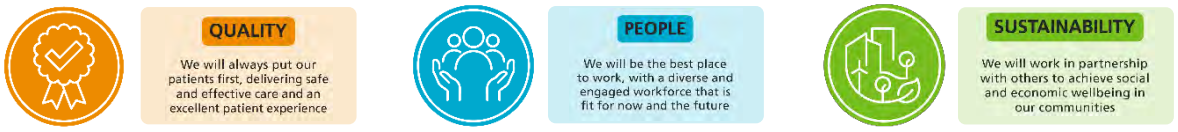
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 2 April 2025, 10.00am – 12:30pm
Lecture Theatre, Halton Education Centre, Halton Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/25/04/01	**10:00**	Engagement Story – Mark's Story – **to be presented on the day**	***To note***	**Presentation**	Jen McCartney, Head of Patient Experience and Inclusion and Leah Johnston, patient's daughter
BM/25/04/02	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/25/04/03	**10:17**	Minutes and Action Log of the previous meeting held on **5 February 2025**	***For approval***	***Minutes***	Chair
BM/25/04/04	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/25/04/05	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/25/04/06	**10:30**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/25/04/07	**10:35**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:					
BM/25/04/08 **(a)**	**10:55**	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard	***For assurance***	***Report***	All Executive Directors
		Quality Dashboard **Including** Assurance Reports Strategic People Committee 11.02.25, 11.03.25	***For assurance***	***Report***	Chief Nurse Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee 19.02.25, 19.03.25	***For assurance***	***Report***	Chief People Officer Julie Jarman, Committee Chair

(c)		**Sustainability Dashboard -** *including Cash Support* **Including** Assurance Reports Finance and Sustainability Committee 24.02.25, 24.03.25	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
d)		**Charitable Funds Committee** Assurance Report 06.03.25	***For assurance***	***Report***	Chair Director of Communications and Engagement
e)		**Audit Committee** Assurance Report 27.02.25	***For assurance***	***Report***	Committee Chair. Mike O'Connor
Strategic aim:			**Quality**		
BM/25/04/09	**11:10**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/25/04/10	**11:15**	**Maternity & Neonatal Update Summary Report to cover:** I. Monthly Maternity and Neonatal review II. Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report Q3 III. Maternity Incentive 5-Year Update including Saving Babies Lives Care Bundle V3 Update IV. Midwifery Safe Staffing Report Q3 V. Avoiding Term Admissions into Neonatal units (ATAIN) Q3 VI. Transitional Care Audit VII. Maternity Survey	***To note for assurance***	***Report***	Director of Midwifery
BM/25/04/11	**11:30**	Compliance Update Q3	***To note for assurance***	**Report**	Chief Nurse
BM/25/04/12	**11:35**	Quality Strategy 2025 - 27	***For Approval***	**Report**	Chief Nurse
Strategic aim			**People**		
BM/25/04/13	**11:45**	EDI Annual Report	***To note for assurance***	**Report**	Chief People Officer

BM/25/04/14	**11:50**	Freedom To Speak Up Guardian Report	***To note for assurance***	**Report**	Exec Freedom to Speak Up Lead
BM/25/04/15	**11:55**	National Staff Opinion Survey	***To note for assurance***	**Report**	Chief People Officer
Strategic Aim	**Sustainability**				
BM/25/04/16	**12:00**	Strategy Bimonthly Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer

For Approval					
BM/25/04/18	**12:10**	Performance Assurance Framework	***For approval***	***Report***	Chief Finance Officer
BM/25/04/19	**12:15**	Integrated Performance Report Refresh	***For approval***	***Report***	Chief Finance Officer

Governance					
BM/25/04/20	**12:20**	Trust Board Cycle of Business	***For Approval***	**Report**	Company Secretary
BM/25/04/21	**12:25**	Committee Terms of reference and Cycles of Business I. Quality Assurace Committee II. Finance & Sustainability Committee III. Audit Committee IV. Strategic People Committee	***For Approval***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/25/04/22	Learning From Deaths Q3	Quality Assurance Committee Ref: QAC/25/03/258 Date: 11.03.25 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/25/04/23	Learning From Experience Q3	Quality Assurance Committee Ref: QAC/25/02/238 Date: 11.02.25 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/04/24	Infection Prevention and Control Update Q3	Quality Assurance Committee Date:11.02.24 Ref: QAC/25/02/239 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/04/25	Guardian of Safe Working Report Q3	Strategic People Committee Date: 19.02.25 Ref: SPC/25/02/189 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/25/04/26	Digital Strategy Group Update	Finance & Sustainability Committee	***To note for assurance***	**Report**	Executive Medical Director

		Date: 24.03.25 Ref: FSC/25/ Outcome: Noted			
BM/25/04/27	Charitable Funds Committee • Governing Document • Cycle of Business	Finance & Sustainability Committee Date:06.03.25 Ref: CFC/25/03/43 Outcome: approved	***To note for assurance***	**Report**	Company Secretary
Closing					
BM/25/04/28	**12:30**	Review of the Meeting	To discuss	**Verbal**	Chair
BM/25/04/29		Any Other Business	To discuss	**Verbal**	Chair
Date and Time of next meeting – 10am, Wednesday 4 June 2025 – Trust Conference Room Warrington					

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

NHS
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NHS Foundation Trust

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 5 February 2025 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
Nikhil Khashu (NK)	Chief Executive
Dan Moore (DM)	Chief Operating Officer and Deputy 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
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Ailsa Gaskill-Jones (AGJ)	Consultant Obstetrician and Gynaecologist
Dr Rita Arya	Consultant Gynaecologist
John Culshaw (JC)	Company Secretary
Sarah Nuttie (SN)	Consultant Midwife (**BM/25/02/140**)
Jen McCartney (JMcC)	Head of Patient Experience and Inclusion (**BM/25/02/140**)
Debbie Edwards -	LMNS BM/25/02/147 only
Clare Fitzpatrick -	LMNS BM/25/02/147 only
Emily Kelso	Corporate Governance and Membership Manager (minutes)
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor
Jo Pickstock	Head of HR & OD
Suresh K Arni Sukumaran	Head of Medical Engineering (MS teams)

Agenda Ref	Agenda Item
BM/25/02/140	**Engagement Story – Personalised Care in Maternity** SN introduced the Engagement Story which focused on the personalised care planning for deaf patient Toni during her pregnancy, including birth planning through to the birth of her baby. The presentation highlighted the key contributors to ensuring Toni and her partner received excellent care and a positive patient experience, these included: • BSL interpreting services – an identified preferred interpreter was in place

	• A good working relationship with the Deafness Resource Centre • The alert function on BadgerNet patient records highlighting reasonable adjustments to be made • Triangulation of care between the MDT to ensure Toni was receiving the most out of her appointments, whilst making the best use of interpretation services • Named community midwife in Team River (enhanced community team) despite being out of area • Text offer – Enhanced communication from Consultant Midwife and named community midwife • Deafness Resource card The presentation also highlighted some areas of improvement for the Trust identified through Toni's experience. JD commented that in her role as maternity safety champion she had regularly experienced the efforts of the Trusts maternity team to go above and beyond to provide the best care and experience for patients and their families, she reflected on Toni's case where Team River was utilised to ensure Toni's needs were met, despite this not being the standard operating procedure. AK reflected on the lessons learned including early intervention and reasonable adjustments, and the improved experience of deaf patients across the Trust as evidenced in a recent survey carried out by Signing Solutions, which noted that the Trust had significantly improved. NK reflected on the alert function on BadgerNet electronic patent record of required reasonable adjustments, noting that it was important for the Trusts new EPR system to also have this function. In addition, NK queried the number of Trust staff that were BSL trained, JMcC responded that there were staff across the Trust that had basic sign language training, however no level 6 trained interpreters. JMcC further explained the Trusts use online programmes to communicate with deaf patients. NK queried whether charitable funds could be considered to support further enhanced training for staff. **The Trust Board discussed and noted the Engagement story.**
BM/25/02/141	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, attendees and observers to the meeting and apologies were noted as detailed above, there were no declarations of interest made. SMcG informed all in attendance that the meeting was to be recorded for minuting purposes using AI, in line with the Digital Acceptable Use Policy, there were no objections **The Trust Board noted the apologies and declarations of interest.**

BM/25/02/142	**Minutes and Action Log of the previous meeting held on 4 December 2024** The minutes of the meeting held on 4 December 2024 were agreed as an accurate record with two minor amendments. The Action Log was reviewed, completed actions were noted. **The Trust Board approved the minutes of the meeting held on 4 December 2024 and noted the Action Log**
BM/25/02/143	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/25/02/144	**Chief Executive's Report** NK introduced the paper, which was taken as read, and highlighted the following key points: • Future name of the organisation – NK thanked the 600+ people who had completed the survey to share their views on a partnership name for the integrated organisation to reflect the Trusts direction of travel • Governor elections – the successful candidates were congratulated, current Governors and those who were not elected were thanked for their commitment and dedication to the Trust • Maternity services – details were provided on the visit to the maternity department on Christmas Day, NK thanked maternity staff across the Trust for the efforts, evidenced by the Trusts maternity services being named in the top 10 in the CQC's annual national maternity survey findings. • MADE event – Multi-Agency Discharge Event (MaDE) had been held from Monday 16 December to Tuesday 31 December 2024, and the MaDE for Christmas campaign had been the most successful yet. Staff across WHH and BCH were thanked for the hard work and energy put into supporting getting people home for Christmas. JS queried what the Trust was doing differently to achieve such a successful MaDE event pre-Christmas and whether this could not be maintained as business as usual, DM responded that a large amount of resource was required for the event which was not sustainable in the long term, however it had enabled the Trust to pilot new ideas some of these would be maintained. DM highlighted the different ways of working to improve discharge including, extending opening hours of frailty unit, improved multi-agency working including the no criteria to reside meetings, which now involved out of area representatives and was continuing to evolve. CR queried the Devolution Priority Programme. It was noted Council leaders of Cheshire West and Chester, Cheshire East Councils and Warrington would continue to work closely regarding the development of a devolution agreement, possible Mayoral elections in May 2026 and the implementation of a new Cheshire and Warrington Strategic Authority in May 2026. **The Trust Board noted the Chief Executive's Report**

BM/25/02/145	**Chair's Report** SMcG provided a verbal update on activities since the last board meeting, highlighting the following: • Integration – Both BCH and WHH were making good progress on plans to become one single organisation, subject to the necessary NHS regulatory approvals. It was reiterated that the change would help both Trusts achieve ambitions and deliver the greatest benefits for patients and staff. • Operational Pressures Escalation Level (OPEL) 4 - the Trust had been escalated to OPEL 4 several times throughout January, he thanked staff for their continued hard work throughout these highly pressured periods • Governor Elections – it was explained that the 2024 elections had been the most successful elections for some time, leaving the Council of Governors with only one public governor vacancy and a high calibre of newly elected current Governors, with broad professional backgrounds. **The Trust Board noted the verbal update from the Chair.**
BM/25/02/146	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the Trusts strategic risks. The key highlights from the report, were as follows: • There had been one update to risk ratings, this was to risk 115, which had been reduced from 16 to 12, given the improved position of nursing establishment. • Following discussions at the December 2024 board meeting it was proposed that a new strategic risk be added to the BAF to capture the risks associated with the integration with BCH. Full details of this risk were included in section 2.1 of the report and Appendix 1. SMcG reflected on the proposed scoring of the new risk which was a moderate 9 (L3xC3), however noted that the biggest concern was around financial planning which was captured in risk 134. SMcG further raised his concerns around whether the risks to WHH associated with managing change– and the capacity challenge - had been adequately captured in the description of the proposed new integration risk. The Board discussed and agreed they were happy to approve the description and scoring of the new risk. However they also agreed that further details around mitigation, assurance and gaps should be provided in future reports to committees and the Trust Board. JC explained that as part of the governance work around integration a separate integration risk register was being considered, which would be managed at the Corporate Risk Register (CRR) level. **Annual Review of Board Assurance Framework & Risk Appetite Statement** JC introduced the second part of the report which provided the Board with an update on the key changes to the BAF throughout 2024/25, the following key highlights were taken from the report: • Risk 1757 had been deescalated, following a reduced scoring and change to the risk description, given that the remaining risk related to the

	operational impact of the GP collective action, the only remaining assurance gap. The risk was now monitored through QAC via the CRR • Each of the monitoring committees undertook a Deep Dive of their strategic risks. to agree risk appetites for each of the Trusts strategic risks and to align target risk ratings to risk appetites. JJ reflected on the rating of risk 134, which was the trust biggest risk around financial sustainability, she queried at what point the rating should be escalated to the maximum 25 (L5x 5C). JC responded that this discussion had also taken place in FSC, he explained the limitations of the 5x5 matrix. It was noted the rating would continue to be discussed by the FSC and escalation would be considered, given the current mandated support, and draft operational plan. The Board agreed the description of risks 1898 and 145 should be reviewed as they were similar and required revised wording to align with integration work. LG & JC agreed to review the description of risks 1898 and 145. **The Trust Board:** • **Approved the changes and updates to the Strategic Risk Register and Board Assurance Framework** • **Approved the addition of the new integration Strategic Risk** • **Approved the WHH Risk Appetite Statement 2025/26**
BM/25/02/147	**Maternity Incentive Scheme Yr 6 Submission** AGJ introduced the presentation which provided the final compliance submission report for the Maternity Incentive Scheme (MIS) Year 6, highlighting the key safety actions and the assurance process. RY Consultant Obstetrician and Gynaecologist was introduced and together they explained the external assurance provided by the LMNS for safety actions 3 through 9, which involved reviewing evidence and declaring compliance, along with the internal assurance process for safety actions 1, 2, and 10. AGJ provided an overview of the compliance with the ten safety actions, highlighting the supporting evidence submitted and the assurance provided by the LMNS. The governance process relating to the scheme was explained, it was noted that an extraordinary Trust Board meeting had taken place 29 November 2024, where the board received and approve the final evidence submission for MIS Year 6. It was explained that following this the LMNS had deemed the Trust compliant, and the final stage was for the Board to declare compliance with all 10 safety actions and submit for ICB sign off prior to the final submission to NHSR by midday 3 March 2025. The Board were made aware of the financial implications, it was explained that the 900k for achieving compliance had been assumed in the financial plan. CR and JD discussed the high assurance received through the Quality Assurance Committee meetings on the improvements to maternity services, evidenced through the recent CQC inspection rating of Good, along with patient feedback, and via regular committee reporting. JD provided the examples of positive interactions with patients and their families during her observational visits as the Trusts Maternity Safety Champion.

	The Trust Board confirmed they were satisfied the evidence provided to demonstrate achievement of the ten maternity safety actions
BM/25/02/148	**Integration Options Decision** NK introduced the paper which detailed the recommended option following the robust options appraisal process. The recommended option was Option 6 the acquisition of Bridgewater Community Healthcare FT by WHH, he emphasised the benefits for patients and staff, and the significant long term financial benefits. It was explained that this was the least risky option for delivery. He further highlighted the importance of the transaction for enabling transformation and change to ensure sustainability of services. LG provided a summary of the robust and transparent options appraisal process undertaken to provide a recommended option to legally integrate the two organisations. Members of both executive teams and trust boards had been engaged throughout the process and approved aspects of the process as appropriate. Partners had also been engaged and NHS England (NHSE) had supported and endorsed the process. It was highlighted that the process was purely about the legal mechanism for integration and was an enabler to transformational change to improve service delivery. LG explained that Option 6, the acquisition of BCH by WHH provided the best value for money and did not present significant delivery risks against the Department of Health and Social Care's (DHSC) risk assessment process JS reflected on the outputs of the Newton investigation and asked when more quantifiable benefits of the transaction would be made available to the Trust Board. NK responded that the transaction would help to seek out those quantifiable benefits. LG explained that work was underway to identify both clinical and corporate benefits, and whist some would have a financial benefit others would not. LG explained, if both Trust Boards approve the recommended option 6, the key next step was to share the draft milestone plan and associated draft transaction timetable with NHSE, which would commence the transaction process. The draft timeline proposes that the two organisations would become a single organisation in April 2027. Furthermore, it was explained that clinical pathway improvements and the integration of corporate services were expected to deliver ahead of completion of the legal transaction. **The Trust Board:** • **approved the recommended option of Warrington and Halton Teaching Hospitals NHSFT acquiring Bridgewater Community Healthcare NHSFT.** • **committed to commencing the formal NHSE transaction process.** • **Noted their legal obligations, including the duty to collaborate and NHS Code of Governance.**
BM/25/02/149	**Integrated Performance Report** NK introduced the agenda item which provided a summary of Trust performance. The Executive Team presented a set of summary slides which highlighted the two KPIs within the IPR that were both failing and had special

cause variation of a concerning nature. These were 23 Sepsis - % screening for all emergency patients and 71. Better Payment Practice Code

Quality:

23. Sepsis

PF explained the challenges in sepsis screening patients not having blood cultures within an hour, the change in clock start time with new sepsis measures and volumes of unwell patients in the department. It was explained that the majority of patients who failed this measure did so solely due to not having blood cultures within the hour.

PF provided reassurance around the improvement measures; blood cultures training for new qualified nursing staff, sepsis assessment trolley, exploring potential for ED HCA staff to be trained in taking blood cultures

AK explained the challenges around maintaining an aseptic field to take blood cultures particularly when caring for patients on ED corridors. AK further explained the work underway to ensure the sepsis assessment trolley was fully equipped and easily accessible in the ED.

JD confirmed that the Quality Assurance Committee were receiving assurance around the action plan for sepsis screening, to address the recent changes in national guidelines and improve compliance, it was highlighted that prior to the release of new guidance the Trust was seeing an improved trajectory, and that on comparison the Trust was still benchmarking well.

Finance and Sustainability:

72 Better payment practice code

JH explained that the team had undertaken a deep dive to identify the key drivers, it was explained that due to a lower number of invoices being approved in October, resulting in payment in November after they had timed out. These invoices had not been placed on hold / in query or transferred to an alternative approver whilst the budget managers were on annual leave which meant that the clock had continued running. JH reassured the Board that guidance was routinely emailed to budget managers advising them of this.

JH further explained that some delayed payments were of complex invoices for energy bills from large suppliers and that small to medium companies were typically being paid on time.

JH explained that At Month 9 the revised plan was a £13m deficit. The actual deficit was £15.6m with the overspend being due to a shortfall in funding in relation to Industrial Action and pay award, shortfall in CIP delivery, cost pressures that have not been offset as in previous months and PwC consultancy costs.

The latest submitted risk adjusted forecast was £19.9m deficit (£8.6m worse than plan). In month 10, the Trust has agreed to accept additional capital to improve the position, and therefore has a revised risk adjusted forecast of £7.8m deficit worse than plan.

People

MC highlighted the potential risk around AFC nursing and midwifery posts; however, this was currently being handled nationally. The NHS Job Evaluation Group had been undertaking a review of the national job matching profiles.

	The Trust had engaged in the process of job evaluation around identifying staff working outside of their "scope" as part of personal development reviews. JJ further highlighted that national review of Physician Associates (PAs), who had been subject to social media trolling. JJ confirmed that the role of physician associates was valued and supported by the Trust, a staff story had been provided to from one of the Trusts PAs highlighting the national issue. PF explained the support provided to PAs and the ongoing national review of their roles, highlighting that recruitment to PA posts had been suspended until the review was complete. It was explained that the Medical Council were asking 24/7 direct supervision by consultants, which would be impossible to deliver as part of the Trusts workforce model. PF agreed to provide the scope and ToR of the Leng review of Physician Associates to Board members, any emerging findings and potential impacts on the workforce model would be overseen by SPC. **Charitable Funds Committee** CR explained that the committee had introduced a Charity Impact Story at the start of each meeting. This was included for the first time in December 2024 and had been well received. JD asked in future the Board receive highlights of the positives within the IPR, examples of falls and elective recovery were highlighted. Executives agreed this would be included in the April report and presentation. **The Trust Board:** • **Noted the contents of the report.** • **Approved cash support of up to £5.166m from NHSE for March 2025.** • **Approved submission of the 2024/25 capital forecast position in line with plan as supported and approved by the Finance and Sustainability Committee.** • **Noted the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.**
QUALITY	
BM/25/02/150	**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: • The services currently designated as fragile were Urology, Orthopaedics Fractured Neck of Femur, ENT and Cardiology and Cardiorespiratory Services • **Urology** – the waiting list position had improved, however there had again been a deterioration 3-week waiters, assurance around how these patients were being tracked was to be presented to the QAC at its February meeting. • **Orthopaedics Fractured Neck of Femur** – remained a challenge particularly around access to theatres, there was an emergent risk around Orthogeriatric review capacity. • **Ear Nose and Throat Surgery** – The waiting list position had improved predominantly due to insourcing. Mitigations were in place for medical

	staffing challenges. Consultant staffing was improving with 3 consultants now in post. The service was becoming less fragile. Strategic reconfiguration work had started with mid and north Mersey to develop a sustainable ENT model. • **Cardiology and Cardiorespiratory Services** – had recently entered fragile services oversight. Demand and capacity mismatch was driven by vacancies and misalignment of demand and capacity in job plans. A job planning exercise was underway. **The Trust Board: noted:** • **the current list of Fragile Services, associated clinical risk and high-level progress updates**
BM/25/02/151	**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: i. Monthly Maternity and Neonatal review ii. MIS year 6 - Safety Action 4b - Anaesthetic, Neonatal and Medical Workforce overview iii. Safe Staffing Report iv. Avoiding Term Admissions into Neonatal Units (ATAIN) Q2 v. Transitional Care Audit Q2 Key themes taken from the summary paper and the Boards discussion were as follows - 15 moderate harm events had occurred in October and November, 14 related to 3rd degree tears in the maternity service. These were reviewed with no concerns identified. However, an increase in 3rd and 4th degree tears (OASI) had been noted in September and October, prompting a cluster review of 33 cases. - The results of the CQC maternity survey were positive with the WHH maternity service revealed to be one of eight Trusts across the country and one of only two in the northwest region whose results were rated as 'better than expected' overall - SMcG reflected on the patient survey, AGJ explained a detailed analysis of the report was underway, the learning and next steps from the analysis would be shared with QAC and Trust Board. The board noted that a new compliance manager was now in place who would be reviewing the data with the support of LMNS benchmarking, however given the data was from 12 months prior, many of the improvement actions were already complete. - The Board discussed Induction of Labour data November data from the LMNS which highlighted that the Trust continues to perform less well with regard to timeliness of IOL activity when compared to other local providers. It was explained that a review of data quality was underway to confirm the Trust was reporting in the same way as other providers. It was highlighted that Improvement work to improve IOL pathways had also commenced, and that a detailed paper was to be presented to the QAC in February.

	- In June 2024, learning from a cluster review of cases where maternal diabetes was a contributory factor was shared with QAC. An improvement project was initiated to address identified themes. - The Trusts ATAIN position was discussed it was noted that providers were providing data in a different way, some Trusts were not counting all babies that went to the neonatal unit, LMNS had confirmed the Trust were recording correctly. JJ queried the time taken for Maternity and Newborn Safety Investigations to be completed, AGJ explained that the MSNI and the Trust stayed in regular contact with families throughout the investigation process and that often investigations were completed in a shorter length of time. It was noted that some delays were caused by families not being ready to talk. SMcG reflected on the Maternity Voices Partnership, he detailed the recent conversations he had been involved in with a representative from the Warrington Walking Mums Group, and the intention to invite a member from the Group to sit as a Partner Governor on the Council of Governors **The Board of Directors noted the appended maternity reports as per national recommendations.**
PEOPLE	
BM/25/02/152	**Communications & Engagement Dashboard Report Q3** KH introduced the report, which had been presented and discussed in detail at the Governors Engagement Group meeting 3 February and would be presented to the Council of Governors on 20 February 2025. The following key points were highlighted: • The Communications and Engagement support for the new Chief Executive included the development of a combined Good Morning messages and refreshed Team Briefs across BCH and WHH. • A Chief Executive interview, discussing the need for a new hospital, had been published as an extended front-page report in the Warrington Guardian on 24 December 2024 • The launch of the redeveloped website for Warrington, Halton, St Helens and Knowsley Breast Screening Service in December 2024. The next website redevelopment project would be that of the charity. • It was noted that since the launch of the Trusts new website, accessibility had improved however there was some further work planned around minimising the use of PDF documents on the website in to improve further. The Board discussed the importance of ensuring the website was accessible to all, KH highlighted that the Expert by Experience group were helping to test websites to identify any issues early, to ensure accessibility to all groups. **The Trust Board noted the update.**
SUSTAINABILITY	
BM/25/02/153	**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: • The Living Well Hub in Warrington had seen over 9,300 visitors attend since the doors opened in mid-March 2024. Around 50% of these attendances had been people "dropping in" to the hub to access a service, and the remainder were for pre-booked appointments. • Community Diagnostics Centre – A more detailed report would be presented to the Finance and Sustainability Committee, around the delay to the third phase of the project, which meant first patients would not be seen until June 2025. It was noted that Kier had taken responsibility for the slippage meaning that that financial impact on the Trust had been mitigated • The new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) was now live and work had also commenced to implement a new gynaecology bleeding pathway utilising the new CDC spaces. • Runcorn Town Deal - the health and education hub project was being led by WHH and was one of 7 projects within the Town Deal plan. The hub would deliver services focussed on prevention, women and children and long-term conditions from a central location in Runcorn.. JD commented that it was important Patient Safety was ticked as one of the benefits of this project on future reports, LG agreed this would be actioned. • New Hospital – as per recent Government plans it was unlikely the Trust would receive funding for a new hospital until at least 2040, given this, the Trust would continue with the phased delivery option and to bid for funds as and when opportunities were available. **The Trust Board noted the report.**
BM/25/02/154	**Strategy Biannual Delivery Report** LG introduced the report explaining that in May 2023 the Trust Board ratified governance and reporting arrangements for the updated Trust Strategy 2023-25. It was agreed that reporting against the delivery of the Strategy would be standardised, including a bi-annual update of progress against the priorities within each of the strategic aims (Quality, People, Sustainability) to the appropriate board committee. The following key highlights were taken form the report: • There were 3 priorities that were behind expectations with limited or no mitigations, these were I. **We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.** It was explained that there were some concerns in Trust ability to reduce CO2 emissions, as the aging estate didn't allow the Trust to deliver. Further guidance had been received on green plans and all Trusts were required to update their green plans for the coming year. II. **We will deliver the Trust's agreed financial plan** – The Trust submitted a revised risk adjusted forecast with a variance of

	£8.6m. details of which had been discussed during agenda item BM/25/02/149, and would be a key item for discussion in Part 2 III. **We will deliver value for money by ensuring efficient use of resources**. Given the Trust was forecasting to be £8.6m worse than plan in 2024/25 and remains in receipt of cash funding, it is expected that the rating for Financial Sustainability will be red again for 2024/25. The report will be received in June 2025. LG explained the arrangements for extending the Trust Strategy to 2026 to enable a comprehensive review in line with the integration programme underway, including proposed updates to strategic objectives and priorities, and work ongoing to rationalise the Trust's Enabling Strategies. **Trust Board is asked to:** • **Noted progress against the delivery of the Trust Strategy 2023-25** • **Noted the process currently underway to refresh the Strategic Objectives and Priorities for the period 2025/26** • **Noted the programme of work underway to rationalise the Trust's Enabling Strategies ahead of the completion of the integration programme between the Trust and BCH**
GOVERNANCE	
BM/25/02/155	**Charity Commission Checklist** KH introduced the report which provided assurance against the six principles as per The Charity Commission for England and Wales guide to meeting Trustees duties. **The Trust Board noted the annual Charity Commission Checklist for Trustees.**
Supplementary Papers – To note for Assurance	
BM/25/02/156	**Learning From Deaths Q2**
BM/25/02/157	**Mortuary Licensed Activity Report (Including Fuller update) – Biannual Update**
BM/25/01/158	**Infection Prevention and Control Board Assurance Framework Compliance**
BM/25/02/159	**Violence Reduction Strategy**
BM/25/02/160	**Agenda for Change – Nursing & Midwifery Job Evaluation**
BM/25/02/161	**Digital Strategy Group Update**
BM/25/02/162	**Trust Senior Management Organograms**
Closing	
BM/25/02/163	**Review of the Meeting** The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items
BM/25/02/164	**Any Other Business** No further business was raised. **Meeting ended at 12:35pm**
The Date and Time of the next Trust Board Meeting is Wednesday 2 April 2025, Education Centre, Halton Hospital	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE	BM/25/04/03	SUBJECT:	ACTION LOG	DATE OF MEETING	02 April 2025

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/25/03/146	05.02.25	Board Assurance Framework (BAF)	Description of risks 1898 and 145 to be reviewed to align with integration work.	JC/LG	02.04.2025	02.04.2025	See agenda item **BM/25/04/07**	
BM/25/02/149	05.02.25	IPR	Highlight slides to include positive trajectories and improvements within the IPR, i.e. falls and elective recovery	Executives	02.04.2025	05.02.25	See agenda item **BM/25/04/08**	

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 – Date to be confirmed during 2025/26	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/25/02/149	05.02.25	IPR	To provide the scope and ToR of the Leng review of Physician	PF	02.04.2025	05.02.25	Being monitored through SPC and email sent to Trust Board members with	

			Associates to Board members				scope and ToR of the Leng review.	

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/25/04/05**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	2 April 2025			
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/25/04/05

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 5 February 2025, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 National News

Recently, Prime Minister Sir Keir Starmer announced plans to abolish NHS England and take its functions back into the Department of Health and Social Care (DHSC). In doing so, it is expected there will be a 50 per cent reduction in staffing numbers (around 9,000 posts). It has also been confirmed that Integrated Care Boards (such as NHS Cheshire and Merseyside) are expected to reduce their running costs by 50 per cent by Quarter 3 of the upcoming financial year. The desire to ensure every NHS pound is optimised so we can give our patients the best care within the resources available.

The goal is to eliminate bureaucracy, save hundreds of millions, and optimise NHS resources for better patient care. While the NHS will remain free and maintain current services, the transition will begin immediately but could take up to two years due to legislative changes.

Locally, Warrington and Halton Teaching Hospitals (WHH) and Bridgewater Community Healthcare (BCH) face existing financial deficits and must achieve significant savings respectively in the next financial year. Plans to meet these targets are being finalised, necessitating changes to the organisations' size and structure while prioritising safe, quality care.

Whilst all this is taking place, the focus remains on valuing staff and improving care amidst these reforms.

2.2 Local Leadership News

Bridgewater Community Healthcare NHS FT - Back in December 2024, it was announced that Karen Bliss, Bridgewater's Chair, would be stepping down at the end of March.

Following a competitive selection process, interviews took place in February 2025,, and a candidate was chosen, with formal approval granted yesterday by Bridgewater's Council of Governors.

I'm delighted to announce that Martyn Taylor assumed the role of Bridgewater's Chair starting 1 April 2025, for a 12-month term. Martyn has served as a non-executive director and senior independent director at Bridgewater for the past three years.

NHS Cheshire & Merseyside - After a thorough national recruitment effort, Cathy Elliott has been named Chief Executive of NHS Cheshire and Merseyside. Throughout the recently concluded selection process. Currently serving as Chair of NHS West Yorkshire Integrated Care Board and Deputy Chair of West Yorkshire Health and Care Partnership, Cathy brings a

diverse and extensive skill set to Cheshire and Merseyside, developed through senior leadership roles across multiple systems and industries

Countess of Chester Hospital NHS Foundation Trust - The Countess of Chester Hospital NHS Foundation Trust has appointed Neil Large MBE as Interim Chair of its Board of Directors, effective 1 March 2025, for six months. This follows collaboration with Cheshire and Merseyside Integrated Care Board (ICB), where Neil currently serves as a Non-Executive Director, a role he will temporarily leave. The interim arrangement ensures stability while a thorough recruitment process for a permanent Chair begins soon.

2.3 Integration

Previously, I outlined the options appraisal process we conducted to determine the best legal approach for merging Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT). The goal is to enhance our ability to improve services and care pathways for the benefit of our patients and local communities.

The options appraisal panel unanimously recommended that WHH acquire BCHT. This proposal was submitted to both Trust Boards in February, and pleasingly that it has been ratified and agreed this is the best path forward for us as a collective.

As I've mentioned previously, uniting our organisations in this manner won't alter our current efforts to collaborate closely as a single team, guided by our shared values and policies. Rather, it will allow us to officially become one entity, pooling our skills and resources effectively to address today's healthcare challenges and those of the future.

What's Next? While we continue advancing our integration efforts, which are already in progress, we will now also begin the 'transaction' phase of this journey. Pending all necessary approvals, our aim is to operate as a single organisation by April 2027, if not before. This transaction process is intricate and time-consuming, but we believe this timeline is both ambitious and realistic.

We intend to merge some services ahead of this date, as uniting sooner offers clear advantages for staff and patients alike. Ongoing efforts within the Better Care Together program—spanning clinical services, corporate functions, estates, and workforce—will be critical to achieving this.

We will be seeking staff perspectives throughout this process on how we can improve as a unified organisation for our patients, services, and communities.

What's in a name? Next steps following our partnership name survey

Thank you to everyone who shared their views in the partnership name survey in January and February. We've pored over the feedback and agreed a way forward at both organisations' Boards earlier this month. To recap, we asked for thoughts on five suggested names to reflect the partnership of our organisations over the next two years, and to inform our future unified organisation's name from April 2027. We also asked for any other suggestions people might have.

We received 370 responses – 77% from staff, 19% from patients, carers and members of the public, and 10% from community groups and partner organisations. In these responses, we

received 178 suggestions for alternative names to consider – most were sensible, a few were definitely amusing! (No, we won't be calling our partnership Warry McHaltface!)

The feedback we received can be summarised as:

- A preference for more geographically specific locations such as North Cheshire, Warrington and Halton
- A dislike for the term 'Mid Mersey'
- A clear desire for the name to feel different that our two existing organisation names, to reflect that we are creating something new together
- A challenge finding a name that works for all of our services, across all of our geographies (for example dental services in Greater Manchester, children's audiology services in Knowsley, and community equipment services in St Helens)

Ultimately, the feedback confirmed that a perfect solution doesn't exist!

So, after careful consideration, taking all the feedback into account and trying to find the most suitable option, our two Boards agreed to go with a name derived from an alternative suggestion: '**North Cheshire and Mersey Healthcare Partnership**'. This will evolve into our future organisational name in April 2027 when we plan to become 'North Cheshire and Mersey NHS Foundation Trust', subject to approval as part of the NHS transaction process required.

2.4 Cheshire & Mersey Devolution

After the Deputy Prime Minister announced six new devolution regions, with plans for mayoral elections by May 2026, a government-led consultation was launched on 5 February 2025, to explore establishing a Mayoral Combined Authority for Cheshire East Council, Cheshire West and Chester Council, and Warrington Borough Council under the Devolution Priority Programme. The consultation began on 17 February 2025 and will run until 13 April 2025. It seeks input from the public and stakeholders on topics such as geography, governance, economic development, social benefits, local services, environmental progress, and community priorities. The process is available online through GOV.UK and the Citizenspace platform.

2.5 Cheshire and Merseyside Acute and Specialist Trust (CMAST) Leadership Board

On March 7th, the CMAST Leadership Board convened to tackle significant system-wide matters. They evaluated advancements made by the CMAST Cardiology Alliance, which is working toward a sustainable cardiology framework. The emphasis is on improving access to diagnostic services and maximising the efficiency of Cardiac Catheterisation Laboratories.

The Board also explored Medicines Optimisation, focusing on high-cost medications, and highlighted a £10.2m saving—exceeding expectations by 40%—driven by NHSE and ICB investments in homecare teams and medication adjustments.

Financial planning was another key topic, with conversations centered on aiding providers, promoting uniformity, and pinpointing creative, forward-thinking solutions for long-term service design in C&M.

Updates were also shared on system finances and operational performance.

2.6 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 11 – February 2025. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.7 Going further, faster – Gynaecology Super Clinics

If you tuned into BBC Breakfast on Sunday 16 March 2025, you may have seen some familiar faces from our Gynaecology Department at Warrington Hospital.

The interview shared insight into our Gynaecology Super Clinics, as part of national media coverage focused on the success of 'Further Faster 20' - an initiative that is part of the national Getting It Right First Time (GIRFT) programme. WHH is one of 20 trusts taking part in the initiative to transform patient pathways and improve access to treatment.

The coverage not only highlighted what a fantastic job the team are doing, but our commitment to innovative clinical transformation to reduce waiting lists and give patients the treatment they need quicker.

A big thank you to all the team who gave up their time to take part in the coverage and to the wider team who have made the Super Clinics such a success.

2.8 Staff Survey 2024

Every one of us has a voice that matters, and each year, the NHS Staff Survey offers us all a chance to share it.

The survey helps us gain insight into staff experiences, highlighting what we're doing right and where we can do better. By learning staff you feel about our part of the NHS, we can foster an inclusive, safe environment where everyone feels valued, ultimately improving patient care and experiences.

On 13 March 2025, the 2024 Staff Survey results were released. I'm delighted to report that WHH achieved a 52% response rate, our highest ever. This reflects how much we all appreciate the chance to have our say.

Later on today's agenda, details of analysis have been provided noting common themes and areas for growth.

We're dedicated to listening and acting on what the Staff Survey reveals, and we'll use these latest findings to keep making our workplaces somewhere you can all flourish.

2.9 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:

February

- LGBT+ History Month
- National Apprenticeship Week
- Ramadan EID al Fitr

March

- Ramadan EID al Fitr
- National No Smoking Day
- Nutrition & Hydration Week
- World Tuberculosis (TB) Day
- World Down Syndrome Day
- International Women's Day
- World Hearing Day

2.10 Employee Recognition

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

You Made A Difference Award (February 2025): Claerwen Snell and Bethany Millington, Speech and Language Therapy.

WHH Thank You Awards – meet your 2024-25 finalists

Since the last meeting, I've had the honour of announcing the finalists of our Warrington and Halton Teaching Hospitals Thank You Awards 2024-25.

It is testament to the positive culture we are continuing to build across both our Trust that we receive so many brilliant submissions for our staff recognition events. Our judging panels at WHH had the task of attempting to whittle down more than 300 nominations to get to our final shortlist of 36 nominees. Having read some of the nominations myself I know this has been no easy feat.

Thank you once again to everyone who took the time to submit a nomination; like last year we will be acknowledging all of them and sharing with individual nominees once the awards ceremony has taken place.

I want to congratulate all of our very worthy finalists featured below. Despite our ongoing pressures and financial challenges, it remains vitally important that we take the time to reflect on our achievements and successes, and it's clear from the record number of entries we received that so many of you have made a significant and lasting impression on your colleagues and teams.

