongside other key workforce metrics. This paper will also provide specific assurance in relation to safety standards as follows: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. • Evidence the maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. • The midwife: birth ratio The calculated total midwifery workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 116.70wte, which includes an additional 10% for non-clinical roles. The midwifery funded establishment at the 31st October 2024 was 128.36wte. The vacancy rate for registered staff as at 31st October 2024 is 0.62%. Midwifery retention rates remain good with turnover at 7.96% at the end of October 2024. Rates below the Trust target have been maintained since December 2023. Sickness rates for October 2024 for registered midwifery staff were 9.88%, this is an increase and

	significantly higher than the Trust target. It is a similar rate to October 2023 when the rate was 9.51%. Monitoring of safe staffing levels is a requirement of the Maternity Incentive Scheme (MIS) Safety Action 6. Within the maternity service, staffing red flags across the maternity service are recorded within the Safe Care module of the health roster. As part of Safety Action 6 there is a requirement to closely monitor two key measures: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour In the period 1st July-30th September 2024 there was no occasions where the Birth Suite Coordinator was not supernumerary at the beginning of the shift. There was one occasion where Birth Suite Coordinator was not supernumerary (for a short period). In the period 1st July-30th September 2024 there was one episode flagged where a woman in active labour did not receive one-to-one care. A red flag was incorrectly raised as the episode was for a short period while transfer to Birth Suite for ongoing care was arranged. An action plan is attached for information. A midwifery workforce deep dive has been completed. This is included in appendix 9b for information.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**Midwifery Summary Safe Staffing Report**	
	Date of meeting	20th November 2024	
	Summary of Outcome		

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

REPORT TO TRUST BOARD

SUBJECT	Midwifery Summary Safe Staffing Report	AGENDA REF:	BM/24/12/159 appendix 9a

1. BACKGROUND/CONTEXT

The purpose of this paper is to provide assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents. This paper will provide specific assurance in relation to safety standards as follows:

- Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.
- The provision of all women receiving one to one midwifery care in active labour

This paper provides an overview of the midwifery staffing position at as 30th October 2024 and red flag position for the period July-September 2024 alongside other key workforce metrics.

2. MIDWIFERY ESTABLISHMENT

This report summarises the current funded and actual staffing establishment as of the 31st October 2024 in comparison to the Birthrate Plus® report and recommendations.

A full maternity workforce planning review using the nationally recognised Birthrate Plus® workforce planning tool was completed in March 2022. This full review followed a desktop review and audit submission undertaken as part of the Ockenden work programme. Birthrate Plus® considers clinical complexity, the number of births, the location of birth and the number of women cared for by Warrington and Halton Teaching Hospitals staff as well as those women who receive care from other providers but who choose to give birth at Warrington and Halton Teaching Hospitals. An additional percentage is added for specialist roles and managers within the service.

The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust as at January 2022 was 116.70wte, which includes an additional 10% for non-clinical roles. At the time of the Birthrate Plus® review there was a positive variance of 5.52wte registered midwives which supported the implementation of the rostered model for Continuity of Carer.

The Maternity funded establishment at the 31st October 2024 is 128.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 31st October 2024 shows a further positive variance of 6.04wte. This further variance is the result of the addition of a number of new full time and part specialist midwifery roles to the midwifery establishment since January 2022 alongside an increase in WTE in some existing posts.

These changes have been made to meet the requirements of external reviews, national recommendations and frameworks including the Ockenden Report recommendations and the Maternity Incentive Scheme Years 4 and 5 (incorporating the Saving Babies Lives Care Bundle. All new posts have been funded within the service via reallocation of existing establishment or via external funding streams. The variance in establishment also includes the increase in establishment agreed via a recent revenue request to support a safer more sustainable maternity triage service.

Review of the maternity workforce using the Birthrate Plus® workforce planning tool is required every three years. Accordingly a full review will be required to be completed by March 2025 in line with Maternity Incentive Scheme Year 6 - Safety Action 5. Work has commenced to complete this assessment and compliance will be monitored as part of the service's usual assurance processes for the Maternity Incentive Scheme.

3. MIDWIFERY RED FLAGS

3.1 Background

A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing with associated risk to the women and babies. If a midwifery red flag event occurs, the midwife in charge of the service should be notified, who should then determine if midwifery staffing is the cause and the action needed. Monitoring staffing red flags is recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015).

NICE Midwifery Red Flags include:

- Delay in induction of labour
- Delay in administration of analgesia
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit.
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

1.2 WHH Midwifery Red Flags

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

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

- Delay in ongoing IOL
- Delayed MOEWS
- Missed/delayed observations.
- IOL handover to C23
- Shortfall in RM time
- Birth Suite Coordinator NOT Supernumerary
- AMBER Alert – Acuity
- AMBER Alert – Staffing
- Inadequate Triage
- Delay in review of a CTG
- Delay in Medical review in triage >30min
- Delay in triage >15mins

3.3 WHH Midwifery Red Flags reported

Where a red flag is raised, this is escalated to the bleep holder and appropriate mitigation/support is provided to resolve the issue. There have been no harm events as a result of issues within the red flag escalation process.

A red flag audit action plan is in place to resolve issues identified as part of the quarterly audit.

Table 1 below details red flags raised in Q2 2023/24.

Table 1 - Midwifery Red Flags reported (July - Sept 2024)

	Number of Red Flags raised		
Red Flag Reason	July 2024	Aug 2024	Sep 2024
Delay in med review triage >30min	28	22	10
Delay in review of CTG	2	0	0
Delay in triage >15min	9	1	0
Delay in triage >30min	2	1	1
Delayed IOL	3	3	0
Delayed MEOWS	1	0	0
Delayed >30min Pain relief	1	0	0
Full clinical examination not carried out when presenting in labour.	0	0	0
Inadequate Triage	2	1	1
Missed Medication	0	0	0
Delay in administration of analgesia	0	0	0
Missed/Delayed Observation	2	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0
Any occasion where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	0	0
Delay in ONGOING IOL	6	8	4
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0
Shortfall in RM Time	32	20	17
Birth Suite Coordinator NOT supernumerary	1	0	0
AMBER Alert - Staffing	3	5	3
AMBER Alert - Acuity	0	0	1
IOL Handover to C23	7	2	0
Time critical activity	1	0	0
Unable to provide Transitional Care	0	0	0

3.3.1 Birth Suite Coordinator NOT Supernumerary

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

In the period 1st July-30th September 2024 2024 there is one episode recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary.

This occurred at a time of high acuity and was for a short period of time while other clinical staff could be redeployed. There are no occasions where there was not a supernumerary Birth Suite Coordinator at the beginning of the shift.

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

If there is an occasion where a woman in active labour is NOT receiving one-to-one care the Birth Suite Coordinator will escalate to the Maternity Bleep Holder and mitigating action is taken to address the issue. A red flag is recorded on SafeCare.

In the period 1st July-30th September 2024 2024 there is one episode recorded in in SafeCare where a woman in active labour is **NOT** receiving one-to-one care.

In this case the Midwife was allocated to the Induction of Labour (IOL) suite. An IOL patient become established in labour. The midwife cared for this patient for a short time while transfer to Birth Suite for ongoing care was arranged. A red flag was incorrectly raised as this episode related to the short period while ongoing care was arranged.

3.3.3 Actions to ensure Birth Suite Coordinator supernumerary and One-to-one care and support to a woman during established labour

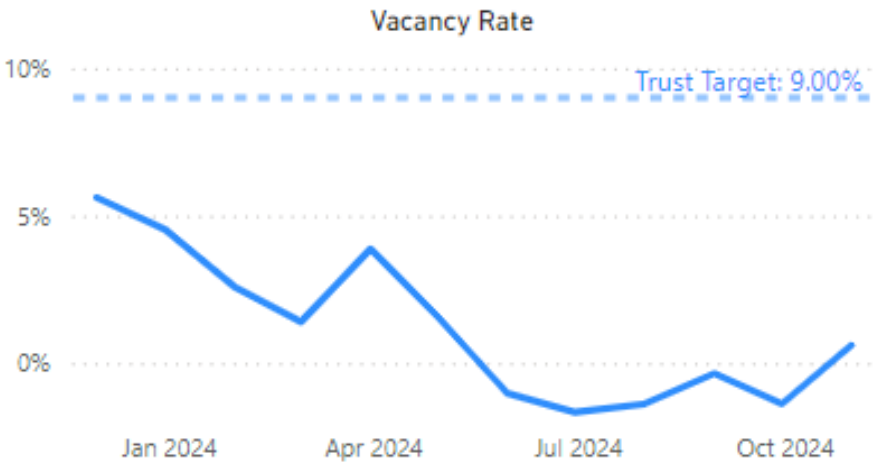
Work is already ongoing to ensure the Birth Suite Coordinator remains supernumerary and that there are robust processes for ensuring women receive one to one care as soon as they are established in labour. This work is included in the action plan detailed below:

Action	Lead	Start date	Due Date	RAG rating
Complete recruitment processes to all midwifery vacancies	Tina Moors	1/7/2024	31/10/2024	
Submit revenue request to increase midwifery establishment to support triage staffing and release capacity elsewhere	Ailsa Gaskill-Jones	1/8/2024	31/10/2024	
Implement updated midwifery rotation processes to ensure staff are able to flex to all areas at time of high acuity	Ward Managers	1/9/2024	31/10/2024	
Clarify the responsibility of Specialist Midwives to be available to work clinically when required to do so	Tina Moors	1/10/2024	31/11/2024	
Work with team to clarify when red flags should be raised and ensure consistency of reporting	Kim Farrell	1/11/2024	30/11/2024	
Complete recruitment of additional staffing resource following approval of Triage establishment revenue request	Kim Farrell	1/11/2024	31/1/2024	

4. WORKFORCE METRICS

4.1 Vacancy rate

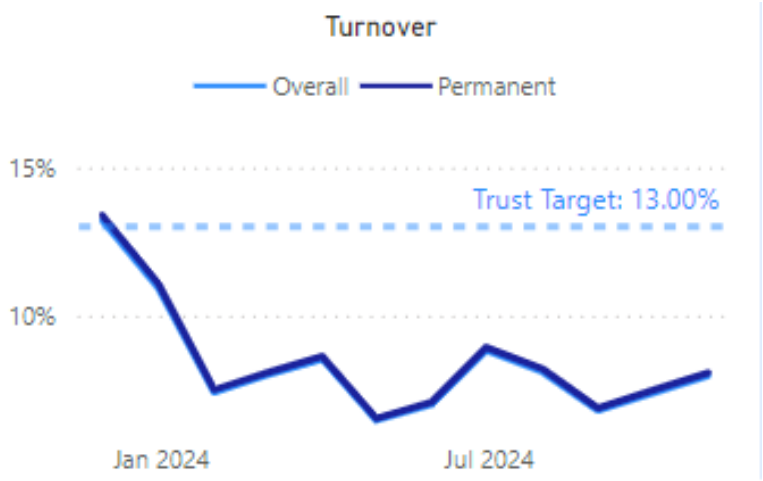
The vacancy rate for registered staff as at 31st October 2024 is 0.62%. This is a significant decrease from the end of Q4 2023/24 when the rate was 5.66% and continues the significant improvement from the end of January 2023 when the vacancy rate was 18.29%.