So please join me in congratulating our 2024-25 finalists (listed in alphabetical order within each category):

Planned Care Team of the Year

1. Birth Suite Team
2. Gynaecology Team
3. Team River (Enhanced Midwifery Care Team)

Unplanned Care Team of the Year

1. Forget Me Not Unit (Ward B12)
2. Transfer of Care Hub
3. Ward A8, General Medicine

Clinical Support Services Team of the Year

1. Musculoskeletal Clinical Assessment and Triage Service
2. Outpatients Department
3. Outpatient Neurological Rehabilitation Team

Corporate Services Team of the Year

1. Communications and Engagement Team
2. Culture, Inclusion and Staff Engagement Team
3. Procurement Team

Living Our Values Award: Colleague of the Year (Clinical)

1. Kaley Whelan, Trainee Advanced Clinical Practitioner (UEC, Acute Medicine)
2. Dr Lesley Moore, Specialty Doctor (IMC Care of the Elderly, Stroke Medicine)
3. Mark Fitzpatrick, Theatre Practitioner (Warrington Theatres)

Living Our Values Award: Colleague of the Year (Non-Clinical)

1. Janet Parker, Deputy Director (Finance)
2. Samantha Durcan, Medical Secretary (Palliative Care Team)
3. Paula Butterworth, Assistant CBU manager (Intermediate Care)

Innovation and Improvement Award

1. Gynaecology Super Clinic Team
2. Virtual Wards Pharmacy Team
3. Paediatric Diabetes Team

Culture and Inclusion Award

1. Clare Fairhurst, Clinical Team Manager (Acute Medical Therapies)
2. Organisational Development Team
3. Digital Analytics Team

Rising Star Award

1. Babu Dharmarajan, Clinical Educator (Integrated Medicine and Community)
2. Erin Tighe, Financial Accounts Assistant (Management Accounts)
3. Pam Aldred, Midwife (Maternity)

Leadership Award

1. Kate Davidson, Medical Education Manager (Medical Education)
2. Lydia Davies, Lead Radiographer (Breast Screening Services)
3. Nancy Harrington, Speech and Language Manager (Therapies)

You Made A Difference Award

1. Felicity Lewis, Specialist Physiotherapist, Rapid Response Team – September 2024 recipient
2. Sandra Millington, Sister, Early Pregnancy Unit, Women's Day Care – March 2024 recipient
3. Wards A3 (Acute Cardiac Care Unit) and B18 (Respiratory Care) – October 2024 recipient

People's Choice Award

1. Jonathan Cliffe, Midwifery Team Leader (Team River)
2. Louise Foley, Specialist Nurse (Colorectal Team)

3. Sue Jones, Specialist Nurse (Children's Epilepsy Team)

The winners will be announced at our WHH Thank You Awards ceremony on Friday 16 May at the Titanic Hotel in Liverpool, where we will be celebrating the contribution made by all of our colleagues and volunteers over the past 12 months. A special Outstanding Achievement Award will also be presented on the night.

2.11 Signed under Seal

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

- Upgrading of the roof of Halton 'C' Block
- Upgrading of Corridor Roof

2 RECOMMENDATIONS

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

3 APPENDICES

Appendix 1: CEO Dashboard – Month 11 (February 2024)

Appendix 1 - CEO Dashboard Month 11 – February 2025

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	95.05%	
RTT 18 Weeks	92.00%	57.86%	
RTT 65+ Weeks	0	1455	
A&E % patients seen within 4 hours	> 75.00%	62.42%	
A&E % waiting longer than 12 hours	< 2.00%	24.08%	
Cancer 28 Day Faster Diagnostic Standard	75.00%	70.30%	
Cancer 62 Day Wait	85.00%	73.70%	
Ambulance Handovers within 60 mins	100%	83.90%	
Discharge Summaries 24 hours	95.00%	89.77%	
Cancelled Operations – 28 days	0	3	
Super Stranded Patients	Trajectory	155	No SPC
Uncapped Theatre Utilisation	85.00%	78.40%	
Capped Theatre Utilisation	85.00%	73.40%	

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	9	
Sepsis Screening Emergency	90.00%	36.00%	
Sepsis Screening Inpatients	90.00%	72.00%	
Sepsis Antibiotics Emergency	90.00%	52.00%	
Sepsis Antibiotics Inpatient	90.00%	68.00%	
Inpatient Falls	20.00% reduction	20	
VTE	95.49%	92.77%	
Pressure Ulcers	10.00% reduction	19	
Medication Reconciliation (24 hrs)	80.00%	50.00%	
Complaints over 6 months	0	2	No SPC
Healthcare Infections - MRSA	0	3 YTD	
Healthcare Infections - MSSA	N/A	34 YTD	No SPC
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	83 YTD	
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	82 YTD	
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	26 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	8 YTD	
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	5.20%	
MUST nutritional assessment completion	85%	62.90%	

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (£m)	-£0.71	-£2.14	No SPC
Capital Spend (£m)	£18.85	£12.07	
Cash Balance (£m)	£6.65	£12.54	No SPC
Better Practice Payment Code (£m)	95%	89%	
CIP In Year Delivered in relation to plan	90%	92%	
CIP In Year Delivered in relation to plan (Recurrent)	90%	70%	
Agency Ceiling	Less than 3.7%	1.9%	

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.93%	
Retention	85.00%	87.28%	
Core/Mandatory Training	85.00%	90.22%	
PDR Compliance	85.00%	78.24%	

Strategy

- **WHH and BCH's respective Trust Boards have now approved the intention for WHH to formally acquire BCH and become one single integrated organisation.** These approvals trigger the start of a transaction process, and it is anticipated that the single organisation will take effect from 1st April 2027, pending approvals. Work continues across all ten workstreams and the process of developing the strategic business case has commenced. The Clinical and Operational services group have facilitated two clinical summits to consider pathways within services identified as priorities for integration

- **The Living Well Hub has recently celebrated its first full year in operation.** During that time, over 15,200 visitors have been through the doors with around 50% of these attendances from people "dropping in" to access a service, and the other 50% attending for pre-booked appointments.

- **Over 89,000 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.

- **The brand-new Living Well on-line in Warrington (virtual health and wellbeing hub) is due to go-live in March.** The new digital platform continues the pioneering collaborative work across Warrington place under the Living Well programme.

- **The new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is embedded** and **work continues to implement the new post menopausal bleeding pathway within the CDC in Halton.** This will enable women to access a one stop clinic for diagnosis of gynaecological cancers.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/07**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	All Executives			
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):*	**Board Assurance Framework** This report provides an update on the Trust's 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:** • Risks 1898, 145 and 125 have been merged to form a single strategic risk 2273 monitored by the Finance and Sustainability Committee (FSC). Given this, risks 1898			

	and 145 have been closed and risk 125 deescalated to the Corporate Risk Register (CRR), these changes have been supported by the FSC and executive leads • The description of risk 2253 has been updated to capture more detail on the *risks associated with shared Board roles, as discussed in the February Board meeting.* • There have been no updates to risk ratings • No target risk ratings or risk appetites have changed Key updates to existing risk; controls, assurances and gaps are detailed within section 2.6 of the report. Detailed individual strategic risk 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.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to: • Discuss and approve the changes and updates to the Strategic Risk Register and Board Assurance Framework • Approve the closure of strategic risks 1898 and 145 along with the de-escalation of risk 125 to the CRR • Approve the introduction of the new strategic risk 2273		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee, Audit Committee	
	Agenda Ref.	Multiple	
	Date of meeting	Multiple	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/25/04/07

1. BACKGROUND/CONTEXT

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. This report provides an update on the Trusts strategic risks as per the Board Assurance Framework.

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 and linked to the Trust's strategic objectives

The latest Board Assurance Framework (BAF) is included as **Appendix 1.** A summary of the current status of each of the Trusts strategic risks, should the proposed amendments within this paper be approved, 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
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	16 (L4xC4) ⟷	Minimal	FSC

		triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety			
2273 **New**	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	16 (L4xC4)	Cautious	FSC
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.	12 (L3xC4) ⟷	Seek	QAC
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 (L3xC5) ⟷	Open	SPC
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management	9 (L3xC3) ⟷	Open	EMT

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

At its meeting 24 March 2025 the Finance and Sustainability Committee (FSC) approved the merger of strategic risks 1898, 145 and 125 to form a single strategic risk 2273, monitored by the FSC. Given this, risks 1898 and 145 have been closed and risk 125 deescalated to the Corporate Risk Register, these changes were supported by both the FSC (24 February 2025) and executive leads, further details are provided below.

Previous risks:

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Risk Appetite	Monitoring Committee
1898 **Closed**	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	3	16 (L4xC4)	Seek	Finance & Sustainability Committee

		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* **Deescalated to CRR**	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)	Open	Executive Management Team
145* **closed**	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)	Open	Executive Management Team

New Strategic Risk:

2273	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	3	16 (L4xC4)	Seek	Finance & Sustainability Committee

2.2 Amendment to risk ratings

Since the last meeting there have been no amendments to risk ratings.

2.3 Amendments to descriptions

The description of risk 2253 has been updated, in order to capture more detail on the risks associated with shared board roles, as discussed in the February Trust Board meeting.

Previous risk description

If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, potentially impacting both Trusts' decision-making and service management.

New risk description:

If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management

2.4 De-escalation of risks

As detailed in section 2.1, risks, 1898 and 145 have been closed and risk 125 deescalated to the Corporate Risk Register, as supported by the Finance and Sustainability Committee and executive leads.

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
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 resulting in an overcrowded Emergency Department.	**Controls** • Trust Wide Capacity meetings led by the Tactical Manager for the day four time a day, bed reports detailing site position, risks and actions circulated 6 times per day • Strategic, Tactical, Operational management structure in place with clear roles and responsibilities aligned to roles • Bi-annual training provided to Tactical managers provided by the EPRR Lead and Director of Operations and Performance • Daily C&M system calls with the system control centre to escalate any risks or any external delays Additional bed capacity opened in response to surge in hospital	**20**	**none**
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then	**Controls**	**20**	

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	• Weekly review meetings with C&M diagnostics hub, Mutual aid opportunities utilised across C&M to reduce delays • Capacity identified and being utilised with appropriate independent sector providers and through mutual aid and surgical hubs • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2025/2026 to support recovery will be reviewed to ensure value for money **Assurances** • Trust Board support for additional use of independent sector to reduce waiting times. Monthly reporting to the Finance and Sustainability Committee. Regional funding to provide 10 additional Cystoscopy lists by April 25 and on-going mutual aid with Arrow Park for Sleep studies		
134	If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken	**Controls** • CDC phase 1 & 2 complete. Phase 3 to be completed by Spring 2025 • Revenue plans 2024/25 approved by the Trust Board in June 2024, high level update on 2025/26 operational plan taken to Board January 202, draft plan approved at Board 5 Feb 25, with update received 5 March • 2023/24 position was in line with original plans and with the reported likely forecast throughout the year. 2024/25 Month 11 position was in line with the forecast, for £7.8m off plan. PWC final report signed off, recommendations being actioned and monitored each has an Exec lead and PID. • 20245/25 received high assurance for gen ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement • Implemented reduction in bank rates 13/01/25, reducing exp circa £700k p.m. • National cash team have indicated that they will not accept cash support application in April 2025 / Q1, the suggested new process will be a meeting with Provider DoF and NHSE Deputy CFO. The Trust has provided the regional team with our Q1 cash requirements which they will collate and submit to the national team for an indication of potential cash requirements. **Assurances** • 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. YTD Month 11 agency is 1.3% • C&M ICS have indicated that there should be a 4% reduction in staffing in the 2025/26 plan in line with the 5% CIP target	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• 2025/26 Operational Plan has been submitted in February 2025. • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position, plus request for cash support approved at Trust Board as required. • In November 2024 submitted revised risk adjusted forecast with £8.6m variance from the control total, following full review of CIP, cost pressures, IA and pay award. In January the position improved to £7.8m variance. **Control & Assurance Gaps** • Additional capacity remained open in quarter 1 closed in June 2024, capacity which should have closed mid-January remains open in March 2025 • Development of Delivery Unit to ensure achievement of operational planned targets.		
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.	**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 assessment is being conducted during February and April 25 **Gaps in Controls** Unsupported software being used by BadgerNet	16	No impact on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	**Assurances** • Plan in place to mitigate for potential coterminous implementation of LIMS – January 2025 • Submitted a OBDC request, approved by ePR IB Board (22/01/24). EMD to take to Executives to approve (23/01/24) which will enable the TRUST to relaunch the ITT January. **Controls** • The collaboration agreement has been developed and endorsed by the joint Procurement Delivery Group and EPCMS Project Group – March 2025	16	No impact on risk rating
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.	**Controls** • Fortnightly review of bank use/staffing challenges at Executive Management Team Meeting, • Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of governance • Gant Chart mapping projections of Maternity Leave and Supernumerary Staff • Sickness Clinics held monthly with Chief Nurse **Assurances**	12	none

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.83 % in December 2024 • Overall CHPPD sustained between 7.6-7.9 in Q3. • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.91% in December 2024 • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. 15 first year students commence in January 2025 and 50 2nd year students return to placement in February 2025 • Cost avoidance of £2,168,508 m (end December 2025) from agency managed service contract started August 2022 • The number of wards achieving 90% fill rate increased to 22 wards in December 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 – an average of 35 additional escalation beds per day were open throughout January 2025 • In quarter 3 over 1200 patients were admitted to WHH with a mental health condition Admissions of patients over 65 continues to range between 900 to 1000 per month.		
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.9% as at February 2025 and is showing a slight increase from December 2024 (5.8%) which is reflective of seasonal trend with an increase in coughs, colds, flu and covid. Trust target is currently 4.2% and is being proposed to increase to 5% following a recent benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. This has been approved by the Strategic People Committee on 19th February 2025 and is being recommended to Trust Board in April 2025 for approval to commence from 1st April 2025. **Controls** • Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. Review of Supporting Attendance Policy underway March 2025. **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	12	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		from 4.39% in April 2022 to 3.8 % in February 2025. • Deep dive focus into Nursing and Midwifery sickness absence currently taking place due to rates being higher according to Model Hospital data. **Turnover and Attraction** Turnover in February 2025 remains below the target of 13% at 12.3%, the same as reported in December 2024. Turnover of permanent staff in February 2025 was 11.74%. The Trust's February 2025 vacancy rate has decreased slightly to 8.09% from 8.26% in December 2024, Trust target is below 9%. **Temporary Staffing and Agency spend** Bank and Agency reliance in February 2025 was 12.9% compared to 13.8% in December 2024. The Trust target is 9%. Bank reliance has reduced to 11.2% from 12.7% in December 2024 and agency reliance continues to decrease to 1.4% compared to 1.6% in December 2024.		

6. RECOMMENDATIONS

The Board is asked to:

- Discuss and approve the changes and updates to the Strategic Risk Register and Board Assurance Framework
- Approve the closure of strategic risks 1898 and 145 along with the de-escalation of risk 125 to the CRR
- Approve the introduction of the new strategic risk 2273

Appendix 1

Board Assurance Framework April 2025

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
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
2273 **New Risk**	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs,	3	16 (L4xC4)	9 (L3 xC3)	Seek	Finance & Sustainability Committee

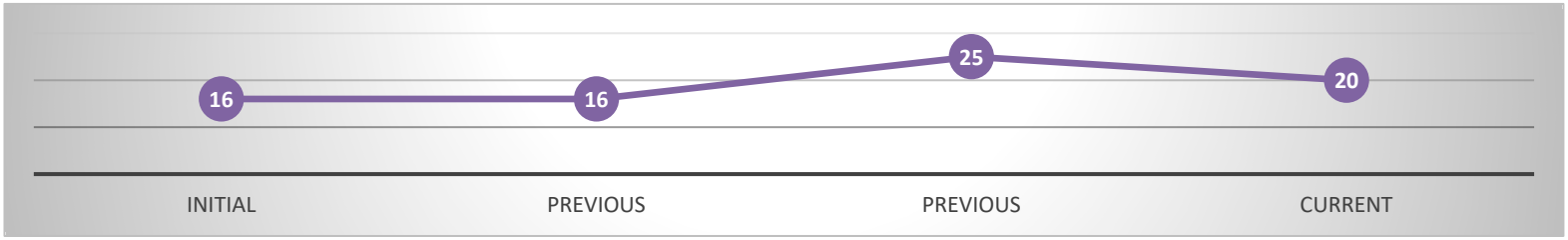
		short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances					
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	12 (L3xC4)	8 (L2xC4)	Minimal	Quality Assurance Committee
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
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management	1,2,3	9 (L3xC3)	2 (1LxC2)	Open	Executive Management Team

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

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** • Trust Wide Capacity meetings led by the Tactical Manager for the day four time a day, bed reports detailing site position, risks and actions circulated 6 times per day • Strategic, Tactical, Operational management structure in place with clear roles and responsibilities aligned to roles • Bi-annual training provided to Tactical managers provided by the EPRR Lead and Director of Operations and Performance • Daily C&M system calls with the system control centre to escalate any risks or any external delays • 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. • Additional bed capacity opened in response to surge in hospital • 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.				

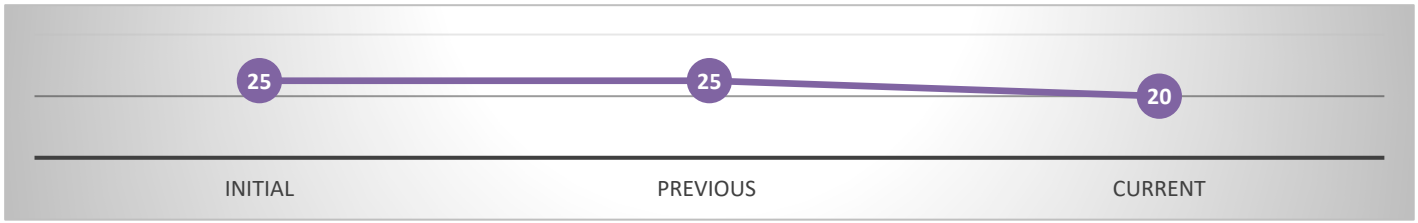
	• Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2024/25 to support flow and urgent care • The Performance 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 • 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	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

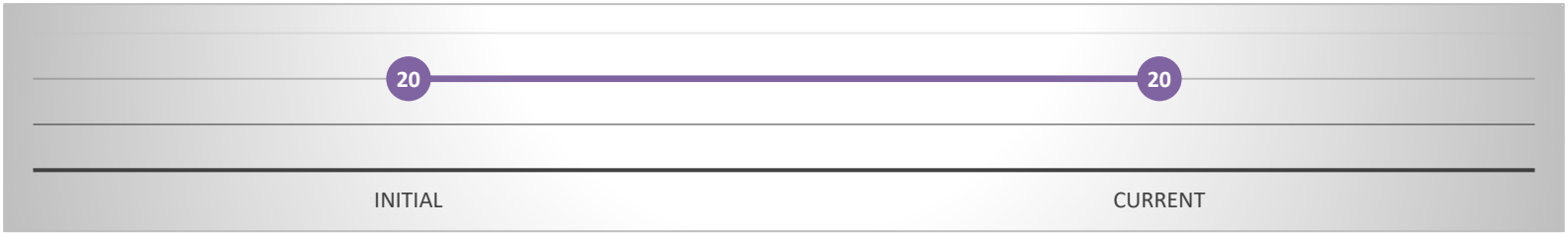
Risk ID	1215	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust does not have sufficient capacity (theatres, 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. • Weekly review meetings with C&M diagnostics hub, Mutual aid opportunities utilised across C&M to reduce delays • 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 and through mutual aid and surgical hubs • 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 Septe 2-25 (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. • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2025/2026 to support recovery will be reviewed to ensure value for money • 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 reduce waiting times. Monthly reporting to the Finance and Sustainability Committee. • Regional funding to provide 10 additional Cystoscopy lists by April 25 and on-going mutual aid with Arrow Park for Sleep studies
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	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 • Deputy 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 18/11/24 • Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to FSC embedded. • Appointed GIRFT Finance Lead and 5 PAs allocated and 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 Spring2025 • Capital Plans for 2024/25 approved by the Trust Board in March 2024. Draft Capital Plan for 2025/26 approved at November Trust Board meeting. • Revenue plans 2024/25 approved by the Trust Board in June 2024, high level update on 2025/26 operational plan taken to Board January 202, draft plan approved at Board 5 Feb 25, with update received 5 March • 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. 2024/25 Month 11 position was in line with the forecast, for £7.8m off plan. • 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 • Tightening controls of non-pay expenditure with executive review of catalogue spend and implemented cease option to purchase some items • Cash Support received for 2024/25 as at 31 December is £12.145m. The maximum expected amount of revenue cash support required for March 2025 is £5.166m.				

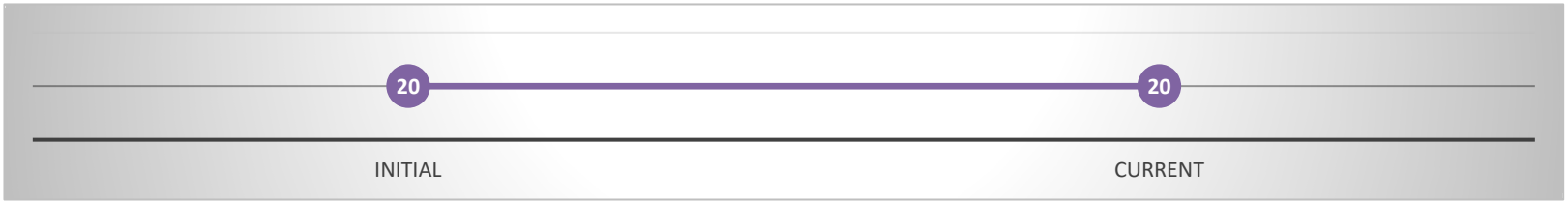
	• Enhanced ECF meetings in place with Chief Executive sign off, with ICS invited. Bridgewater Community Healthcare NHS FT in attendance. • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • 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. • review of Nurse variable pay – 3 times per week • Weekly review of medic variable pay • PWC final report signed off, recommendations being actioned and monitored each has an Exec lead and PID. • 20245/25 received high assurance for gen ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement • Implemented reduction in bank rates 13/01/25, reducing exp circa £700k p.m. • National cash team have indicated that they will not accept cash support application in April 2025 / Q1, the suggested new process will be a meeting with Provider Dof and NHSE Deputy CFO. The Trust has provided the regional team with our Q1 cash requirements which they will collate and submit to the national team for an indication of potential cash requirements. **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. YTD Month 11 agency is 1.3% • C&M ICS have indicated that there should be a 4% reduction in staffing in the 2025/26 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We 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. • Draft2025/26 Operational Plan has been submitted in February 2025. • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position, plus request for cash support approved at Trust Board as required. • 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 £8.6m variance from the control total, following full review of CIP, cost pressures, IA and pay award. In January the position improved to £7.8m variance.
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, capacity which should have closed mid-January remains open in March 2025 • 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/ CIPThere is a risk that NHSE will not approve the cash request. Mitigations to this could include, using capital cash in the short term and delay of payments to creditors • Development of Delivery Unit to ensure achievement of operational planned targets.

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	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 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) • Increasing demand				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Fragile services actions to be managed through individual Fragile Services action plans	Fragile Services action plans reviewed at PSCESC	Continued review of Fragile Services action plans at PSCESC	PF	ongoing	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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:** • Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • 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:** • **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. • [**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 • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • Secondary secure backup at Halton Data Centre • [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy				

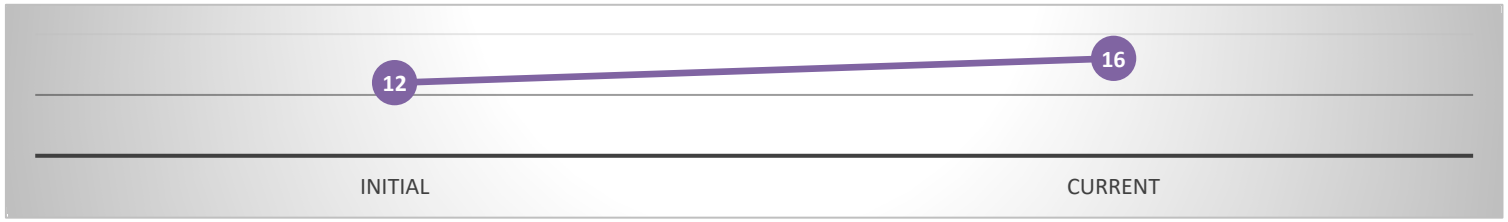
	• New Phishing exercise by NHS England has been arranged for 24/25 • Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • MFA active on new starters for NHSMail • MUSE migrated to new server
Assurance 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 assessment is being conducted during February and April 25 • 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” • No dedicated logging tool to pull all key logs together and provide useable alerts. • Lack of process to check antivirus/MDE alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Version 7 of Clinisys Ice is end of life • Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network. • Unsupported software being used by BadgerNet

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows	Migrate all 2003 and 2008 servers to 2016.	The SIRO has asked iMerseyside to provide support to migrate the remaining HR elements of the ECF process to SharePoint Online. 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.	Deacon, Stephen	31/03/25	

Server 2008 to Windows 2016 (Latest server operating system).					
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 Testing of the migrated reports found the technical process that HD clinical are using to migrate reports from old system to new is unreliable. While working with the vendor to resolve, an in place upgrade of the server operating system is being considered. This would resolve any cyber-related issues.	Waterfield, Tracie	31/03/25	
Multifactor authorisation (MFA/PAM) 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.	National monies identified and obtained for the purchase of a Privilege Access Management (PAM) system. This will protect network accounts with elevated admin controls, whether on the network or on the critical systems. Evaluation and purchase of a common PAM system between WHHT & BW is being considered. Once purchased the system will need to be installed and configured.	Deacon, Stephen	31/05/2025	
Migrate Windows 10 to Windows 11	Migrate Windows 10 to Windows 11 before end of life date of 30/10/25	Migrate Windows 10 to Windows 11 before end of life date of 30/10/25 Process: Testing in IT Services (COMPLETE) Testing with critical systems (COMPLETE) Rollout with new devices (STARTED) Rollout with rebuilt devices (STARTED)	Waterfield, Tracie	31/10/2025	
Migrate/decommission Windows Server 2016	Migrate/decommission Windows Server 2016 to the newest version of Windows Server as support for security updates case in Oct 2026	Develop action plan for migration for the more difficult servers to migrate. Currently 8/67 (12%) have been migrated or decommissioned.	Waterfield, Tracie	29/01/2027	
Removal of generic Window accounts	Removal of generic Window accounts	Plan for the removal of generic Window accounts in clinical areas to reduce cyber risks. Staff to log in as their own accounts. Planning of the	Waterfield, Tracie	31/12/25	

		removal is required to minimise clinical disruption to patient care.			
Mitigate the unsupported software used in BadgerNet	BadgerNet products have been discovered to have 2 3rd party components used within BadgerNet that no longer under support from their vendors. They have made NHS England and the National Chief Midwifery Information Officer (CMdIO) team aware and provided a mitigation plan.	The 69 release is schedule for 18th March to retire the code referring to the out-of-support software, but the software will be on the clients. The Trust can remove the software manually from the devices after the 69 release as it will not be handing any data (can be a bit of work for IT Services), however, 70 release in June will clean up the software fully which will require a client install. Whether we remove the binaries or wait until release 70 client will be individual trust decision. Vendors and NHS Cyber Security Operations Centre (CSOC) consider the risk to be low. While no vulnerabilities have been found in SQL CE v3.5, it's important to note that it will not receive patches if any are discovered in the future.	Deacon, Stephen	30/06/25	

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">Assurances:
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
• Plan in place to mitigate for potential coterminous implementation of LIMS – January 2025
• Submitted a OBDC request, approved by ePR IB Board (22/01/24). EMD to take to Executives to approve (23/01/24) which will enable the TRUST to relaunch the ITT January.

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 and FD program supportive of managed convergence relaunch in partnership with Merseyside and West Lancs NHS Trust – 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
• The collaboration agreement has been developed and endorsed by the joint Procurement Delivery Group and EPCMS Project Group – March 2025</td></tr>
<tr><td>Assurance Gaps</td><td colspan="5">Gaps In Assurance
• New Frontline Digitisation (FD) EPR Convergence Guidance (November 2024) represents significant challenge
• Requires partnership procurement and a single EPR instance to be fully compliant with guidance and to gain access to FD Funding
• Direct consolidation to a single EPR instance appears non-viable in current timeframe – possible approaches being explored with MWL, NHSE and FD
• 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</td></tr>
</table>

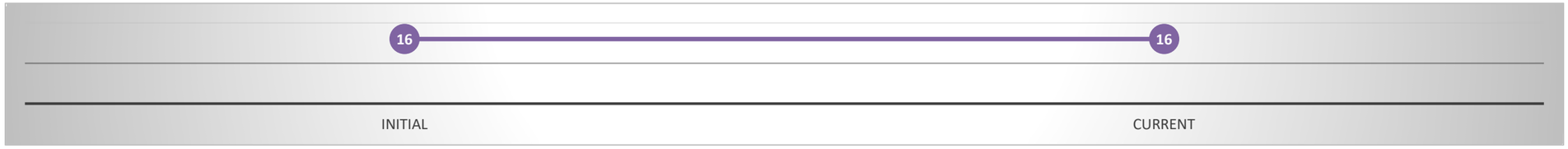
Board Assurance Framework

	• Deficit in programme year 3 • Further assurance required regarding state of readiness for implementation

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop the programme governance model for the joint EPR procurement, and subsequent implementation for approval by trust boards	Develop the programme governance model for the joint EPR procurement, and subsequent implementation for approval by trust boards	The governance chart is in draft awaiting for the joint Exec Programme Board to be set up. Exec to Exec meeting took place 10th March working towards setting up Exec Programme Board in April.	Poulter, Tom	30/04/2025	
Co-develop procurement (and if possible, implementation) timeline with LPP for Trust Board approval	Co-develop procurement (and if possible, implementation) timeline with LPP for Trust Board approval	Joint planning meeting took place 4th March joint plan agreed ready for Exec Programme Board approval. Working towards setting Exec Programme Board in April	Poulter, Tom	30/04/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

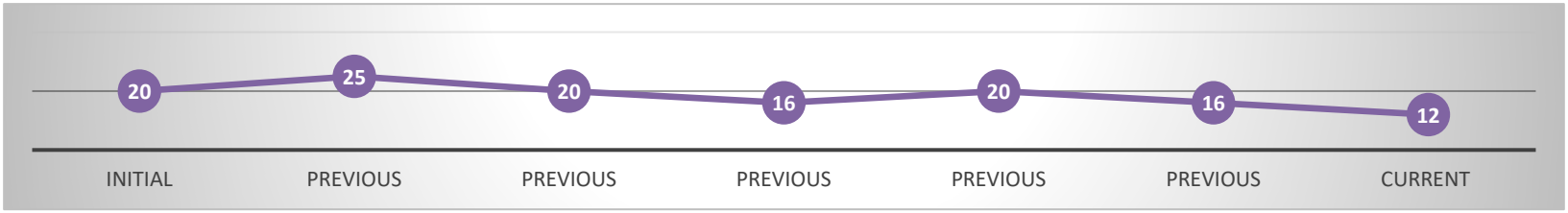
Risk ID:	2273	**Executive Lead:**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities				
Risk Description:	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the support and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances			**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** • Annual capital funding is allocated for mandated and statutory estates projects. • Estates team manages Planned Maintenance (PPM) and reactive maintenance through CAFMS. • Six Facet survey annually assesses estate conditions, informing backlog maintenance priorities. • The 10-year planned maintenance capital program is updated yearly based on the Six Facet survey and completed works. • Effective clinical networking and partnerships are in place. • Full delivery of the TIF (elective) programme due to complete in 2024/25, which includes £9m investment to provide 2 new operating theatres, an Endoscopy Room and Elective ward capacity. • Full Business Case (FBC) for Pathology Hub to be created with MWL to be presented to the Trust Board in Quarter 1 2025/26 • CSPO participates in Runcorn and Warrington Town Deal Boards, overseeing £50m in regeneration funds. • Living Well Hub funded via Warrington Town Deal fund led by WHH opened in March 2024 • Runcorn Health & Education Hub funded by the Runcorn Town Deal led by WHH due to open in Quarter 4 2025/26 • Strategy refresh for 2025/26 approved by the Trust Board. • WHH leads on addressing health inequalities and sustainability, with initial recognition in Cheshire & Merseyside. • Consistent Trust representation in Cheshire & Merseyside ICS and Place-based boards. • One Public Estate funding supports Halton redevelopment and Warrington public sector estate review. • Partnerships with educational institutions have enable tailored education and research. • CSPO co-led CMAST priorities for ICB 5-Year Joint Forward Plan. • Trust estates priorities reflected in the ICB infrastructure plan. • Agreement from the Boards of Warrington & Halton and Bridgewater to progress transaction to become a single organisation in 2027 • Joint Executive Team meetings with Bridgewater Community Healthcare NHS FT. • Estates strategy for new hospital plans completed. • External funding sought for estates developments supporting new hospitals. • All partners support new hospitals plans, including MPs, Councils, Education Providers, Place Partners, and ICB. • Financial and economic cases for new hospitals to be updated, with funding options explored. • Capital Planning Group oversees capital funding allocation, prioritised schemes reported monthly • Health and Safety Sub-Committee escalates estates issues, managed through relevant safety groups. • The Government's White Paper, “Integration and Innovation: working together to improve health and social care for all,” published in February 2021, continues to inform and guide Trust activities. **Assurances** • 3 Phase CDC funded nationally due to complete in June 2025. CDC Phase 2 opened in December 2023, including ultrasound, spirometry, sleep studies, audiology, and phlebotomy services at Halton Health Hub. CDC Phase 3 (including CT and MRI) is scheduled for June 2025. • Regular meetings through Capital Planning Group and Tactical Estates Group (TEG) support decision-making on estate allocations and capital expenditure. • Estates priorities identified through PLACE assessments, health and safety audits, and risk registers. • Safety and Compliance - Ongoing monitoring for compliance with Health Technical Memorandum (HTM) standards, with actions taken to reduce identified risks. • Remedial Works - RAAC survey completed, identifying small extension building with RAAC, with NHSE funding secured for necessary remedial actions, including roof replacement. Environmental health inspection upgrades completed for Warrington kitchen facilities in October 2024 • Halton Health Hub opened in November 2022 in Shopping City, Runcorn, supported by Halton Borough Council and Liverpool City Region Town Centre Fund for a phased reconfiguration of the Halton site. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside, with the hub opening in 2024. • Strategic and Collaborative Efforts - Regular strategy updates are provided to the Council of Governors and Trust Board. The Trust is engaged in national initiatives, including securing funding for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside, with the draft business case approved by the Trust Board in June 2024				
Assurance Gaps	**Funding and Financial Challenges** • **Unsuccessful NHP Phase 3 Funding:** The Trust was unsuccessful in securing funding via the NHS Phase 3, which is a major setback for completing the development of the phased new hospital plan, with funding for a new hospital unlikely before 2040. • **Limited Capital Funding:** There is a lack of sufficient capital funding nationally to address the full backlog, which delays and limits key infrastructure and maintenance projects. • **Unfunded Maintenance Costs:** Unforeseen and emergency maintenance costs continue to be a significant burden on the income and expenditure (I&E) budget, making it harder to stay on top of all required maintenance and upgrades. • **Cost Pressures on Capital Schemes:** The process to obtain full design costs for capital schemes is lengthy, and with the uncertain market conditions, this adds additional pressure on project timelines and costs.				

	• Trust allocates depreciation generated capital funds to mandated and statutory estates projects and is therefore reliant on external funding via bids for strategic development. **Staffing and Resource Constraints -** Staffing shortages further exacerbated by the requirement to meet non-clinical Cost Improvement Program (CIP) targets, adding strain to already stretched resources. **Operational and Infrastructure Issues -** Some equipment is difficult or impossible to access for maintenance due to age and design, and the absence of a permanent decant ward complicates this further, particularly for ongoing repairs or upgrades. **Governance Development at Place Level:** Self-assessments indicate that Halton is in the early stages of its place-based governance development, while Warrington is more established. There is a need for further development to ensure that both boroughs can benefit from potential future autonomy

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	30.03.2026	
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	31.03.2026	
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	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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	12 (L3xC4)
				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 every 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 and professional judgement 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
- Fortnightly review of bank use/staffing challenges at Executive Management Team Meeting,
- Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of governance
- Gant Chart mapping projections of Maternity Leave and Supernumery Staff
- Sickness Clinics held monthly with Chief Nurse

Assurances

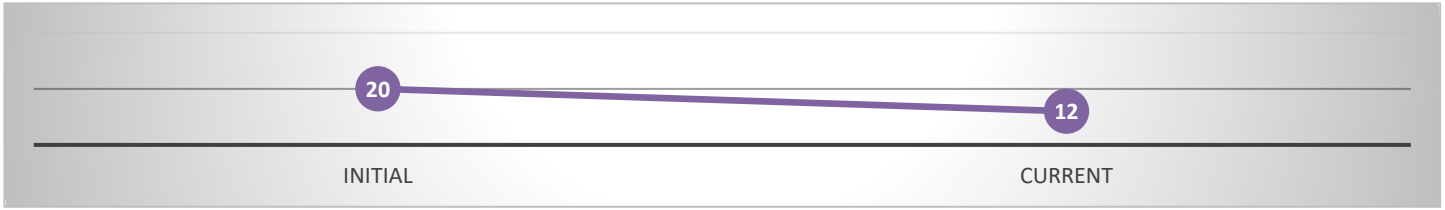
- Increase in registered nursing establishment in the Emergency Department, November 2024 reducing band 5 vacancy rate to 39.8 WTE from 46.84 WTE in May 2024
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.83 % in December 2024
- Overall CHPPD sustained between 7.6-7.9 in Q3.
- Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.91% in December 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. 15 first year students commence in January 2025 and 50 2nd year students return to placement in February 2025 • Cost avoidance of £2,168,508 m (end December 2025) from agency managed service contract started August 2022 • 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 of Directors 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) 12x CSWDs commenced Q3 with 4 x 12 cohorts planned for 2025. • The number of wards achieving 90% fill rate increased to 22 wards in December 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 – an average of 35 additional escalation beds per day were open throughout January 2025 • Increased requests 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 and overnight in Discharge lounge • Partially funded revenue requests • Time to post when recruiting new staff. • 556 Red Flags reported in December 2025 compared to 368 August 2024- Red Flags were linked to difficulties in providing enhanced care. • In quarter 3 over 1200 patients were admitted to WHH with a mental health condition • Admissions of patients over 65 continues to range between 900 to 1000 per month.

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	November 2024

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 5.9% as at February 2025 and is showing a slight increase from December 2024 (5.8%) which is reflective of seasonal trend with an increase in coughs, colds, flu and covid. Trust target is currently 4.2% and is being proposed to increase to 5% following a recent benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. This has been approved by the Strategic People Committee on 19th February 2025 and is being recommended to Trust Board in April 2025 for approval to commence from 1st April 2025. **Controls** • Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. Review of Supporting Attendance Policy underway March 2025. • 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 ICB 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 3.8 % in February 2025. • 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. • Deep dive focus into Nursing and Midwifery sickness absence currently taking place due to rates being higher according to Model Hospital data.				

Turnover and Attraction
Turnover in February 2025 remains below the target of 13% at 12.3%, the same as reported in December 2024. Turnover of permanent staff in February 2025 was 11.74%.

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

The Trust's February 2025 vacancy rate has decreased slightly to 8.09% from 8.26% in December 2024, Trust target is below 9%.

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 as part of the culture plan, an improved approach to agile and flexible working has been lauched through the #MYFlex campagin which incldues two wards going live with preference rostering from Jan 2025.
- 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:
    - 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. #MYFlex campaign has been launched with a central recording of flexible working requests enabling greater understanding/scrunity.
- The responses to Exit Interviews are positive, only 10.93% (November 2024) of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses.
- As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. November 2024 staff in post is 4,287 FTE..
- Staff completing apprenticeships is above target at 3.7%, target is 2.3%

Temporary Staffing and Agency spend

Bank and Agency reliance in February 2025 was 12.9% compared to 13.8% in December 2024. The Trust target is 9%. Bank reliance has reduced to 11.2% from 12.7% in December 2024 and agency reliance continues to decrease to 1.4% compared to 1.6% in December 2024.

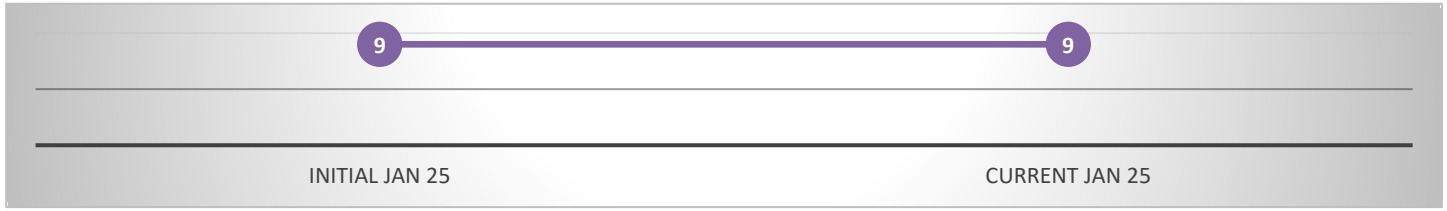
	Controls • Bank reliance is driven by the Trusts plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. • The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies, overtime and medical agency. • The Resourcing Task and Finish group previously 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 enabled the organisation to develop plans to improve the effectiveness of workforce deployment. The recent PWC audit has reviewed the plans and developed an action plan to address some of the gaps to enable the Trust to effectively and cost efficiently deploy it's workforce. **Assurances** • Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee • To support agency controls, a refined ECF process has been introduced. • Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives.
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. • 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 • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2025	

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	31.03.25	
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	Actions partially complete, actions now superseded by the PWC action plan.

Board Assurance Framework – Proposed New Risk Integration

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	2253	**Executive Lead**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management.			**Initial**	9 (L3 x C3)
				Current	9 (L3 x C3)
				Target	2 (L1 x C2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	The integration programme- "Better Care Together" has been established. Each workstream is developing a delivery plan and working with partners to deliver objectives. 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. **Controls** • Nikhil Khashu commenced as Chief Executive Officer for both Trusts on the 1st November • Paul Fitzsimmons appointed as joint Executive Medical Director • Dan Moore appointed a joint Chief Operating Officer • Summary case for change – approved – Novembver 2024 • Signed data sharing agreement **Assurance** • 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 • Held first clinical and operational services workshop to identify where services can align to deliver patient benefit • Contract Review • Communication and Engagement Plan drafted				
Assurance Gaps	• Uncertainty concerning the role of the Chair at Bridgewater Community Healthcare Trust • Lack of integrated governance systems				

Board Assurance Framework – Proposed New Risk Integration

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Boards at both Warrington and Halton Teaching Hospitals (WHH) and Bridgewater Community Healthcare FT (BCH) to approve the recommendation for WHH to acquire BCH	Boards at both WHH and BCH to discuss the recommendation for WHH to acquire BCH to be presented to retrospective Boards on 5th and 6th of February 2025	Proposal for WHH to acquire BCH to be presented to respective Boards on 5th and 6th February 2025.	Lucy Gardner	06.02.2025	
Implement a more integrated governance structure to support timely and effective decision making	Develop, agree and implement a joint integrated governance structure	Develop, agree and implement a joint integrated governance structure.	John Culshaw	01.04.2025	

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/25/04/08**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	2 April 2025	
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; 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 **#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** f 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. **#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>
Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>
The Trust has 75 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>6 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality:
o 22. Mixed Sex Accommodation Breaches (ITU) (NEW)
o 23. Sepsis - % screening for all emergency patients
Access and Performance:
o 35. A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC) (NEW)
o 76. A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC) (NEW)
Workforce
o 63. Supporting Attendance (NEW)
Finance and Sustainability:
o 74. CIP – % delivery against plan (recurrent) (NEW)
As previously reported to Board, there were 2 failing and declining indicators; 1 of these indicators now has normal variation, so has been removed from the category ‘<u>both failing and special cause variation of a concerning nature’</u>. This indicator is included below:
o 72. Better Payment Practice Code
</td></tr>
</table>

<table>
<tr><td></td><td colspan="3">From month 11, we will be including metrics that fall into the category “special cause variation of a concerning nature with no target” in the exception report, to ensure IPR metrics without a target are also monitored.

There are 2 metrics new to the category <u>‘special cause variation of a concerning nature with no target”</u>, these are:

Quality:
o 16. Mortality ratio – HSMR (NEW)
o 17. Mortality ratio – SHMI (NEW)

At Month 11 the revised plan was a £13.9m deficit. The actual deficit was £19.3m with the overspend being due to a shortfall in CIP delivery, a shortfall in funding in relation to Industrial Action and pay award, cost pressures that have not been offset as in previous months and PwC consultancy costs.

The Trust has received notification of non-recurrent surge funding in March 2025 of £2.3m which has offset the impact of the pay award and the cost of industrial action. This funding is required to improve the bottom line; therefore the Trust is now forecasting a deficit of £16.8m (£5.5m worse than plan) which is expected to be achieved.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to:
1. Approve cash support of up to £16.449m from NHSE for Quarter 1 2025/26.
2. Approve submission of the 2024/25 capital forecast position in line with plan as supported and approved by the Finance and Sustainability Committee.
3. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
4. Note the contents of this report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Finance + Sustainability Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">FSC/25/03/286
FSC/25/03/293</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">24/03/2025</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Cash support application supported for approval at Trust Board.

Submission of 2024/25 forecast capital position in line with plan supported and approved.

Changes to the capital contingency supported and approved.</td></tr>
</table>

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/25/04/08

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**	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & NO SPC**
	Quality 22. Mixed Sex Accommodation Breaches (ITU Only) **(14 – 0 target)** ↓ 23. Sepsis - % screening for all emergency patients **(36% - 90% target)** **A&P** 35. A&E Wait Times - % patients waiting under 4 hours **(62% - 75% target)** ↓ 76. A&E Wait Times - % patients waiting under 4 hours (include WUTC) **(62% - 75% target)** ↓ **Workforce** 63. Supporting Attendance **(5.93% - 4.2% target)** ↓ **Finance & Sustainability** 74. Cost Improvement Programme (recurrent forecast) In year performance to date **(5.93% - 4.2% target)** ↓	**Quality** 1.Incidents 10. VTE Assessment ↓ 13. Medication Safety - Reconciliation within 24 hours 21. Friends and Family (ED and UCC) 24. Sepsis - % screening for all inpatients 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis 31. MUST nutritional assessment completion ↓ **A&P** 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 38. 28 Day Faster Cancer Diagnosis Standard ↓ 40. Cancer 62 Days First Treatment 41. Ambulance Handovers within 15 minutes 42. Ambulance Handovers within 30 minutes 43. Ambulance Handovers within 60 minutes ↓ 61. Uncapped Theatre Utilisation 62. Capped Theatre Utilisation **Finance & Sustainability** 72. Better Payment Practice Code ↑	**Workforce** 66. Bank and Agency Reliance 68. PDR	

	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**Quality** 3. Healthcare Acquired Infections (MRSA) ↓ 19. Complaints open over 6 months **Finance & Sustainability** 71. Capital Programme	**Quality** 5. Healthcare Acquired Infections (CDI) 6. Healthcare Acquired Infections (Ecoli) 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 11. Inpatient Falls & harm levels 12. Pressure Ulcers 15. Staffing Care Hours per patient day (CHPPD) 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ↑ 29. Maternity Postpartum Haemorrhage ↑ **A&P** 32. Diagnostic Waiting Times 6 Weeks ↑ 44. Discharge Summaries - % sent within 24hrs ↓ 47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation 53. Elective Outpatient Activity 55. Patients seen in the Fracture Clinic within 72 hours	**A&P** 45. Discharge Summaries - Number NOT sent in 7 days	
	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
 **Consistently Passes the Target (based on the last 7 months)**		**Quality** 2. Duty of Candour (serious incidents) 20. Friends and Family (Inpatients & Day cases) 28. Acute Kidney Injury **A&P** 39. Cancer 31 Days First Treatment 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 ↑ 48. Urgent Operations Cancelled for 2nd Time **Finance & Sustainability** 73. Cost Improvement Programme (recurrent and non-recurrent) In year performance to date (£m) ↓	**Quality** 14. Staffing - Average Fill Rate 18. NICE Compliance **Workforce** 64. Retention 65. Turnover 67. Core/Mandatory Training **Finance & Sustainability** 75. Agency Ceiling	

	NO ASSURANCE SPC & DECLINING PERFORMANCE	NO ASSURANCE SPC & VARYING PERFORMANCE	NO ASSURANCE SPC & IMPROVING PERFORMANCE	NO ASSURANCE SPC & NO SPC
No SPC **No SPC/Not Enough Datapoints/Not Applicable**	16. Mortality ratio – HSMR ↓ 17. Mortality ratio – SHMI ↓	**Quality** 4.Healthcare Acquired Infections (MSSA) 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks ↓ 27. Ward Moves between 10pm and 6am 30. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 49. Super Stranded Patients 50. No Criteria to Reside (NCTR) 58. Reduction in Outpatient Follow Ups	**A&P** 37. Average time in department ED ↑ 57. Type 5 attendances 59. % Patients discharged to their usual place of residence 60. Virtual Appointments	**A&P** 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)

Key:

Areas requiring focus – areas are failing to meet the target and declining in performance
Areas of a concerning nature due to either: • **indicators not meeting (failing) their set target** • **declining nature of the performance**
Areas exceeding the target and continuously maintaining/improving 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 February 2025 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. The Trust has received notification of non-recurrent surge funding in March 2025 of £2.3m which has offset the impact of the pay award and the cost of industrial action. This funding is required to improve the bottom line, therefore the Trust is now forecasting a deficit of £16.8m (£5.5m worse than plan) which is expected to be achieved. The drivers of the £5.5m variance to plan are due to the following risk areas:

- CIP delivery including the £3m integration stretch target.
- PwC costs and other cost pressures – cost pressures up to month 8 were offset with underspends, however this was not possible from month 9 onwards. This was anticipated as part of the risk adjusted forecast. An enhanced monitoring process is in place to mitigate these cost pressures where possible and mitigations including benefits from the PwC work are forecast to deliver in March 2025.
- 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 February 2025 is £12.5m, of which, £2.4m is related to capital creditors. The Trust was allocated a share (£16.458m) of the £150m deficit support provided to the Cheshire and Merseyside ICS and the Trust has received £15.1m of this year to date.

A cash support request for March 2025 of £5.166m was submitted to NHSE, however this was not approved due to the Trust receiving a funding allocation from the ICB in March 2025. The Trust therefore would not have needed to draw down the cash requested for March 2025.

Approval was given on 5 March by the Trust Board to request in April up to the value not received in March, therefore a submission was made to the NHSE regional team on 11 March 2025 setting out the cash requirements for the Trust (£3.641m) to facilitate their discussion with the national team.

A meeting has subsequently been arranged between the Trust and the national team to discuss ongoing cash requirements. As per the new process, the Finance and Sustainability Committee discussed and supported the application for cash support for Quarter 1 2025/26 from NHSE subject to ongoing discussions with the national team and finalising the operational plan. The Trust Board is asked to approve up to £16.449m cash support for Quarter 1 2025/26. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

CIP

At 28 February 2025, the Trust has delivered a CIP of £15.4m against a target of £16.8m, therefore £1.4m off plan. Of the £15.4m CIP delivered, £11.8m is recurrent. It should be noted that the delivery year to date has been mainly achieved from central items and reduction in non-clinical posts. The Trust had plans to deliver the £19.4m CIP programme however the current forecast is £16.9m as £2.5m of high risk schemes have not yet been mitigated.

Capital Programme

The Trust total capital funding consists of £7.6m CDEL (Capital Departmental Expenditure Limit) and £15.5m external funding, a total of £23.1m. The Trust also has £1.8m CDEL associated with lease expenditure (IFRS16).

The Trust year to date capital spend at month 11 is £12.4m which is £2.9m below the Trust plan of £15.4m. This is due to timing and is expected to be fully delivered by year end. The Finance and Sustainability Committee discussed and supported the 2024/25 forecast position which includes an allowable overspend of £0.2m. The Trust Board is asked to approve submission of the 2024/25 capital forecast position in line with plan.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 11		**110**
Proposed changes in month		
VAT Recovered		**42**
Underspends to be returned to contingency supported at CPG 14.03.2025		
Six Facet Survey	12	
Nurse call extension - paeds	33	
Cell washer - Halton Transfustion Laboratory	29	
Sub Total		**74**
Requests supported at CPG 14.03.2025		
Addendum - X-Ray room	- 11	
Inter-oral scanner - Halton	- 24	
Ultrasound Scanner	- 118	
Sub Total		**- 153**
Emergency schemes:		
Catering Boiler - 61839	- 43	
Sub Total		**- 43**
Contingency as at end of month 11		**30**

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. Approve cash support of up to £16.449m from NHSE for Quarter 1 2025/26.
2. Approve submission of the 2024/25 capital forecast position in line with plan as supported and approved by the Finance and Sustainability Committee.
3. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
4. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

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	9	Feb-25		1	Jan-25	
2	Duty of Candour (serious incidents)	100.00%	100.00%	Feb-25		100.00%	Jan-25	
3	Healthcare Acquired Infections (MRSA)	0	1	Feb-25		1	Jan-25	
4	Healthcare Acquired Infections (MSSA)	No threshold set	3	Feb-25		5	Jan-25	No SPC
5	Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	9	Feb-25		4	Jan-25	
6	Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	2	Feb-25		2	Jan-25	
7	Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	1	Feb-25		3	Jan-25	
8	Healthcare Acquired Infections (PA)	Less than 2 - annual	0	Feb-25		0	Jan-25	
9	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Feb-25		1	Jan-25	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

10	VTE Assessment	95.00% (quarterly position)	92.77%	Feb-25	L	95.15%	Jan-25	?
11	Inpatient Falls & harm levels	20% or more decrease from previous year	20	Feb-25		42	Jan-25	?
12	Pressure Ulcers	10% reduction	19	Feb-25		19	Jan-25	?
13	Medication Safety Reconciliation within 24 hours	80.00%	50.00%	Feb-25		54.00%	Jan-25	F
14	Staffing - Average Fill Rate	90.00%	97.77%	Feb-25		90.43%	Jan-25	P
15	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.5	Feb-25		7.6	Jan-25	?
16	Mortality ratio - HSMR	No target set	94.49	Feb-25	H	93.55	Jan-25	No SPC
17	Mortality ratio - SHMI	No target set	101.62	Feb-25	H	101.62	Jan-25	No SPC
18	NICE Compliance	90.00%	93.55%	Feb-25	H	94.00%	Jan-25	P
19	Complaints	Zero complaints open over 6 months old/in the backlog	2	Feb-25	H	3	Jan-25	?

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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*based on the last 6 datapoints/months

20	Friends and Family (Inpatients & Day cases)	95.00%	96.00%	Feb-25		97.00%	Jan-25	P
21	Friends and Family (ED and UCC)	87.00%	74.00%	Feb-25		78.00%	Jan-25	F
22	Mixed Sex Accommodation Breaches (ITU Only)	0	14	Feb-25	H	24	Jan-25	F
23	Sepsis - % screening for all emergency patients.	90.00%	36.00%	Feb-25	L	70.00%	Jan-25	F
24	Sepsis - % screening for all inpatients	90.00%	72.00%	Feb-25		84.00%	Jan-25	F
25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	52.00%	Feb-25		74.00%	Jan-25	F
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	68.00%	Feb-25		56.00%	Jan-25	?
27	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	2	Feb-25		5	Jan-25	No SPC
28	Acute Kidney Injury	Less than previous month	162	Feb-25		170	Jan-25	P
29	Maternity Postpartum Haemorrhage	3.70%	5.20%	Feb-25		3.10%	Jan-25	?

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	18%	Feb-25		14%	Jan-25		No SPC
31	MUST nutritional assessment completion	above > 85%	62.90%	Feb-25		63%	Jan-25		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

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	Plan/Target	Actual	Period	Variation	Actual	Period	
32	Diagnostic Waiting Times 6 Weeks	95.00%	95.05%	Feb-25		86.80%	Jan-25	
33	Referral to treatment Open Pathways	92.00%	57.86%	Feb-25		58.60%	Jan-25	
34	RTT - Number of patients waiting 52+ weeks	0	1455	Feb-25		1293	Jan-25	
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	75%	62.42%	Feb-25		62%	Jan-25	
76	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	75%	67.27%	Feb-25		67%	Jan-25	
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	24.08%	Feb-25		26.4%	Jan-25	
37	Average time in department ED	No Target	418	Feb-25		458	Jan-25	No SPC
38	28 Day Faster Cancer Diagnosis Standard	75%	70.30%	Jan-25		73.80%	Dec-24	
39	Cancer 31 Day Wait	96%	98.70%	Jan-25		97.30%	Dec-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

40	Cancer 62 Day Wait	85%	73.70%	Jan-25		79.00%	Dec-24	F
41	Ambulance Handovers within 15 minutes	65%	33.60%	Feb-25		21.10%	Jan-25	F
42	Ambulance Handovers within 30 minutes	95%	68.54%	Feb-25		49.11%	Jan-25	F
43	Ambulance Handovers within 60 minutes	100%	83.90%	Feb-25		68.62%	Jan-25	F
44	Discharge Summaries - % sent within 24hrs	95%	89.77%	Feb-25		90.05%	Jan-25	F
45	Discharge Summaries - Number NOT sent within 7 days	0	14	Feb-25		0	Jan-25	?
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%	0.98%	Feb-25		1.40%	Jan-25	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	3	Feb-25		2	Jan-25	?
48	Urgent Operations Cancelled for 2nd Time	0	0	Feb-25		0	Jan-25	P

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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- Consistently fails the target*

*based on the last 6 datapoints/months

49	Super Stranded Patients	Trajectory	155	Feb-25		166	Jan-25	No SPC
50	No Criteria to Reside (NCTR)	No Target set	212	Feb-25		237	Jan-25	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
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%	90%	Feb-25		85%	Jan-25	?
55	Patients seen in the Fracture Clinic within 72 hours	95%	100.00%	Feb-25		94%	Jan-25	?
56	% patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Feb-25	No SPC	0	Jan-25	No SPC
57	Type 5 attendances	No Target set	2114	Feb-25	H	2029	Jan-25	No SPC
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	90%	Feb-25		85%	Jan-25	No SPC
59	% Patients discharged to their usual place of residence	No Current Threshold	96%	Feb-25	H	96%	Jan-25	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

*based on the last 6 datapoints/months

60	Virtual Appointments	No Target set	19%	Feb-25	H	20%	Jan-25	No SPC
61	Uncapped Theatre Utilisation	85%	78.40%	Feb-25		80%	Jan-25	F
62	Capped Theatre Utilisation	85%	73.40%	Feb-25		75%	Jan-25	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%	5.93%	Feb-25	H	5.92%	Jan-25	F
64	Retention	85.00%	87.28%	Feb-25	H	87.26%	Jan-25	P
65	Turnover	Below 13%	12%	Feb-25	L	12%	Jan-25	P
66	Bank and Agency Reliance	9% or Below	12.99%	Feb-25	L	13.34%	Jan-25	F
67	Core/Mandatory Training	85.00%	90.22%	Feb-25	H	90.08%	Jan-25	P
68	PDR	85.00%	78.24%	Feb-25	H	79.11%	Jan-25	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*

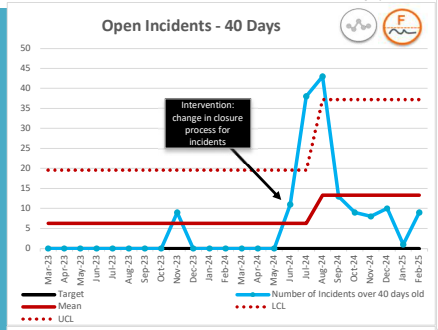
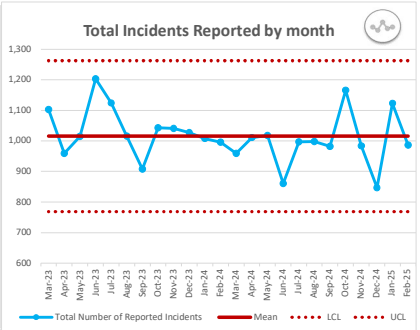
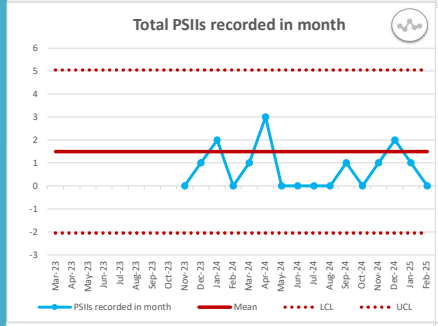
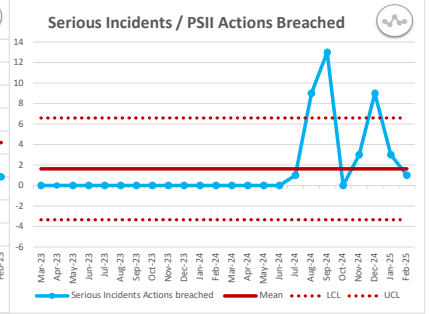
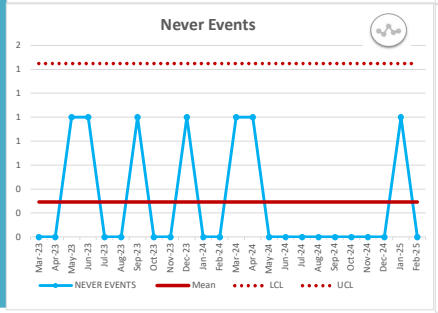
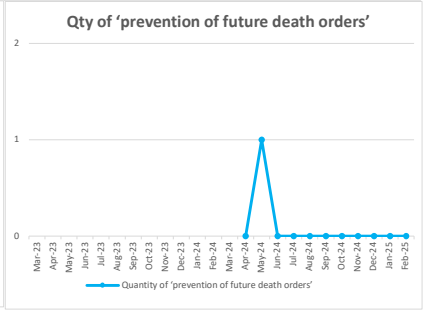
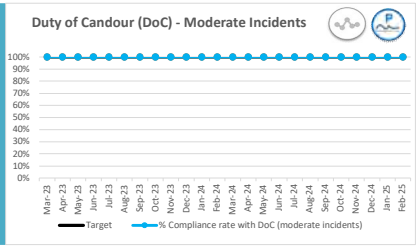
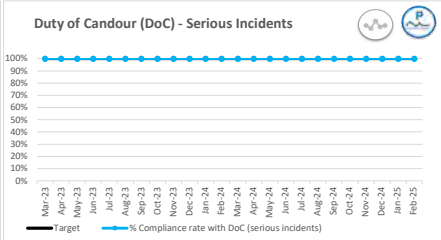
*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
69	Trust Financial Position (£m)	-£0.71	-£2.14	Feb-25	No SPC	-£1.51	Jan-25	No SPC
70	Cash Balance (£m)	£6.65	£12.54	Feb-25	No SPC	£13.56	Jan-25	No SPC
71	Capital Programme (£m)	£18.85	£12.07	Feb-25	L	£8.53	Jan-25	?
72	Better Payment Practice Code	95%	89%	Feb-25		91%	Jan-25	F
73	Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	90%	92%	Feb-25		92%	Jan-25	P
74	Cost Improvement Programme (recurrent) – In year performance to date (£m)	90%	70%	Feb-25	L	73%	Jan-25	F
75	Agency Ceiling	Less than 3.2%	1.9%	Feb-25	L	1%	Jan-25	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

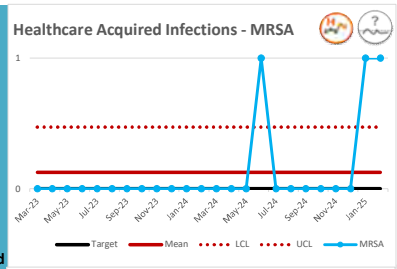
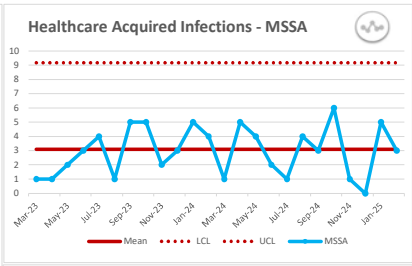
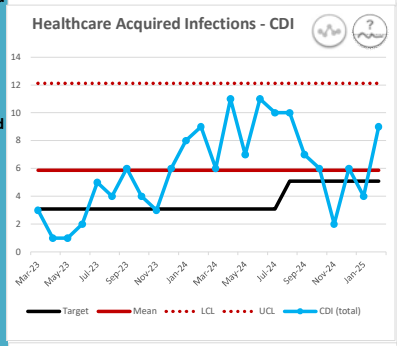
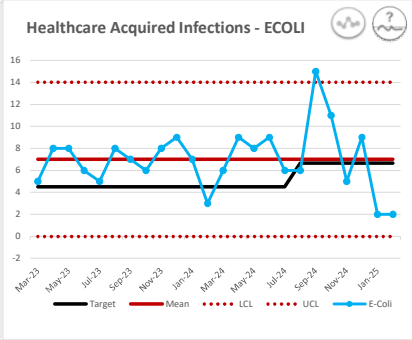
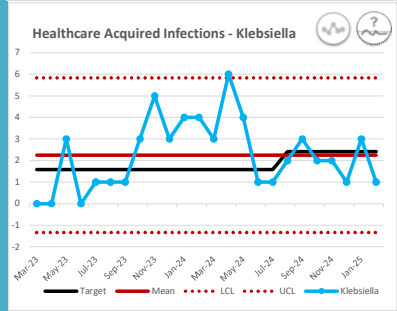
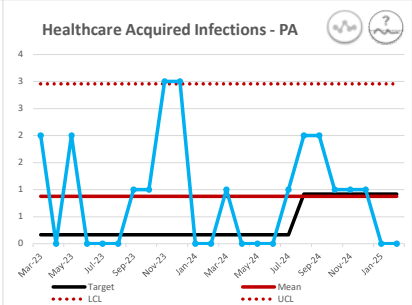
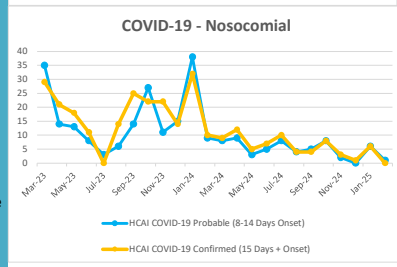
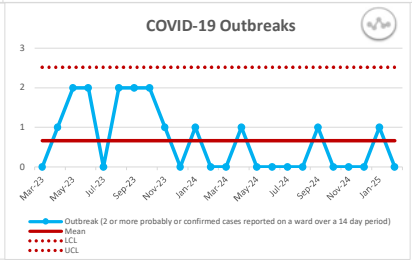
Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	     	**There was 9 incident over 40 days old.**	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation**	**There were 0 PSIIs reported in February 2025** **There were 9 incidents open over 40-days at the time of reporting and 1 breached patient safety incident investigation actions at the time of reporting that has since closed**	**Incidents overdue 40 days- Overdue incidents are escalated daily to the triumvirates for the relevant areas, and this work is being prioritised. These are also overseen weekly in the Safety Oversight Meeting by the Executive Team.** **Datix system alerts at an additional lower threshold (30 days) to enable further support to be provided when incidents are overdue. A daily report of the learning response position and outstanding actions is produced for the Care Group Triumvirate's oversight, this commenced from March 2025** **PSII's** **Weekly monitoring continues through the weekly Executive Led Safety Oversight Meeting with appropriate escalation to the Clinical Business Unit leads.**
2. Duty of Candour (serious incidents) **Target: 100%**	 	**The Trust achieved 100% for Duty of Candour in month.**	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**There is no variance in Duty of Candour, the Trust remains 100% compliant.**	**Weekly monitoring is undertaken to ensure that compliance continues to be sustained. Oversight of the position continues through the weekly Executive Led Safety Oversight Meeting**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

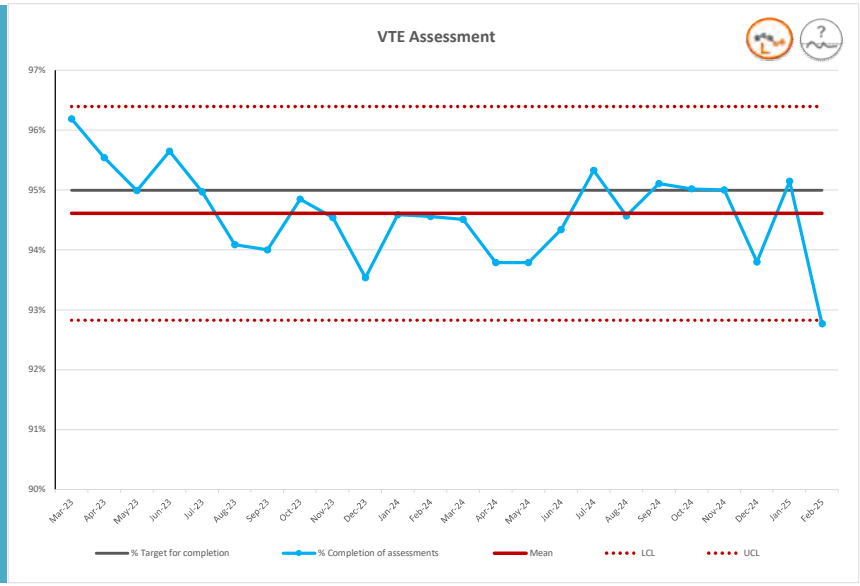
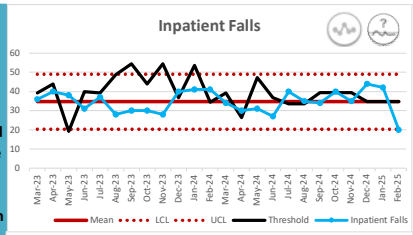
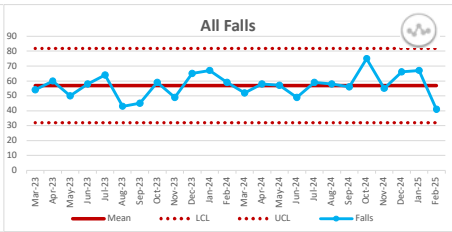
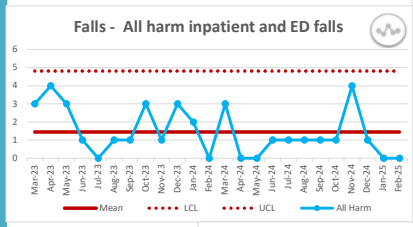
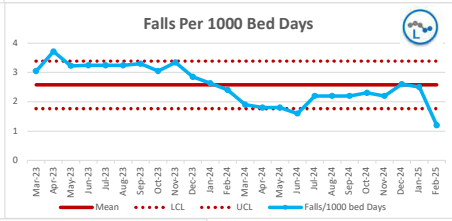
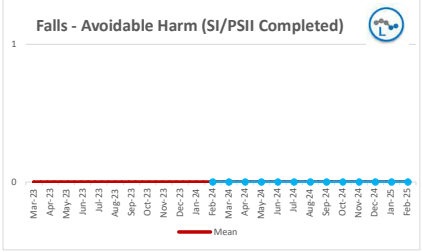
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO	MRSA cases YTD - annual threshold exceeded by 3		(MRSA) Assurance: The Trust consistently passes the target. Variation: Variation: Special cause variation of a concerning nature.	Revised reporting rule since April 24 where decision to admit (instead of admission date) is used , resulting in additional HCAI cases being apportioned to acute Trusts. There was 1 MRSA Bacteraemia in February - learning identified relates topical treatment management in patients who are self-caring. Regional/national increase in C. difficile cases. UKHSA has declared the rise in cases as a national standard incident. CDT cases increased in February (n=9) Noted increase in MSSA cases nationally which NHSE are reviewing, further information awaited from National Team. WHH is not flagging as an outlier on cases/rates of infection. There are multiple likely primary sources for these infections, some are deep seated infections and likely unavoidable.	MRSA: MSSA: Drive compliance with ANTT training and competency assessments. ANTT eLearning presentation updated; increasing ANTT competency assessors; focus on IV device care bundle and audit of compliance. CDI: CDI prevention action plan in place. Brilliant Basics Action Plan co-produced with Senior Nursing Team. Communication strategy implemented which includes education across all staff groups. Plan to host a system-wide seminar on CDI - agenda to be finalised. Senior nursing leadership team IPC visits and spot checks continue. Swarm Huddles commenced for all hospital onset healthcare associated cases. Trust-wide deep cleaning programme continues. Review of National Action Plan on Antimicrobial Stewardship in progress. Review of patients with recurrent CDI commenced -looking at an evaluation study on diarrhoea management. Plan to look at using probiotics for prevention of CDI. Review of CMAST CDI Toolkit. ECOLI: Klebsiella: Pseudomonas aeruginosa: UTI audit completed, and findings have been disseminated at UEC Governance Meeting and Nursing and Midwifery Forum in Q4. Plan to present at the system collaborative for IPC with the ICB Place Team. Revision and relaunch of the GNBSI Prevention Group in Q4. Increased focus on wards with higher UTI associated cases.
4. Healthcare Acquired Infections (MSSA) Annual threshold: NA	MSSA 34 cases YTD - no threshold set				
5. Healthcare Acquired Infections (CDI) Annual threshold: 61	CDI 83 cases YTD - annual threshold exceeded by 22 cases		(CDI) Assurance: The Trust inconsistently passes/fails the target. (CDI) Variation: Variation: Common Cause (Normal) variation.		
6. Healthcare Acquired Infections (Ecoli) Annual threshold: 80	E. coli 82 cases YTD - annual threshold exceeded by 2 cases		(ECOLI) Assurance: The Trust inconsistently passes/fails the target. (ECOLI) Variation: Variation: Common Cause (Normal) variation.		
7. Healthcare Acquired Infections (Klebsiella) Annual threshold: 29	Klebsiella spp. 26 cases YTD - annual threshold exceeded by 0		(K) Assurance: The Trust inconsistently passes/fails the target. (K) Variation: Common Cause (Normal) variation.		
8. Healthcare Acquired Infections (PA) Annual threshold: 11	P. aeruginosa 8 cases YTD - annual threshold exceeded by 0		(PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Common Cause (Normal) variation.		
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)	0 in month COVID-19 outbreak. Covid-19: 1 day 8-14 cases probable healthcare associated cases in month. 0 day 15+ cases definite healthcare associated in month.	 	(C19) Assurance: N/A - No target. (C19) Variation: Special cause variation of an improving nature.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

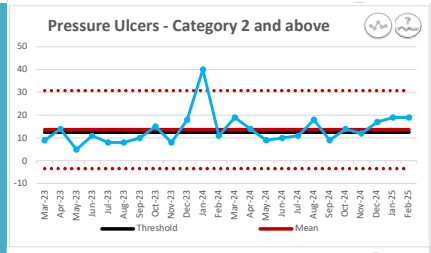
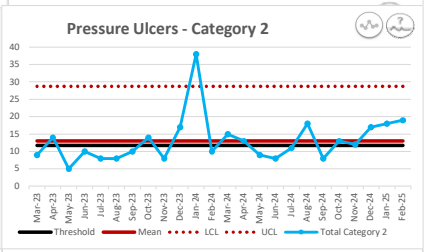
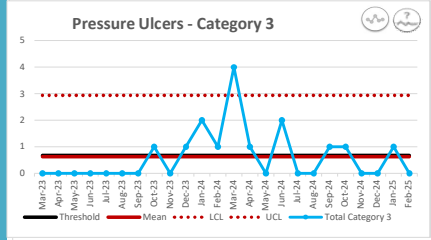
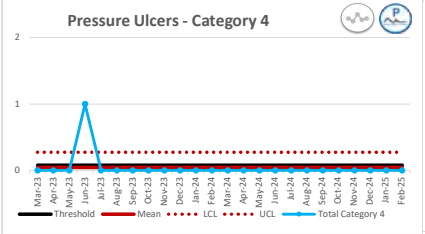
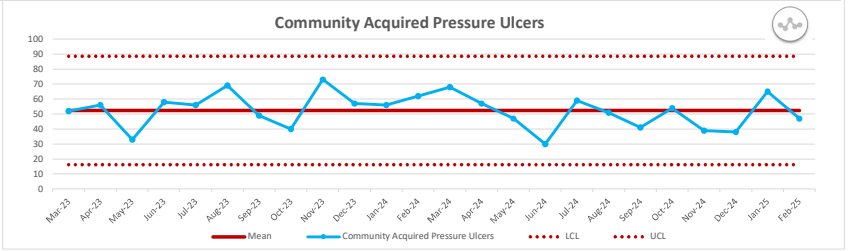
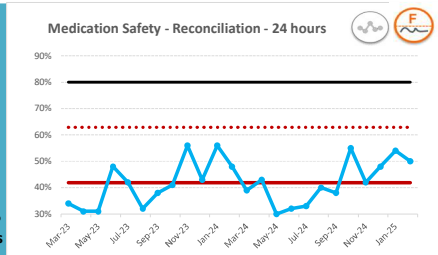
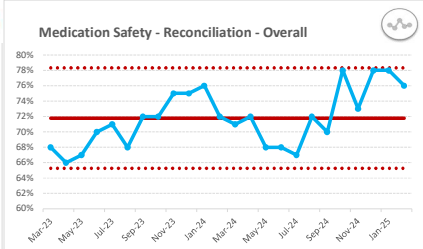
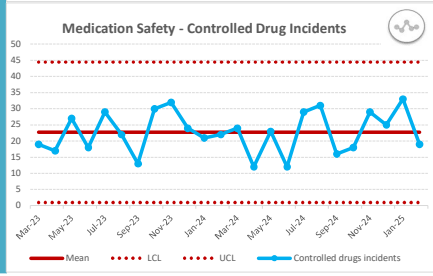
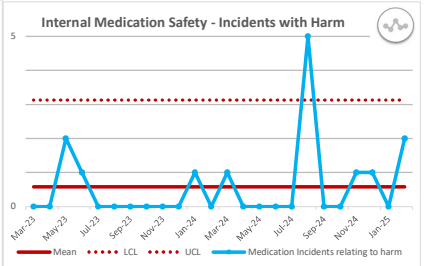
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment **Target: 95% (quarterly position)**	The Trust did achieve the required target at 92.77% for VTE assessments in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special cause variation of a concerning nature	VTE risk assessment (RA) performance target in February 2025 was below the mandatory threshold at 92.77 %. There is no single identified cause for this reduction.	Actions already taken to improve VTE RA compliance: Non-completion of VTE risk assessments data on GIRFT In-patient Ward Productivity Dashboard is projected on ward level e-whiteboard to encourage the completion of outstanding risk assessments in real time. Data on this dashboard can be drilled down daily at ward level for identification of patients, this enables ownership by the clinicians to improve overall compliance. Further improvement actions for VTE RA compliance: VTE Risk Assessments Dashboard is now live on LION Dashboard and the link has been shared widely. VTE compliance is a standing agenda item on the monthly CBU Governance Meetings commencing from Q3. Close monitoring is ongoing of the top ward 5 wards for non-compliance so additional support can be offered as required. Thrombosis Group continues to monitor the data trends and the traction of CBUs improvement plans.
11. Inpatient Falls & harm levels **Target: decrease from 23/24 (418 Inpatient Falls in 2023/24)**	41 total falls were reported in month. 20 of these were inpatient falls. There was 0 fall(s) in month with harm. There were 671 total falls in 2023/24. There have been 641 total falls YTD in 2024/25. We are expecting a 4% increase in falls from last year. There were 418 inpatient falls in 2023/24. There have been 378 inpatient falls YTD in 2024/25. We are expecting a 1% increase in falls from last year.	    	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	During February 2025 there were 20 inpatient falls and 2 in ED, which remains within expected variation. 20 inpatient falls is the lowest number of falls within the Trust since the data started being recorded on the current SPC chart in April 2021. There were no falls with moderate harm. February noted the lowest recorded Falls per 1000 bed days (n=1.20)	1. The Patient Safety Improvement Nurses (PSINs) completed data collection for the Trust wide falls audit in February 2025. The report is being drafted supported by the Clinical Audit Team for release in Q4. 2. The PSIN are meeting with the Ophthalmology Team during March to progress the launch of the bedside eyesight test Trust wide from Q1. 3. The falls prevention leaflet is being updated. Further Patient Feedback/coproduction work is planned for March relating to the leaflet. 4. A Senior Leadership Walk around with the Chair took place in February 2025. The theme was supporting reduction in deconditioning by encouraging patients to up and get more active. 5. The Enhanced Care Policy is being ratified following changes to reflect the levels of enhanced care contained in the Safer Nursing Care Tool, this will support the standardisation of how enhanced care needs are met and described.