There are a number of midwives who will be retiring during Q3.Recruitment has been completed to backfill the majority of these vacancies with 8 newly qualified midwives commencing during November and December. Processes are underway to complete the remaining recruitment of band 6 experienced midwives to ensure the service can maintain appropriate skill mix..

4.2 Retention/turnover rate

Midwifery retention rates remain good with turnover at 7.96% at the end of October 2024. Rates below the Trust target have been maintained since December 2023.



4.3 Sickness absence

Sickness rates for October 2024 for registered midwifery staff were 9.88%, this is an increase and significantly higher than the Trust target. It is a similar rate to October 2023 when the rate was 9.51%. Proactive management of matters relating to workforce are ongoing.

5. MIDWIFERY WORKFORCE DEEP DIVE

As has been previously reported, despite a significantly improved midwifery retention position and a vacancy rate below the Trust target since November 2023 red and amber staffed shifts persist and there have been eight maternity diverts since August 2023 due to staffing and acuity. In the period January-July 2024 the maternity service was in escalation (as per the North West maternity escalation policy) at the start of the day on 19 occasions (amber 13 occasions, red 4, black 2). To understand this better a deep dive of workforce and acuity factors was completed. This highlighted there are a number of multifaceted reasons identified a number of factors at play which impact on staffing:

- Establishment uplift (headroom) not representative of absence.
- Impact of maternity leave
- Impact of other workforce factors e.g. supernumerary, flexible working and restrictions on clinical duties
- National ask re implementation of Birmingham Symptom Specific Obstetric Triage system (BSOTs)
- Impact of measures to ensure retention of staff especially newly qualified
- Changes in service delivery including relocation of Maternity Triage, establishment of Nest MLU, increased caesarean section rates, longer length of stay
- Complexity of families receiving care has increased

Next steps

- Recruitment of additional midwifery resource to support national ask re BSOTs for Triage as per recently agreed revenue request
- Birth rate+ assessment to be completed January 2025
- Findings to be discussed at next Midwifery senior team meeting to identify any further actions/improvement to workforce planning to reduce the impact of these factors

The detail of the deep dive is attached for information in appendix 9b.

6. RECOMMENDATIONS

Members of the Trust Board are requested to receive and note the findings of this paper with regard to midwifery staffing.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Workforce deep dive – November 2024

Ailsa Gaskill-Jones – Director of Midwifery

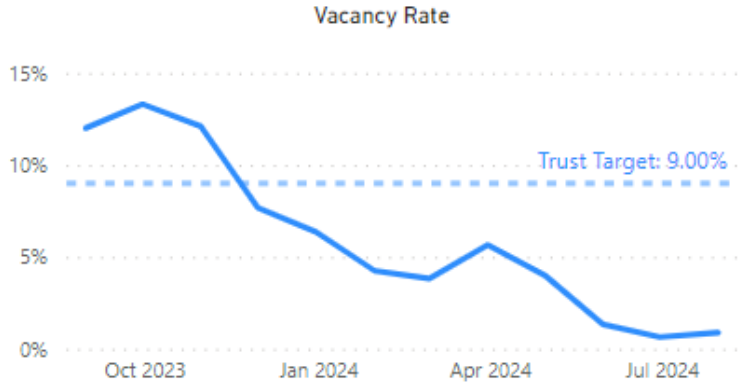
Tina Moors – Deputy Director of Midwifery



Background

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Increased clinical midwifery posts April 2019 v April 2024 (total increase 23.93fte.
- Increase largely to reflect national agenda regarding specialist midwifery services and leadership capacity
- Increase in band 6 establishment 8.74fte Band 6
- Significantly improved midwifery vacancy position 2024 compared to 2023
- Vacancy rate below Trust target since November 2023
- Specialist midwives and ward managers work clinically as part of their rostered shifts either as bleep holder or in support of telephone triage. These staff are also key resource at times of escalation.
- Despite this red and amber staffed shifts persist
- 8 maternity diverts since August 2023 due to staffing and acuity
- Service in escalation (as per the North West maternity escalation policy) at the start of the day on 19 occasions Jan-July 2024 (amber 13 occasions, red 4, black 2)
- Service an outlier regarding delays in induction of labour pathways compared to other Cheshire & Mersey providers
- Ongoing reliance on NHSP including enhanced rates to ensure safe staffing
- Total cost of NHSP April-June 2024 £380,042 (potential annual cost 24/25 £1.1m)
- Additional cost of utilising enhanced rates May-July 2024 £5483 (potential annual cost £21,934)



Deep dive findings

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Multifaceted factors at play:

- Establishment uplift (headroom) not representative of absence.
- Impact of maternity leave – not included in establishment uplift
- Impact of other workforce factors e.g. supernumerary, flexible working and restrictions on clinical duties
- National ask re implementation of BSOTs for Triage
- Impact of measures to ensure retention of staff especially newly qualified
- Changes in service delivery – relocation of maternity Triage, establishment of Nest MLU
- Complexity of care has increased

Establishment uplift

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	YEAR			
	2021	**2022**	**2023**	**Average**
% of establishment - Annual Leave	12.45%	11.22%	11.85%	11.84%
% of establishment -Training (maternity specific only)	2.46%	2.14%	2.95%	2.52%
% of establishment -Training (Trust mandatory & role specific)	0.89%	0.70%	1.07%	0.89%
% of establishment - Maternity Leave	4.43%	3.96%	4.85%	4.41%
% of establishment - Sickness (from dashboard)	10.15%	9.72%	6.98%	8.95%
TOTAL	**30.39%**	**27.73%**	**27.70%**	**28.82%**

- Ockenden recommended all maternity providers review absence data for the previous three years with a view to ensuring minimum staffing levels include a calculated uplift, representative of absence (including maternity leave).
- Increasing ask in relation to maternity specific mandatory training required to ensure compliance with Maternity Incentive Scheme
- The three-year average for WHH is 28.61% compared to a current Trust uplift of 23%. This equates to 6.7fte registered midwives.

Other workforce factors

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Impact of other workforce factors e.g. supernumerary, flexible working and restrictions on clinical duties

Currently 43 RMs with either flexible working agreements (all appropriately reviewed) or with occupational health restrictions.

19 RMs with OH restrictions including:

- 13 with restrictions related to the intrapartum setting. Of these 11 cannot provide intrapartum care on Birth Suite, 1 cannot do night shifts and 1 cannot work on the Nest
- Whilst staff are deployed in a way which reflects their restrictions, of the staff who you would expect to be able rotate to Birth Suite this equates to 5.74fte not able to work in this area
- 3 Specialist RMs have restrictions of where they can work at time of escalation

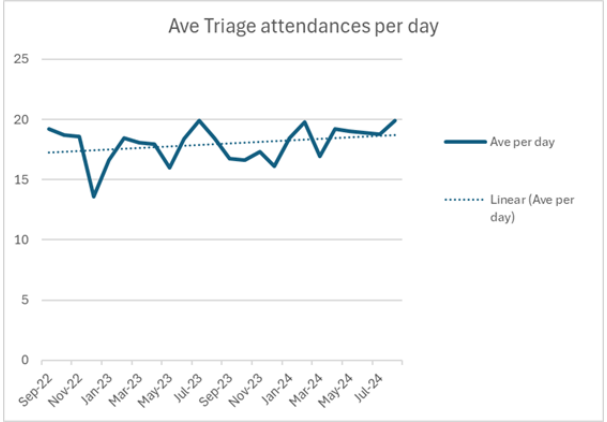
There are 3.0fte internationally trained RMs currently completing their preceptorship. All remain supernumerary.

Changes in service delivery since 2019

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Opening of the Nest (MLU) and relocation of Maternity Triage to the ground floor footprint required redeployment of midwifery establishment
- Implementation of Birmingham Symptom Specific Obstetric Triage System (BSOTS) model requires provision of a dedicated Triage team and increased establishment.
- Currently staffed via formal movement of establishment from CoC and flexing of staff from other areas
- Triage attendances have shown an upward trend since September 2022
- National guidance in relation to induction of labour (IOL) has changed which has sustained high rates of IOL (over 50% of births) and associated outcomes (e.g. emergency caesarean, instrumental birth and length of stay)
- More women choosing elective caesarean section as mode of birth - again impact on outcomes and length of stay

Rate	2018/19	2023/24
Induction of labour	55%	51.3%
Emergency caesarean section	17%	26.4%
Elective caesarean section	14.2%	17.7%
Ave length of stay	2.19 days	2.7 days



Increased complexity of families

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Maternity Complex Cases	2023	2024	Comparible Data
Perinatal Mental Health Specialist Midwife Jan - June			
Perinatal MH Referals	37	175	↑ 138
Perinatal MH Parents in Mind	23	60	↑ 37
Total PMH	**60**	**235**	**↑ 175**
Team River 6 Months Data January - June			
Bookings	146	153	↑ 7
Complex Cases			
Drug Misuse	4	7	↑ 3
Alcohol Misuse	14	19	↑ 5
Social Services Involvement	102	195	↑ 93
Domestic Abuse	102	157	↑ 55
LD	85	101	↑ 16
Non English Speaking	71	73	↑ 2
MH	462	683	↑ 221
Homelessness	3	7	↑ 4
Asylum Seekers	12	13	↑ 1
FGM	7	7	↔ 7
Total Complex Cases	**862**	**1262**	**↑400**
Additional Duties			
CP Conferences inc Report	22	26	↑ 4
CIN	29	38	↑ 9
PMH	8	4	↓ 4
Multi Agency Strategy	11	16	↑ 5
Early Essential Referals	17	21	↑ 4
Total Additional Duties	**87**	**105**	**↑ 18**