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** **In month there were 19 hospital acquired category 2 pressure ulcers, 0 Category 3 pressure ulcers and 0 Category 4 ulcers in month.** **There were 47 community aquired pressure ulcers in month.**	    	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**An increase in Category 2 pressure ulcers has been noted in the last quarter n=19 in February 2025. This aligns with the increase WHH is seeing in frail patients admitted to hospital.** **There were 0 Category 3 or Category 4 pressure ulcers in February 2025.** **There were seven device related pressure ulcer in February 2025 -(O2 tubing, TED stockings, nasal high flow, Aspen collar, O2 mask, O2 mask with glasses and catheter).**	**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.Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.** **3.Compliance/review meetings are taking place with the Deputy Chief Nurse. Lessons learned shared.** **4.A thematic review of pressure ulcers in ITU has been completed – no single theme has been identified** **5.Plans to roll out Purpose T (pressure ulcer risk assessment) remain on track with training being provided throughout March 2025.** **6.Test of change being trailed in ED relating to a revised process for Care and Comfort rounds – early indications note positive results.**
13. Medication Safety **Reconciliation within 24 hours Target: 80%** **Medicines reconciliation was completed within 24 hours of admission for 50% of patients. 76% of patients had MR completed during inpatient stay.** **There were 19 controlled drug incidents.** **There were 2 medication harm incident reported in month.**	   	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**1.Medicines Reconciliation: Overall improving trend although a slight deterioration was noted in February** **2.Controlled drug incidents: there is no target for this metric. There were 19 controlled drug incidents in February 2025, with administration (n=8) and storage errors (n=4) being the most commonly reported subcategories. No specific themes or trends identified.** **3.Incidents causing harm: there is no target for this metric. There were 2 incidents recorded as causing moderate harm, one incident remains open and under investigation.**	**Ongoing training of new Pharmacists. Medicines reconciliation (MR) improvement action plan in place, overseen at Pharmacy Specialty Governance Meeting. Work underway to reimplement MR completion by Midwives for antenatal women in Q1. Reviews of all patients with Length of Stay >72 hours who do not receive MR is being undertaken to identify lessons learned.** **Medication/controlled drug incidents: all incidents are reviewed by a multiprofessional group and lessons learned are disseminated. Themes are identified and action plans are monitored through the medicine's governance structure.**

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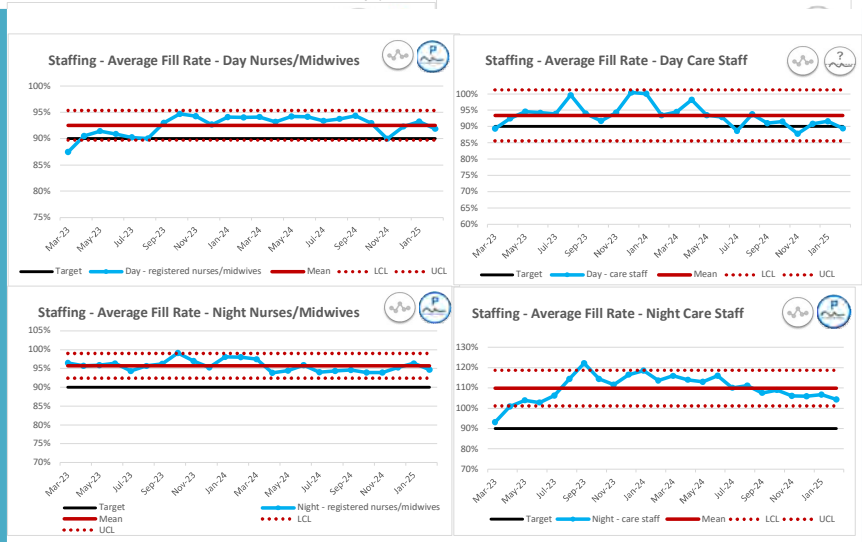
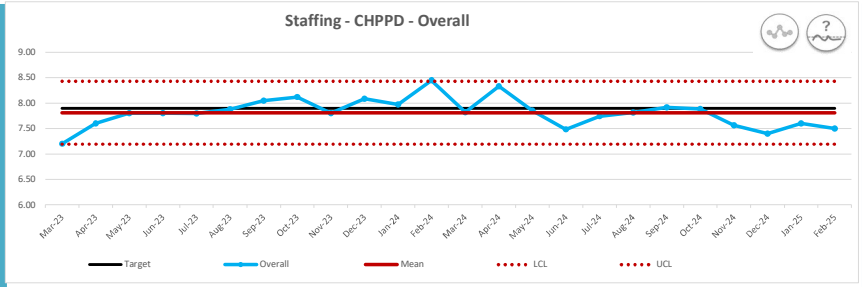
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate **Target: 90%**	**In month, the average staffing fill rates were:** **Day (Nurses/Midwife) 91.86%** **Day (Care Staff) 89.42%** **Night (Nurses/Midwife) 94.68%** **Night (Care Staff) 104.28%**		**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**Fill rates remain within normal variance. Additional beds in use across the Trust due to increased demand in ED, 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 February 2025 for registered staff is 10.03% against a Trust target of 9%. This is mainly due to AED increased establishment of 37.9 WTE at Band 5.** **Specialist recruitment is taking place within areas with remaining vacancy. 10x HCA's were appointed to the Trust in February 2025. There is an HCA open event taking place 10 March for IM&C CBU who have the largest HCA vacancy currently. An RN open event is planned for May 2025 to support 3rd year students qualifying this summer to apply for posts.** **The current percentage vacancy for February 2025 for unregistered staff is 13.72% against a Trust target of 9%. The first cohort of NHSP Care Support Worker Development staff x 12 have been interviewed and appointed and will commence their ward placement in March 2025, with 3 further cohorts of 12 CSWD planned for 2025.**
15. Staffing - Care Hours Per Patient Day (CHPPD) **Target: 7.9 CHPPD**	**In month, the average CHPPD were:** **Nurse/Midwife: 4.2 hours** **Care Staff: 3.3 hours** **Overall: 7.5 hours**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**The CHPPD for February 2025 has decreased from 7.6 in January 2025 to 7.5 in February 2025 which is below the national target of 7.9. this is influenced by higher sickness rates and the increased numbers of beds open.**	**Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety. There are clear processes for escalation to ensure staffing is based upon acuity to ensure patient safety.** **It is expected the number of escalation beds open will reduce from Quarter 1.** **The Chief Nurse has held sickness clinics with both Care Groups to ensure sickness is managed in line with policy.**

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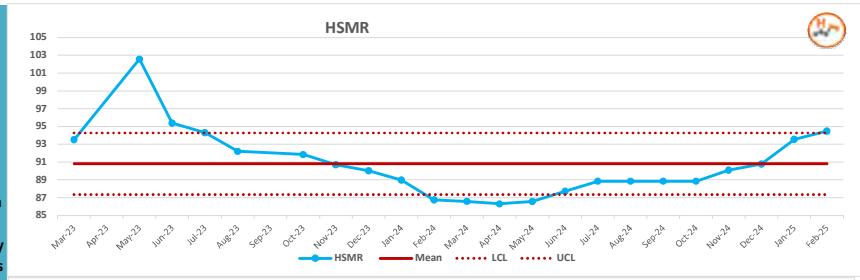
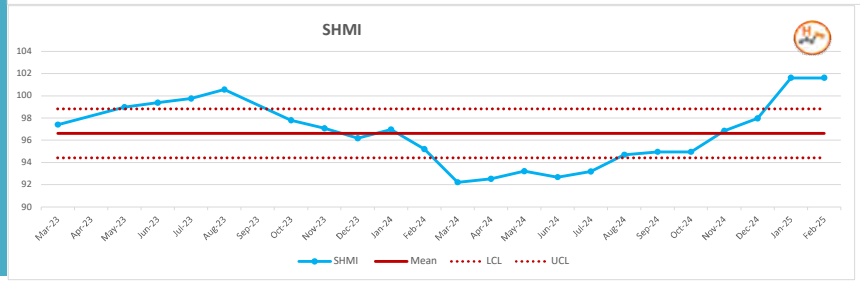
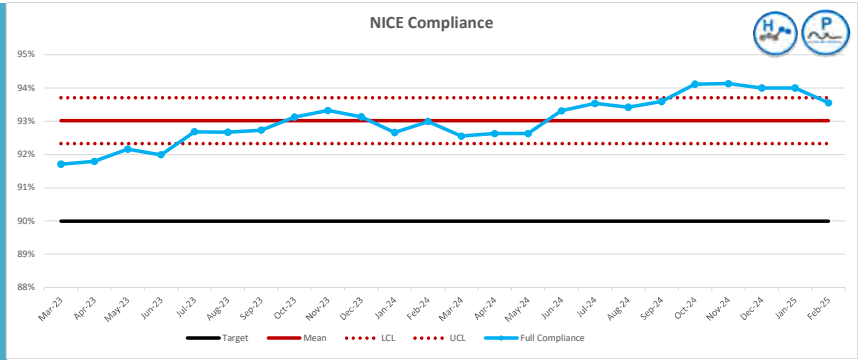
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 94.49. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 101.62.	 	(HSMR) Assurance: NA - no target Variation: Common Cause Variation. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature.	There has been a spike in HSMR/ SHMI which has been felt to be likely secondary to Same Day Emergency Care activity (low risk patients' exclusion). This is being monitored through the Mortality Review Group(MRG).	Subject Judgement Review backlog was discussed at Quality Committee February 2025. There has been a considerable improvement noted in the month of February with a reduction of 27 SJR's in month (SJRs outstanding more than 8 weeks reduced from 39 to 22). The importance of timely closures was again re-iterated in February MRG, and this will continue to be closely monitored. A meeting has been arranged with the Stroke Consultants to feedback findings from a detailed review of Stroke patients. Actions will be tracked via MRG.
18. NICE Compliance Target: 90%	The Trust achieved 93.55% 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.	We currently have 641 pieces of NICE guidance where a total of 544 are agreed as" full compliance", 36 are agreed as "partial compliance", 35 are 'partial compliance' 21 are for information only and 5 are currently under review. Based on this WHH is 93.55% compliant with NICE Guidance. The Clinical Business Units' (CBU's) are asked to review the partial compliance and when relevant actions have been completed the guidance is re-reviewed to determine the updated compliance against the relevant guidance. WHH continues to consistently remain above the 90% compliance target.

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Appendix 2

19. Complaints

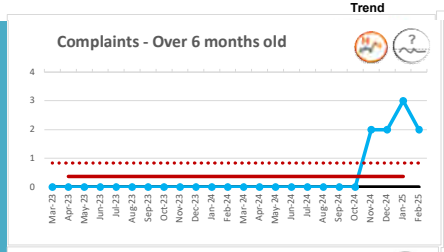
Target: Zero complaints open over 6 months old/in the backlog

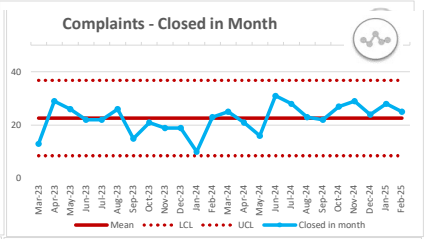
Trust Performance

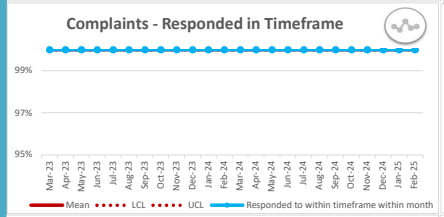
In month, 27 new complaints were received to the Trust which was a decrease of 4 from the previous month. There were 2 cases reopened in month, which is the same as the previous month.

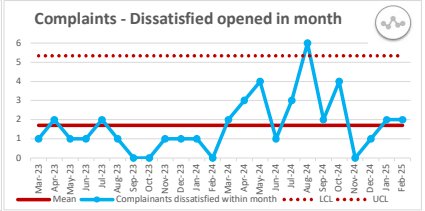
7 PHSO cases were open at the time of reporting, these were not linked to a specific area or theme.

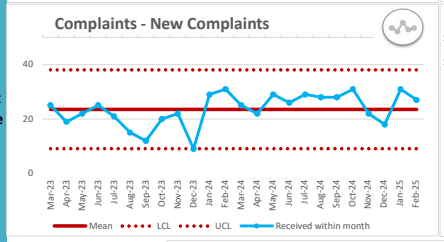
Trend

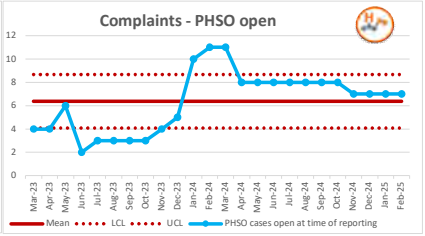


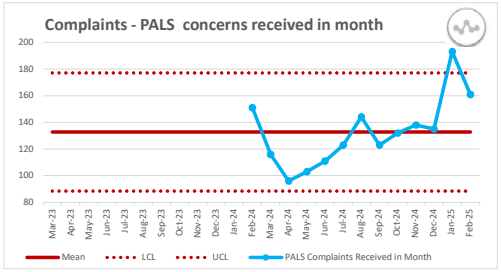












Statistical Narrative

Assurance: The Trust inconsistently passes/fails the target.

Variation: Special Cause Variation of a concerning nature.

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

The Trust continues to sustain performance in the timely completion of complaints. At the time of reporting, there were 2 complaints over 6 months old.

1 was on hold due to the Trust awaiting further questions from the complainant, these were obtained, and the case has now been closed. The second case was on hold as the Trust were awaiting further questions, these were obtained on 3 March 2025, and the complaint investigation has now commenced.

WHH is noting a small reduction in the number of PHSO cases being seen.

Higher numbers of Pals concerns are being seen in recent months, key themes relate to delays for appointments and waiting times.

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

There were 81 open complaints at the time of reporting. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams, as well as follow up meetings upon receipt of the initial response letter. All CBUs have a designated complaints case handler to ensure consistent support for each area. All complaints are Quality Checked by the Deputy Chief Nurse/Director of Governance and the Chief Nurse.

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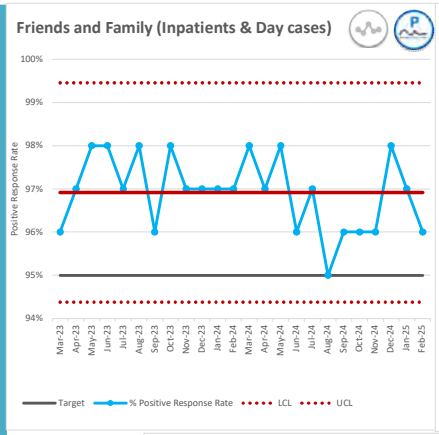
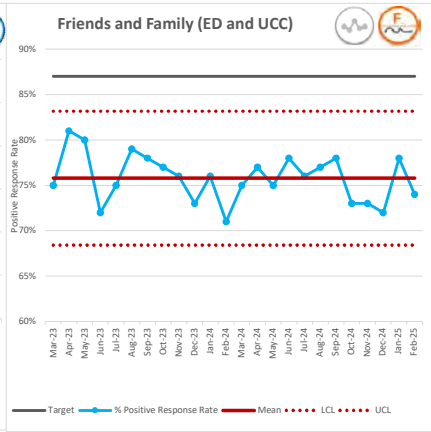
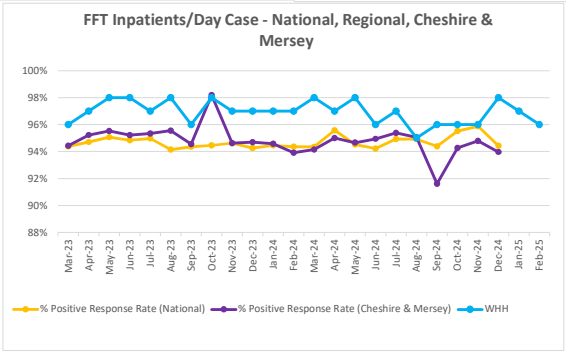
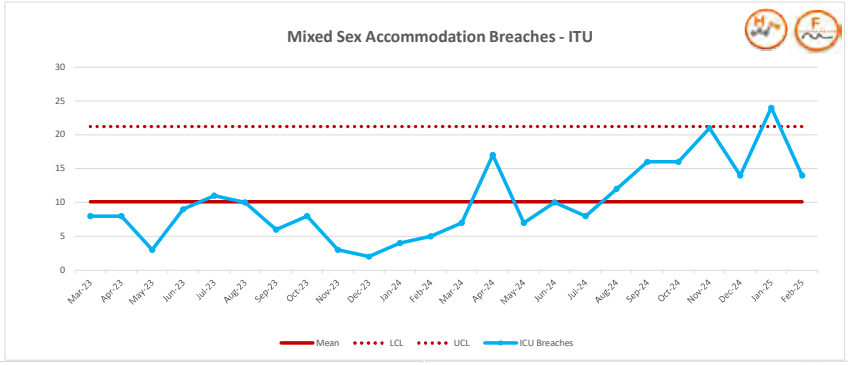
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) **Target: 95%** **21. Friends and Family (ED and UCC)** **Target: 87%** **The Trust achieved 96% in month for Inpatient & Day case FFT and 74% 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: Common Cause (Normal) variation**	**Inpatient/Day Case - The Trust achieved a 96% positive recommendation rate in February 2025 against a target of 95%.** **ED/UCC - The Trust achieved 74% positive feedback in Friends and Family Test results in February 2025.** **The main theme continues in relate to waiting times within the department.**	**An ED leaflet has been produced in the interim to aid communication and a nurse is allocated to care for patients in the waiting room who can answer any concerns raised by patients.** **The Patient Experience and Inclusion Team and Communications Team are progressing the procurement of information screens in key areas in the Trust, these will include key messages in relation to waiting times.** **Themes are monitored through dashboard and free text comments to identify areas for improvement, best practice is shared at Patient Experience and Inclusion Sub-Committee (PEISC)** **Trust Board, Governors, PLACE and Patient Experience Team observations are fed back to wards/department and action plans are created are monitored via PEISC** **Patient journeys are being mapped to understand the support required at each touch point** **Patient stories are shared at the Board of Directors and Quality Assurance Committee for learning** **Recruiting volunteers to support patients with FFT completion**
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 14 MSA incident(s) within the ITU.**		**Assurance: The Trust consistently fails the target.** **Variation: Variation: Special Cause variation of a concerning nature.**	**There were 14 mixed sex breaches in February 2025, this is a decrease of 10 compared to January 2025. 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 ITU 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 policy relating to mixed sex accommodation breaches is currently being updated.**

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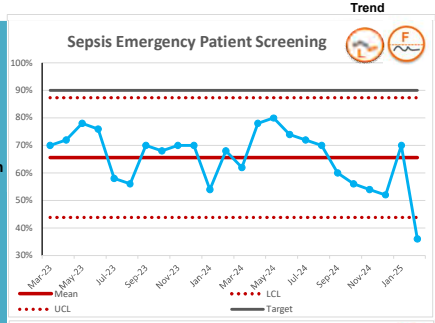
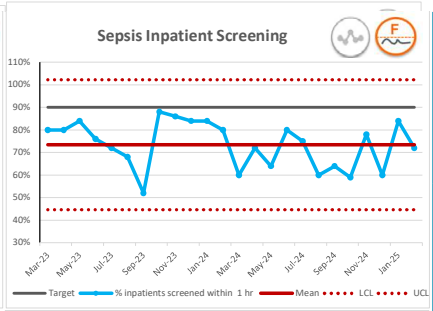
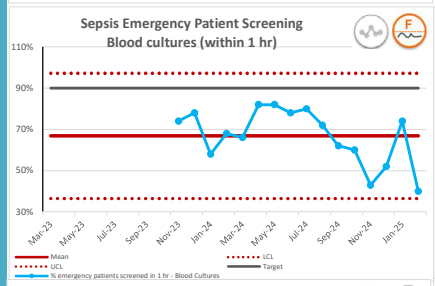
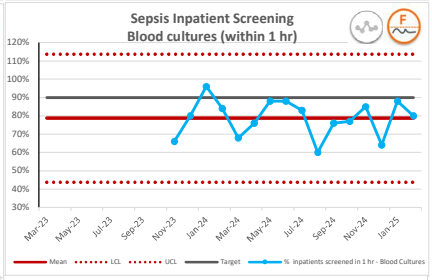
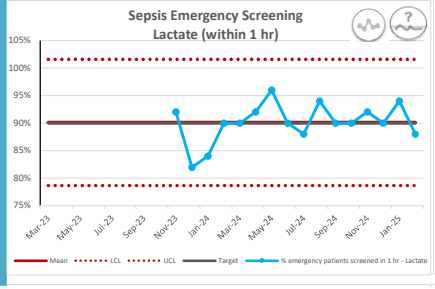
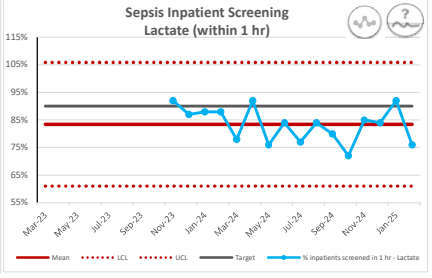
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%**		(Emergency) Assurance: The Trust consistently fails the target. Variation: Variation: Special Cause variation of a concerning nature.	The new NICE Guideline 51 was implemented in September 2024. A key change from the guidance is that time zero (the time at which the one hour clock starts ticking), is now taken from when the patient observations (NEWS2 score) resulting in the identification of level of risk e.g. moderate or high risk as opposed to red and amber flags. Previously this was at a later time when clinical staff document that Sepsis is suspected to the Sepsis Tool was launched on Lorenzo. Within ED, lactate compliance is consistently higher than blood culture compliance due to different staff groups undertaking the different elements of screening at different times e.g. HCSWs take lactates as part of the screening process and registered nurses or medical staff take blood cultures as part of the Sepsis 6 response. ED Has a number of new staff who are just undergoing clinical skills training.	Promotion of key messages through Trust-wide communications and in practice training continues. ED are undertaking a Test of Change relating to launch of the Sepsis tool and prioritisation of blood cultures. HCSWs in ED training to undertake blood cultures. Clinical Lead for Sepsis has met with ED Teams (February 2025), space utilisation for patients being treated for suspected Sepsis and equipment has been reviewed with changes and changes implemented. Compliance data is shared monthly with Lead Nurses and discussed at Operational Patient Safety Group. Updated sepsis policy to be ratified in Q1.
24. Sepsis - % screening for all inpatients **Target: 90%**		(Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.		
The Trust achieved: **• 36% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** **• 72% screening for all inpatients with suspected sepsis within 1 hour.**				
Blood Cultures: **• 40% screening for Emergency patients with suspected sepsis within 1 hour.** **• 80% screening for Inpatients with suspected sepsis within 1 hour.**				
Lactate: **• 88% screening for Emergency patients with suspected sepsis within 1 hour.** **• 76% screening for Inpatients with suspected sepsis within 1 hour.**				
				

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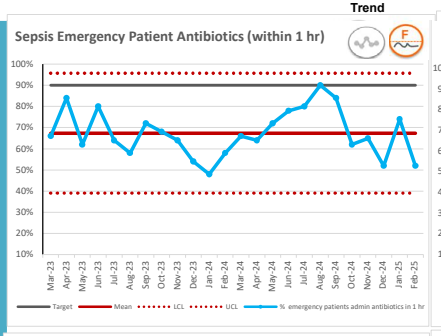
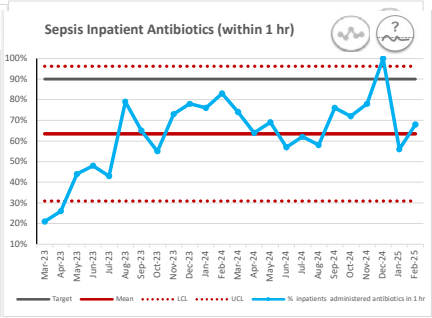
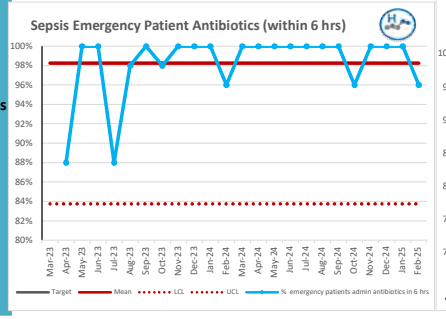
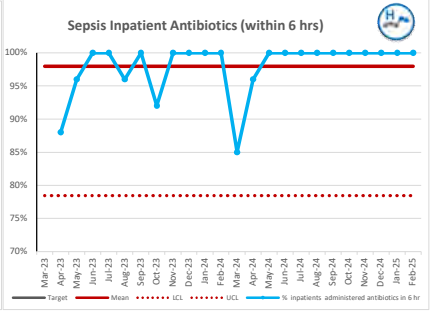
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%** **26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis** **Target: 90%**	   	**The Trust achieved:** **• 52% 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 6 hours of a diagnosis of sepsis being made.** **• 68% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.** **• 100% of inpatients had antibiotics administered within 6 hours 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.**	**The new NICE Guideline 51 was implemented in September 2024. A key change from the guidance is that time zero (the time at which the one-hour clock starts ticking), is now taken from when the patient observations (NEWS2 score) resulting in the identification of level of risk e.g. moderate or high risk as opposed to red and amber flags. Previously this was later from when clinical staff document that Sepsis is suspected to the Sepsis tool was launched on Lorenzo.** **All inpatients received their antibiotics within 6 hours.**	**Services have been encouraged to launch the Sepsis Tool on suspicion of Sepsis to support timely decision making. A single point lesson on how to access the tool continues to be promoted Trust-wide. The new e-learning package continues to be promoted for completion. Laptop aids providing information about launching the tool have been recirculated.** **Compliance data is shared monthly with Lead Nurses and discussed at Operational Patient Safety Group.**

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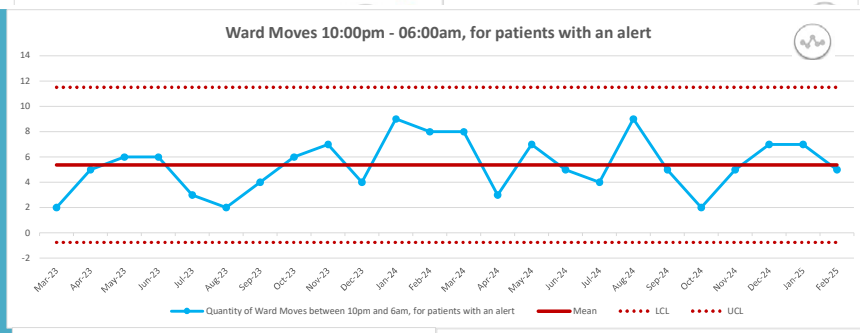
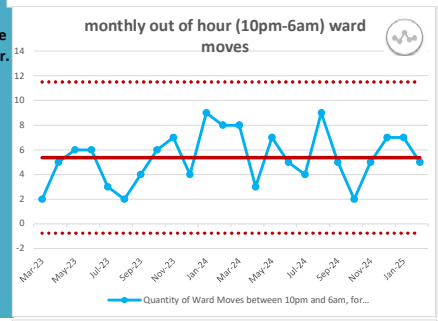
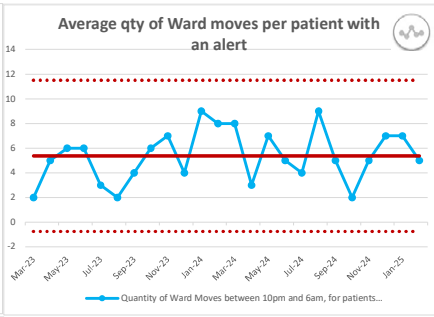
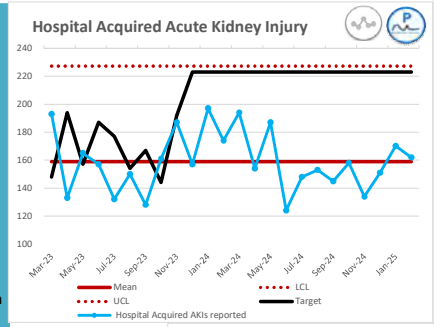
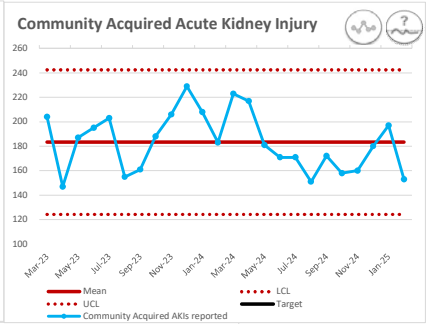
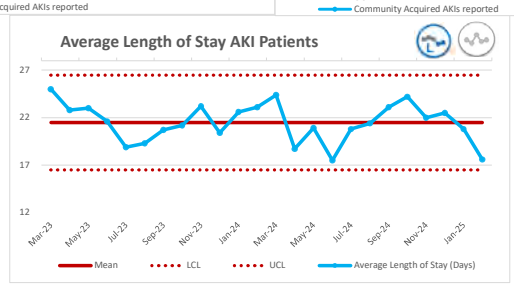
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am with a dementia, LD and/or Mental Health alert **No Target**	**There were a total of 5 ward moves in month between 10pm-6am for patients with an alert, compared to 8 in the same period in the previous year.**	  	**Assurance: N/A No Target set.** **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 10 pm. 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 162 acute kidney injuries reported in month compared to 170 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.**	**Trust wide focus on accurate and appropriate fluid balance chart completion. This will not only support AKI but assist with the early recognition of the deteriorating patient. AKI e-learning package simplifies understanding of AKI and promotes awareness of fluid balance charts. Updated fluid balance guidelines more clearly define roles and responsibilities.** **AKI update presented at Chief Nurse Check In February 2025.** **Day to day ward-based AKI education ongoing part by the AKI lead.**

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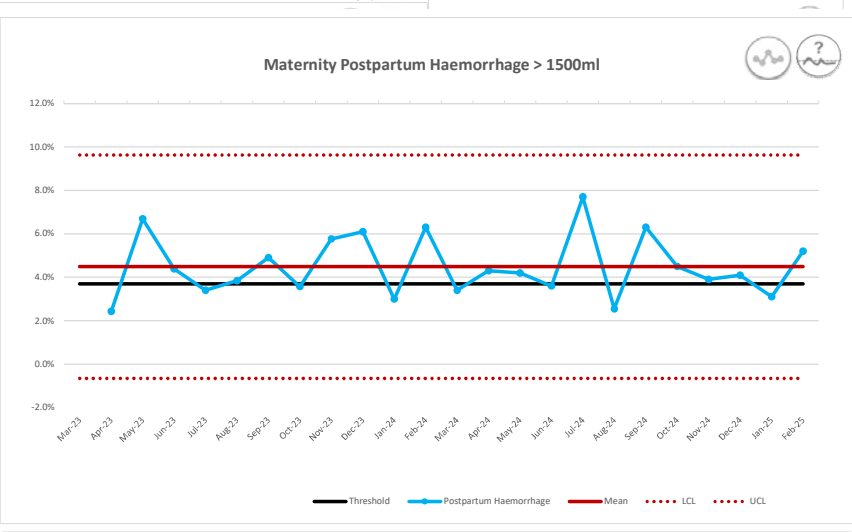
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 5.2% Postpartum Haemorrhages >1500ml in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**Rates for PPH >1500ml continue to fluctuate. The service has recently received comparator data from the Cheshire and Mersey (C&M) LMNS which notes an average rate for C&M of 38/1000 births. The WHH rate is 45 cases per 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.** **A number of actions are now underway including sharing of good practice and implementation of bespoke training for resident doctors in relation to management of the 3rd stage of labour. A new regional guideline re PPH is due to be published shortly. Colleagues from WHH have participated in the regional working groups tasked with developing this guideline and many of the change ideas advocated by WHH will be included within the guideline.** **The Working Group will continue but change its focus to the implementation of new standards. The PPH action plan is reported monthly to QAC alongside an SPC chart which currently shows common cause variation.**

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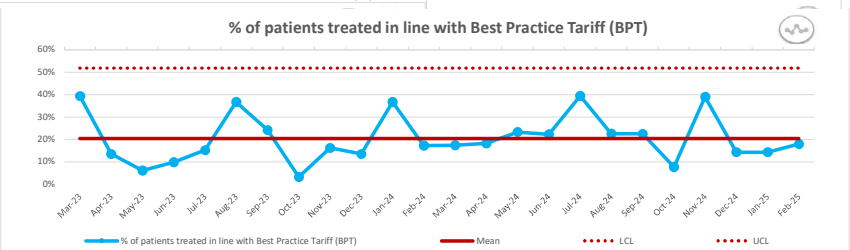
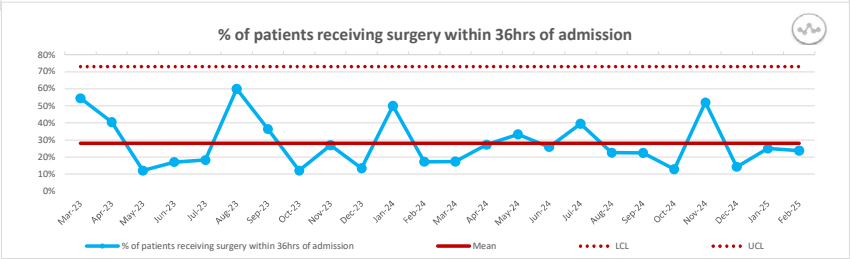
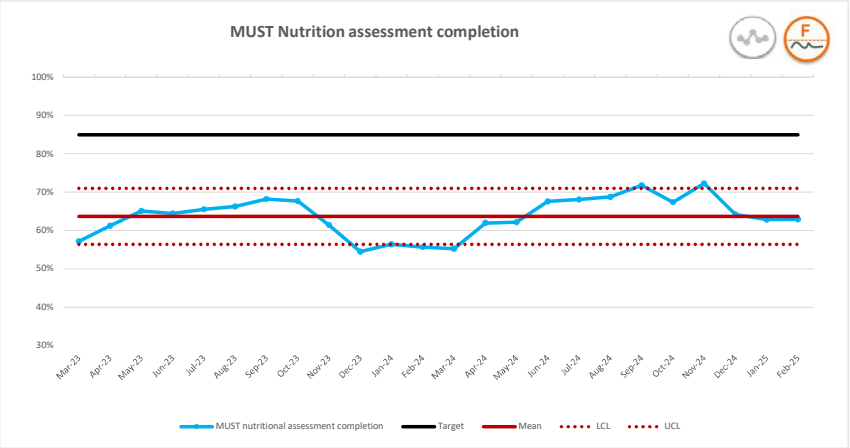
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
30. Fractured Neck of Femur **Target: Best Practice Tariff**	**17.95% of patients were treated in line with Best Practice Tariff (BPT) in Feb-25.**	 	**Variation: Common Cause (Normal) variation.**	**There was an increase in the number of patients admitted with a #NOF in January and February adding increased pressure to the service. Whilst improvements have been seen in some areas of the Best Practice Tariff, challenges remain with timely surgery for this staff group.**	**There was an increase in the number of patients admitted with a #NOF in January and February adding increased pressure to the service. Whilst improvements have been seen in some areas of the Best Practice Tariff, challenges remain with timely surgery for this staff group.** **We need to continue to ensure that NOF patients are admitted directly to the Orthopaedic ward, again in February we saw only 57% of our patients be admitted to the Orthopaedic ward from A&E** **Performance is monitored against KPI's and BPT and presented this data to the NOF Group and Patient Safety and Clinical Effectiveness Sub Committee (PSCESC) an action plan has been developed with the aim of improving these outcomes. The revised NOF escalation SOP is being presented next CBU Clinical Governance Meeting to support patients receiving surgery within 36 hours.**
31. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 62.9% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**MUST compliance continues to improve slowly, with work ongoing with clinical teams to improve this. There was a dip in performance in the previous two months this aligns with staffing challenges due to staff sickness.**	**The clinical indicators function on Lorenzo is being improved to enable teams to see that the compliance is about to turn red (this will appear amber) giving teams the opportunity to complete and improve compliance.** **The ED team have received training following a noted low compliance in EAU which was impacting on ward compliance figures. Nutrition status and MUST assessments are being included in other harm profile reviews such as Pressure Ulcers to raise awareness of the interdependencies between nutrition and pressure ulcer prevention to promote change.**

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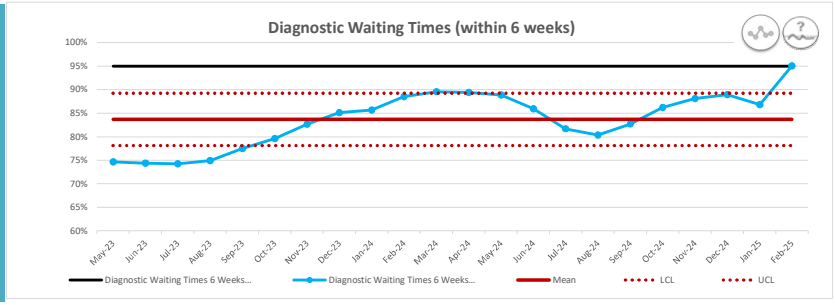
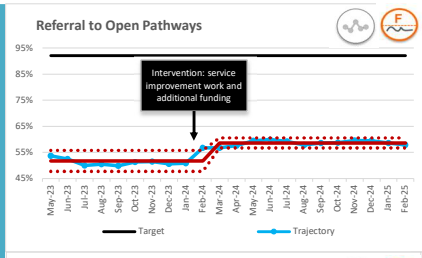
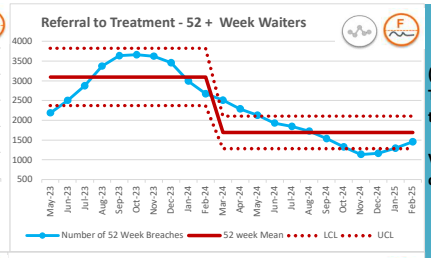
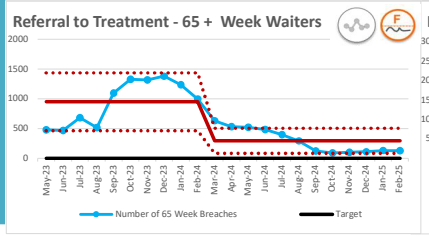
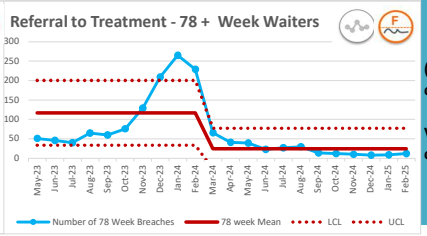
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Diagnostic Waiting Times 6 Weeks Target: 95%	**The Trust achieved 95.05% in month.**		**Assurance: The Trust inconsistently passes and fails the target.** **Variation: There is common cause variation.**	**The diagnostic target has been achieved ahead of trajectory.**	**This recovered position will continue to be monitored through Performance review group to ensure continued achievement.**
33. Referral to treatment Open Pathways Target: 92% 34. RTT - Number of patients waiting 52+ weeks Target: 0	**The Trust achieved 57.86% in month. There were 1455, 52 week breaches, 12, 78 week breaches and 126, 65 week breaches.**	   	**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: There is common cause variation.** **(52+) Assurance: The Trust consistently fails the target.** **Variation: There is common cause (normal) variation.**	**RTT performance - 52 weeks is behind trajectory, mainly in planned care. 65 weeks has a small residual number of patients remaining with 127 submitted for Feb. This continues to be within a few specialties, T&O, Gynae, Pain and Max Fax.**	**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.**

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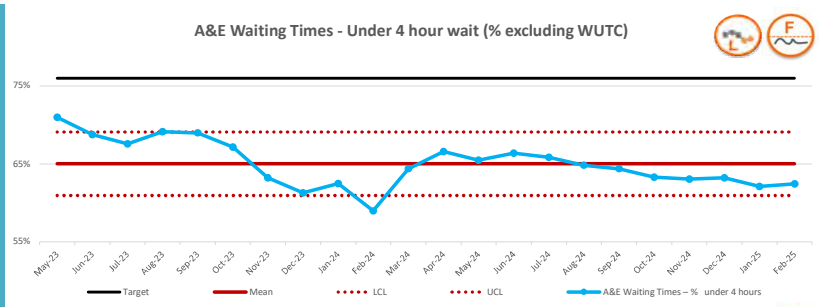
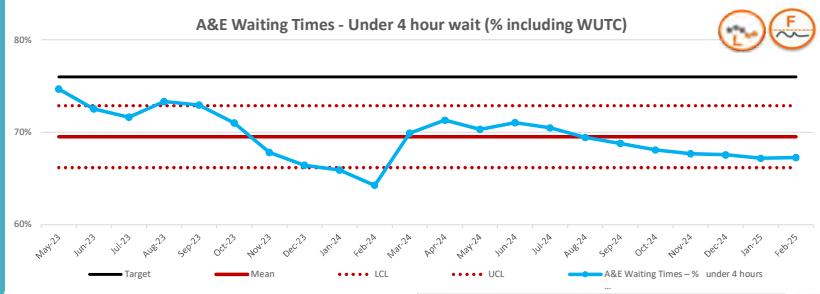
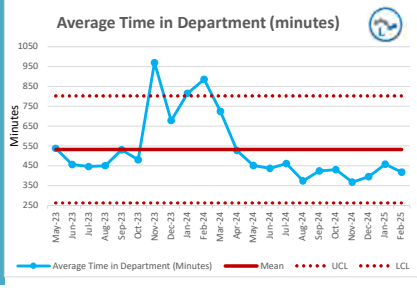
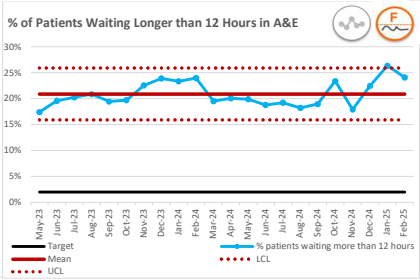
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
35.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC) Target: 75%	**The Trust achieved 62.42% excluding Widnes UTC in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**Performance continues to be negatively impacted by 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.** **• 21 Additional beds were opened on ward B4 in Feb to support the position, A10 remains open.**
76.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) Target: 75%					
36. Average time in department ED No Target	**The Trust achieved 67.27% excluding Widnes UTC in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**		
37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	**24.08% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 418 minutes.**	 	**Assurance: No Target set** **Variation: Special Cause Variation of an improving nature.** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**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 2024/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 2024/25 is set up to support improvement.**

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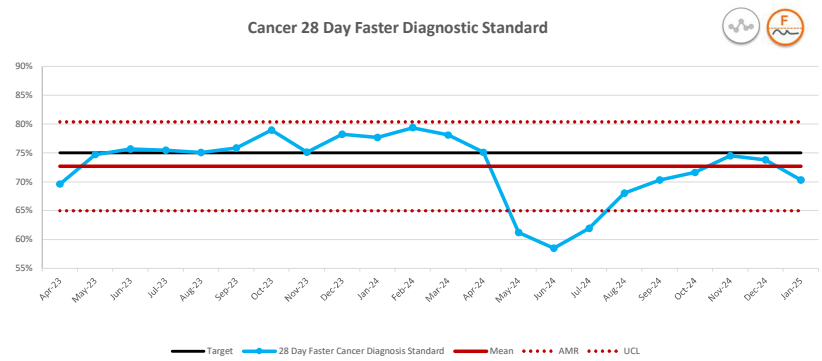
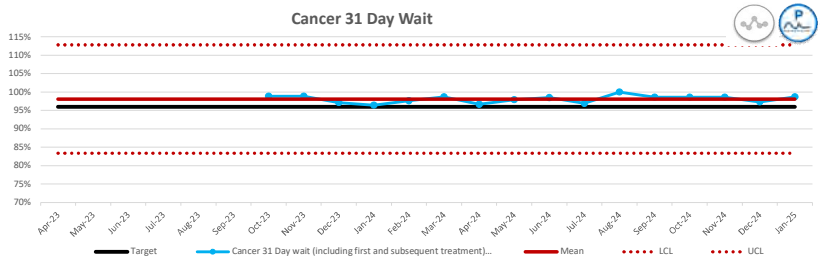
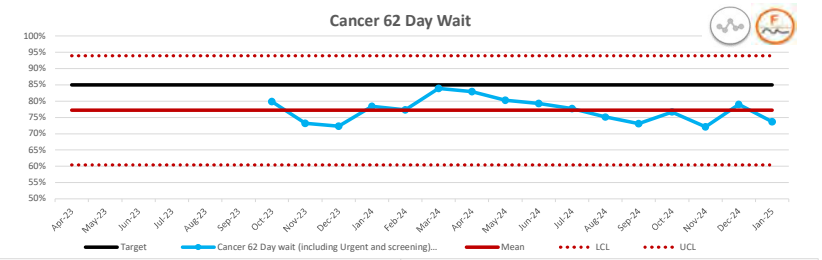
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
38. 28 Day Faster Cancer Diagnosis Standard Target: 75%	The Trust achieved 70.3% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The Trust is not currently meeting the 28 Day FDS. This has been due to specific issues with breast first appointment capacity which has affected performance. The capacity issue has resolved mid-July but the effect has continued into following months. This is a resolving position and a trajectory to reach the 77% stretch target by March 25 has been put in place. The trajectory has underperformed in January due to activity loss and patient choice over the Christmas period. There are longer term plans to achieve a sustained improvement in performance in gynae and lower GI pathways. 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 2025.	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 98.7% in month for Cancer 31 Day Wait.		Assurance: Target met consistently Variation: There is Common Cause (normal) Variation.	The Trust achieved the 31 day target.	
40. Cancer 62 Day wait Target: 85%	The Trust achieved 73.7% in month for Cancer 62 Day Wait.		Assurance: The Trust consistently fails the target. There is a commitment to achieveing 70% by March 25 required nationally. This is currently being met. Variation: There is Common Cause (normal) Variation.	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.	

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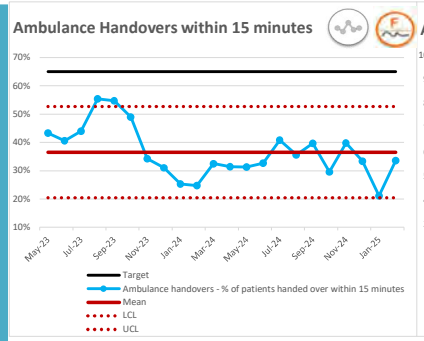
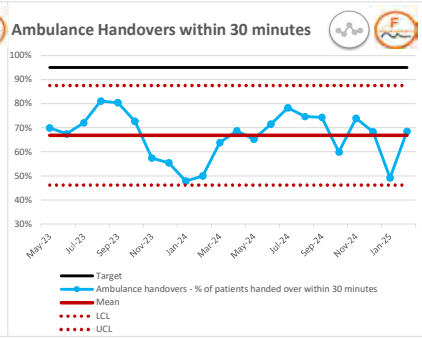
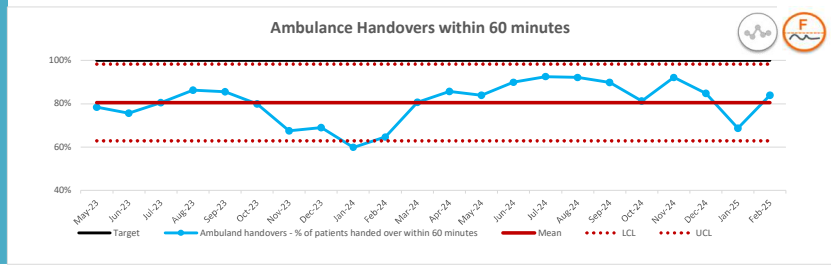
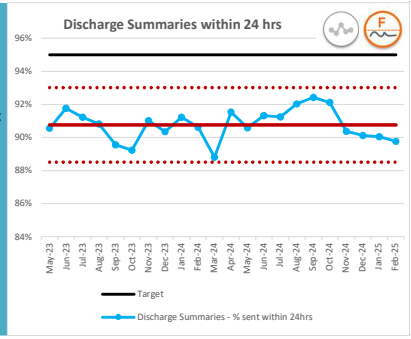
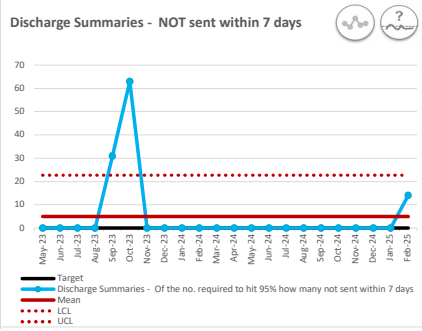
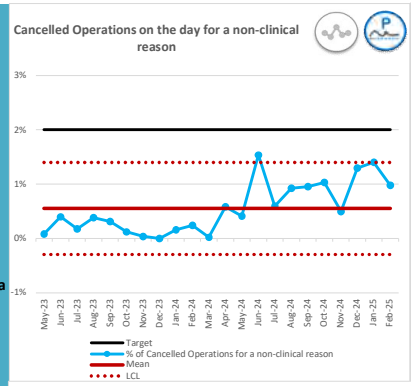
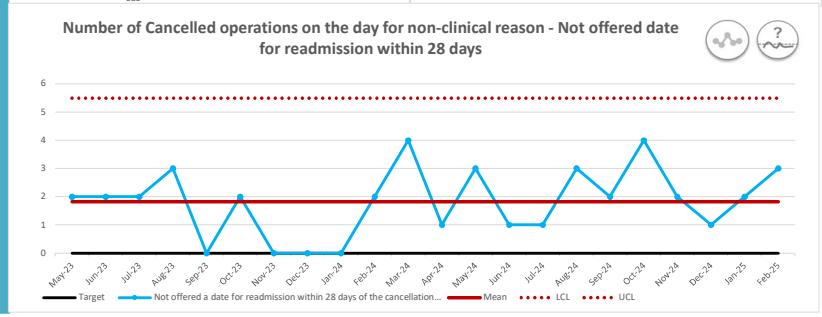
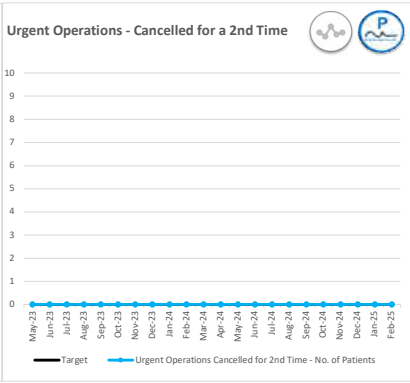
Access & Performance - Trust Position

	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)?
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 the Trust achieved:** **- 33.6% Ambulance Handovers within 15 minutes (65% target)** **- 68.5% Ambulance Handovers within 30 minutes (95% target)** **- 83.9% Ambulance Handovers within 60 minutes (100% target)**	  	**Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.** **(60) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) variation)**	**The Trust continues to work with NWAS to support improving this metric. Call before your convey test of change commenced from 3rd Feb 2025 to support reducing arrivals, data is being collated to understand the impact**	
44. Discharge Summaries - % sent within 24hrs Target: 95% 45. Discharge Summaries - Number NOT sent within 7 days Target: ZERO	**The Trust achieved 89.77% in month for discharge summaries sent within 23 days, against the target of 95%.** **There were 14 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: Common Cause (Normal) variation.**	**Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed. The increase seen in February is under review by the care groups**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**

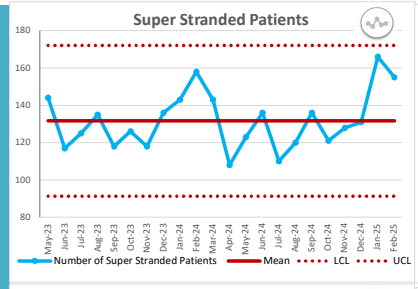
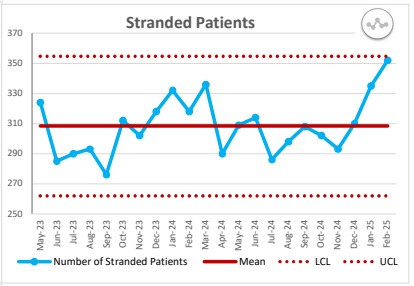
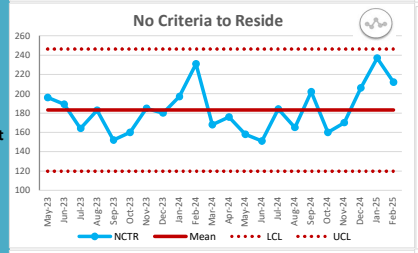
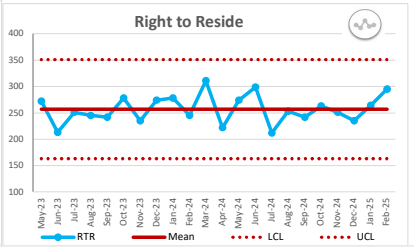
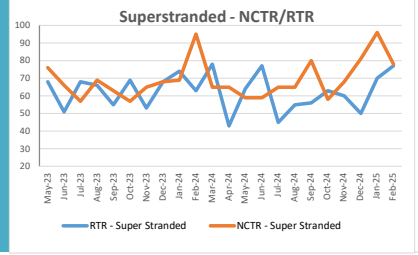
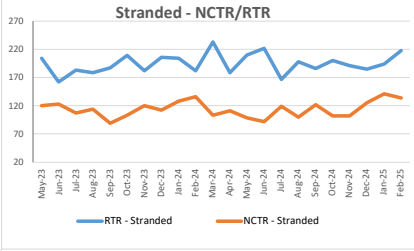
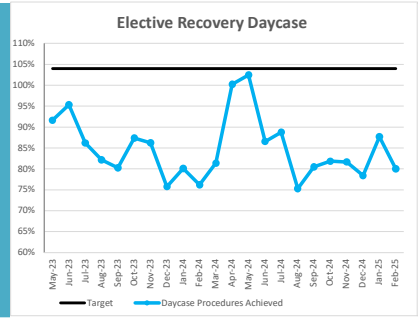
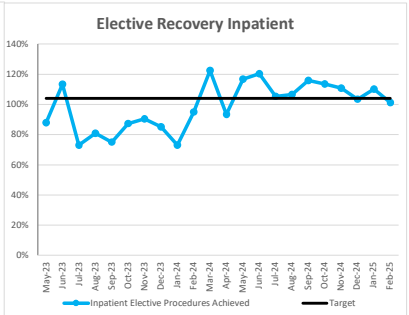
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
46. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	Cancelled operations for a non-clinical reason was 0.98% in month. 3 cancelled operation wss not offered a date for readmission within 28 days.		(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	A change in reporting following identification of a DQ issue has caused the variation in numbers, this remains inline with Peers.	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.		

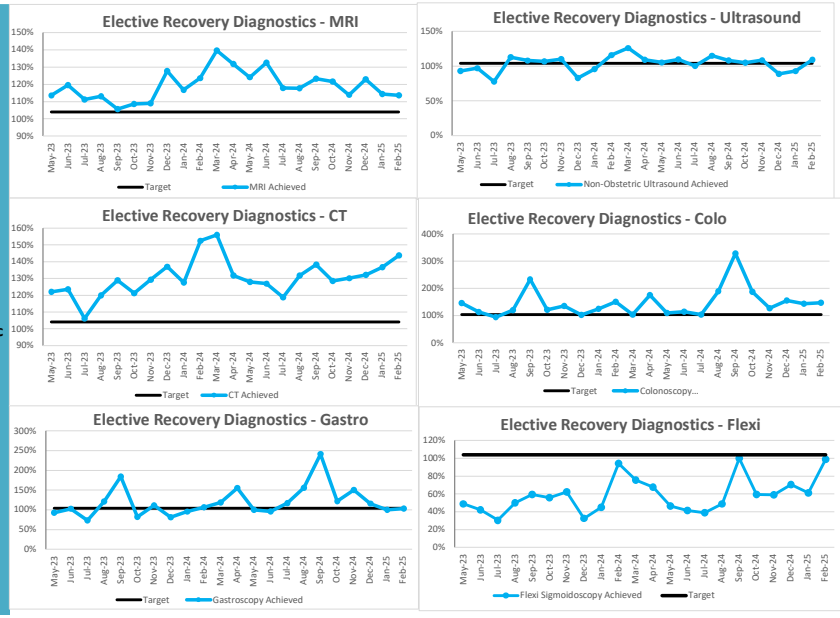
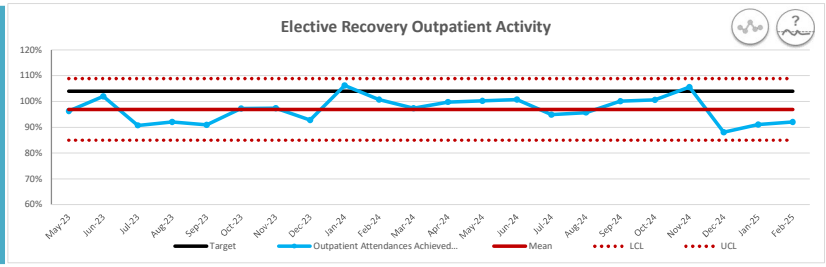
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
49. Super Stranded Patients Target: Trajectory 50. No Criteria to Reside (NCTR)	There were 352 stranded and 155 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 stranded patients has increased in month, this has been compounded by IPC constraints.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
51. Elective Recovery 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 80% of Daycase Procedures and 101.16% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient electives continues to over perform a decrease in day cases was seen as a result of the focus on clearing the complex long waiters.	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

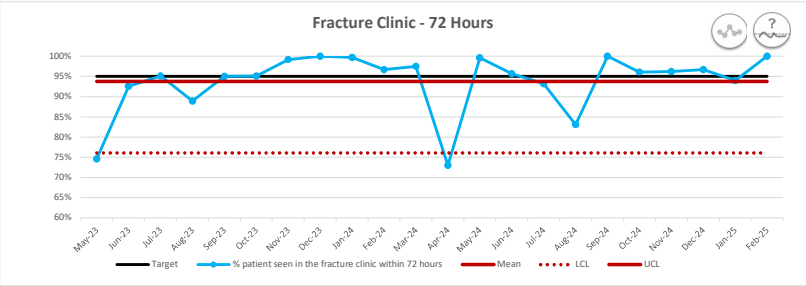
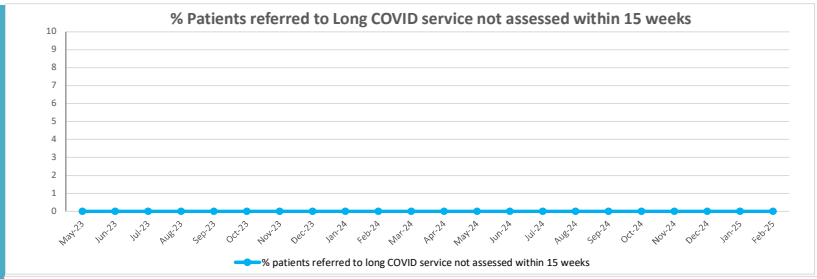
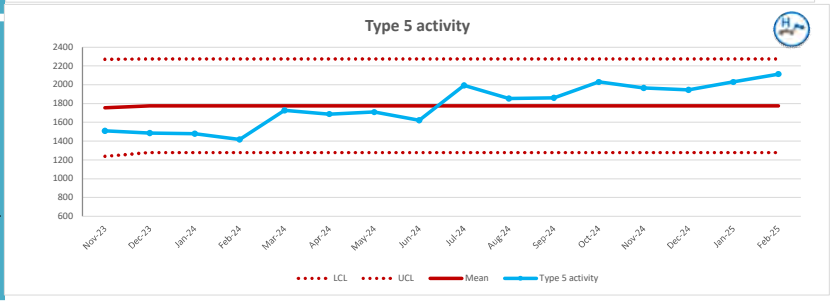
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20	In month, the Trust achieved the following % of activity against 2019. This included: 113.62% of MRI 143.74% of CT 109.36% of Non-Obstetric Ultrasound 98.84% of Flexi Sigmoidoscopy 148.03% of Colonoscopy 103.3% 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 Outpatient Activity Aggregate Target: 104%	In month, the Trust achieved 92.01% 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 in line with operational planning guidance	The Trust continues to restore clinical services in line with the national operating guidance. The position will improve following completion of coding of OPD procedures.

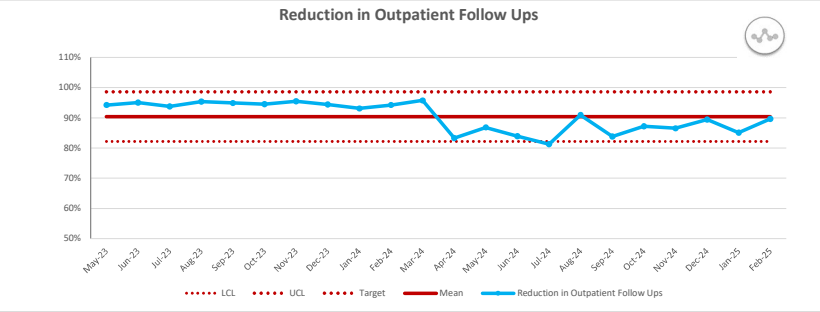
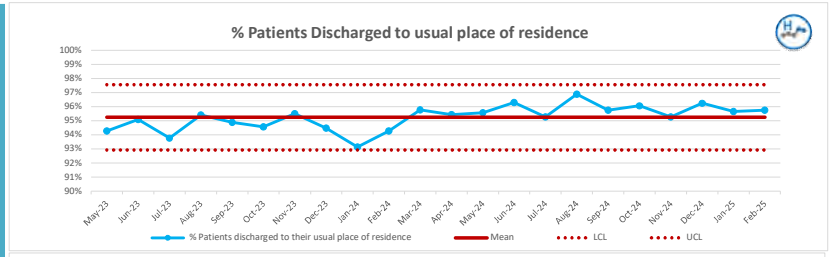
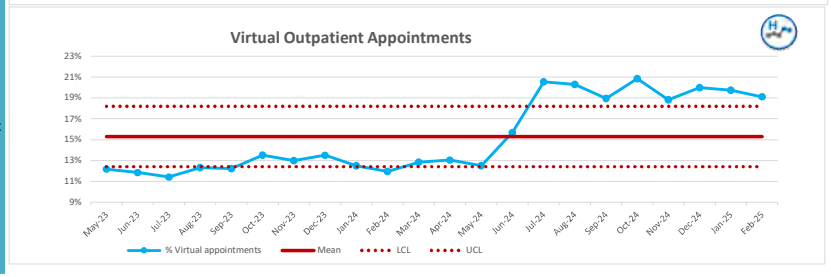
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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.				
57.Type 5 activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 2114 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.	

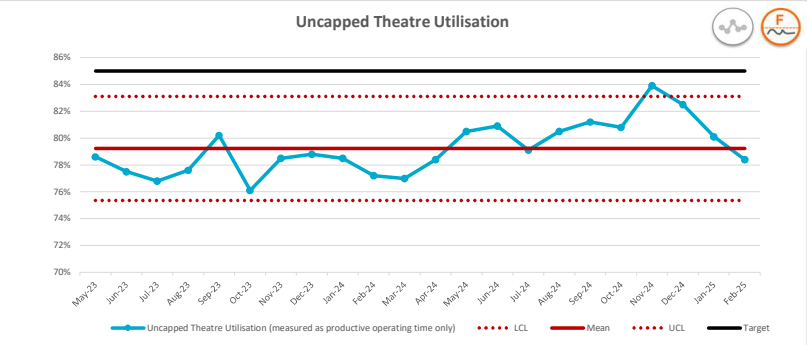
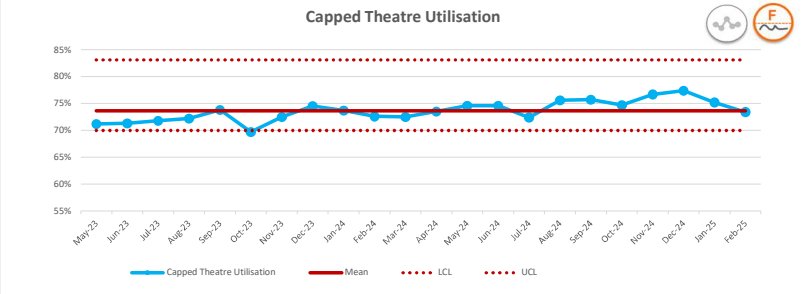
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 89.69% 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)	**19.11% Virtual Outpatient appointments in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**	**Virtual outpatients continues to be monitored via the performance review group.**	

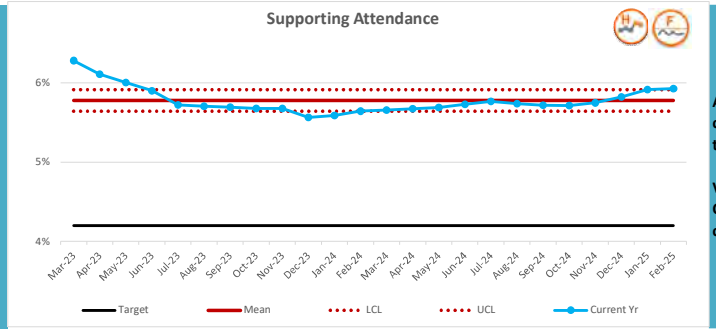
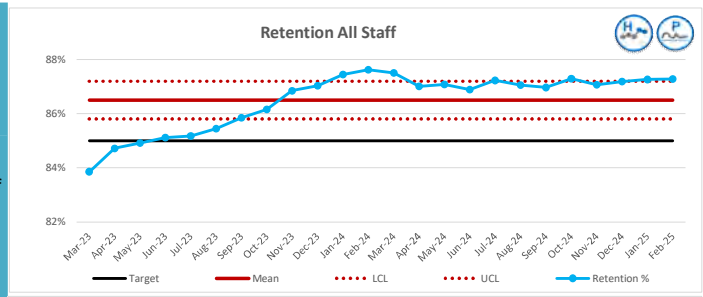
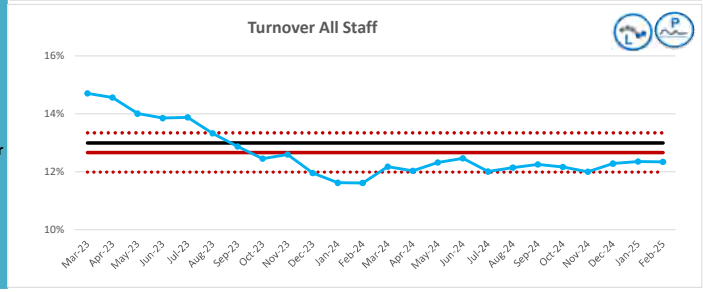
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
61. Uncapped Theatre Utilisation (measured as productive operating time only) Target: 85%	**78.4% Uncapped Theatre utilisation in month (measured as productive operating time only).** **73.4% Capped Theatre utilisation in month (measured as productive operating time only).**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Theatre Utilisation remains a challenged area, a focus on late starts and improving productivity are key priorities for 2024/25.** **The decrease in performance seen in February was compounded by a leak in theatres which resulted in cases being moved between theatres, a data quality issue in the way this was reported has been identified by Planned care, a mitigation plan is being produced to support a manual check of data accuracy prior to reporting nationally is being implemented.**	**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.** ***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.**
62. Capped Theatre Utilisation Target: 85%			**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.**

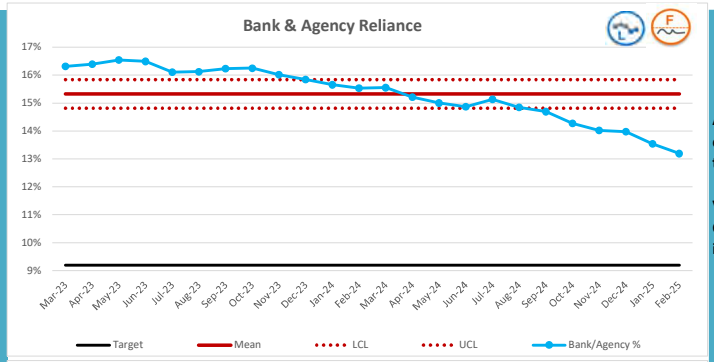
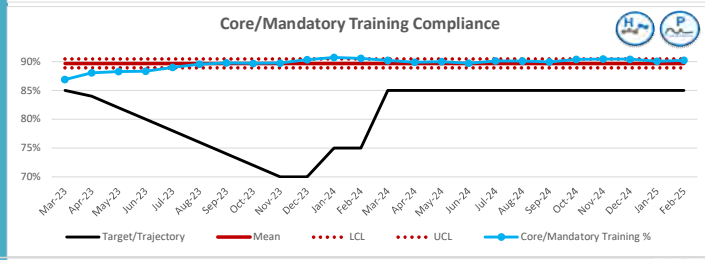
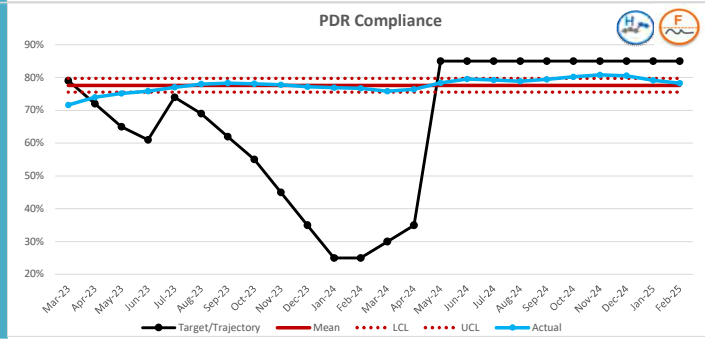
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

	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 5.93%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	The annualised sickness absence percentage in February 2025 was 5.93%, an increase from December 2024 at 5.82%, and an increase from the previous 12 months. Reasons for the reduction in sickness absence from 2022 has been 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. Stress, anxiety and depression and MSK continue to be the highest reason for sickness absence. OH continue their partnership with Maximus Service to support staff returning to work from LTS. Rugby League Cares are providing 1:1 and group sessions for staff where there is high absence for stress and anxiety. Where areas are above 5%, reviews are underway to target sickness.
64. Retention Target: 85%	The Trust's annualised retention of all staff was 87.28%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Retention of all staff in February 2025 was above Trust target at 87.28%, a slight increase from 87.17% in December 2024. Retention for permanent staff in February 2025 remains above Trust target at 89.39%.	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. Following the launch of a refreshed flexible working offer, renamed #MyFlexWHH, the Trust is now piloting Preference Rostering on two wards (ACCU and Ward B19). The first roster designed using the Preference Rostering methodology went live in November 2024 for shifts in January 2025. The percentage of staff who worked their preferred shifts increased from 7.2% to 63.9% across both wards. In February 2025, this has increased to 89% for Ward B19 and 79% for ACCU, with Bank spend the lowest in January 2025 for the last 12 months. Further metrics are being reviewed including quality and sickness absence with a view for wider roll out across the Trust.
65. Turnover Target: Below 13%	The Trust's annualised turnover of all staff was 12.34%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover in February 2025 was 12.34%, a slight increase from December 2024 at 12.28%. Turnover of permanent staff in February 2025 remains below Trust target at 11.74%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

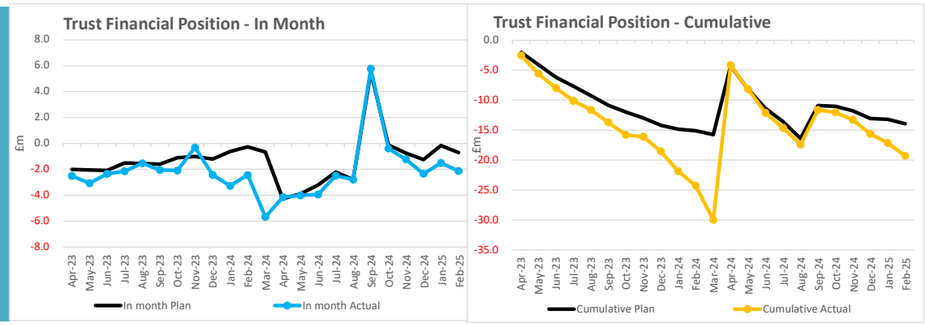
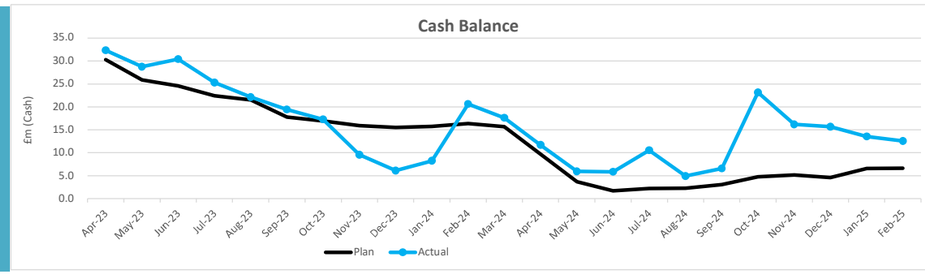
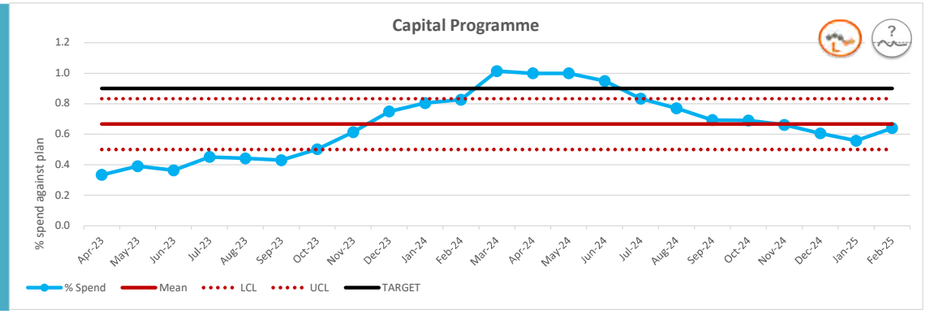
Workforce - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Bank and Agency Reliance Target: 9% or Below	Annualised Bank and Agency Reliance was 12.99%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Bank and Agency reliance in February 2025 was 12.99%, a decrease from 13.78% in December 2024. Bank reliance in February 2025 is 11.9%, a decrease from 12.67% in December 2024. Agency reliance continues to decrease and was 1.5% in February 2025 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 have action plans in place to support reductions. The Care Groups also have sight of the top earning bank and agency workers and have been developing plans for turning off which is reported to the Executive team for further oversight and review.
67. Core/ Mandatory Training Target: 85%	Core/Mandatory training compliance was 90.22% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	In February 2025, CSTF Mandatory Training compliance was 90.22%.	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%	Annualised PDR compliance was 78.24%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	In February 2025, appraisal compliance was 78.24%, a slight decrease from 79.81% in December 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
- RR116: Risk Register
- CQC: Care Quality Commission
- Trust Strategy

	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**		The Trust has recorded a year to date deficit position of £19.3m at 28 February 2025 against a revised deficit plan of £13.9m. The Trust has a revised risk adjusted forecast of £5.5m deficit and the year to date position is in line with this forecast.	The drivers for the deficit being worse than plan are CIP not being delivered, the cost of the pay award in excess of funding received, the impact of Industrial Action, cost pressures that have not been offset as in previous months and PwC consultancy costs with benefits forecasted in March 2025.	The Trust has received notification of non-recurrent surge funding in March 2025 of £2.3m which has offset the impact of the pay award and the cost of industrial action. This funding is required to improve the bottom line, therefore the Trust is now forecasting a deficit of £16.8m (£5.5m worse than plan) which is expected to be achieved.
70. Cash Balance **Target: On or better than plan**		The cash balance at 28 February 2025 is £12.5m.	The current cash balance is £12.5m which is £5.9m higher than the cash plan. This is predominantly due to payment of £15.1m deficit support funding. Of the £12.5m cash, £2.4m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A total of £19.39m has been received to date of which £12.145m relates to 2024/25. Further cash support of £5.166m was requested for March 2025., however, this was not approved due to the Trust receiving a funding allocation from the ICB of £2.3m in March 2025. The Trust therefore would not have needed to draw down the cash requested for March 2025.
71. Capital Programme **Target: On plan 90%-100%**		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a declining nature.	Capital expenditure at the end of month 11 is £12.1m against a plan of £18.9m. The NHSE plan includes Frontline Digitisation funding for the EPCMS project which has been deferred to 2025/26. This has been adjusted in the Trust internal plan. Capital expenditure at month 11 is £1.6m behind the Trust internal plan of £13.7m. This is due to timing and is expected to be fully delivered by year end.	The reason for the year to date variance is due to timing and is expected to be fully delivered by year end. The risk associated with delivering the 2024/25 capital plan is being monitored at CPG and reported to FSC. Work has also continued 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:
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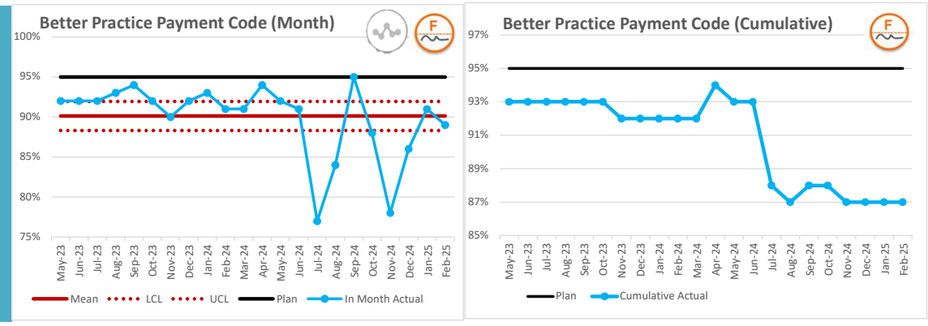
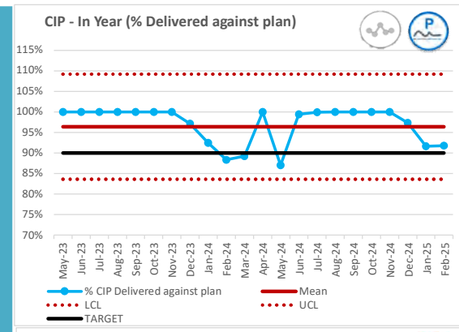
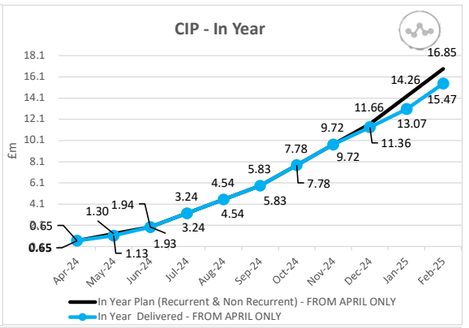
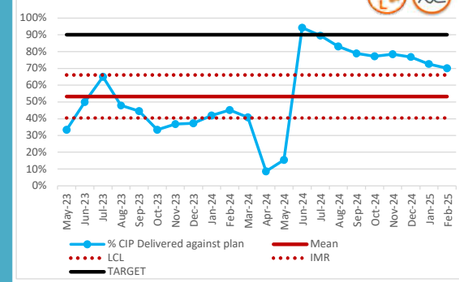
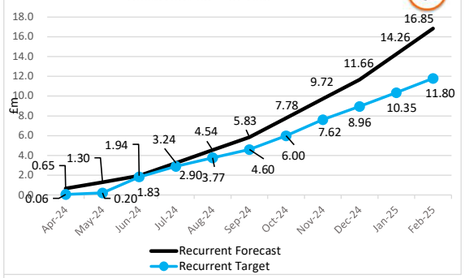
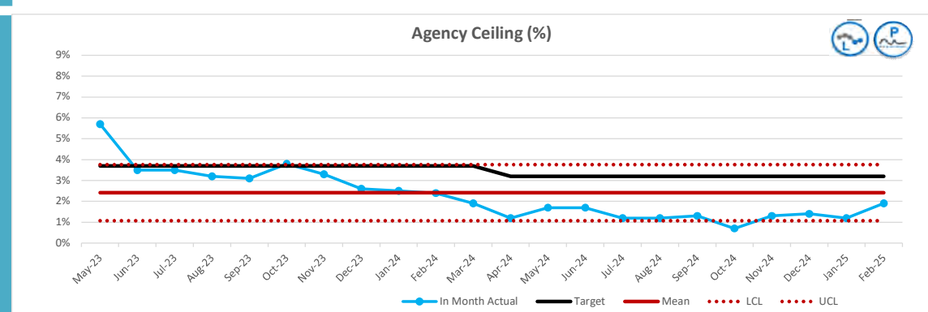
	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
72. Better Payment Practice Code **Target: Cumulative performance 95%**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**Cumulative BPPC performance is 87% which is below the national target of 95%.** **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 87%.**	**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.** **BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME.**
73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently passes the target.** **Variation: Common cause (normal) variation.**	**At month 11 £15.4m has been delivered against a target of £16.8m.** **The £1.4m under delivery of CIP relates to unachieved non-clinical vacancy and clinical procurement CIP schemes both of which are part of the £2.5m high risk CIP included in the Trust's latest risk adjusted forecast of £5.5m away from plan.**	**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 December 2024 coding freeze, the Trust achieved 98.6% which has deteriorated from November 2024 which was 99.3%.** **The Trust had plans to deliver the £19.4m CIP programme however the current forecast is £16.9m as £2.5m of high risk schemes have not been mitigated and form part of the latest risk adjusted forecast of £5.5m away from plan.**
74. Cost Improvement Programme (recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**£11.8m CIP has been delivered recurrently against the target of £16.8m.** **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.**	**As part of 2025/26 operational planning, work continues to identify recurrent CIP schemes. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Health and GIRFT are being used.**
75. Agency Ceiling **Target: Agency spend should not exceed 3.2% of total pay (ICS target)**		**Assurance: The Trust consistently passes the target** **Variation: Special Cause Variation of an improving nature.**	**The Trust Agency spend in month is 1.9% against a target of 3.2%.** **The national agency ceiling is 3.2% in 2024/25. Trust agency spend is still significantly below the target at 1.9%.**	**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.** **This indicator will be updated to reflect the scrutiny on bank and agency expenditure in April 2025.**

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?