- Complexity of need/care has increased significantly
- Increase in relation to mental health, families where domestic abuse is a factor and where there is the involvement of social care
- Specialist Midwife - Perinatal Mental Health and Team River provide continuity of care to women and families with additional vulnerabilities but level of complexity will create activity felt across the maternity service

Conclusion

- Despite increase in band 6 establishment and significantly improved midwifery vacancy position 2024 compared to 2023 red and amber staffed shifts persist
- Have been several maternity diverts since August 2023 due to staffing and acuity and Trust an outlier regarding delays in induction of labour pathways
- Detailed review of workforce has identified increase in acuity/complexity of workload alongside a potential shortfall in Midwifery establishment due to several factors

Next steps

- Birth rate+ assessment will take place January 2025
- Findings to be discussed at next Midwifery SLT meetings to identify any further actions/improvement to workforce planning
- To share and discuss with the Chief Nurse
- To share with maternity safety champions and Strategic People Committee

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Reason	FTE
Shortfall in uplift	6.71fte
Supernumerary staff	3.0fte
Unable to work in intrapartum settings	5.74fte

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/129**			
SUBJECT:	**Communications and Engagement Update – Q2 2024-25**			
DATE OF MEETING:	4 December 2024			
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report updates on communications and engagement activity during quarter 2 of 2024-25. It incorporates the quarterly reporting on the Working with People and Communities Strategy and elements of the previous Communications and Engagement Dashboard into one report. The report consists of: • Overview of Q2 communications and engagement activity from July 2024 to September 2024 • Updates on Experts by Experience activity and involvement • Key communications campaigns and highlights from Q2			

	• Working with People and Communities Strategy Q2 2024-25 update Details of the current plan of upcoming engagement events which the Trust is hosting or attending during autumn / winter 2024 and dates currently scheduled for 2025		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the quarter.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors	
	Agenda Ref.	COG/24/11/64	
	Date of meeting	14 November 2024	
	Summary of Outcome	To note	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and engagement update
Quarter 2 2024-25 (July to September)

Trust Board

Kate Henry, Director of Communications and Engagement
4 December 2024



Our role within WHH

The Communications and Engagement Team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including – content development for trust's corporate social media channels and updates to the website
- Identity, branding and design
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information

During the Q2 period (July to September 2024) the Communications and Engagement Team…

- processed and allocated **45** communications 'Job Requests' for design, film, photography and communications campaign support
- prepared / issued a total of **9** media statements
- issued **9** media releases
- arranged and facilitated **1** media feature
- handled **13** enquiries from local, regional and national print and broadcast media

Q2 activity and achievements overview

- Delivered both a new intranet and website during August / September
- Provided design support for the introduction of WHH Charity donation stations across Trust sites and relaunched the ‘Pennies from your payslip’ campaign / payroll giving
- Started to redevelop the website for Warrington, Halton, St Helens and Knowsley Breast Screening Service
- Developed initial communications and engagement approaches with Bridgewater colleagues to support the Better Care Together programme
- Supported Cheshire and Merseyside Endoscopy Transformation Programme with an opening event for the new Endoscopy Hub
- Provided communications support for governor elections campaign
- Supported NHS Staff Survey campaign and staff flu / COVID campaigns
- Re-introduced a monthly Stakeholder Bulletin
- Updated Production of Patient Information Policy and initiated policy approval process



Details of other communications and engagement activity is included in the highlights section of this update.

Media

The Trust issued 9 media releases and 1 media feature during Q2 including:



WHH maternity initiative shortlisted for the HSJ Patient Safety Awards
Read the release



Warrington and Halton patients can manage appointments online
Read the release



New garden balcony to transform care for patients on Intensive Care Unit
Read the release



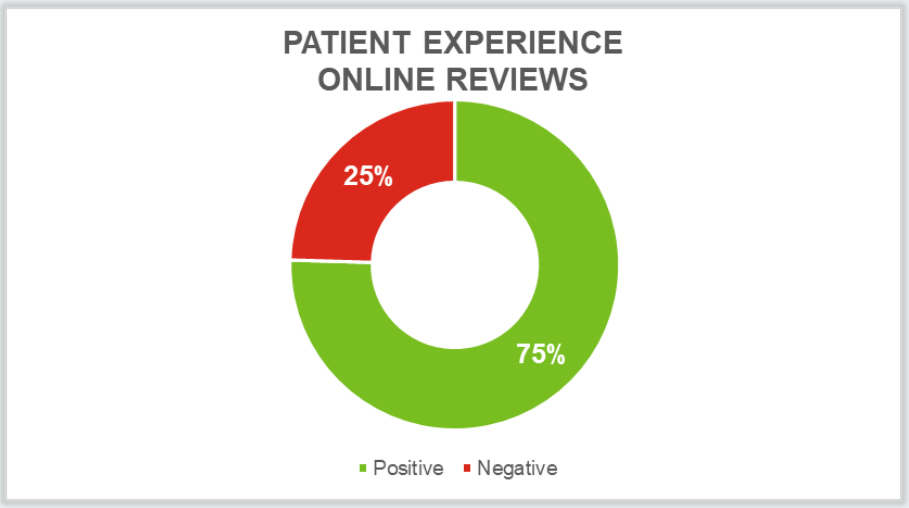
Expectant parents urged to take up new RSV vaccination
Read the release

Engagement, involvement and insight

During Q2 (July to September 2024) we recruited 19 Experts by Experience (EbyEs)

We received requests for engagement support for the following projects:

- Signage and wayfinding survey
- Translation and interpretation service feedback
- Digital questionnaire feedback for COPD / lung conditions
- PLACE Assessors recruitment
- EbyE equality and diversity monitoring



A total of 53 online reviews from patients rating their WHH experience were published in Q2.

Sources of data:

- NHS Choices
- Google reviews
- I want great care

Experts by Experience (EbyE) projects

Project Name	Overview	No of EbyEs req	Outcomes
Signage and wayfinding survey	Request for EbyE feedback on Trust signage, maps and wayfinding	Unlimited	• 23 EbyEs participated in survey • 15 EbyEs recruited to join future work • 2 Governors recruited to join Task and Finish Group
Interpretation and translation services survey	Request for EbyE feedback on current WHH interpretation and translation services	Unlimited	• 7 EbyEs participated in survey • Feedback shared with project lead (Patient Experience Team)
PEP - digital questionnaire feedback for COPD / CPAP	Request for EbyEs to inform PEP questionnaires for patients with experience of respiratory conditions	Unlimited	• 2 EbyEs recruited to take part in questionnaire development and testing
PLACE Assessors	Request for EbyE involvement in PLACE assessments, exploring how environment supports provision of clinical care	2	• 2 EbyEs recruited • Assessments held 07/10/2024

Experts by Experience projects (continued)

Project Name	Overview	No of EbyEs req	Outcomes
EbyE demographics survey	Request to explore representation within EbyE programme	Unlimited	• 36 EbyEs participated in survey • Final results to be built on, to ensure community representation within EbyE programme
Website user testing	Request for EbyE testing of newly redeveloped website (via 16 tasks)	Unlimited	• 14 EbyEs participated in testing • 3 staff participated in testing • Website pathways moved following feedback, with search engine functionality improved

Local / national campaigns shared with EbyEs: 3

- Ageing Well in Warrington (Warrington Borough Council)
- Runcorn Old Town investment (Halton Borough Council)
- Pharmacy First (Healthwatch Warrington)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

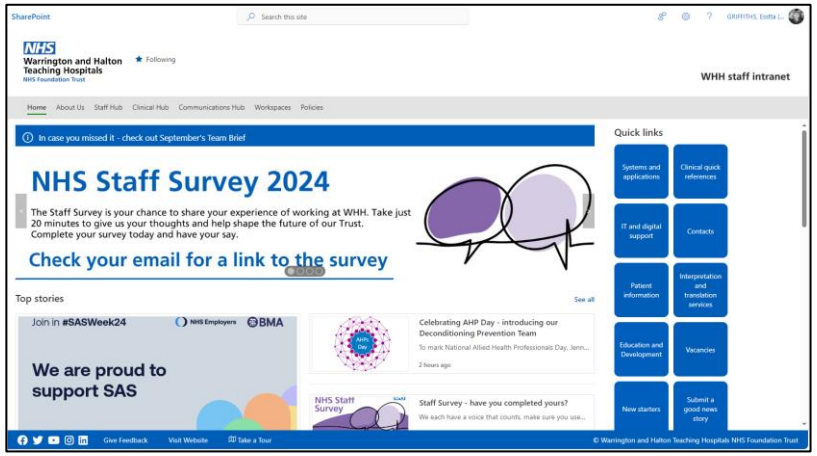
Key campaigns / highlights from Q2

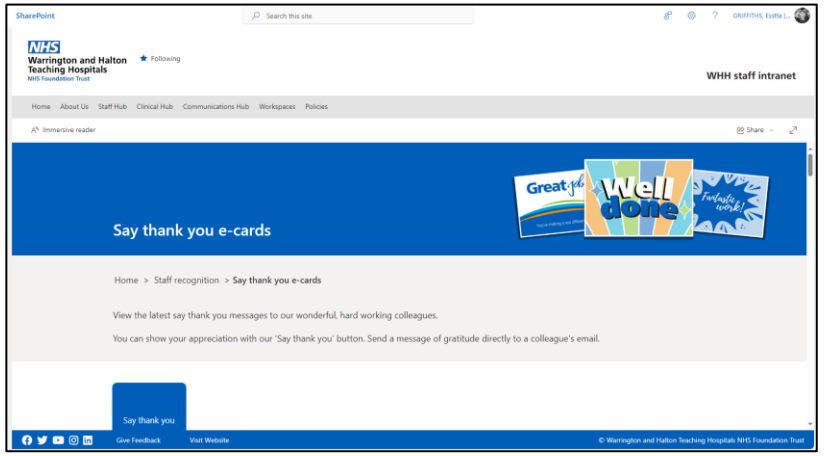
Intranet launch

A complete redevelopment of the Trust's **intranet on the SharePoint platform went live on 22 August 2024**:

New features

- Dedicated 'Hub' pages (including three key areas - staff, clinical and communications)
- New display system for applications and systems, including quick links
- Redeveloped team workspaces
- Links to share good news stories
- e-cards/messages to thank colleagues
- Online staff events calendar





Intranet analytics and feedback

First month activity (September 2024)

Overall traffic

- Average unique viewers: 1,016
- Site visits: 163,104
- Average daily site visits: 5,624

Top three most popular pages (after home page)

1. System: 8,565 views
2. Staff Hub: 5,033 views
3. Workspaces: 2,823 views

Device usage

- 99% of traffic comes through the desktop – a mobile SharePoint app is due to be launched in 2025

"I love the new intranet it's very easy to use with everything in one place. Well done WHH."

Suzanne Miller, Staff Nurse

"I very much like the appearance of the new site, and the quick links make searching a lot easier."

Julie Ann Kiernan,

Clerical Worker

‘Say thank you’

A new function added to the intranet to allow staff to say thank you or congratulate their colleagues on a job well done has proved popular.

In addition to a post on the home page, it sends an e-card to recipient via email with the full message and details of who has submitted it. In September (the first full month since launch) 42 messages were shared.

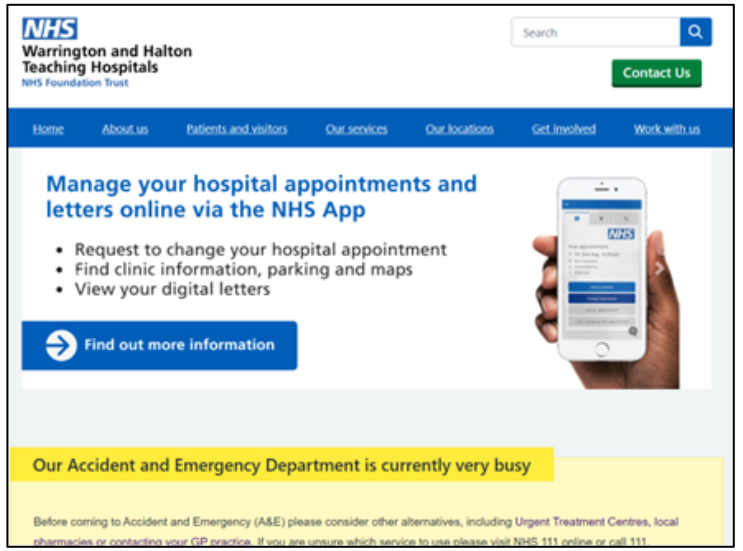
Recipient	Message	Card	
CORNTHWAITE, Kathryn	Kat has been very instrumental in helping me organise our Shared Learning Forum and other events. Her organisational skills and value are commendable!	Fantastic work!	1 like
CARR, Michelle DEAN, Susan	Thank you for coordinating and leading the Inclusion Masterclass, this was received very well and will make such a difference, thanks for being you!	Well done	1 like
CARR, Michelle DEAN, Susan	Thank you for arranging and facilitating a brilliant Inclusion Masterclass yesterday. Well done!	Fantastic work!	1 like
BARLOW, Sophie	Congrats on completing your specialist portfolio (finally!!!)	Great job!	1 like
DIXON, Abbey	A big thank you for all your help over the last couple weeks!	Thank you	1 like
FALLON, Christopher MORRISON, Amy REDDINGTON, Matthew FURFIE, Tim	Just wanted to say thank you for all of the extra work in supporting the Trust in managing the financial position with the extra scrutiny on orders.	Thank you	1 like
DONEGAN, Susan DOBSON, Matthew MASTERS, Daniel TWIGG, Jane DENBRABER, Rebecca STOREY, Julie	The team have successfully built an new trust induction to offer an immersive and engaging start with our organisation. Starting 07/10/24.	Fantastic work!	1 like

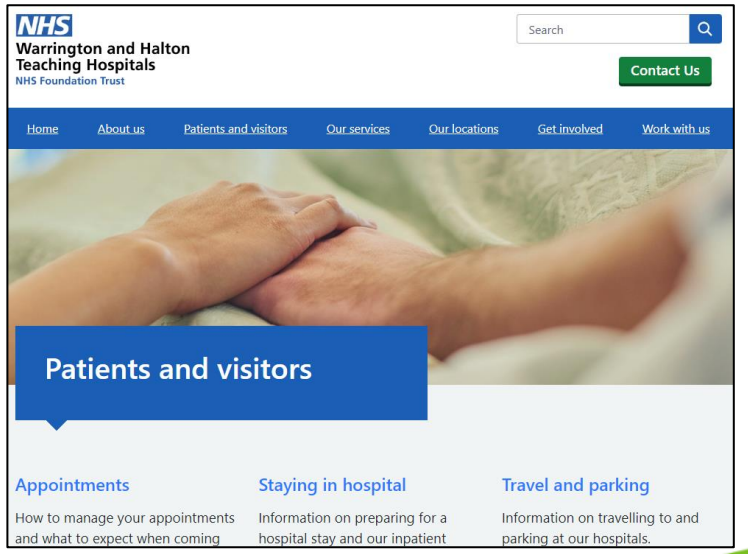


Website redevelopment

Fundamental principles

- Clear NHS branding using NHS templates
- Simplification of information
- Consistent format for service and location entries
- Clearer navigation structure
- Reduced image use (must include alt text)
- Mobile friendly
- Built using the ‘3-click rule’
- Web Content Accessibility Guidelines (WCAG) 2.2 compliant
- Celebrate and explain accreditations
- Housekeeping process for review of all sections





Website redevelopment engagement

Involvement stages (with Experts by Experience unless otherwise stated):

- Website redevelopment survey (Nov 2023)
- Equality and Health Inequalities Impact Assessment (EHIA) completed
- Online website redevelopment session (May 2024)
- Individual website redevelopment session (May 2024) with a specific focus on accessibility for people who are visually impaired
- Governor Engagement Group demo (July 2024)
- Accessible form testing (August 2024)
- User testing of set navigation tasks - included staff, governors, EbyEs, Healthwatch and community partner / advocacy groups (August / September 2024)
- Website showcase (September 2024)
- **Website launched 18 September 2024** with a feedback form to gather further feedback from users

Website analytics and feedback

First month activity (18 September to 17 October 2024)

Overall traffic

- Total unique users: 31,123
- Total page views across the site: 104,928

Top three most viewed pages (after home page)

1. Job vacancies: 10,695 page views
2. Our services: 3,447 page views
3. Work with us: 3,326 page views

Device usage

1. Mobile: 20,140 users (64.9%)
2. Desktop (computer or laptop): 10,234 users (33%)
3. Tablet: 667 users (2.1%)

"Generally [the new site is] much better."

Claire Kirk

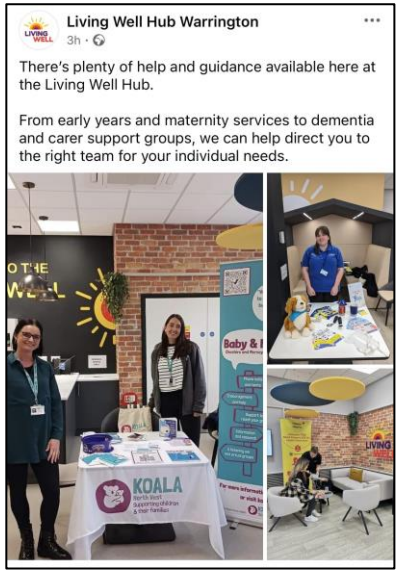
"So much easier to read. The previous website seemed cluttered and hard to navigate."

Suzanne Taylor,
Expert by Experience

Living Well Hub

- Extensive coverage undertaken to mark the first six months of the Living Well Hub and the milestone of its 5,000th visitor through the doors.
- Media reports included a double page spread in the print edition of the Warrington Guardian.
- NHS Property Services also spent a day filming video interviews with staff and representatives from many of the partners involved.
- Dedicated new Living Well Hub Facebook page launched in October which gained more than 600 followers in its first two weeks.
- Communications worked with the hub team to create branded templates, draft content and provided advice and guidance in relation to our Trust style and social media policy.





Endoscopy Hub opening

On Friday 6 September we invited staff, contractors and colleagues from Cheshire and Merseyside Endoscopy Transformation Programme's Endoscopy Network to celebrate the opening of the new £5m Endoscopy Hub at Halton Hospital Nightingale Building.



The hub comprises:

- three new endoscopy rooms
- state of the art Olympus scopes
- a five-bed recovery area



For more information read WHH's news article.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy
Q2 update

Pillar 1: Co-production in Service Change/ Development

Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 37 Experts by Experience recruited during 24/25 (19 in Q2). • 165 Experts by Experience total (cumulatively to date). • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs from the outset of projects (#StartwithPeople). • Hosted 2 stands at community events to promote EbyE recruitment.(DAD and Warrington Mela).	• Ongoing
2. Support EbyE recruitment and retention	• 10 EbyE Projects delivered in 24/25 (plus 2 extended projects – PEP, WHH website). • Pending EbyE projects have been cleared from 2023/24. • 84 EbyEs (currently) participating in Q2 projects.	• Ongoing
3. Enhance our programme for involvement	• Annual involvement timetable for Awareness Days and Events informs engagement plan – dependent on team availability (see slides 21 and 22). • Ongoing discussions with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement / representation.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• Inclusion of EbyE engagement from beginning of significant projects e.g. WHH website redevelopment has continued. • Ongoing EbyE participation to be included in Q3 projects including Breast Screening Service website redevelopment and Better Care Together engagement approach.	• Ongoing
5. Ensure representation to support Place-Based integrated care delivery	• Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy/equality groups. • Involvement of PLACE leads within project events e.g. Endoscopy Hub launch, upcoming Q3 EDS work.	• Ongoing

Pillar 2: Accessible Information Standard (AIS)

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient Letters	• Patient Engagement Portal (PEP) launched in Q2 / Q3, in partnership with DrDoctor. • Work has commenced on tendering for a new Electronic Patient Record (EPR) system to succeed the current system, Lorenzo. Functionality to support accessible information and communication needs will be key to this development.	• 2024-25
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• Current website design and content has been developed in line with Web Content Accessibility Guidelines (WCAG) 2.2. • A new Trust website (and intranet) have been launched in Q2. Overall feedback has been positive, with both designs felt to be more accessible and easier to use. • Work has begun on a new more accessible website for the Warrington, Halton, St Helens and Knowsley Breast Screening Service based on the Trust website accessibility approach.	• Ongoing
3. Accessible content creation	• The maternity series of six animations to provide information to women and families during pregnancy have now been uploaded to the new Trust website and Badgernet. Videos include subtitles and interpretations of five languages most commonly requested by users of the service, plus British Sign Language.	• Ongoing
5. Patient Information	• An updated Patient Information Policy has been developed and is awaiting ratification to reflect increasing use of subtitled videos to support patients as part of the clinical pathway in addition to leaflets. • Awaiting completion of digital system changes to launch Communications Passport – see update on EPR above.	• Ongoing
7. Signage/Wayfinding	• Delivered via Wayfinding and First Impressions programme.	• Ongoing