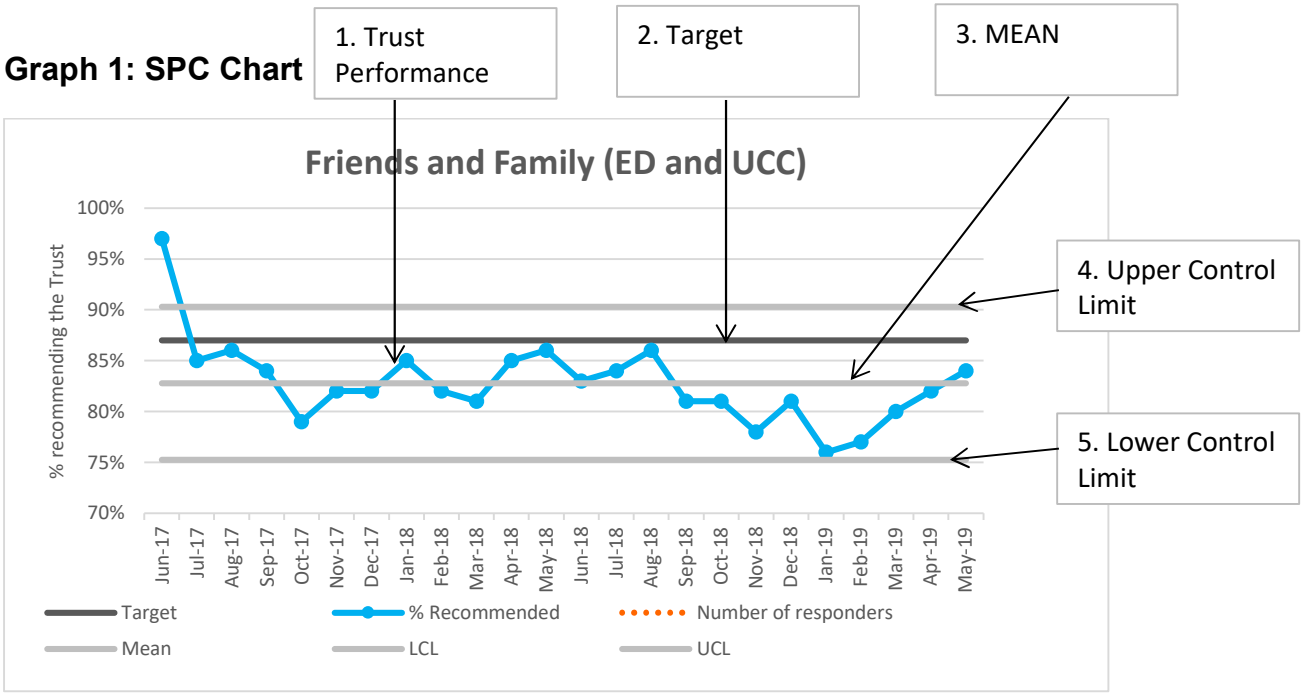
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

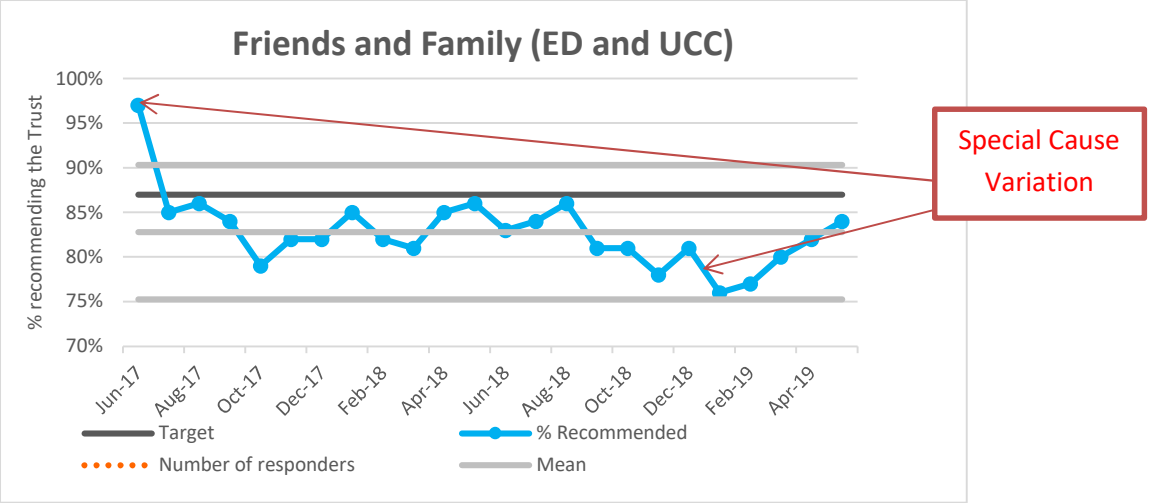


2.1 Interpreting a SPC Chart

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 28th February 2025

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	**341,562**	**28,447**	**28,265**	**-181**	**312,849**	**315,417**	**2,568**
Non NHS Clinical Income							
Private Patients	8	1	1	0	7	7	0
Non NHS Overseas Patients	71	5	5	0	66	70	4
Other non protected	670	61	44	-17	607	870	263
Sub total	**749**	**67**	**50**	**-17**	**680**	**947**	**267**
Other Operating Income							
Training & Education	9,541	782	789	7	8,759	9,542	783
Donations and Grants	50	5	-7	-12	45	76	31
Miscellaneous Income	14,681	1,223	1,509	286	13,279	16,926	3,647
Sub total	**24,272**	**2,010**	**2,291**	**281**	**22,083**	**26,544**	**4,461**
Total Operating Income	**366,582**	**30,524**	**30,606**	**82**	**335,612**	**342,908**	**7,296**
Operating Expenses							
Employee Benefit Expenses	-265,264	-21,888	-22,977	-1,090	-246,365	-256,076	-9,710
Drugs	-21,934	-1,811	-2,077	-266	-20,123	-20,848	-726
Clinical Supplies and Services	-23,849	-1,949	-2,523	-573	-21,900	-25,418	-3,518
Non Clinical Supplies	-46,875	-3,908	-3,584	324	-42,812	-42,540	272
Depreciation and Amortisation	-15,843	-1,320	-1,342	-22	-14,523	-14,620	-97
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**	**-30,877**	**-32,503**	**-1,626**	**-345,722**	**-359,502**	**-13,779**
Operating Surplus / (Deficit)	**-7,183**	**-353**	**-1,897**	**-1,544**	**-10,110**	**-16,594**	**-6,484**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	1	1	0	14	14
Interest Income	393	19	112	93	371	1,350	979
Interest Expenses	-147	-12	-20	-8	-131	-135	-4
PDC Dividends	-4,834	-398	-398	0	-4,438	-4,438	0
Total Non Operating Income and Expenses	**-4,588**	**-391**	**-305**	**86**	**-4,198**	**-3,209**	**989**
Surplus / (Deficit) - as per Accounts	**-11,771**	**-744**	**-2,201**	**-1,458**	**-14,308**	**-19,803**	**-5,494**
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	7	12	-45	-76	-31
Add Depreciation on Donated & Granted Assets	487	41	54	14	446	604	158
Total Adjustments to Financial Performance	**437**	**36**	**62**	**26**	**401**	**528**	**127**
Adjusted Surplus / (Deficit) as per NHSI Return	**-11,334**	**-708**	**-2,140**	**-1,432**	**-13,907**	**-19,275**	**-5,367**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR – February 2025 Detail
2nd April 2025

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There are **6 indicators that are both failing and have special cause variation of a concerning nature**, these are:

- **22.** Mixed Sex Accommodation Breaches (ITU) **(NEW)**
- **23.** Sepsis - % screening for all emergency patients

Access and Performance:

- **35.** A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge **(NEW)**
- **76.** A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC) **(NEW)**

Workforce

- **63.** Supporting Attendance **(NEW)**

Finance and Sustainability:

- **74.** CIP – % delivery against plan (recurrent) **(NEW)**

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There are **2 indicators that have special cause variation of a concerning nature and do not have a target**, these are:

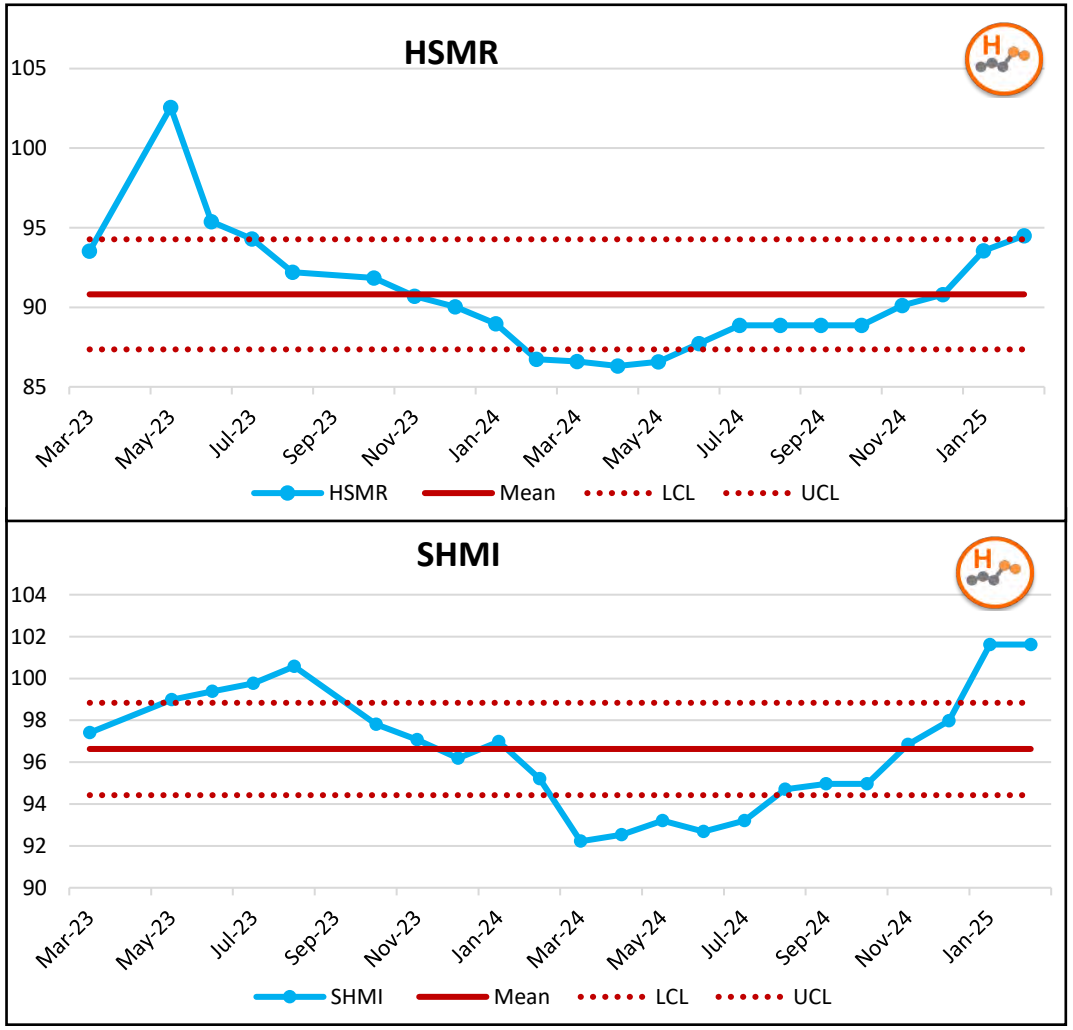
Quality:

- **16.** Mortality ratio – HSMR **(NEW)**
- **17.** Mortality ratio – SHMI **(NEW)**

February 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

16,17. Mortality ratio – HSMR and SHMI



HSMR and SHMI rates are not outliers – green rating on HED data.

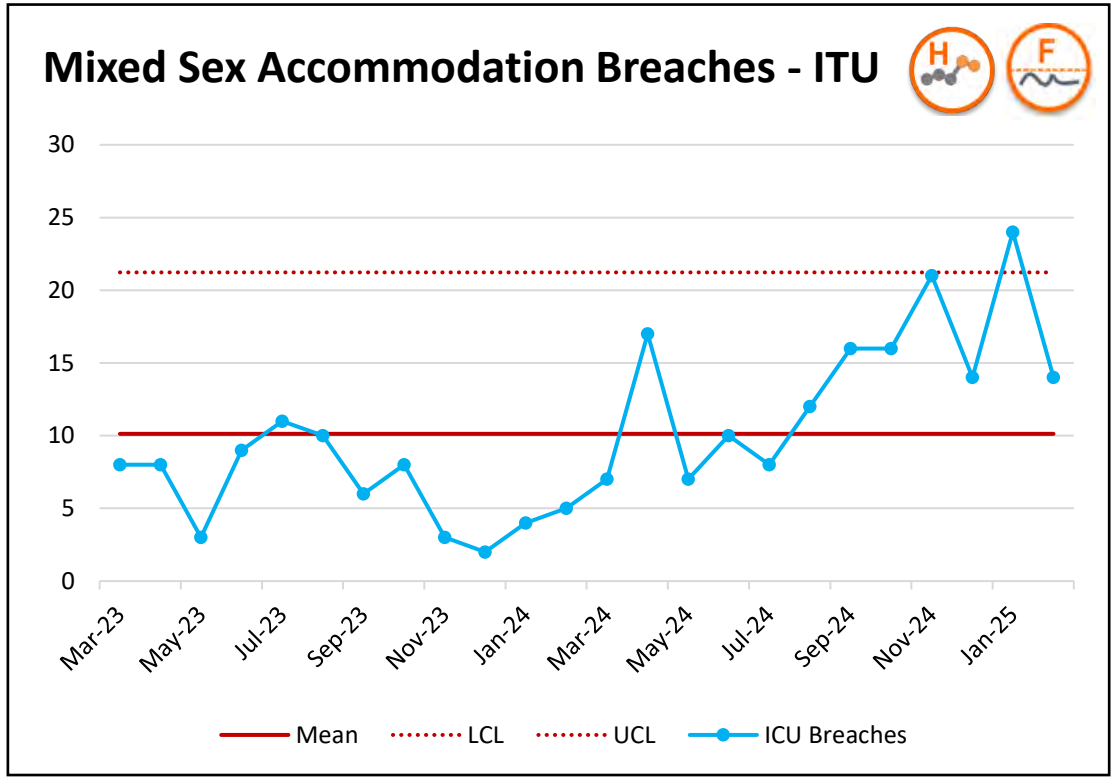
There has been a rise in SHMI and HSMR due to coding changes in SDEC activity (low risk patients' exclusion from 'admitted patients' dataset due to a move to type 5 UEC activity coding).

This is being monitored via HED, and is data reviewed through MRG. In addition, the use of Type 5 reporting will be reviewed by the Trust Executive Team.

February 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust

22. Mixed Sex Accommodation Breaches (ITU)



All breaches are a direct result of delayed discharges from ITU. There were 0 breaches in all other ward areas.

Any delays in discharges are escalated to the patient flow Team and the Tactical Manager of the day. They are also discussed at each bed meeting.

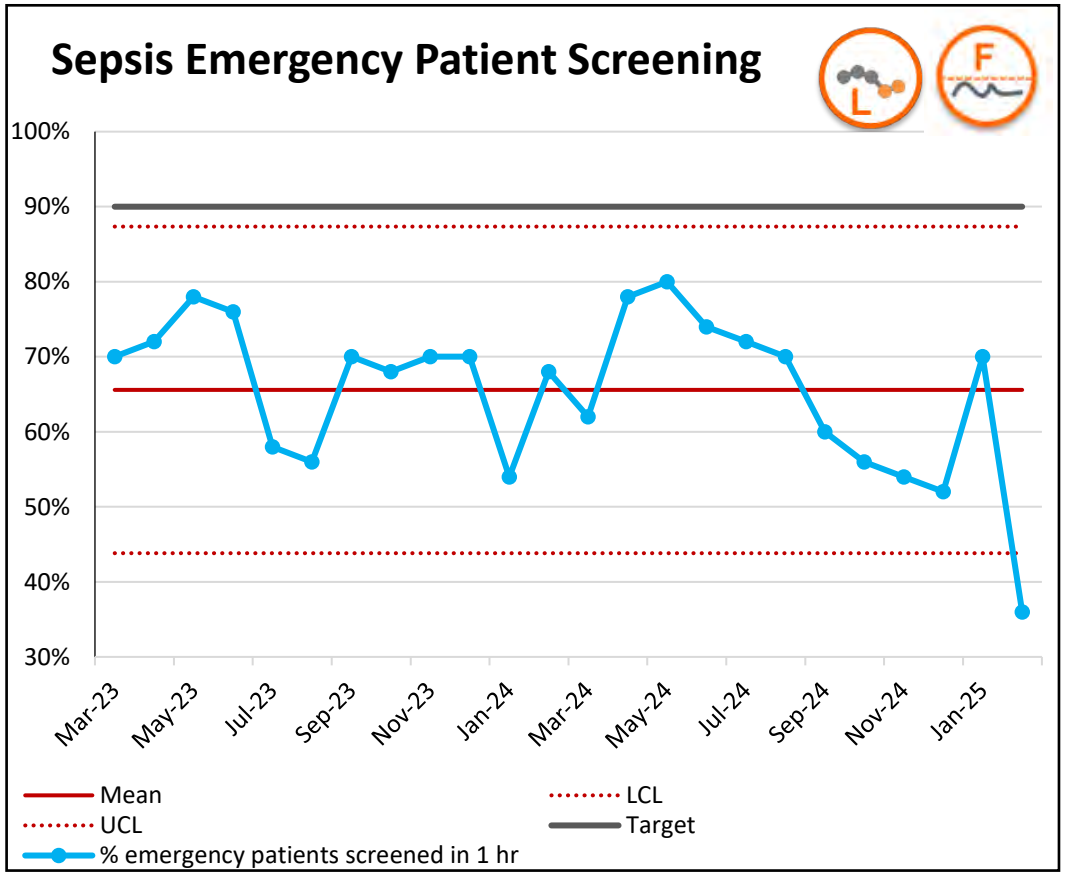
Risk-based decisions are made live each day to prioritise the step down of level 1 ITU patients to the appropriate areas as the operational and clinical context allows.

Breaches are driven by high occupancy levels, ED crowding and high numbers of No Criteria to Reside patients. A review of the trust policy relating to Mixed Sex accommodation breaches is currently being updated.

February 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust

23. Sepsis - % screening for all emergency patients

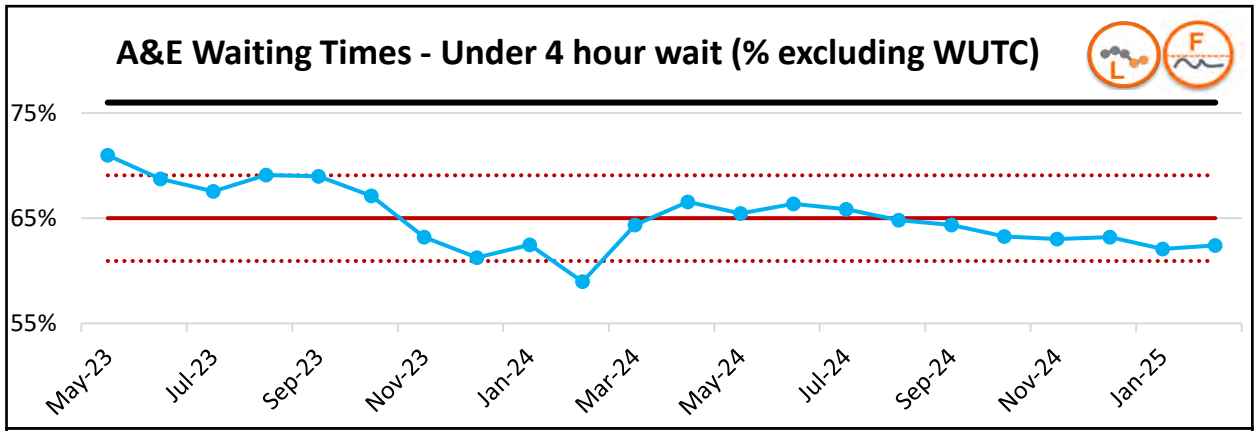


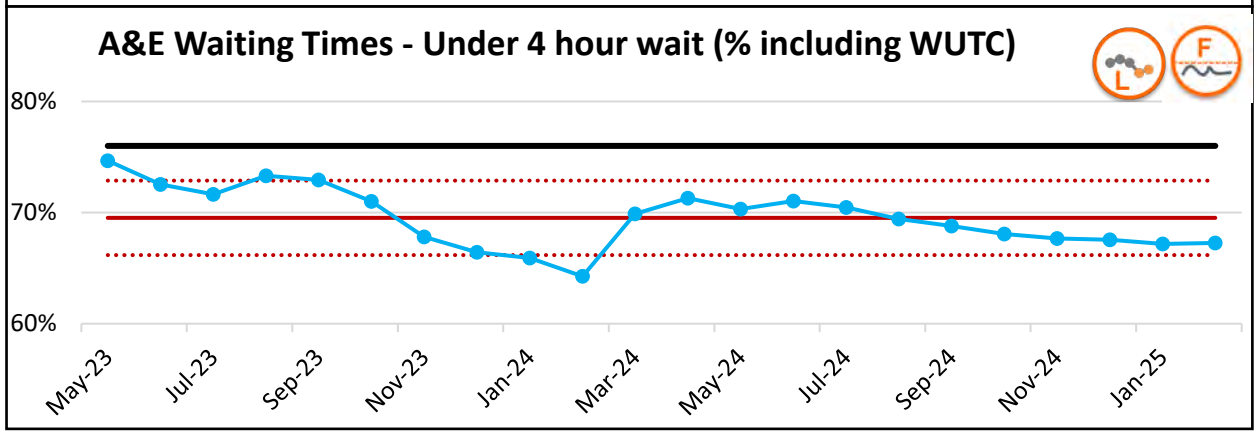
- The main issues driving the fall in sepsis screening performance are:
  - Patients not having blood cultures within an hour
  - A change in clock start time with new sepsis measures
  - The volume of unwell patients in the department
- The majority of patients who failed this measure did so solely as they did not have blood cultures within the hour (88% had a blood lactate performed within 1hr).
- Improvement measures:
  - Blood cultures training for new qualified nursing staff
  - Sepsis assessment trolley
  - Explore potential for ED HCA staff to be trained in taking blood cultures

February 2025 IPR by Exception – Access & Performance

Warrington and Halton Teaching Hospitals NHS Foundation Trust

35, 76. A&E Waiting times - % of patients waiting under 4 hours from arrival to admission, transfer or discharge



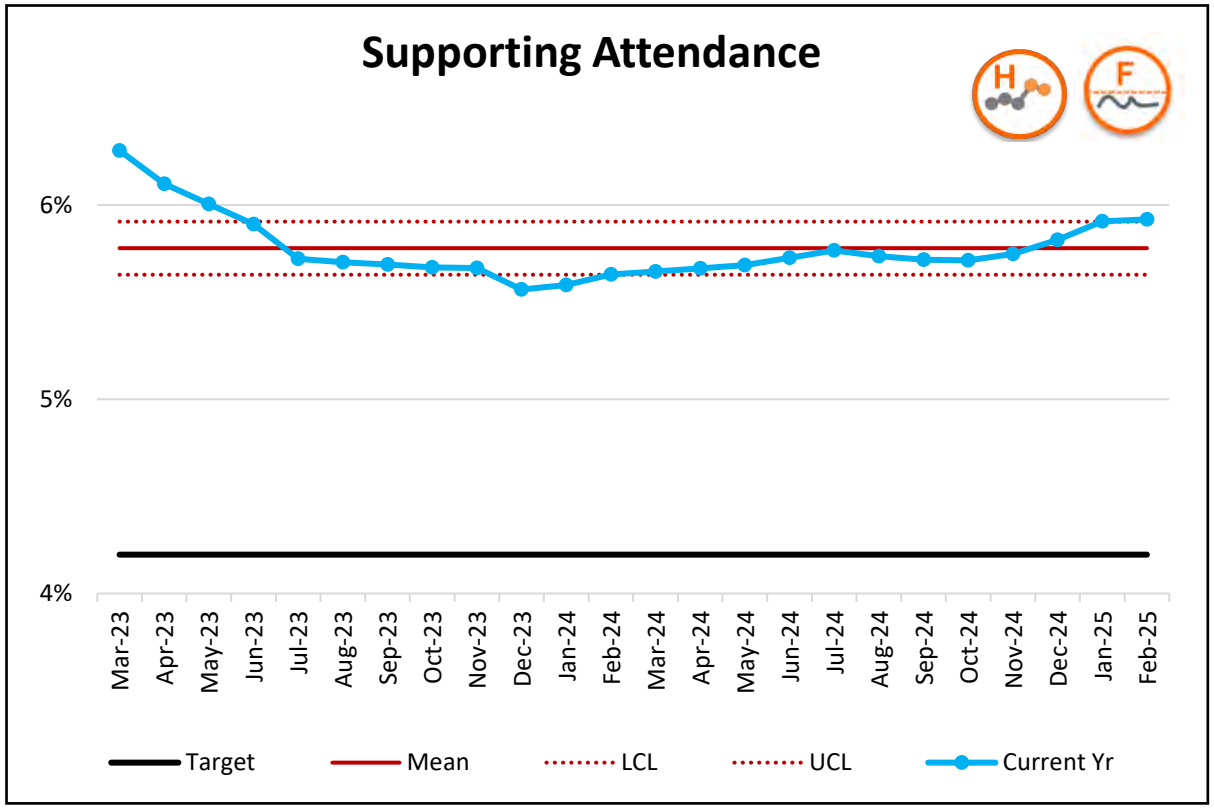


- Continued work via the UEC System Improvement Programme with system partners.
- Deep dive to triangulate attends vs performance underway to be completed for April 2025.
- Ambulance handover times continue to one of the best in C&M.
- Continued focus on admission avoidance and alternatives to ED.
- Call before convey test of change February 2025.

February 2025 IPR by Exception – Workforce

Warrington and Halton Teaching Hospitals NHS Foundation Trust

63. Supporting Attendance

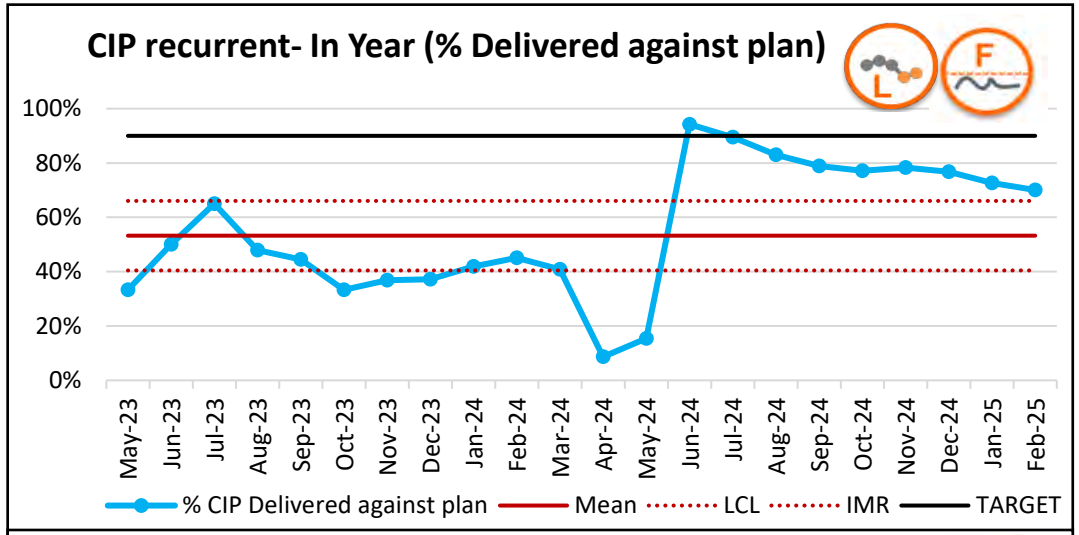


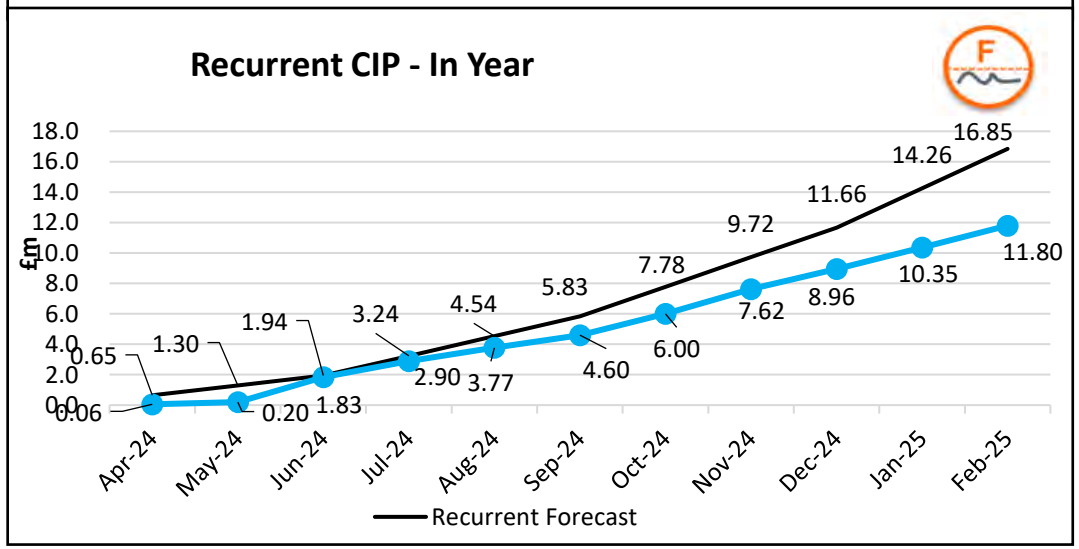
- Targeted approach to high areas of sickness reason – for example MSK in HCAs is high, working with OH to do a session on this.
- Introduced compassionate stage 3 sickness absence to fast-track cases where appropriate.
- Pattern of sickness absence increase identified nearing the end of the month, review underway.
- OH Specialist Nurses working with line managers in areas of high absence to offer further support.

February 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

74. CIP – % delivery against plan (recurrent)





£11.8m CIP has been delivered recurrently against the target of £16.8m.

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.

For 2025/26 a delivery unit has been established to support delivery of the CIP programme. This will include ensuring CIPs are recurrent and quality impact assessed.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 8 IPR indicators.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/04/08a (i)	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	11 February 2025
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/25/02/231	**HOT Topic- Maternity Mortality and Governance**	The Committee received a presentation in response to the news report relating to a Leeds based Trust highlighting concerns relating to baby deaths The presentation included - • MBRRACE UK data 2019-2023 – noting WHH consistently below UK average since 2021 Noted improvements in intrapartum stillbirths with zero reported in 3 out of 5 years	Moderate Need to see improvements in intrapartum stillbirths sustain	Substantial: Monthly reporting with Non-Executive/ Executive oversight through Quality Assurance Committee	Monthly reporting via QAC Bimonthly oversight at Board of Directors
QAC/25/02/232	**Patient Safety and Clinical Effectiveness Fragile Services report**	The committee received the fragile service report noting • Cardiology Job Planning commenced aligning capacity with demand • Urology – Training underway for Nurse specialist cystoscopy • ENT – Position improving due to Insourcing. Mitigations in place for medical gaps • Fractured neck of femur- new model being trailed supporting patients on ward – GP supporting sessions • Gall bladder Disease Pathway -waiting times have increased for cholecystectomy. Job	Moderate Need to see further improvements in all fragile services	Substantial: Monthly reporting via Patient Safety and Clinical Effectiveness Sub Committee	Monthly reporting via Patient Safety and Clinical Effectiveness Sub Committee Escalations monthly to Quality Assurance

		planning changes being made to improve capacity of service.			Committee (QAC)
QAC/25/02/236	**Surveillance programmes backlogs**	The committee received an update following previous Deep Dive which was presented in October 2024- Key highlights note • Endoscopy – overdue numbers have reduced • Clinical Haematology – number reduced • Ophthalmology – numbers have increased. Biweekly overview now in place with the Service Lead with close monitoring from Waiting List Team	Moderate Need further reduction in backlogs to be seen	Substantive Oversight by Executives Directors and Non-Executives at QAC.	QAC Quarterly

The Committee also received the following items.

QAC/25/02/233 Quality IPR Metrics
QAC/25/02/234 Safer Staffing Update
QAC/25/02/235 Compliance Q3 update
QAC/25/02/237 Mental Health Update
QAC/25/02/238 Learning form Experience Q3 Update

QAC/25/02//239 Infection Prevention and Control Q3 update.
QAC/25/02/240 Post Partum Haemorrhage Audit update
QAC/25/02/241 Palliative and End of Life Biannual Report
QAC/25/02/242 ED Long Waits and Harm Profile
QAC/25/02/243 Maternity Update
QAC/25/02/244 Sepsis High Level Q3 update
QAC/25/02/246 High Level Enquiries Assessments/inspections

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/25/04/08a (ii)	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	11 March 2025
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/25/03/254	**Deep Dive – Critical Medication**	The Committee received a presentation - Deep Dive in relation to Critical Medication in the Emergency Department The presentation included • Overview of Incidents/themes and actions • Overview of rates and categories of incidents relating to omitted medicines Points to note include • No incidents causing moderate or above harm • Bi Dashboard data validation underway following data anomaly. • Dispensing time for critical meds reduced to an average of 30 minutes. • QI project planned to address the omission of critical medicines. - improvements delivered re Antiepileptic drugs.	Moderate Strong governance and senior oversight. harm profile is low/no Harm need to see further reduction in omitted medication incidents in a wider range of medicines. Assurance needs to be provided on quality of BI Dashboard data.	Substantial: Monthly chairs reporting with Executive oversight through Patient Safety and Clinical Effectiveness Sub Committee. (PSCESC) Escalated to through reporting to Quality Assurance Committee (QAC) as necessary.	Biannual reporting via QAC.
QAC/25/03255	**HOT Topic- MIAA Theatre Safety**	The Committee received a presentation - Deep Dive in relation to Critical Medication in the Emergency Department The presentation included -	Limited Following concerns increasing	Substantial: Monthly reporting with Executive oversight through	Monthly reporting via PSCESC and QAC

		• overview of 7 key findings 3 Red 4 Amber • Overall assurance was noted as limited assurance by MIAA • Overview of management responses • Areas of good practice noted • Overview of governance arrangements	governance and senior oversight. need to see delivery of actions outlined in the MIAA management responses	Patient Safety and Clinical Effectiveness Sub Committee. (PSCESC) Escalated reporting to Quality Assurance Committee (QAC) in Fragile Service Report.	Oversight also in Audit Committee
QAC/25/03/257	**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 • Cardiology – improvements in recruitment – anticipating will be stepped down from fragile services in the coming months • Urology – P2 improved, Cystoscopy waits significantly reduced • Emerging risk re MDT in urology – no harm however focused work in this area • Fracture NOF – Theatre delays remain a challenge	Moderate Assurance received – regarding fragile services – further improvements required.	Substantial Monthly oversight at QAC Executive oversight monthly of all fragile services via PSCESC	March 2025 PSCESC
QAC/25/03/259	**Delay to Follow Up Backlogs**	The committee received an overview of • Backlog increased post pandemic • Operational guidance note focus on new patients increasing pressure on follow ups • Insourcing outsourcing – enabled further reduction • 1.5% increase noted • Focus on high-risk patients	Moderate Strong governance and senior oversight.	Substantive Oversight by Executives Directors and Non-Executives at QAC.	QAC Biannually

			Await external sign off for final accreditation		

The Committee also received the following items.