Pillar 3: Reducing Health Inequalities

Using WHH engagement and understanding health inequalities to geographical areas of Warrington North, Warrington South, Widnes and Runcorn

1. Strengthen WHH engagement programme	• Work ongoing with collective WHH teams (Patient Experience and Inclusion, Workforce EDI / Culture and Inclusion, Membership and Governance, Children / Young People, Dementia, Staff Health and Wellbeing team, charity, volunteers, chaplaincy, catering/estates, ward/service reps) to set/link events calendars and activities for 2024/25. • Relaunched Quarterly WHH events meetings to be scheduled in Q3, co-hosted by Engagement and Involvement/Patient Experience, to discuss and agree 2024/25 plans together.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. speaking with visitors about the constituencies they represent, showcasing their roles, sharing info, collecting details of visitors interested in becoming a WHH Foundation Trust Member. Events undertaken in Q2 were: ✓ WHH Shared Learning Forum ✓ Warrington Mela	• Ongoing
3. Support Place Based activity and other key local events	• Ongoing promotion of Warrington Living Well Hub via WHH social media. • Endoscopy Hub opened in September 2024.	• Ongoing

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key campaigns, health improvement and economic wellbeing initiatives. • Support Wellbeing Enterprises to promote the Active Travel project, being delivered from WHH's Halton Health Hub. • Inclusion of Apprenticeship Team information (and attendance where available) in Trust and community engagement events e.g. Warrington Mela. • Ongoing Team sharing of '350 Careers, One NHS, Your Future' booklet and online link to information.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer in order to enhance the aspirations and life chances of local people. • Level of engagement with social media and websites. • Promoted upcoming Clinical Careers event (Halton) in October 24.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Cherry Tree Courtyard hub – working with People Directorate to ensure this facility is accessible and available to support patient / community engagement where appropriate. • Continue work with charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at Patient Experience Sub Committee (PESC) and Patient Equality, Diversity and Inclusion Sub-Committee (PEDISC). • Charity stakeholder and staff newsletters created and shared monthly.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2024 / 25

Date	Event	Time	Venue	Event purpose
20 May 25	WHH International Clinical Trials Day	10am to 2pm	Atrium Warrington Hospital and George Lloyd Restaurant, Halton Hospital	Trust-led, annual event promoting the accomplishments of clinical research professionals in public health/medicine and their efforts in clinical trials.
June 25	Warrington Pride	TBC	Warrington town centre / Golden Square	Annual partnership event celebrating the LGBTQIA+ community in the town.
28 June 25	Warrington Armed Forces Day	9am to 6pm	Crosfields Rugby Club, 91 Hood Lane North, Warrington, WA5 1ET	Annual community event comprised of Armed Forces Rugby League games, military displays, stands and activities.
13 July 25	Disability Awareness Day	10am to 4pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual family fun day and pan-disability event led by Warrington Disability Partnership.
Sept 25	Warrington Mela	TBC	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion within the town.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/130**	
SUBJECT:	Bi-monthly Strategy Highlight Report	
DATE OF MEETING:	4 December 2024	
AUTHOR(S):	Megan Wainwright, Strategy Project and Team Support Officer	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

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

	Further Information:		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	• A single Chief Executive Officer has been appointed for Warrington and Halton Hospitals NHS Trust and Bridgewater Community Healthcare NHS Trust. Nikhil Khashu started in post on 1st November. • The Living Well Hub in Warrington has seen over 7,500 visitors attend since the doors opened in mid-March 2024. Around 55% of these attendances have been people "dropping in" to the hub to access a service, and the remainder have been for pre-booked appointments. • Over 64,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023. • A new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is due to be implemented by the end of the year. Clinical posts are currently being recruited to and the project team are engaging with primary and secondary care colleagues to develop the clinical pathway. • Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. A high-level strategic case for change has been approved along with the high- level milestone plan. Workstream teams are developing delivery plans and the Clinical and Operational services group have facilitated their first workshop to bring senior clinical and operational staff together to shape the way forward and begin prioritising services for integration. • The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to Urgent Community Response (UCR) and Same Day Emergency Care (SDEC) have increased and are consistently above target, ED attendances are down by 4% compared to the same period last year and time spent on the ED corridor has reduced from 10 hours to 4. Trusted assessor and direct referrals have been implemented in Halton. Over 65 admissions remain a challenge. • The contract was recently signed to develop a new virtual health and wellbeing hub for Warrington following work to secure funding and support from across place partners.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**

RECOMMENDATION:	The Trust Board is asked to note this report for information.	
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.	

Strategy update
September-October 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Section 1 - Key messages	
Slide 2	Summary of key developments this reporting period
Section 2 - Stakeholder engagement	
Slide 3-5	Summary of key stakeholders engaged during the reporting period

Section 3 - Key strategic projects

Page	Project	Strategy Lead	Status
Slide 6-7	WHH/BCH Integration programme	Hayley Heard	
Slide 8-9	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 10-11	Community diagnostic centre	Stephen Bennett/Lefteris Zabatis	
Slide 12-13	New hospitals programme and strategic estates	Carl Mackie/Viviane Risk	
Slide 14	Completed projects	Strategy team	

Section 4 - Other trust strategic updates	
Slide 15-17	Summary of other Trust strategy related updates
Section 5 - Place-based strategic updates	
Slide 18	Summary of strategic updates from local places (Warrington and Halton)
Section 6 - Cheshire and Merseyside strategic updates	
Slide 19	Summary of strategic updates from Cheshire and Merseyside

Key messages

- A single Chief Executive Officer has been appointed for Warrington and Halton Hospitals NHS Trust and Bridgewater Community Healthcare NHS Trust. Nikhil Khashu started in post 1st November.
- The Living Well Hub in Warrington has seen over 7,500 visitors attend since the doors opened in mid-March 2024. Around 55% of these attendances have been people “dropping in” to the hub to access a service, and the remainder have been for pre-booked appointments.
- Over 64,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023.
- A new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is due to be implemented by the end of the year. Clinical posts are currently being recruited to and the project team are engaging with primary and secondary care colleagues to develop the clinical pathway.
- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. A high-level strategic case for change has been approved along with the high- level milestone plan. Workstream teams are developing delivery plans and the Clinical and Operational services group have facilitated their first workshop to bring senior clinical and operational staff together to shape the way forward and begin prioritising services for integration.
- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to Urgent Community Response (UCR) and Same Day Emergency Care (SDEC) have increased and are consistently above target, ED attendances are down by 4% compared to the same period last year and time spent on the ED corridor has reduced from 10 hours to 4. Trusted assessor and direct referrals have been implemented in Halton. Over 65 admissions remain a challenge.
- The contract was recently signed to develop a new virtual health and wellbeing hub for Warrington following work to secure funding and support from across place partners. A new project manager has now commenced in post to lead the project over the next 12 months.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Fiona Watson	Public Health, Halton	One Halton- SRO delivery group
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates
Naz Ghodrati	CEO, Warrington Voluntary Action	Warrington and Virtual Hub, UEC Steering group
Ian Triplow	CDC Programme Director, Cheshire & Merseyside	Community Diagnostic Centre
Damian Nolan	Director Commissioning and Provision, Adult Social Care, Halton Borough Council	Urgent and Emergency Care System Improvement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme and Virtual Hub
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities and prevention programme in Halton
Gill O'Hare	Service Development Manager, Adult Social Care, Warrington Borough Council	Development of Community Networks across Warrington and links to Living Well programme
Rob Cooper	Managing Director, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Sangeetha Steevart	General Practitioner, Clinical Director, Warrington Place	Living Well Hub and women's health
Steve Cullen	CEO, Warrington Citizen's Advice Bureau	VCFSE connections as part of Living Well programme
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy
David Wilson	One Halton Clinical director	UEC Steering group

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
Nick Armstrong	Cheshire and Merseyside ICB	Strategic estates planning, Warrington
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan
Ben Wakerley	CEO, Warrington's Own Buses	Potential to deliver health checks on buses in Warrington
Augustine Ikeakor	Strategic Programme Lead, Mid-Cheshire hospitals	Living Well Hub and transfer of learning
Michael Wood	Head of Health Economic Partnerships, NHS Confederation	Healthy Cities conference Liverpool, discussing health on the high street and WHH community Hubs
Stephanie Lord	Strategic Account Manager, ORCHA	Warrington Virtual Hub
Mike Northey	GP	Urgent and emergency care system improvement steering group
Graham Urwin	CEO, NHS Cheshire and Merseyside	Integration
Harriett Corbett Neil Herbert Richard Hayhurst Steve Roberts Sarah Bowman-Jones Mathew Jones Asia Bibi	Alder Hey Children's Hospital, Paediatric Surgical team	Paediatric hub project team meeting

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Senior operational pathology team	Mersey and West Lancashire Teaching Hospitals	Pathology collaboration network meeting
Chris Woodforde	GP- Halton	CYP CDC Respiratory diagnosis pathway
Debbie Watson	Director of Public health, Warrington Borough Council	Warrington- Urgent and emergency care system improvement
Paul Tyerman Lee Matthews Laurence Pullan Tom Kearney Rachel Cartwright	Warrington Borough Council	Living well virtual Hub
Louise Berry	Partnership Manager, Warrington disability partnership	Living well virtual Hub
Jay Deakin	Talk Hub C.I.C	Living well virtual Hub
Jane Kinnaird	Samaritans Warrington Manager	Living well virtual Hub
Sam Birchall	Warrington Housing	Living well virtual Hub
Alice Fairhurst	Warrington Youth Zone/CAMHS Partnership	Living well virtual Hub
Paul Corless	Transformation and PCN Lead, ICB	Living well virtual Hub
Charlotte Nichols	MP	New hospitals programme
Sarah Hall	MP	New hospitals programme

Integration – part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Programme Overview

Bridgewater Community Healthcare NHS Foundation Trust (BCH) and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) are coming together and working as one to improve healthcare services for our communities. Warrington and Halton need strong and resilient clinical services, and our healthcare system must be sustainable for the future. We know that we can achieve more together for both our patients and staff.

The integration programme- “Better Care Together” has been established with 7 workstreams: Clinical and operational servicers, corporate services, communication, digital, finance, estates and workforce. Each workstream is developing a delivery plan and working with partners to deliver objectives.

What does this mean for WHH?

Over the coming months, we will be working to finalise governance arrangements, introduce a shared executive team, and make progress in delivering improved pathways for our patients. Together, we will develop new and improved ways of working, starting first with services identified as an urgent priority. Subject to all necessary approvals, we hope to become a single organisation as soon as possible.

Progress:

- Nikhil Khashu commenced as Chief Executive Officer for both Trusts on the 1st November
- Each workstream has allocated senior responsible officers and project management support
- Drafted and approved high level summary case for change
- Workstreams identified 6, 12 and 24 month priorities
- Programme governance arrangements in place, including joint executive team meetings, delivery group and steering group
- Held joint board sessions
- Developed and approved initial milestone plan
- Signed data sharing agreement
- Held first clinical and operational services workshop to identify where services can align to deliver patient benefit

Integration – part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Joint Chief Executive Officer commenced in post	November 2024
High-level case for change approved	November 2024
Contract review	November 2024
Communication and engagement plan	November 2024

Better Care Together

Home · Community · Hospital

Integrating community and hospital services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

Contact details
Lucy Gardener
Chief Strategy and Partnerships Officer WHH
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Hayley Heard
Deputy Director of Strategy and Partnerships
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Runcorn town deal-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long-term conditions from a central location in Runcorn.

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

What does this mean for WHH?

- Delivery of WHH services, including maternity, respiratory, and phlebotomy, from a convenient and accessible town centre location.
- Opportunity to work with local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies.
- Opportunities to further integrate services with other providers across health, care and wellbeing.

Progress since last report

- Tender documents issued and tenders received. Currently undergoing assessment and moderation, with a preferred way forward due mid-November.
- Continued development of the Heads of Terms for the lease agreement for the location, the current library building on Granville Street, Runcorn.
- Impact of the legally binding collaboration agreement which formally sets out roles and responsibilities of all parties when operating the hub currently being assessed by partners.

Runcorn town deal- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people ✓**	**Working in partnership✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Tender application s reviewed	November 2024
Approval of Collaboration Agreement	December 2024
Heads of Terms drafted	November 2024







Contact details
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Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

Community diagnostic centre-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.
- The final approved CDC Programme covers three phases:
    - Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton.
    - Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City.
    - Phase 3 will see the development of a new build extension to the CSTM building on the Halton site to accommodate additional CT and MRI services.

What does this mean for WHH?

- Additional capacity to undertake diagnostic testing for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.
- New estate at Halton General Hospital and at the Halton Health Hub in Runcorn Shopping City, which supports new hospitals plans and the estates strategy.

Progress since last report

- Over 64,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023.
- Basic external structure for the final phase is now complete and brickwork is now in progress.
- New substation and generator is installed to support the power supply to the new building.
- Completion of the final phase of the programme is planned for March 2025 with clinical activity scheduled to commence from April 2025.
- Funding has been secured to implement a new pathway for paediatric respiratory diagnosis and a new gynae bleeding pathway in CDC Phase 2 (Runcorn Shopping City).

Community diagnostic centre- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	Looking after our people	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	Working responsibly
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Breakthrough into existing CSTM space to connect new build	Nov 2024
Completion of new build CDC (phase 3)	Mar 2025







Contact details
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Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New hospitals and strategic estates planning- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending Captain Sir Tom Moore to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

What does this mean for WHH?

- Delivery of Trust services from modern, accessible and safe environments.
- Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations.

Progress since last report

- Assessment of latest draft of Cheshire and Merseyside NHS Infrastructure Plan
- Meetings with local MPs, including Mike Amesbury and Sarah Hall to discuss the recent estates developments and the progress of the new hospital plans in both Warrington and Halton, as well as key opportunities for investment and development.
- Key public sector contacts, including representatives from Halton Borough Council, Liverpool City Region, and Homes England, toured the Trust's Halton site, in relation to opportunities around the regeneration of Halton Lea as per the Council's local plan, and the Trust's vision for the Halton Hospital and Wellbeing Campus
- Communications plan in development to engage with staff on the upcoming publication of the Trust's estate strategy

New hospitals and strategic estates planning- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Commissioning of updated new hospital plan including phased opportunities for investment	December 24





Contact details
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Halton Health New Town and Strategy Manager
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Completed Projects

Halton Health Hub

- Halton Health Hub Phase 1 was completed in November 2022, enabling the delivery of orthoptics, optometry, audiology, and dietetic therapy services from within the Runcorn Shopping City centre in Halton Lea.
- Services in Phase 1 have since been expanded to add MSK therapies, a GP out-of-hours service, public health services, including weight management and smoking cessation, and a Wellbeing Service delivered by Wellbeing Enterprises CIC.
- In November 2023, Phase 2 opened. Phase 2 comprises a Community Diagnostics Centre, offering residents improved access to range of diagnostics and treatments usually only accessible via an acute hospital.
- By October 2025, more than 50,000 patient contacts have occurred at the hub.

Warrington Living Well Hub

- The Living Well Hub has seen over 7,500 visitors attend since the doors opened in mid-March 2024. Around 55% of these attendances have been people “dropping in” to the hub to access a service, and the remainder have been for pre-booked appointments.

- The service model continues to evolve with the following new services commencing in
    - Female contraceptive fitting clinic (Primary Care)
    - Breast Cancer Fit to Move Forward exercise group (WHH)
    - South Asian dementia support group (Warrington Speak Up - VCFSE partner)
    - Prostate Cancer Workshop (Clatterbridge)
    - Domestic Abuse “Own My Life” workshop (WBC)
    - Later life adult memory service – post diagnostic dementia support group (Merseycare)
    - Youth Service Drop in (WBC)
    - Neuro diversity support group (DWP)

Other Trust strategic updates

Daycase Unit & Theatre 5 at CSTM, Halton

- Construction works complete
- All areas handed over to operational teams

C&M Endoscopy Hub at Nightingale Building, Halton

- First patient seen in Endoscopy Hub on Monday 9th September 2024
- Decontamination unit handed over as planned on Monday 23rd September 2024
- All areas handed over to operational teams

Theatre 3 at Nightingale Building, Halton

- Isolations completed and currently in construction phase
- WHH Project Team working closely with contractors to manage early warning notices and compensation events

Upgrade to Ward B2 at Nightingale Building, Halton

- WHH Project Team and Estates Capital Team are appointing construction company
- Aim for construction works to start November 2024

Other Trust strategic updates

Digital Projects

EPCMS Update

- EPCMS Readiness workstream will continue at pace
- Preparation is underway for the next procurement, clinicians are currently reviewing and amending the OBS technical questions structure as well as the demonstration scripts.
- Pre-market engagement is taking place in December with interested suppliers and the trust.
- Procurement timelines have been revised with a current go-live of September 2027.
- Work is on-going on the revised OBC ready for internal and NHSE sign off.
- Lessons learnt has been conducted and finalised and will be going to the FSC board meeting.

PEP

- 47% of appointment letters have been read digitally reducing the need for printing and postage of letters
- 111k Messages have been sent to our patients, 20k were read in the NHS App giving us an 18% reduction in SMS message costs
- The PEP Engagement Showcase took place on 4th October. WHH had the opportunity to connect with a handful of highly engaged staff members who stand to benefit significantly from various elements of the PEP, particularly in the areas of two-way messaging and assessments. Looking ahead, we plan to collaborate closely with the Anti-Coagulant and Physiotherapy departments in the coming months to further integrate and support their use of the PEP platform
- Phase 2 planning has begun and is expected to start early November. Phase 2 consists of 2 Way Messaging and Video Consultations
- The Trust is now live with appointment letters directly into the NHS App. This feature is expected to significantly reduce the need for SMS reminders, leading to potential cost savings on SMS services.
- 59% of patients have registered on the NHS app, 61% at Warrington and 56% at Halton

Other Trust strategic updates

Digital Projects

Connectivity & Wi-Fi

The aim of this workstream is to ensure that secure network connectivity is available to all health and social care staff within the WT partnership arrangements.

- Broadcasting the WHH Wi-Fi network in Bridgewater and Council buildings where “hot desking” or drop-ins are beneficial to save on travel time
- Broadcasting the Council Wi-Fi network at NHS sites, so that social care staff can easily connect to the Council’s systems
- Broadcasting Bridgewater Wi-Fi network at WHH and Council sites, providing Community staff with additional connectivity options

As part of WHH and Bridgewater integration, a network connection has been specified and ordered, enabling the core network infrastructure for Wi-Fi sharing – switch on expected by end of 2024

With regards to connectivity for Warrington residents to access public services online, a “Digi Care” project is being led by Warrington Council, planning to provide wireless digital connectivity in more deprived areas of the Borough – planning meeting scheduled for 21st Nov 2024

Place based strategic updates

Urgent and Emergency Care System Improvement

- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to Urgent Community Response (UCR) and Same Day Emergency Care (SDEC) have increased and are consistently above target, ED attendances are down by 4% compared to the same period last year and time spent on the ED corridor has reduced from 10 hours to 4. Trusted assessor and direct referrals have been implemented in Halton. Over 65 admissions remain a challenge.

Warrington

- A new project is now underway to develop and implement a new digital health and wellbeing hub for the population of Warrington. The “virtual hub” will create a single point of access and/or information for residents to find out about services on offer in the borough to support health and wellbeing. The initial version of the software is planned to be live to the public before the end of the financial year. A new project manager (Rachel Moran) is now in post and will lead the project over the coming 12 months.

Halton

- Delivery plans for each specialist area of the Wider Determinants of Health group are being developed and priority areas for focus have been identified. Priority areas include, employment, workforce and education, violent crime reduction, economic regenerations and living conditions and each has established a subgroup to take this work forward.

Cheshire and Merseyside strategic updates

Laboratory Information Management System (LIMS)

- The Full Business Case for a unified LIMS across 5 healthcare organisations was approved by the Trust Board in June 2024. The contract has been awarded to the preferred supplier and implementation is planned to begin in 2027. The LIMS project team are linking closely with the pathology collaboration team working on the hub model to ensure alignment.

Pathology collaboration

- The pathology hub delivery group (East) has been established and a potential Target Operating Model described. An outline Business Case has been developed and approved by WHH Trust Board. Detailed work is ongoing to develop a full business case which will be presented to Trust Board early in the new year.