QAC/25/03/255 MIAA Theatre safety
QAC/25/03/256 Board Assurance framework
QAC/25/03/258 Learning from Deaths Q3 Update
QAC/25/03/260 Quality Priorities Report Q3
QAC/25//03/261Quality Priorities 2025/2026
QAC/25/03/262 Quality Strategy Update
QAC/25/03/263 Better Care Update
QAC/25/03/264 ED Long Waits and Harm Profile
QAC/25/03/265 Maternity Update
QAC/25/03/267 Information Governance and Corporate Records Q3
QAC/25/03/268 High Level Enquiries Assessments/inspections

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/25/04/08b (i)	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	Wednesday 19th February 2025
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/25/02/182	**Deep Dive - Safer Nursing Care Tool**	**Chief Nurse: Ali Kennah** The Committee were given an overview of the Safer Nursing Care Tool and the results of the data collection review in November 2024. The review highlighted a need for increased WTE across 15 wards. Professional judgement was applied to the review which determined that 9 wards required extra staff with a total WTE uplift of 61.63. The Committee were advised that all wards are safely staffed with a mix of substantive and bank workers. Further work will be explored on impact of no criteria to reside patients and the Safer Nursing Care Tool and the impact on mental health patients within the organisation. Agreement for a further deep dive to explore this topic in Q1 2025/26	The Committee received **moderate assurance** on delivery due to outside influences such as the impact of mental health patients in acute settings.	The Committee received **substantial assurance** on the governance of the Safer Nursing Care Tool.	Q1 2025/26
SPC/25/02/188	**Better Care Together Update**	**Deputy Director of Strategy and Partnerships: Hayley Heard** **Head of Strategic Workforce Development: Adam Harrison-Moran**	The Committee received **substantial assurance** on	The Committee received **substantial assurance** on	March 2025

		The Committee received an update on the substantial progress made as part of the Better Together Programme including decisions communicated to the workforce. The update was specifically related to: Workforce Workstream; Communications and Engagement Workstream and Corporate Services Workstream and addressed progress against agreed milestones, and how benchmarking was being used to support WTE reduction and reflected BAU CiP plans within both Trusts. The Committee received an overview of the progress made including a joint OD package to support with a robust culture plan, joint policy development and planning for an organisational change framework.	delivery noting the progress against all corporate workstreams.	governance arrangements.	
SPC/25/02/189	**Guardian of Safe Working Q3 Update**	Rachel Wallis: Guardian of Safe Working The Committee received an update on Q3 escalations in line with the Guardian of Safe working guidelines. The Committee were advised that the report included an overview of rota gaps which will be a feature of the report moving forwards. The Committee noted that there is a concern regarding rota gaps nationally and this is intrinsically linked with workforce expectations shifting.	The Committee received **moderate assurance** on delivery relating to rota gaps which is reflected as an issue nationally	The Committee received **substantial assurance** on the governance to respond to escalations as appropriate.	Q1 2025/26

Other reports received by the Committee:

- SPC/25/02/180 – Minutes and action log of the meeting on 15th January 2025
- SPC/25/02/183 – Chief People Officer report
- SPC/02/25/184 – Workforce Brief on National, Regional ICB or Local Workforce Issues
- SPC/02/25/185 – Workforce Integrated Performance Recommendations 2025/26
- SPC/02/25/186 – Midwifery Safe Staffing Report
- SPC/02/25/187 – Safer Staffing Report
- SPC/02/25/190 – Equality Delivery System (EDS) 2025

Chairs Logs received by the Committee:

- SPC/25/02/191 – Workforce Inclusion and Culture Sub-Committee
- SPC/25/02/192 – 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
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/04/08b (ii)	Meeting	Trust Board	Date Of Meeting	2nd April 2025

Date of Meeting	Wednesday 19th March 2025
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/25/03/199	**Hot Topic – PWC Final Report**	The Committee received an overview of the final PWC report, the 15 grip and control recommendations and progress against the 36 workforce actions.	The Committee received **substantial assurance** on delivery of the PWC final report.	The Committee received **substantial assurance** on the governance of the delivery of the PWC final report.	Q1 – 25/26
SPC/25/03/200	**Deep Dive – E-Rostering, Flexible Working with a focus on Preference Rostering**	The Committee received a summary of the #WHHMyFlex programme with a specific focus on the preference rostering pilots within Rapid Response, Ward B19 and Ward ACCU. The pilots have progressed well and the benefits for both employees and patients were demonstrated through metrics including bank costs which have reduced and discharge times, with work ongoing to review further quality and staffing metrics.	The Committee received **substantial assurance** on delivery of Flexible Working; Preference Rostering.	The Committee received **high assurance** on governance arrangements for of Flexible Working; Preference Rostering.	Q1 – 25/26
SPC/25/03/201	**Review of:** • **Terms of Reference**	The Committee received an update on the approach to the People Committee in common with Bridgewater NHS Healthcare Trust, the proposal was presented for approval to go live from April 2025.	The Committee received **moderate assurance** on the delivery of the	The Committee received **substantial assurance** on the	Apr-25

	• **Cycle of Business**		People committee in common approach.	governance relating to the People committee in common approach.	
SPC/25/03/202	**EDI Annual Report (Public Sector Equality Reporting – Patients and Workforce)**	The report included: • Equality Duty Assurance Report • Workforce Equality Assurance Report • Pay gap reporting (Race, Gender and Disability) • National EDI Improvement Plan • Staff Network activity and performance • Health inequalities reporting (patients, public and workforce) • Achievements made in order to meet the public sector equality duty general and specific requirements The Committee approved the report for publication on the Trust website by 30 March 2025 on behalf of the Trust Board. A full copy of the report can be found here.	The Committee received **high assurance** on the delivery of actions relating to the EDI Annual Report.	The Committee received **high assurance** on governance arrangements relating to the EDI Annual Report.	March 2026
SPC/25/03/208	**Freedom to Speak Up Bi-Annual Report**	The Committee received an update on the activity relating to Freedom to Speak up which highlighted an increase in disclosures when compared to the 12 months previous. The main themes remain; culture, bullying and relationships. Very little disclosures relating to patient safety, but where they have been made, actions were progressed quickly.	The Committee received **substantial assurance** on delivery arrangements relating to FTSU.	The Committee received **substantial assurance** on governance arrangements relating to FTSU.	

		Chair raised query regarding time allocated for the Guardian having reduced, Chair to discuss further with Executive lead.			

Other reports received by the Committee:

- SPC/25/03/203 – Board Assurance Framework
- SPC/25/03/204 - Chief People Officer report
- SPC/25/03/205 – Workforce Brief on National, Regional ICB or Local Workforce Issues
- SPC/25/03/206 – Workforce Integrated Performance Report
- SPC/25/03/209 - Safer Staffing Report
- SPC/25/03/210 - Better Care Together Update

Chairs Logs received by the Committee:

- SPC/25/03/211 - Operational People Committee
- SPC/25/03/212 - Workforce Review Group

Assurance Key:
Delivery Assurance: *Assurance in achieving outcomes*
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/04/08c (i)	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	24 February 2025
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/25/02/253	**Hot Topic – Operational Plan Capacity Strategy Drivers of the deficit**	The Committee received the presentation noting:- • Underlying deficit for 2024/25 of £45.2m, additional impacts such as CNST increase, inflation, convergence, deficit repayment, etc taking the deficit before CIP to £68.8m. CIP of £20m reduces the deficit to £48.8m which has been submitted to the ICS and will be submitted to NHSE this week. • To meet control total CIP of £48.8m (12.3%) required. If all benchmarking achieved total CIP of £32m (8%), reality is two thirds of this therefore £20m (5%). PIDs in the process of being drafted so CIP can start to deliver from the beginning of the year. • Steps being taken to improve the run rate in 2024/25 which will improve the 2025/26 position (reduced NHSP rates, enhanced ECF process, forensic examination of budgets with each Care Group, etc.) • Governance structure to be set out clearly with PIOG being the meeting that feeds up to FSC and Trust Board. • Focus needs to be on the capacity of delivering the 2025/26 plan, who is going to deliver and how given current workload of the proposed team. Plans are being drawn up with detail to be brought back to next FSC.	The Committee received **limited** assurance based on the level of the deficit in the operational plan	The Committee **noted** and discussed the report receiving **limited** assurance until governance structure in place	**Trust Board March 2025**

		• Risk raised around taking WTEs out in nursing and midwifery when safer staffing is saying to increase. Safer staffing levels already in place through the use of bank and agency. Opportunity in nursing in non-ward areas as well as reducing agency and NHSP staffing / rates.			
FSC/25/02/254	**Deep Dive – Theatre Productivity**	The Committee received the presentation noting:- • Theatre Improvement Group established in May 2024 with an aim to increase capped utilisation to 85% (April 2024 72%, January 2025 performance 75.8% vs target of 81.9%) • Eight workstreams to be set up which will go through the whole patient journey as part of the future operating model • Job planning round taking place now, need to look across the full year • Cultural changes required as well as communication across all areas • The focus next year will be on the sessions that didn't happen at all despite there being staff budgeted to deliver them. If these sessions were used it would generate circa £1m additional income as well as improving elective recovery	The Committee received **limited** assurance given the targets not being met	The Committee **noted** and discussed the report receiving **limited** assurance	
FSC/25/02/255	**Corporate Performance Report**	The Committee received the report noting:- • Patients waiting over 12 hours in department deteriorated and is significantly worse than this time last year, additional escalation opened as a result as well as the Trust being on Opal 4. C&M as a region are under scrutiny. • 4 hour performance has decreased slightly in month following an increase in winter pressures	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report receiving **substantial** assurance around level of detail reported	**FSC March 2025**
FSC/25/02/256	**Monthly CIP Update**	The Committee received the report noting: • Month 10 CIP position is off plan by £1.2m • Forecast delivery is £16.9m excluding £2.5m of high risk CIP • £3m collaboration target also deemed high risk • Plans are being drawn up for 2025/26 with PIDs also being written. Phasing expected to be 40% in the first half of the year.	The Committee received **limited** assurance based on delivery of CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC March 2025**
FSC/25/02/257	**Recovery Update M10**	The Committee received the report noting:- • £2.5m spend year to date which straight line would forecast a £3m spend compared to the £3.3m approved spend	The Committee received **moderate** assurance given the	The Committee received **substantial**	**FSC March 2025**

		• T&O cancellations due to ambulatory trauma and reduced spend in Pain due to a consultant being off sick • Based on forecast this would leave 100 65 week waiters at the end of March (30-40 likely to be capacity related), potential tiering system to be in place again next year linked to capacity breaches	progress that has been made	assurance given the plans in place	
FSC/25/02/259	**Monthly Productivity Improvement Update**	The Committee received the report noting:- • **Theatres** – Dip in performance for all metrics in January. • **Outpatients improvement –** Reduced performance for all metrics in January. Short notice cancellations failed the metric for the first time this year. • **UEC –** £2.6m was highlighted by Newton as a full year potential saving, work ongoing to determine how much can be included in the 2025/26 CIP plan	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 March 2025**
FSC/25/02/264	**Monthly Finance position – month 10**	The Committee received the report noting:- • At M10 the Trust is reporting a year to date £17.1m deficit (adverse variance of £3.9m due to Industrial Action, pay award, under delivery of CIP, cost pressures not offset and PwC costs) • Revenue request supported by the Executive Team included • Additional capital of £1m requested and approved, £0.8m improvement on revenue position expected which brings the forecast deficit to £19.1m (£7.8m worse than plan)	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance	**FSC March 2025**
FSC/25/02/266	**Capital Position Month 10** **Schemes over £500k**	The Committee received the report noting:- • Increase in capital funding along with approval to use IFRS16 CDEL to purchase K25 and to overspend by £0.2m • Movement in capital contingency was approved • Supported the forecast position including the allowable overspend of £0.2m for Trust Board approval acknowledging that the risk of delivery is being monitored by CPG • TIF risk to year end delivery due to fire risk strategy and delay in build completion moving spend to 2025/26. This is to be mitigated through VAT recovery, an external bid for funding in 2025/26 and bringing spend forward where possible	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** the forecast	**FSC March 2025**

Items for noting

FSC/25/02/258 *Cost Pressures M10*
FSC/25/02/260 *Pay Assurance*
FSC/25/02/261 *Benefits Realisation Q3 Update*
FSC/25/02/262 *Integration Update*
FSC/25/02/265 *Revenue Request – Drugs – To be circulated outside the meeting for support to go to Trust Board for approval*
FSC/25/02/267 *Digital Strategy Group Update*
FSC/25/02/268 *Update Event Planning Meeting*
FSC/25/02/269 *Medical Workforce Review Group Minutes*

Assurance Key:

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

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/04/08c (ii)	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	24 March 2025
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/25/03/276	**Hot Topic – Transformation monitoring / governance and capacity**	The Committee received the presentation noting:- • The challenge the Trust is managing • The purpose, role and resourcing of the delivery unit • The Executive Team and Care Group and Service Leads are accountable for the execution of the finance and operational plan • The proposed governance noting the expectation that FSC is an assurance Committee • The change in culture towards finances	The Committee received **limited** assurance given that the delivery unit is not yet in place and delivering	The Committee **noted** and discussed the report receiving **moderate** assurance given plans in place	
FSC/25/03/277	**Deep Dive – CIP & Cost Pressures**	The Committee received the presentation noting:- • The progress of the CIP schemes for 2025/26 by care groups and corporate directorates with current gaps highlighted and RAG rating for delivery • The phasing of CIP Plans for 2025/26 with 40% in H1 • Further work to be undertaken to develop and deliver plans, ensure PIDs are completed with appropriate QIA, reduce the risk on CIP plans where possible and identify plans in excess of the target to mitigate against non-delivery • The increased grip and control of cost pressures during 2024/25 and the new approach to budget setting being based on outturn	The Committee received **limited** assurance given the targets not being met	The Committee **noted** and discussed the report receiving **moderate** assurance given improvement compared to the prior year	
FSC/25/03/279	**Operational plan and**	The Committee received the presentation noting:-	The Committee received **limited**	The Committee noted and discussed	**Trust Board**

	final capital plan	• The latest position had been shared at an extraordinary Board on 20 March 2025 • C&M system has a significant gap to achieve a £178m deficit and therefore it is expected the Trust will need to improve further • It has been suggested the Trust improves from £48.8m to £30.4m, the Board discussed this but thought it would be possible to get to £41.9m with the additional £2.9m income, increase in CIP £1.5m, review of run rate and UEC costs in the underlying position £2.5m • The presentation also included the assurance statement which was discussed at length amended and agreed • The Final Capital plan was presented and supported for Board approval	assurance given the plan has not yet been agreed by NHSE	the report receiving **limited** assurance	**April 2025**
FSC/25/03/280	**Corporate Performance Report**	The Committee received the report noting:- • DM01 performance achieved the national standard at 95.05% • ED performance 4 and 12 hours remain a concern	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report receiving **substantial** assurance around level of detail reported	**FSC April 2025**
FSC/25/03/281	**Monthly CIP Update**	The Committee received the report noting: • Month 11 CIP position is off plan by £1.4m • Forecast delivery is £16.9m excluding £2.5m of high risk CIP • £3m collaboration target also deemed high risk	The Committee received **limited** assurance based on delivery of CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC April 2025**
FSC/25/03/282	**Recovery Update M11**	The Committee received the report noting:- • £2.7m spend year to date which straight line would forecast a £3m spend compared to the £3.3m approved spend • T&O reduced WLI pick up and reduced spend in Pain due to a consultant being off sick	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC April 2025**
FSC/25/03/284	**Monthly Productivity Improvement Update**	The Committee received the report noting:- • **Theatres** – continued dip in performance for some metrics in February, although theatre utilisation has seen an improvement into March. Three red metrics have turned to amber.	The Committee received **limited** assurance on the delivery of the	The Committee **noted** and discussed the report receiving **substantial**	**FSC April 2025**

		• **Outpatients improvement –** more confident in delivery into next year as this is expected to be delivered through improved recording / rectification of system issues • **UEC –** £2.6m was highlighted by Newton as a full year potential saving, work ongoing to determine how much can be included in the 2025/26 CIP plan	improvement savings	assurance of the plans in place	
FSC/25/03/286	**Cash Support**	The Committee received the report noting:- • Whilst the Board approved the request for cash support for March or April (up to the same value if not received) this was not required in March due to receipt of central funding. • The Trust has asked for cash support for April and awaits the outcome • Support for up to a maximum of £16.449m cash support for Q1	The Committee received **moderate** assurance on the monitoring of cash requirements	The Committee **noted** the report receiving **moderate** assurance and **supported** the Q1 cash request	**Trust Board April 2025**
FSC/25/03/291	**Monthly Finance position – month 11**	The Committee received the report noting:- • At M11 the Trust is reporting a year to date £19.3m deficit (adverse variance of £5.4m due to Industrial Action, pay award, under delivery of CIP, cost pressures not offset and PwC costs) • The Trust received notification of non recurrent surge funding in March 2025 of £2.3m improving the forecast deficit from £19.1m to £16.8m • Ongoing downward trend of combined bank and agency • The run rate indicating a reduction in running costs	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance	**FSC April 2025**
FSC/25/03/294	**Capital Position Month 11**	The Committee received the report noting:- • Confirmation of funding for DDCP £0.5m, increasing capital plan to £21.7m • Movement in capital contingency was approved • Supported the forecast position including the allowable overspend of £0.2m for Trust Board approval acknowledging that the risk of delivery is being monitored by CPG	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** the forecast	**FSC April 2025**

Items for noting

FSC/25/03/278 Board Assurance Framework and Corporate Risk Register
FSC/25/03/283 Cost Pressures
FSC/25/03/285 Pay Assurance
FSC/25/03/287 Costing Update
FSC/25/03/288 Integration Update
FSC/25/03/289 EPR Procurement Update – deferred
FSC/25/03/290 Integrated Performance Report – supported to go to Trust Board for approval
FSC/25/03/292 Revenue Requests – none
FSC/25/03/293 A10 Winter Funding addendum – supported to go to Trust Board for approval
FSC/25/03/294 Schemes over £500k
FSC/25/03/295 ToR / Cycle of Business
FSC/25/03/296 Digital Strategy Group Update
FSC/25/03/297 Update Event Planning Meeting
FSC/25/03/298 Medical staffing resource Review Group Minutes

Assurance Key:

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/04/08d	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	6 March 2024
Name of Meeting & Chair	Charitable Funds Committee, Chaired by Steve McGuirk
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
CFC/25/03/35	**Charity Impact Story**	The committee heard an impact story detailing the benefit that charity funding brings, with a presentation from Children's Ward play specialists Jane Forber and Jill Holland on the impact of WHH Charity funding.	The Committee received high assurance as hearing first hand the positive impact the charity can make	The Committee received high assurance as committee members hear directly the positive impact	**June 2025**
CFC/25/03/36	**Fundraising Report and Quarterly Workplan**	CFC noted the quarterly fundraising report, including updates on key campaigns, discussions with community partners, plans for a new supporters' club, and progress against the charity's three-year strategy. **Lead:** Kate Henry / Helen Higginson	The Committee received substantial assurance as the Charity is on track for delivering against its strategy	The Committee received high assurance as performance is monitored at each meeting of the Committee and a Charity Leadership meeting has been established	**June 2025**
CFC/25/03/37	**Finance Report Q3 Update**	CFC noted the financial position for quarter 3 (1 October to 31 December 2024) and the period 1 April to 31 December 2024 is as follows: • Income is £63k above plan in quarter 3 and £89k above plan YTD.	The Committee received substantial assurance as income is ahead of plan	The Committee received high assurance as sufficient processes and	**June 2025**

		• Expenditure (overheads) is £26k (£1k below plan) in quarter 3 and £2k above plan YTD. • Expenditure (disbursements of funds) is £44k in quarter 3 and £105k YTD. • The net fund balance is £641k. • The balance after commitments for purchases, reserves and overheads is £206k. **Lead:** Tina Littler		reporting are in place	
CFC/25/03/39	**Bid Applications**	Two bids were approved by CFC: • Equipment purchases for Clinical Haematology/PIU - funded by CANsupport Charity • Delamere Cancer Information Centre complementary therapies and courses – funded by Pink Ribbon Foundation and departmental fundraising efforts An update was provided on bids under £5k approved since the last committee meeting, either by the director of comms and engagement (up to £1k) or by execs (up to £5k). **Lead:** Kate Henry	The Committee received high assurance that the approved bids will be delivered and any unspent funds returned	The Committee received high assurance as the application process is robust, proportionate, and aligned with the Governing Document	**June 2025**
CFC/25/03/40	**Annual Operational Plan**	CFC noted the Charity's annual plan for 2025/26, acknowledging increased sustainability the charity has seen in recent years and plans to develop a new strategy for the Charity for 2026-29. CFC discussed the future strategy being about continuation of the work done to date and accommodating the WHH / Bridgewater integration agenda. **Lead:** Hayley Smith	The Committee received substantial assurance	The Committee received high assurance	**Trust Board April 2025**
CFC/25/03/41	**Charity Budget for 2025/26**	CFC approved the annual budget for 2025/26, with planned income of £402k. The planned overheads to income ratio (28%) is lower than the average Acute Trust ratio (38% - taken from the Charities Together data 2022/23). **Lead:** Tina Littler	The Committee received substantial assurance as the budget has been stress tested and is	The Committee received high assurance as quarterly reports are received by CFC and annual accounts are	**June 2025**

			based on 24/25 performance.	independently audited	

The committee also received reports on:

- **CFC/25/03/38** - Investment Annual Update
- **CFC/25/03/42** - Overhead Policy Review
- **CFC/25/03/43** - Governing Document & Cycle of Business

Assurance Key:

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/03/08 (e)	Meeting	Trust Board	Date Of Meeting	2 April 2025

Date of Meeting	27 February 2025
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/25/02/85	**Internal Audit Progress Report on Follow Up Actions**	The committee received the report providing details of the Internal Audit Reports that had outstanding agreed management actions which had exceeded the due date. Extensions were granted; however, the sickness absence action was to be closed and reported to the Committee via email. Job planning would be brought back to the yearend audit committee.	**Moderate –** the committee received evidence there is an adequate system of internal control; however, that there were some areas of weaknesses.	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Year End Audit Committee meeting 24.04.25**
AC/25/02/89	**Anti-Fraud progress report and plan**	The committee received the report which set out the activities undertaken, and outcomes achieved, in accordance with the agreed anti-fraud work plan, compliance with counter fraud standard requirements, and in response to any referrals / investigations reported, during the period of November 2024 to February 2025. The committee agreed consideration was to be given about how and when to pursue low level/value fraud	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Quarterly reporting to continue**

Other agenda items:
AC/25/02/83– Board Assurance Framework
AC/25/02/84- Committee Assurance update from Chairs of FSC, SPC, QAC
AC/25/02/86- Internal Audit Plan & Fees

AC/25/02/87 - Internal Audit Follow Up Report
AC/25/02/88 - Internal Audit Progress Report
AC/25/02/ 90 - External Audit Progress Report & Sector Update
AC/25/02/91 - Review Losses & Special Payments Q3 2023/24
AC/25/02/92 - Review of Quotation + Tender Waivers Q3 2024/25
AC/25/02/93 - Annual Report & Accounts Timetable and Plans
AC/25/02/94 - Draft Annual Accounts Accounting Policies
AC/25/02/95 - NW Skills Network (NWSD) Bi-Annual Report
AC/25/02/96 - ICON Programme Bi-Annual Report
AC/25/02/97 - Terms of Reference & Cycle of Business Annual Review

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/09**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	2/ April 2025	
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.	Y
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:			

<table>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="3">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
Cardiorespiratory/Cardiology Services

Services de-escalated from Fragile Services oversight since last report:
None

Services entering Fragile Services oversight since last report:
Chronic Pain Service</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">Trust board is asked to:
Note the current list of Fragile Services, associated clinical risk and high-level progress updates
Note the emergent risk and harms in Urology cancer services with a Deep Dive to be presented at QAC April 2025
Note clear progress towards stabilising the ENT staffing position with plans to the reduce cost of mitigating actions
Receive further Fragile Service Oversight reports</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/25/04/09

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

None

3. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

Chronic Pain Service

To be escalated to Fragile Services Oversight following presentation as a Deep Dive to QAC in May 2025.

Escalation indicated following external service review commissioned by the Medical Director.

4. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

Summary

Improving waiting list position, recent improvement in P2 waiting list, service remains fragile from staffing and capacity / demand profile perspectives

Recent cluster of Urology Cancer incidents with harm – Deep Dive cluster review of cases and action plan to be presented at QAC April 2025

- 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 remains static
- P3 & P4 waiting lists show an overall positive reducing trend – P3 reducing again after recent growth
- Transperineal prostate biopsy position shows sustained improvement, with further improvement in February and March (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance cystoscopy position very significantly improved from peak, with waiting list now consistently fewer than 100 patients
- Increasing numbers of patients awaiting first appointment

- 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 as required
    - Ongoing harm review process
    - Specialist nurse delivered cystoscopy training underway with practitioners approaching completion of training

- Ongoing improvement plan actions:
    - Urology Cancer Deep Dive – QAC April 2025
    - Urology Specialty Doctors require additional support to move to independent practice – plan in place
    - Follow up backlog remains a challenge – some insourcing capacity being diverted to service high risk follow up demand – position stabilised
    - 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 highlighted in February report now resolved

- 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
- 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 appointed to
    - Additional ad hoc fractured neck of femur lists utilising bank locum consultant
    - Clear escalation protocol for Orthogeriatric issues developed with juniors and implemented
    - Medical and Orthopaedic team have progressed a longer term sustainable model for ensuring adequate medical support / orthogeriatrics is in place

- 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

Ear Nose and Throat Surgery

Summary

Waiting list position improved predominantly due to insourcing. Mitigations in place for medical staffing challenges, improving consultant staffing – 3 consultants now established in post, further fixed term consultant joined in March – service becoming less fragile

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
  Significant medical staffing challenges – improving consultant staffing – 3 consultants now in post, further consultant joined in March
- No harm reported to date
- 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 with sustained improvement

- Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
  - Additional ENT stacker and scope in procured 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 –1 started Jan and Second March

- Ongoing improvement plan actions:
  - Ongoing strategic conversation with MWL and LUHFT regarding process to develop a sustainable ENT model for Mid and North Mersey
  - Job plan review January 2025 to incorporate 3rd and 4th Consultant
  - 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 vacancies and misalignment of demand and capacity in job plans

- 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
- Emergent risk identified in a group of outpatients who are in 'Investigation Pending' access pathways with evidence of delay
- No patient harm identified to date

- Completed Actions
    - Task and finish group established
    - Presented as hot topic to QAC
    - Fixed term consultant appointed to vacant post
    - Job planning process completed – supported by MD
    - Band 7 physiologist post recruited to
    - WatchPat device introduction will reduce formal sleep study demand and workload

- Current mitigations
    - Cardiology locum supporting safe ward and acute care staffing
    - Insourcing and Mutual Aid used as available/required to support diagnostic wait position
    - Successful recruitment into the Assistant Technical Officer posts resulting in a reduction in spirometry wait
    - Medical Director, AMD and CD have undertaken a Consultant team job planning meeting to establish principles of re-aligning job plan capacity with demand

- Ongoing improvement plan actions:

    - Complete scoping exercise for ambulatory disposable patches
    - Revisit job plans and WLI use as part of April 2025 Job Planning round to explore potential to reduce WLI spend through consultant appointment
    - 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 revie

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note a recent cluster of Urology Cancer incidents with harm – Deep Dive cluster review of cases and action plan to be presented at QAC April 2025
- Note the stabilised position with regards to ENT Medical Staffing, reduction in associated cost pressures and likelihood of stepdown from Fragile Services oversight in the coming months
- Receive further Fragile Service Oversight reports

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/25/04/10</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Maternity & Neonatal Update</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">2 April 2025</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Ailsa Gaskill-Jones, Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Ali Kennah - Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">SO1 We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future
SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities.</td><td>X

</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="5">#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</td></tr>
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<tr><td>X</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.</td></tr>
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(KEY ISSUES):</td><td colspan="3">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:

• February Maternity Quality & Safety update – appendix 1a & 1b
• March Maternity Quality & Safety update – appendix 1c-1e
• Maternity Incentive Scheme Year 5 and 6 – appendix 2a-2c
• ATAIN Q3 2024/25 – appendix 3
• Transitional Care Q3 2024/25 – appendix 4
• PMRT Q3 2024/25 – appendix 5
• CQC Survey 2024 – appendix 6
• Midwifery Safe Staffing Report Q3 – appendix 7</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to note the contents of this report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee
Strategic People Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">QAC/25/02/243
QAC/25/03/267
SPC/25/02/186</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">11 February 2025
11 March 2025
19 February 2025</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Noted and approved</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update Summary Report	AGENDA REF:	BM/25/04/10

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:

- February Maternity Quality & Safety update – appendix 1a & 1b
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- Maternity Incentive Scheme Year 5 and 6 – appendix 2a-2c
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- Transitional Care Q3 2024/25 – appendix 4
- PMRT Q3 2024/25 – appendix 5
- CQC Survey 2024 – appendix 6
- Midwifery Safe Staffing Report Q3 – appendix 7

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 – 1e.

2.1 Patient Safety Events

In December 2024 and January 2025 themes from patient safety events were as follows:

- Admission of term babies admitted to Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH) 1000ml-1500ml
- Postpartum Haemorrhage (PPH) >1500ml
- 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.

2.1.1 Term Admissions to NNU

All term admissions are reviewed via the ATAIN process, which reports quarterly to the Quality Assurance Committee (QAC). An overview of the Q3 2024/25 report is included in section 4 of this summary paper.

2.1.2 Postnatal Readmissions

The Q3 cluster review of postnatal readmissions covered the period from October 1 to December 31, 2024.

25 women were readmitted following 600 births, resulting in a readmission rate of 4.2%. This rate increased by 0.65% from Q2 but remained 0.67% lower than Q1. Of the 25 readmissions, 20 were deemed unavoidable (80%) and 5 avoidable (20%), marking a 25% decrease in avoidable admissions from Q2.

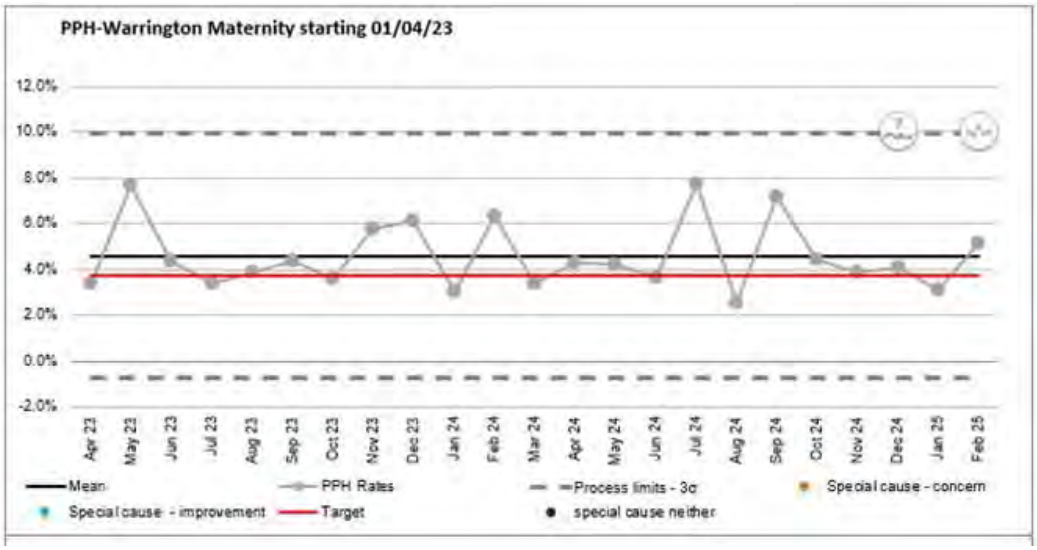
Four avoidable readmissions were due to hypertension management. A Hypertension Working Group has been established, and new NICE guidelines are expected to support consistent pathways. An isolated avoidable readmission was due to a missed haemoglobin recheck, leading to anaemia.

Three unavoidable readmissions were wound-related, a significant decrease from 50% in Q2 to 12% in Q3. Mastitis accounted for six readmissions (24%), peaking in Q3. These cases occurred post-community midwifery discharge, with maternity care meeting expectations. Findings of the cluster review will be shared with the 0-19 service to support collaborative efforts to reduce future cases.

2.1.3 Postpartum Haemorrhage (PPH)

There was an increase in PPH 1000ml-1500ml in January 2025. There was however a reduction in the number of cases of PPH ≥1500mls in the same month. It is likely this will have partly contributed to the increase in the lower rates of PPH in that earlier recognition and management of PPH 1000ml-1500ml is preventing these cases developing into PPH ≥1500mls. However, this does not account for the total increase in PPH 1000ml-1500ml. Should this increase in rates of PPH 1000ml-1500ml persist a cluster review will be conducted to ensure all learning has been captured.

The SPC chart for PPH ≥1500mls to end of February continues to show common cause variation.



All cases of PPH ≥1500mls continue to be reviewed by the Intrapartum Review Group (IRG), with learning shared and urgent actions completed.

Quality Improvement (QI) project progress
The PPH QI project had been ongoing throughout 2024, A new regional guideline for PPH is due to be published soon. WHH colleagues have contributed to the regional working group developing this guideline, incorporating many of WHH's change ideas.

The PPH QI working group has acknowledged limitations in trialling change ideas while awaiting the guideline publication. Therefore, the formal QI project has been stood down. The working group will now focus on implementing the new standards, continuing to meet bi-weekly to share learning and support the guideline's implementation once published.

2.2 Moderate Harm Events

There were no severe harm or fatal events in December or January 2025 within the Maternity Service. There were seven moderate harm events.

One case related to a term baby born in poor condition following placental abruption. The case was referred to MNSI for review and this has been rejected following their triage process. The case will be presented through the Maternity Service's Perinatal Meeting to facilitate an MDT review. An Initial Safety Review (ISR) was completed.

The remaining six moderate incidents were OASI. These cases were reviewed by the Maternity MDT through Intrapartum Review Group (IRG). A downward trend in OASI has been noted. Learning from the IRG reviews of these cases will feed into the existing workstream related to OASI.

2.3 Workforce metrics

At the end of January compliance for mandatory training across maternity and child health colleagues is 89.46% for Trust mandatory training (including safeguarding training), 87.02% for role specific training (both above the Trust target). Compliance with PDR completion was 81.19% at the end of January 2025. A targeted piece of work is underway to improve compliance above the Trust target.

Good compliance with maternity specific training standards is being sustained. Compliance with K2 (fetal surveillance competencies) has moved below target for Obstetric Consultants. A plan is in place to achieve compliance by the end of March 2025.

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
Midwives	99%	100%	91.1%	100%	97.7%
Obstetric Consultants	100%	100%	83.3%*	n/a	n/a
Other Obstetric	100%	100%	77.7%**	n/a	n/a
Obs Anaesthetic	96.5%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	100%
Neonatal medical and ANNP	n/a	n/a	n/a	94.4%	n/a

*two Obstetric Consultants not compliant – plan in place
** two new members of the medical team – within 6 month grace period. Plan in place

2.4 External feedback

Representatives from Cheshire and Mersey Local Maternity and Neonatal System (LMNS) conducted an annual assurance visit on the 16 December 2024 and 22 January 2025. There were no urgent concerns raised as part of the visits. Formal written feedback was received on 14 February 2025 and is included as appendix 1d for information. Many of the areas highlighted within the feedback as 'Actions & Next Steps' relate to existing workstreams within the service. Those not already captured are being formulated into a formal action plan which will be presented to April QAC for approval.

The North West regional maternity team completed their annual visit on 29th January 2025. Feedback from the visit was very positive with no concerns raised. In particular the team noted:

- Colleagues were able to articulate the service vision.
- The drive to improve was tangible across the service.
- It was clear the team are cohesive and work well together.
- Commitment to the equality and equity agenda was evident across numerous workstreams.
- The service is using data well to drive change.
- Practical and innovative solutions have been used to support improvement work in particular in relation to improving workplace culture.

Formal feedback was received from the regional team on 4th February 2025 and this in included in appendix 1b for information.

2.5 Staff feedback

A maternity safety champion walkaround took place on 14th January 2025. The safety champions visited Maternity Triage, Antenatal Day Unit, Antenatal services, Neonatal Unit, and the community team. There were no urgent matters for escalation.

Trust Board have been sighted on a programme of work is ongoing across the Maternity and Neonatal Services to further improve workplace culture. As part of this, and as reported previously, a series of ideas events with clinical teams has been completed. Whilst staff who have attended the sessions have been positive and solution focussed it is clear there is work

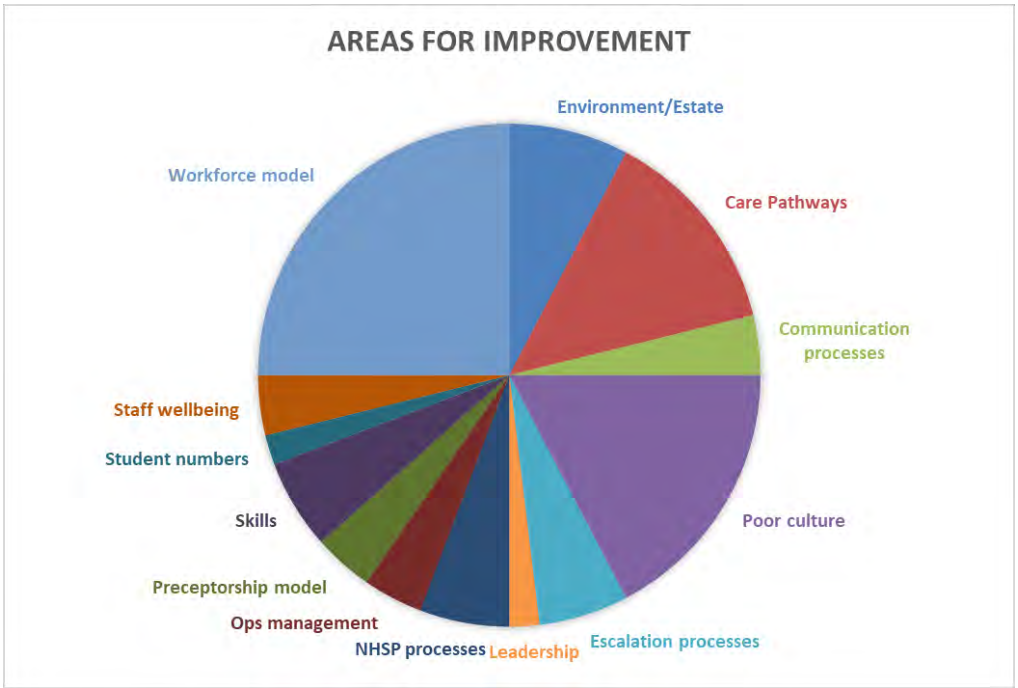
to do across the service. A thematic analysis of this feedback has been completed with 87 individual pieces of feedback collated.