Paediatric surgery

- The pilot of Alder Hey @ Warrington continues with paediatric theatre lists being delivered by Alder Hey surgeons in Warrington. Further collaboration with Alder Hey is continuing with a view to expanding the project to incorporate some activity on the Halton site.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/131**	
SUBJECT:	**EPRR Core Assurance Update**	
DATE OF MEETING:	4th December 2024	
AUTHOR(S):	Rachel Clint, Head of EPRR, Daniel Moore, Chief Operating Officer	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival **#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. **#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 **#1757** If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services. **#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#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. **#1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	

<table>
<tr><td></td><td>#1898 If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.
#125 If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns
#145 If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.
#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</td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>This report will:-
Provide an overview of the Emergency preparedness, resilience and response (EPRR) annual assurance process for 2024-25
Provide an overview of Warrington and Halton Teaching Hospital’s compliance with the EPRR Core Standards
Provide an overview of the deep dive into Cyber Security</td></tr>
</table>

	• Outline a workplan to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to support and note the EPRR annual Core Assurance Submission		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	**FSC/24/11/174**	
	Date of meeting	Monday 25th December 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	EPRR Core Assurance Update	AGENDA REF:	BM/24/12/131

1. BACKGROUND/CONTEXT

Organisations, including acute trusts are asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each. The compliance level for each standard is defined as:

- Fully compliant: fully compliant with the core standard.
- Partially compliant: not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
- Non-compliant: not compliant with the core standard. Compliance will not be reached within the next 12 months

In September, the Finance and Sustainability Committee were appraised of the annual self-assessment predictions for Core Standards in Emergency Planning, Resilience and response.

Since, the Integrated Care System EPRR team has assessed a sample of the core standards and owing to the feedback, the Head of EPRR and the Trust Accountable Emergency Officer (Chief Operating Officer and Deputy Chief Executive) have reflected and adjusted the self-assessment based on the comments received.

2. KEY ELEMENTS

In 2023/24, WHHFT received an outcome of **5%** and non-compliant in the annual round of core assurance.

In the 2024/25 cycle, the Head of EPRR self-assessed the compliance rating as **73%**, a score still rated as non-compliant (77% required to reach partial compliance and 88%+ to achieve substantial compliance). A number of priorities were identified in the workplan to continue the path of continuous improvement in this workstream and a number of these have already been addressed.

In October, following the submission of the annual self-assessment, the ICB EPRR team sampled six of the standards that were self-assessed as being 'fully compliant'. The ICB Director of Performance and Planning / AEO shared the following comments.

Having conducted the review, it is clear there has been significant improvement made following the 2023-2024 process, this includes:
• An EPRR Policy which includes detailed reference to risk management and links to the organisations Risk Management Policy.
• An EPRR Policy which aligns to the Trusts Strategic Plan and objectives.

Next Steps:
1. The AEO is asked to note the outcome of the review and ensure learning is incorporated within the EPRR Work Programme.
2. The AEO is asked to reassess their rating based on feedback provided and resubmit their signed Statement of Compliance (if the compliance level has changed as a result) to the ICB EPRR Team by 17:00hrs on Friday 22nd November 2024 (via EPRR@cheshireandmerseyside.nhs.uk).

3. The AEO is asked to present the results of the annual EPRR assurance process and compliance position to the organisations Public Board.

Feedback was offered in relation to the evidence submitted and the ICB assessed five of the six standards as partially compliant rather than fully compliant.

After review and further discussions with the EPRR network and the Head of EPRR at the ICB, it was made clear that the ICB process was a peer review, rather than an assessment and therefore the final assessment and scoring should be considered by the Accountable Emergency Officer across respective Trusts.

This presented three options in relation to the self-assessment.

1. Maintain the original self-assessment score for WHHFT (73%)
2. Consider the feedback in relation to each standard and identify any risk in relation to not accepting the partially compliant ICB ratings
3. Accept all of the comments and assessment from the ICB, giving a final assessment outcome of 61%

The AEO and Head of EPRR determined Option 2 to be the most appropriate, considering the nature of the feedback, the level of risk associated with the comments received and what processes work at WHHFT.

The adjusted compliance score has been submitted as **68%**, with 42 of the 62 standards being assessed as fully compliant, and 20/92 as partially compliant.

Table 1 is a summary of the feedback and assessment outcomes.

Standard	Summary of feedback	ICB Assessment	WHHFT Re-assessment
1 Governance Senior Leadership	Minor amends to content	Fully compliant	Fully compliant
2 Governance EPRR Policy Statement	Minor amends to content and terminology	Partially compliant	Fully compliant No risk, ICB lacks understanding of WHHFT processes
14 Duty to maintain plans Countermeasures	Amends to training details	Partially compliant	Accept partially compliant In the absence of updated national or regional guidance, this policy is currently relevant to WHHFT
18 Duty to maintain plans Protected Individuals	5-year review cycle – feedback suggests a 1-year review of a Policy and 3-year review of a plan	Partially compliant	Accept partially compliant No risk attached to this. Communications Team to review policy as part of 5-year review cycle and will incorporate VIP/ Celebrities as inpatients. NHS England and ICB suggest a 1 year review cycle of policies and a 3-year review cycle of plans. This practice is not carried out at WHHFT, nor is it apparent in national guidance.
31 Response Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Not in Tactical Commander Handbook	Partially compliant	Fully compliant No risk. This is a national guideline and is available in various formats
49 Business Continuity Data Protection and Security Toolkit	Trust compliance rating with DPST is approaching standards	Partially compliant	Partially compliant based on approaching standards on DPST review. Digital Services to continue to pursue improvement in standards

Table 2 shows the domain related self-assessment.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	7	4	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	4	6	0
Hazmat/CBRN	12	2	10	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	42	20	0

The WHHFT experience was similar to other acute and community providers across Cheshire and Merseyside. A number of system partners have suggested they will act similarly in relation to the ICB feedback in readjusting scores, others have suggested they will maintain their original self-assessment.

The Head of EPRR has requested further ICB led opportunities to support improvement looking at the Core Standard domains and sharing good practice. This request has not been accepted, with the suggestion to informally work with EPRR Leads and Officers across the Cheshire and Merseyside system to share plans, policies and learning.

The Head of EPRR has requested an ICB led debrief to ensure learning for the next cycle is captured and embedded. This has not yet been put in place.

Nationally, the three-year cycle for EPRR Core Assurance is due to be refreshed for 2025/26. Updates to the domains and process are likely and should be communicated 12-months prior to the start of the next cycle of assurance. The Head of EPRR will remain vigilant of any updates.

The Trust Head of EPRR will continue to collaborate with key stakeholders to support WHHFT moving towards achieving substantial compliance in the 2025/26 core assurance cycle.

In November, MIAA are completing an audit of WHHFT EPRR capabilities, this should present more opportunity for reflection and further improvement.

In December, NWAS are carrying out an audit of the Trust's CBRNe capabilities, this is an area the Head of EPRR has started to focus on in collaboration with UEC senior and middle managers following self-assessing 10/12 of the standards at a partially compliant status.

3. MONITORING/REPORTING ROUTES

EPRR updates will continue through the refreshed EPRR Group (former Event Planning Group) and the Finance and Sustainability Committee. Any significant incidents or events are also reported through the Strategic Executive meetings.

Future EPRR assurance

NHS England are currently reviewing the EPRR assurance process to ensure that it continues to develop and support continual improvement. The NHS core standards for EPRR will continue to be reviewed and updated every 3 years, this is due in 2025. Each new updated set of standards will be published no less than 12 months ahead of them being used for assurance purposes, it is therefore expected that the next set of standards will be received in the coming months.

The reviewed process will see changes from 2025/26 which will include:

- Ensuring ICBs are empowered and supported to take the lead with regards to local delivery of the EPRR agenda (in line with the NHS England operating framework, seeking further opportunities to embed new ways of working in all our activities) - this includes ICBs being responsible for gaining the NHS EPRR assurance compliance rating from their providers of NHS funded care, under the terms of the NHS Standard Contract
- NHS England developing its relationship with related regulatory bodies to share and secure a common understanding regarding assurance outcomes, ensuring that compliance is achieved through a single mechanism - these organisations include the Care Quality Commission and the Health and Safety Executive
- Identifying any unconditional compliance requirements of the NHS core standards for EPRR
- NHS England annually self-assessing its EPRR compliance as a single organisation, including all relevant departments and regions
- Evaluating options for a digital solution to facilitate delivery of the overall assurance process.

4. TIMELINES

The EPRR annual report will be presented to Board in July 2025.
The next self-assessment will be presented to Board in October 2025 providing national and regional timescales remain in place.

5. ASSURANCE COMMITTEE

EPRR Group, held monthly.

6. RECOMMENDATIONS

The Board are asked to note the EPRR Annual Assurance self-assessment rating as non-compliant, however recognise a significant amount of work has been put in to support progress towards partial compliance. It is important to note that where there have been partially compliant ratings, the Trust does have resilience, and work continues to fulfil the requirements in line with current legislation and guidance.

The Finance and Sustainability Committee is asked to support the workplan in moving towards full compliance with all 62 standards**.**

Appendix 1 – ICB summary report

EPRR Assurance Process 2024-25

ICB EPRR ASSURANCE REPORTING TEMPLATE

1 ICB Name: NHS Cheshire and Merseyside

Overall Compliance Statement
The ICB has assessed their compliance as: Partially Compliant **The overall assessment of the NHS within the ICB is:** Partially Compliant **The overall assessment of CBRNe/Hazmat readiness within the ICB is:** Partially Compliant
Describe the process used to gain confidence with the organisational ratings:
Peer Reviews held: 4th September 2024 – Community, Specialty, Mental Health Trusts 6th September 2024 – Acute Trusts **Panel Reviews** held throughout October 2024 by NHS Cheshire and Merseyside Head of EPRR and Deputy Head of EPRR. Following these reviews, contact made with Trust EPRR Leads to provide feedback on areas of development where applicable, and 5 additional days for potential missing evidence to be submitted. Once the 5 days were complete, a final summary of the review process was provided to the Trust AEO and EPRR Leads.

Thematic review of standards – following completion of your LHRP discussions, which core standards have the highest level of partial/non-compliance within your ICB	
1	**(16) Evacuation and Shelter** In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
2	**(25) Staff Awareness and Training** There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
3	**(64) Staff Training - recognition and decontamination** The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres). Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented.
Assessing Risk – following completion of your LHRP level review of risk as directed by NHS England. What are your ICB's top 3 risks (these should include risks across the full spectrum of national, regional and local risks)	
1	Evacuation and Shelter, as detailed within local, regional, and national risk registers. Requires collaborative working with NHSE regional and national teams as it all feeds into each other.
2	Cyber, as detailed within local, regional, and national risk registers.
3	Training (multi-agency and internal training) for on-call members of staff, as detailed in local risk registers.

Issues identified and actions agreed to rectify (including organisations identified as partially compliant or non-compliant, and governance process agreed for oversight of action plans)

All Providers have received feedback on the 6 core standards reviewed for their organisation. Provider AEOs have been requested to note the outcome of the review and ensure learning is incorporated within the EPRR Work Programme and to present the final results of the annual EPRR assurance process and compliance position to the organisations Public Board. The Self-Assessment template has produced an action plan for each Provider which will be incorporated into the EPRR Work Programmes for each organisation. One of the 16 Providers reported non-compliance for two core standards, and one provider reported non-compliance with one core standard, which will be focused on upon completion of their action plans. Action plans will be monitored via the LHRP Tactical Group with updates on progress provided.

Good practice identified

- The process undertaken by the ICB this year has provided an opportunity for all Providers to act upon and improve on the constructive feedback received. This has resulted in the majority of Providers updating their EPRR Policy thereby strengthening the approach to EPRR across Cheshire and Merseyside.
- A selection of the good practice identified and fed back to Providers is below:
  - *Strong evidence of EPRR policies and plans consultation, including responses received and actions taken as a result.*
  - *Reflective practice within CPD portfolios for Commanders available.*
  - *Version control incorporated within training packages to highlight key changes to legislation/working practice.*
  - *A Commander Plan awareness form which is a comprehensive way to ensure relevant staff have the correct materials to effectively respond.*
  - *Protected Individuals Policy covers VIPs both as a visitor and as a patient.*
  - *Business Continuity Dashboards provide good oversight.*
  - *A Fit Testing SitRep is good practice to have.*
  - *An EPRR Training Needs Analysis which is inclusive of numbers of staff that require the training, along with the current percentages which is beneficial for reporting and governance.*
  - *An EPRR Training Needs Analysis which aligns to the National Occupational Standards.*
  - *CBRN Training records held for Emergency Departments which are comprehensive.*
  - *A SOP to support staff with the completion on a Business Impact Analysis/Business Continuity Plan.*
  - *A thorough EPRR Projects Plan and Actions, with owners and timescales included.*
  - *An MS Teams link for Loggists to complete, following their training, to capture their consent.*
  - *A comprehensive Debrief Policy with templates for conducting hot and cold debriefs internally.*
  - *A detailed annual EPRR Report provided to Board for assurance, which included key EPRR workstreams and the compliance position.*
  - *Alternative ICC has been identified and is detailed within EPRR documentation.*

Issues to raise regionally

- Concern regarding Core Standards process moving forwards and approach to be taken.
- Concern regarding Core Standards wording and relevancy/appropriate for Trust types.
- Concern regarding CPD portfolios and lack of availability of training required to meet the requirements.
- Concern regarding the availability of regional current guidance for Evacuation and Shelter in order to make arrangements and meet the requirements.

High level findings of 'deep dive' into Cyber Security & IT related Incident Response

- Four of the 16 Providers have reported Full Compliance for the deep dive.
- Not all Providers have dedicated cyber plans.
- Some Providers have plans that are outdated.
- Ample attendance and engagement of ICS Cyber Plan exercises.
- Cyber awareness is included in some bespoke EPRR training packages.
- Providers have considered Cyber across their business impact analyses and business continuity arrangements.
- Overall there are good planning arrangements in place or being developed across all Providers.

Issues to raise nationally

- As per issues to raise regionally.
- Standardised national templates to be produced to ensure consistency for all Providers across regions.
- Although there are four Providers who have reported overall non-compliance, this should not be mistaken for a lack of progress. Each Provider has built upon the feedback provided form NHSE Northwest in the 2023-24 process and workstreams are still ongoing and being developed further.

Feedback and recommendations on the EPRR Assurance process

- The debrief sessions indicated in the 'check and challenge' letter for 2023-24 sent to all Providers by NHS England did not take place, thereby the Tri-annual review of core standards at National level and request for volunteers has been welcomed.
- Would recommend a clearly documented approach of the Core Standards Self-Assessment process at a national level to ensure a standardised approach is reflected in each region for 2025-26.
- Would recommend the introduction of an Operational Principles of Health Command training package.

Summary position for your ICB

Acute Trusts	Compliance Level	Compliance Trend from 2023/24	Fully compliant standards	Partially compliant standards	Non-compliant Standards	Overall compliance percentage
Alder Hey	Non	Increased %	42	20	0	68%
Countess of Chester	Partial	Increased	50	12	0	81%
East Cheshire	Partial	Increased	50	10	2	81%
Liverpool University	Substantial	Increased	55	7	0	89%
Mersey & West Lancashire	Partial	Increased	50	12	0	81%
Mid Cheshire	Non	Increased %	47	15	0	76%
Warrington and Halton	Non	Increased %	42	20	0	68%
Wirral University Hospitals	Partial	Increased	52	10	0	84%
Specialist Trusts						
Clatterbridge Cancer Centre	Substantial	Increased	56	3	0	95%
Liverpool Heart and Chest	Partial	Increased	51	8	0	86%
Liverpool Women's Hospital	Non	Increased %	43	16	0	73%
The Walton Centre	Partial	Increased	46	13	0	78%
Community and Mental Health Trusts						
Bridgewater	Partial	Increased	47	9	2	81%
Cheshire and Wirral Partnership	Partial	Increased	49	9	0	84%
Mersey Care	Substantial	Increased	56	2	0	97%
Wirral Community	Partial	Increased	50	7	1	86%
ICB						
NHS Cheshire and Merseyside	Partial	Increased	41	6	0	87%

Status	2023 / 24		2024 / 25	
	Number of Trusts	%	Number of Trusts	%
Fully Compliant	0	0%	0	0%
Substantially Compliant	0	0%	3	19%
Partially Compliant	0	0%	9	56%
Non-Compliant	16	100%	4	25%

2 Organisational Assurance Summary

Organisation	Services provided or organisational type (X those which apply)											Compliance achieved:		
												Full / Substantial / Partial / Non		
	Acute providers	Specialist providers	NHS Ambulance services	Patient Transport Providers	NHS 111	Community services providers	Mental health providers	ICB	Primary care (GP, community pharmacy)	Other NHS funded organisations	NHS England	2023 / 2024	2024 / 2025	Change ↔ ↑ ↓
NHS Cheshire and Merseyside								X				Non	Partial	↑
Countess of Chester Hospital NHS Foundation Trust	X											Non	Partial	↑
East Cheshire NHS Trust	X											Non	Partial	↑
Mid Cheshire Hospitals NHS Foundation Trust	X											Non	Non	↔
Warrington and Halton Teaching Hospitals NHS Foundation Trust	X											Non	Non	↔
Alder Hey Children's Hospital NHS Foundation Trust	X											Non	Non	↔
Liverpool University Hospitals NHS Foundation Trust	X											Non	Substantial	↑
Mersey and West Lancashire Teaching Hospitals NHS Trust	X											Non	Partial	↑
Wirral University Teaching Hospital NHS Foundation Trust	X											Non	Partial	↑
Clatterbridge Cancer Centre NHS Foundation Trust		X										Non	Substantial	↑
Liverpool Heart and Chest Hospital NHS Foundation Trust		X										Non	Partial	↑
Liverpool Women's NHS Foundation Trust		X										Non	Non	↔
The Walton Centre NHS Foundation Trust		X										Non	Partial	↑
Bridgewater Community Healthcare NHS Foundation Trust						X	X					Non	Partial	↑
Cheshire and Wirral Partnership NHS Foundation Trust						X	X					Non	Partial	↑
Mersey Care NHS Foundation Trust						X	X					Non	Substantial	↑
Wirral Community Health and Care NHS Foundation Trust						X	X					Non	Partial	↑

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/12/132**			
SUBJECT:	Scheme of Reservation and Delegation Amendments			
DATE OF MEETING:	4 December 2024			
AUTHOR(S):	Alison Parker, Associate Director of Procurement			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Standing Financial Instructions (SFIs) determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SORD). This paper details a change to the SORD in the removal of the £5,000 authorisation level.			
PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee
	Agenda Ref.	AC/24/11/76
	Date of meeting	21 November 2024
	Summary of Outcome	Changes noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO TRUST BOARD

SUBJECT	Scheme of Reservation and Delegation Amendments	AGENDA REF:	BM/24/12/132

1. BACKGROUND/CONTEXT

The Trust's Standing Financial Instructions (SFIs) determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SORD). This paper proposes details a change to the SORD in the removal of the £5,000 authorisation level.

Authorisation levels are set for all goods and services inclusive of equipment, call-off orders, services, buildings & engineering works, computers, pathology reagents, management consultants and agency staffing. These approval limits are subject to compliance with Table B, 6.1 of the SORD regarding the approval of expenditure.

2. KEY ELEMENTS

On the 9 October, a proposal was tabled at the Finance Control Group (FCG, previously Finance Wednesday) to review delegated levels of authority as detailed in the SORD in support of increased financial controls across the Trust.

Three options were tabled:

- Option 1 – remove the £5k limit
- Option 2 – remove both the £5k and £10k limits
- Option 3 – a line-by-line review within each Care Group/Directorate to determine which limits are to be removed

The agreement was to remove the £5,000 limit so all expenditure would be approved by those members of staff with a minimum level of delegated authority of £10,000.

This proposal and agreement were to introduce an increased level of scrutiny by more senior staff to support a reduction in the Trust's deficit position.

Subsquently a paper was tabled at the Audit Committee dated 21 November 2024, for the Audit Committee to note the changes that has been made.

Table 1 details the authorisation limits

Table 1

REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
Revenue Expenditure - Delegated Authority (excluding consultancy services, capital and removal expenses)	up to £5,000	Divisional Administrator (or equivalent) Theatre Manager Ward Manager
	up to £10,000	Department Manager Lead Nurse Matron
	up to £25,000	Assistant Clinical Business Manager Associate Directors (not named elsewhere) Deputy Chief Pharmacist Head of Service
	up to £50,000	Chief Pharmacist Clinical Business Unit Manager Deputy Chief Information Officer
	up to £75,000	Deputy Directors Associate Director Clinical Support Services Associate Director of Estates & Facilities Associate Director Planned Care & Halton Associate Director Unplanned Care Chief Information Officer Company Secretary & Associate Director of Corporate Governance
	up to £100,000	Deputy Chief Finance Officer Director of Operations and Performance & Deputy Chief Operating Officer
	up to £250,000	Executive Directors
	over £250,000	Chief Executive (delegated to Deputy Chief Executive in absence of CE)

3. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report, and the changes made to the SORD.