These can be categorised as follows:

- 52 related to areas for improvement
- 23 related to positive feedback.
- 12 related to specific improvement ideas

With regard to the potential areas for improvement these can be categorised into a number of themes with the highest number of concerns relating to the following:

- Care Pathways – 13%
- Poor culture – 17%
- Workforce models (including staffing) 25%



The sessions have provided rich learning for the Senior Leadership Team and a series of next steps and actions are being developed. It is anticipated this will be a significant and multi-faceted MDT workstream for 2025/26.

2.6 Maternity Triage

In January 2025 621 triage attendances were recorded on the BadgerNet patient record system. This is an increase of 16% from December and shows sustained attendance levels throughout 2024 with an average 18.64 attendances per day December 2024 – January 2025.

Triage attendances Dec 24 – Jan 25		
Month	**Attendances**	**Ave per day**
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
October	545	17.5
November	539	17.9
December	531	17.1
January	621	20

92% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes and an improvement from previous months. 98% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this is beyond the KPI which stipulates 95% review within 30 minutes.

Recruitment processes have been completed for the additional triage staffing establishment, 2.5 WTE Midwives and 2.69 WTE Maternity Support Workers have been recruited and are progressing through HR appointment processes.

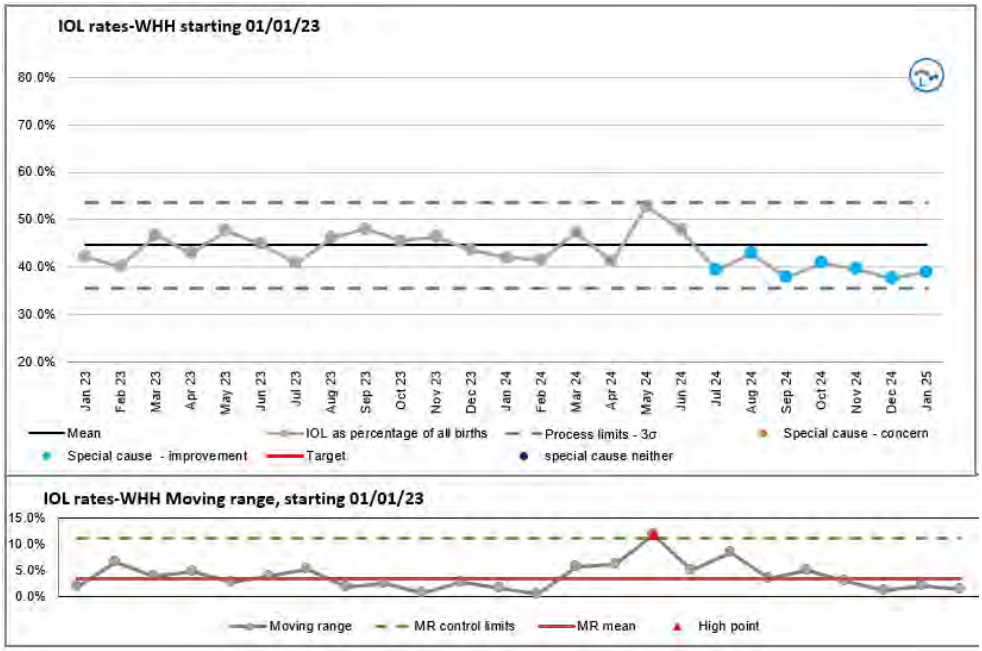
2.7 Induction of Labour (IOL)

Trust Board will be aware the service has been identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes. A transformation project is underway to improve performance across the induction of labour pathways. As described previously, the Triage task and finish group have instigated a number of actions to gain additional insight into pathways and contributory factors to delays. This includes a monthly audit of the following:

- Length of stay during the induction process.
- Number of outpatient inductions conducted.
- Duration of delays experienced during the induction process.
- Inappropriate inductions.

A potential factor in overarching rates of IOL is inappropriate IOL which will contribute to flow and lack of capacity. The February audit identified eight inductions were booked inappropriately. Work is ongoing with the team including development of education materials for patients and staff.

A target for IOL rates is under discussion which will consider the potential impact of the new regional guideline. The SPC chart to end of January 2025 shows improvement in the position since avoidance of inappropriate IOL and wider work around IOL has become a focussed workstream.



Full details regarding this workstream are included in the Quality & Safety reports included in appendices 1a and 1c.

2.8 Maternity and Newborn Safety Investigation (MNSI) position

2.8.1 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.

2.8.2 MNSI cases year to date

In the period March 2024 – February 2025, MNSI have accepted six cases for investigation. Position as at 25/3/2025 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	07/11/2024	25/11/2024	10/12/2024
25/08/2024	MI-038061	HIE/Cooling	In progress	Awaiting	Awaiting	Awaiting	
25/11/2024	MI-039124	HIE/Cooling	In progress	Awaiting	Awaiting	Awaiting	

One case was referrred to MNSI in January but this case was rejected by MNSI following review of the criteria and discussions with the family. An MDT Initial Safety Review has already been completed into this event. As the case will not now be explored via MNSI, an After Action Review (AAR) will be completed which will take account of any questions from the family.

No MNSI reports were received in January or February 2025.

2.8.3 Overview of all MNSI cases in Maternity Services for Board oversight

To further ensure Quality Assurance Committee and Trust Board have effective oversight of MNSI investigations, there is an expectation an annual report is provided to provided the committee with an overview of all MNSI referrals.

The 2024 report is included in appendix 1a for information. The reporting period is in line with the requirement of MIS year 6 reporting.

2.9 2023 MBRRACE-UK perinatal mortality report

The 2023 MBRRACE-UK perinatal mortality rates report was received on 6 February 2025. This report concerns stillbirths and neonatal deaths among the 2,454 babies born at the Trust in 2023. It includes details of the stillbirths and Neonatal deaths for births that occurred in the Trust in 2023, as well as background information on all births.

The full report is included in appendix 1e for information.

Key matters to note are as follows:

All deaths

- WHH stabilised & adjusted stillbirth rate is 2.91 per 1,000 total births. This is around the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted Neonatal mortality rate is 1.03 per 1,000 live births. This is around the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted extended perinatal mortality rate is 3.94 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

- WHH stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is 2.68 per 1,000 total births. This is around the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted Neonatal mortality rate excluding deaths due to congenital anomalies is 0.73 per 1,000 live births. This is more than 5% higher than the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is 3.41 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

The report suggests where mortality rates are up to 5% higher or up to 5% lower than the average for the group or more than 5% higher than the average for the group, the service should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. This work will now be commenced.

Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards are advised to use the national PMRT process to review all their stillbirths and neonatal deaths. This is fully emebedded at WHH.

2.10 Complaints

One complaint was received relating to care in the maternity and neonatal services in the period 1st December 2024 – 31st January 2025.

Specialty	Description	Complaint Opened
Maternity	Patient had C-section but wound was not sutured correctly leaving raw exposed edge, leaving patient with disfigured scar.	03/12/2024

2.11 Coroner Enquiries

No Regulation 28 enquiries have been received.

3. MATERNITY INCENTIVE SCHEME (MIS)

NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) aims to enhance maternity and perinatal care by ensuring compliance with ten Safety Actions. These actions support the national goal of reducing stillbirths, neonatal and maternal deaths, and brain injuries by 50% from the 2010 rate by the end of 2025.

Currently, NHSR is in the sixth year of the Clinical Negligence Scheme for Trusts (CNST) MIS, with guidance published on 2 April 2024 outlining eligibility conditions for payment under the scheme.

The reporting period for MIS Year 6 ended on 30 November 2024. The Cheshire & Mersey LMNS has conducted external assurance for Safety Actions 3, 4, 5, 6, 7, 8, and 9, deeming WHH compliant. Safety Actions 1, 2, and 10 are validated externally.

Internal assurance processes at WHH were completed in early February 2025, and the formal Board Declaration Form was signed and submitted to NHSR on 27 February 2025, ahead of the 3 March 2025 deadline. MIS Year 7 is set to launch on 2 April 2025.

Regular meetings with the Local Maternity and Neonatal System (LMNS) are held to review progress against the Saving Babies Lives Care Bundle v.3 (SBLCBv3), with the next review scheduled for March 2025.

The full reports are included in appendix 2a-2c.

4. Q3 2024/25 AVOIDING TERM ADMISSIONS TO THE NEONATAL UNIT

4.1 WHH ATAIN Position

This report reviews all term babies admitted to the NNU during Q3 (1st October to 31st December 2024). Each case is reviewed by a multidisciplinary team (MDT) including Obstetricians, Neonatologists, Midwives, Neonatal Nurses, and Operational Management. The ATAIN Group meets fortnightly to capture learning promptly, with the capacity to increase meeting frequency if needed. The Maternity Incentive Scheme (MIS) requires providers to report ATAIN data quarterly to the Trust Board, but longer-term data review is essential due to the small number of cases.

4.2 Summary of Unexpected Term Admissions to NNU

The Q3 ATAIN rate was 6.17% which is higher than the national and NWNODN targets but a decrease of 0.44% on the last quarter.

As per the previous report, other Trusts exclude Neonatal Unit admissions of less than six hours duration from ATAIN data. However, WHH continues to report on these cases and work is ongoing through the ODN to align other Trusts to also report all admissions.

Of the 37 term admissions, two did not require review as part of the ATAIN process as the baby was well and admitted for social reasons. It should be noted, if these admissions were not included, this would reduce the WHH ATAIN rate for Q3 to 5.8%.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	Total Number of term admissions as a % of live births (babies with <6 hrs admission)	National target 6%	NWNODN Target 5.6%
Q1 Apr – Jun 2024	612	42	6.86%	5.8%		
Q2 Jul – Sept 2024	680	45	6.62%	5.6%		
Q3 Oct – Dec 2024	600	37	6.17%	6.0%		

As part of the ATAIN review, the team will consider whether an admission to NNU was avoidable if care had been optimal. Significant progress can be seen in this measure. From Q3 2023/24 to Q2 2024/25 the average avoidable was 34.5% of admissions. In Q3 2024/25 the proportion avoidable was 21.6%.

WHH Oct 2022 - Mar 2024	Number of Term Admissions	Outcome of ATAIN review		% avoidable
		Avoidable Admissions	Unavoidable Admissions	
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%
Q2 Jul – Sept 2024	45	16	38	35.5%
Q3 Oct – Dec 2024	37	8	27	21.6%

4.3 Themes and Learning: Outcomes of ATAIN review

Reasons for categorising term admissions as avoidable included:

- PEEP for 30 minutes may have avoided admission
- Care could have been provided on Transitional Care
- Earlier delivery could have been facilitated
- Early term caesarean section should not have been facilitated

4.3.1 Good Practice:

- Examples of good communication and excellent documentation from the MDT team
- Timely step down of baby from NNU to Transitional Care
- Intubation prevented by use of less invasive surfactant administration

4.3.2 Learning Points/Themes/Actions:

- Simulation training to be implemented to support the team in the care of the deteriorating baby
- Use of life start trolley in caesarean sections where general anaesthetic is used to be considered. This will require training and simulations.
- Gestational Diabetes Mellitus (GDM) guideline to provide further guidance in relation to timing of birth (depending on different treatments) to support decision making and risk assessment as to whether reasonable to delay delivery

Individualised learning and facilitated reflection have taken place for specific intrapartum and postpartum care issues as appropriate with the support of colleagues/supervisors.

4.3.3 Recommendations:

- Continuation of facilitating reflective discussions with staff as required from cases requiring individualised learning.
- Continue regular ATAIN Meetings ideally involving rotation of obstetric trainees to participate in the meetings.
- 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.

The full report is included in appendix 3

5. Q3 2024/25 TRANSITIONAL CARE REPORT

5.1 Overview

During Q3 2024/258, 18 babies met the criteria for TC. The audit identified the following:

- Babies admitted direct to TC: 1
- Babies who received NNU care and stepped down to TC: 2
- Babies allocated to PEEP for 30 pathway: 5
- Term baby requiring feeding support: 1
- Term baby requiring double phototherapy 1
- Did not receive TC: 8

5.2 Key Findings

In Q3, 18 babies met the criteria for Transitional Care (TC). One baby was admitted to TC from birth and stayed for 4 days. Four babies were eligible for TC from birth, but due to high acuity and staff sickness, it was not possible for the Neonatal Unit (NNU) to staff the model. One baby was ready to step down to TC on day two, but their mother discharged home after 24 hours.

Two babies were potential for TC at time of birth, NNU could not staff TC, and the babies therefore should have been admitted to NNU however they both remained with their parents for a period. During this time one baby became cold and the other was fed a large volume causing possible aspiration leading to this baby requiring ventilation. A baby of 35+6 gestation did not receive TC care as was not identified as meeting the criteria however at 2 days of life was noted to be jaundiced and required admitting to NNU for treatment.

A cluster review of these patient safety events will be carried out to identify learning. An immediate safety alert was issued to remind teams of the criteria and the need to admit babies to NNU if TC is not available.

The other 10 babies who met the broad TC criteria required respiratory support and were initially cared for in NNU. Of these, three were appropriately stepped down to TC, one term baby required double phototherapy and IV fluids, and five followed the PEEP for 30 pathway. This pathway is part of a Quality Improvement (QI) project to quickly wean babies off respiratory support and establish feeding with regular observations.

Significant improvements in timely step-down to TC have been noted this quarter due to continuous education and collaboration between midwifery and neonatal services.

5.4 Good Practice

- Utilising TC to support infants who require support with feeding, rather than admitting to NNU.

- Excellent Neonatal Care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Sharing of audit outcomes across the MDT with both Midwifery and Neonatal Teams to ensure learning is communicated.
- Significant improvements in relation to the timely step down of these babies to TC
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Unavailability of TC now added to terms of reference for Operational Review Group to ensure senior oversight and review

5.5 Recommendations

- Time to be given to the Midwifery Lead for TC to complete the TC training programme.
- An immediate safety alert to all maternity and neonatal teams reminding teams of criteria and highlighting if a TC is unable to be provided the baby must be admitted to NNU (complete)
- Review of "Think TC" boards to ensure staff in all areas can identify babies who meet TC criteria.
- Education regarding importance of ensuring babies receive adequate thermoregulatory care.
- Focussed learning from TC review to be included on Neonatal Natter and OWL
- Staffing – Continue to ensure neonatal staff are allocated to TC babies.
- NNU Matron to review occasions where NHSP has been utilised to support TC staffing to support long term staffing plan.
- Following NHSP review, finance to provide costings for Band 4 Nursery Nurses to support long term staffing plan and inform a potential future revenue request.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

5.6 Outstanding Actions

- **Ongoing Audit:** Continue TC audits and report findings.
- **IV Policy Review:** Enable midwifery staff to undertake IV antibiotics on babies.
- **TC Bay Establishment:** Establish TC Bay on C23.

The full report and associated documents are included in appendix 4.

6. Q3 2024/25 PERINATAL MORTALITY REVIEW TOOL REPORT

During Q3 2024/25, no babies met the criteria for reporting to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK):

WHH stillbirth rate for Q3 2024/25 was 0.0 per 1000 births. Rolling year Q4 2023/24-Q3 2024/25 WHH rate is 2.82 per 1000 births. The MBRRACE-UK national rate is 4.0 per 1000 births.

WHH Neonatal mortality rate during Q3 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births.

During Q3, WHH undertook one PMRT review panel of a stillbirth (a baby born at 32+2 weeks). Parental perspective of the care they received was sought in this case. The panel review of the stillbirth case graded care as A.

There were no issues with care identified for the mother and baby up to the point that the baby was confirmed to have died. There were no issues identified with the care of the mother following confirmation of the death of her baby.

The full Q3 2024/25 PMRT report is included in appendix 5.

7. CQC MATERNITY SURVEY 2024

Service users were eligible to participate in the 2024 CQC Maternity Survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 29 February 2024. If there were fewer than 300 people within an NHS Trust who gave birth in February 2024, then births from January were included. As there were 186 people who gave birth at WHH in February 2024, births from January 2024 will also have been included.

7.1 Response rate/demographics

The response rate for WHH was 44%, higher than the national average of 41% and an increase from WHH's 2023 rate of 41%.

Maternity Services are under scrutiny to reduce health inequalities, focusing on those at risk of poor outcomes. Capturing the voices of these groups in the CQC Maternity Survey is crucial.

- **BME Backgrounds**: 9% of maternity bookings at WHH are from BME backgrounds, with a response rate of 13%.
- **Non-English Speakers**: 3.9% of bookings are from individuals whose main language is not English, with a response rate of 9%.
- **Under 24**: 6% of bookings are from individuals under 24, with a response rate of 3%. Efforts will be made to improve response rates from this group for the 2025 survey.
-

Further analysis of the demographic of those who responded is underway paying particular attention to those whose baby received Neonatal care as evidence suggests experiences of maternity services can have a long-term impact on this cohort.

7.2 Results

The overall survey results for the Trust were rated as ‘better than expected,’ placing WHH in the top eight Trusts nationally and one of only two in the Northwest with this rating. Families' experiences with Maternity Services were substantially better than the national average. The 2024 survey included 57 scoreable questions, up from 54 in 2023.

Better Than Expected Scores

- C6: Appropriate advice and support at the start of labour.
- C10: Staff introductions.
- C20: Awareness of medical history during labour and birth.
- C21: Kindness and compassion during labour and birth.
- D7: Pain management in hospital after birth.

Somewhat Better Than Expected Scores

- C11: Not left alone by staff when worried.
- C18: Confidence and trust in staff during labour and birth.
- F11: Information about mental health changes post-birth.

About the Same Scores

The remaining 49 questions scored ‘about the same’ as the national Trust scores.

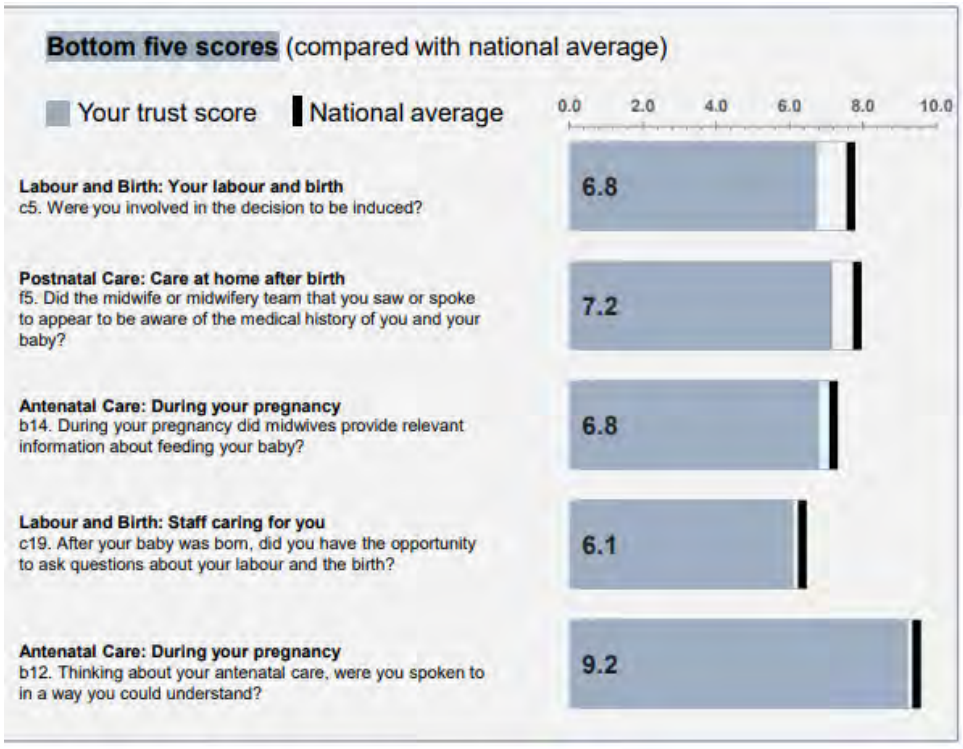
Score Comparison to 2023

The 2023 survey identified five areas for improvement:

- Choice of where to have the baby
- Information to decide where to have the baby
- Awareness of medical history during antenatal check-ups
- Information about feeding the baby during pregnancy
- Confidence and trust in antenatal care staff:

The 2024 survey recognised improvements in all five of these areas, now regarded as ‘about the same’ as the national average. There were no statistically significant decreases in scores, with 10 statistically significant increases and the remainder showing no significant change.

7.3 Areas for improvement



The bottom five scores for 2024 are listed above. Although these are our ‘bottom’ scores, all have been assessed as aligning with the national trust comparisons.

- C5. Were you involved in the decision to be induced?
- F5. Did the Midwife or Midwifery Team that you saw or spoke to appear to be aware of the medical history of you and your baby?

- B14. During your pregnancy did Midwives provide relevant information about feeding your baby?
- C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?
- B12. Thinking about your antenatal care, were you spoken to in a way you could understand?

The bottom five scores for 2024 do not highlight any areas of significant concern as they are all ‘about the same’ as the national average score. However, it is important the team are aware of these areas in order to target any potential areas for improvement.

7.4 Next steps

The 2024 Maternity Survey results for Warrington and Halton (WHH) show significant improvements and positive feedback from those giving birth. All areas identified for improvement in 2023 have seen progress, with eight areas scoring higher than expected compared to other Trusts. Measures are in place to target lower scores, and additional analysis has been conducted on data from January-February 2024 and December 2024-January 2025 to assess the current position. Key findings are as follows:

Involvement in Induction Decisions:

- Jan-Feb 2024: 100% of women had documentation showing an Induction of Labour (IOL) plan was discussed, and 90% had documentation of agreement.
- Dec 2024-Jan 2025: 92.5% had documentation of IOL plan discussion, and 95% had documentation of agreement.
- To ensure further assurance, BadgerNet has been updated to make these fields mandatory.

Information on Infant Feeding:

- Improvements in responses regarding infant feeding information are noted, with ongoing work to automatically share information at set gestations.
- A new infant feeding support worker has been recruited to enhance support.

Opportunity to Ask Questions Post-Birth:

- The Consultant Midwife leads the birth reflections service, offering people the chance to discuss their birth experiences.
- A survey is being prepared to gather feedback and further develop this service.

Communication During Antenatal Care:

- Efforts continue to ensure clear communication, especially where language barriers exist. Team River has developed flashcards to assist communication, and information leaflets are available in other languages.
- The Badger app allows people to record questions for their next appointments. A task and finish group is reviewing processes to ensure interpreter services are offered and utilised effectively.

Awareness of Medical History:

- Team River, the enhanced continuity of care team, receives positive feedback for their engagement and support.
- The Badger app helps people share information with the team.

- The team will continue to seek feedback from people using services through surveys and MNVP to ascertain how performance against this metric can be improved

The full report is included in appendix 6 for information.

8. MIDWIFERY SAFE STAFFING REPORT

8.1 Safe Staffing

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

The Maternity funded establishment as per the workforce dashboard at the 31st January 2025 is 130.28fte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The variance against the position in January 2022 is the result of the addition of a number of new full time and part specialist midwifery roles to the midwifery establishment since that time 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 and is therefore due. The assessment process is currently underway, and the outcome of the assessment will be reported to Strategic People Committee in May 2025.

8.2 Red Flag measures

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 October 2024 – 31st December 2024 there were 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 October 2024 – 31st December 2024 there was no episodes flagged where a woman in active labour did not receive one-to-one care.

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. An action plan was shared to Strategic People Committee to reflect these workstreams as is attached as part of the full report.

8.3 Workforce Metrics

8.3.1 Vacancy Rate

The vacancy rate for registered staff is 7.1%, including additional positions approved in November 2024 to support maternity triage. Recruitment is ongoing, with 5.1 FTE midwives in the pipeline. The vacancy rate for positions not yet recruited is 3.2%. Eight newly qualified midwives have now commenced with the trust. Processes are underway to complete the remaining recruitment of band 6 experienced midwives to ensure the service can maintain appropriate skill mix.

8.3.2 Retention/Turnover Rate

Midwifery retention rates have deteriorated to 12.33% at the end of January 2025. This is partly due to flexible retirements in December and January, along with other resignations. Exit interviews have been conducted, and feedback is being integrated into the retention workstream.

8.3.3 Sickness Absence

Sickness rates for registered midwifery staff in January 2025 were 11.59%, significantly higher than the Trust target. Proactive workforce management is ongoing to address this issue.

The full report is included in appendix 7

9. 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.

10. ASSURANCE COMMITTEE

The contents of this report has previously been noted and discussed at Quality Assurance Committees on 11 February 2025 and 11 March 2025 and at Strategic People Committee on 19 February 2025.

11. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="4">BM/25/04/10 appendix 1a</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Maternity & Neonatal Quality Review – December 2024</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="4">2 April 2025</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="4">Ailsa Gaskill-Jones – Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="4">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="3">SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="4">SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td rowspan="6">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:</td></tr>
<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 colspan="4">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.</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 colspan="4">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.</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>
</table>

	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 to the Board on maternity and neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and Trust Board. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Maternity & Neonatal Safety Investigations (MNSI) update • Complaints • Coroner Regulation 28 position There were four moderate harm events in December 2024. All related to incidence of OASI (3rd degree tear). There were no severe or fatal harm events in December 2024. Themes from maternity/neonatology patient safety events in December 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 with regular updates provided to Quality Assurance Committee (QAC) and Trust Board. At the end of December compliance for mandatory training across maternity and child health colleagues is above the Trust target as is compliance with PDR completion. A maternity safety champion walkaround took place on 14th January 2025 There were no urgent matters for escalation. Representatives from Cheshire and Mersey Local Maternity and Neonatal System (LMNS) conducted an annual assurance visit on the 16th December 2024 and 22nd January 2025. There were no urgent concerns raised as part of the visits. The service awaits the formal report.

	The North West regional maternity team completed their annual visit on 29th January 2025. Feedback from the visit was very positive with no concerns raised. The service continues to achieve its KPIs for Maternity Triage. WHH continues to perform less well than other providers in relation to timeliness of induction of labour (IOL). A transformation piece of work is underway to improve the position. An overview of the service's position with regard to cases being investigated by MNSI is provided for oversight by Trust Board alongside an annual review of MNSI cases. Work is ongoing across the maternity and neonatal services to further improve workplace culture. An update is provided with regard to this workstream. Five complaints were received in the CBU in December 2024. One related to care within the maternity service. The remainder related to care within the gynaecology/paediatric services. 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/25/02/243iii**	
	Date of meeting	11 February 2025	
	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 – December 2024	AGENDA REF:	BM/25/04/10 appendix 1a

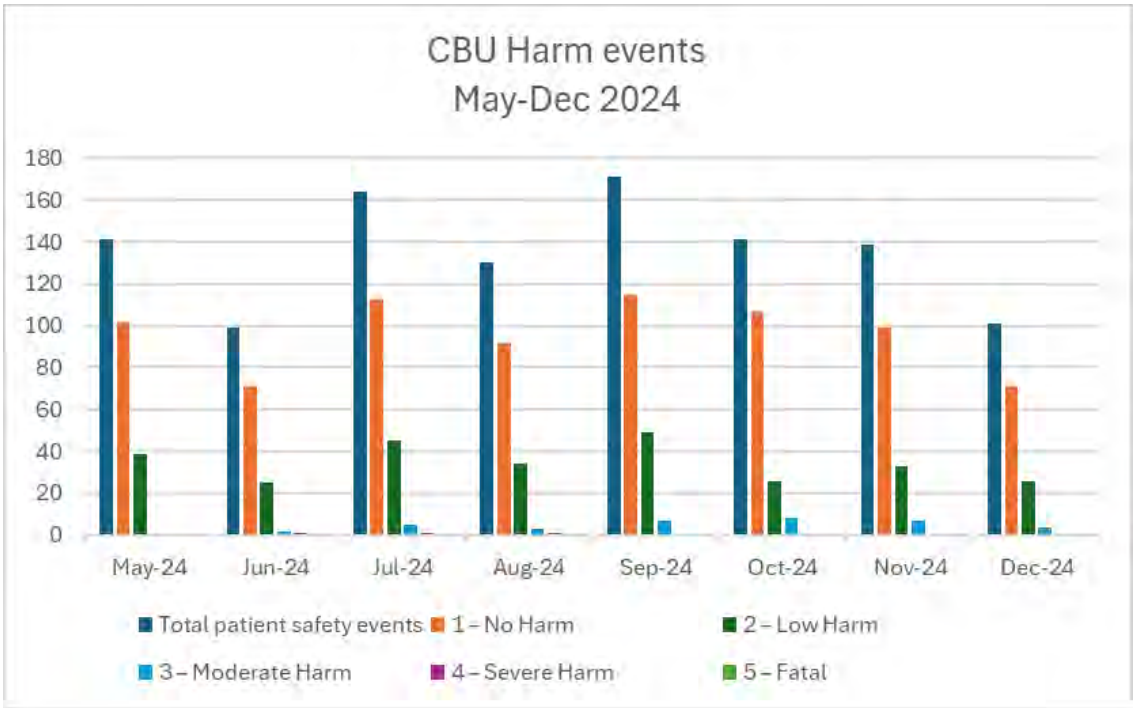
1. BACKGROUND/CONTEXT

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

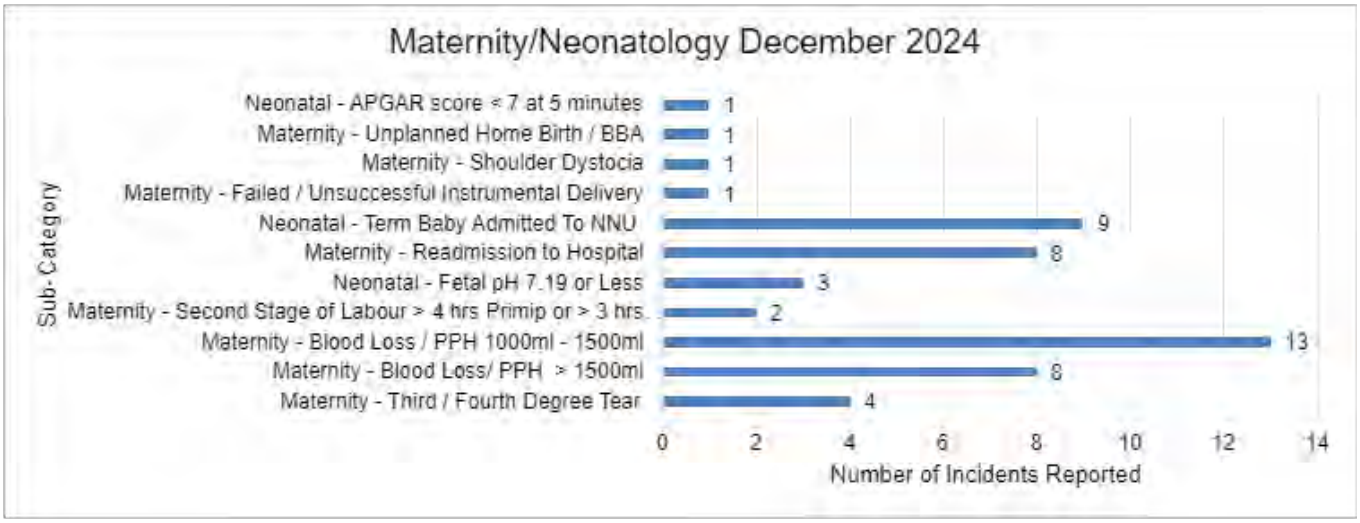
Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU for the period May - December 2024:



There were 101 patient safety events reported across the CBU in December 2024. This is reduced position and relates to a reduction in reporting from within child health services. The Governance lead for the CBU is exploring this further with child health colleagues.

There were no severe harm or fatal events in December. There were four moderate harm events. All four occurred in the maternity service and related to OASI (3rd & 4th degree tears). These cases were reviewed in the MDT Intrapartum Review Group (IRG) and learning from the IRG reviews will feed into the existing workstream related to OASI.

In total there were 12 moderate/low harm reviews undertaken in IRG in December. All incidents reported are reviewed by the Governance Team and escalated where required. Themes from maternity/neonatology in December 2024 are detailed in the table below:

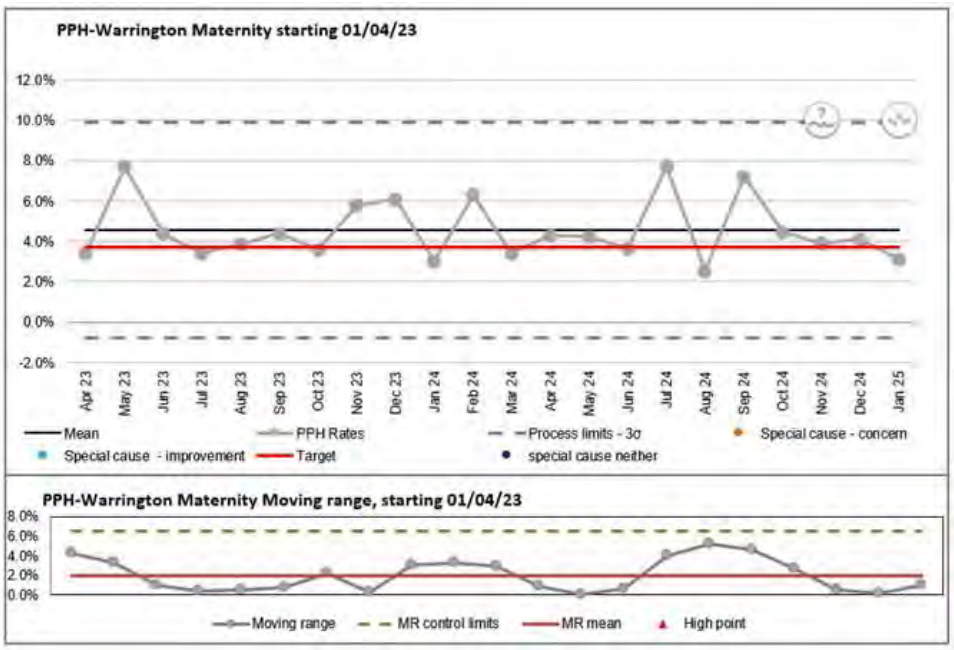


9 term babies were admitted to the neonatal unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC and Trust Board.

8 postnatal readmissions were reported in December 2024. Work remains ongoing to reduce avoidable readmissions through a number of workstreams. In particular workstreams related to reducing wound infections and management of hypertension

There were 13 cases of PPH 1000ml-1500ml and 8 cases of PPH ≥1500mls in December 2024. The PPH audit is complete and was shared to February QAC.

The SPC chart for PPH ≥1500mls continues to show common cause variation, but with some stability highlighted by four consecutive months below the mean.



The new regional PPH guideline is anticipated to be launched in February 2025 and will incorporate change ideas identified as part of the WHH QI project. In the interim, all cases of PPH ≥1500mls are reviewed via IRG with learning shared and any urgent actions completed.

3. WORKFORCE METRICS & MEASURES

Work remains ongoing across the Maternity and Neonatal teams to sustain compliance with mandatory training and completion of staff appraisals.

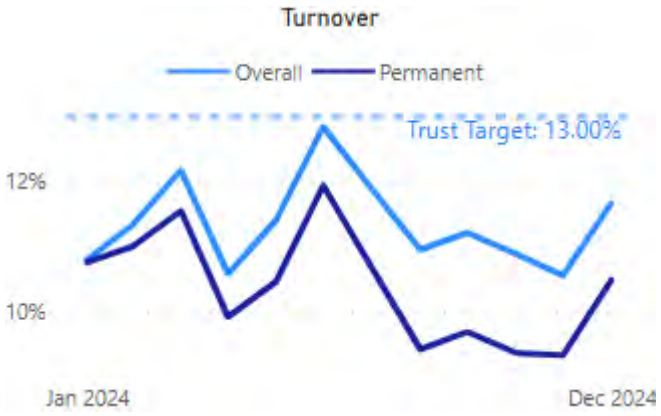
At the end of December compliance for mandatory training across maternity and child health colleagues is 89.59% for Trust mandatory training (including safeguarding training), 87.16% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long term basis. Compliance with PDR completion continues to improve from 77.33% in October (excluding those with a long term absence) to 86.01% at the end of November and 89.19% at the end of December 2024. Excellent compliance with maternity specific training standards is being sustained.

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	100%	98.4%	95.2%	100%	98.3%
Obstetric Consultants	100%	100%	100%	n/a	n/a
Other Obstetric	100%	90%	100%	n/a	n/a
Obs Anaesthetic	93.3%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	100%
Neonatal medical and ANNP	n/a	n/a	n/a	94.4%	n/a

Turnover for maternity and child health staff (permanent staff) in December is 10.48% 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:



A deteriorating position can be noted. Work is ingoing within the teams to monitor reasons for leaving which is feeding into the wider work around culture and workforce retention.

The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target. This is illustrated in the graph below:

4. EXTERNAL FEEDBACK

Representatives from Cheshire and Mersey Local Maternity and Neonatal System (LMNS) conducted an annual assurance visit on the 16th December 2024 and 22nd January 2025. There were no urgent concerns raised as part of the visits.

Informal feedback provided on the day identified some strength areas within the service. In particular:

- Commitment to the population health agenda.

- The enhanced midwifery offer.
- Collaborative work in Halton particularly in relation to the family hubs.
- The way in which the maternity service had harnessed the opportunity offered by the Living Well Hub.
- Investment in the maternity estate and the difference this is making to families.
- Understanding across the team with regard to their services, opportunities, and challenges.
- Sustained improvement in workforce metrics.
- Care provided by the bereavement team.
- Work ongoing to develop an equity dashboard.
- MDT maternity specific training programme.

In addition, the LMNS team were very satisfied with the service's governance arrangements and were assured in particular with regard to PSIRF and PMRT processes.

The team acknowledged work which is ongoing in relation to some areas of challenge and are keen to support the maternity service as it moves through the improvement journey. This was particular in relation to:

- Transitional Care offer and staffing model
- Midwifery led offer and how to capitalise on space offered via the Nest.
- Challenges in relation to induction of labour (IOL) delay
- Ongoing work to avoid divert of the maternity unit at times of high acuity/staffing challenges.

Formal written feedback will be provided. Once received this will be shared with QAC and Trust Board for information.

The North West regional maternity team completed their annual visit on 29th January 2025. Feedback from the visit was again very positive with no concerns raised.

In particular the team noted:

- Colleagues were able to articulate the service vision.
- The drive to improve was tangible across the service.
- It was clear the team are cohesive and work well together.
- Commitment to the equality and equity agenda was evident across numerous workstreams.
- The service is using data well to drive change.
- Practical and innovative solutions have been used to support improvement work in particular in relation to improving workplace culture.

Formal feedback was received from the regional team on 4th February 2025 and this in included via appendix one for information.

5. STAFF FEEDBACK

A maternity safety champion walkaround took place on 14th January 2025. The safety champions visited Maternity Triage, Antenatal Day Unit, Antenatal services, Neonatal Unit, and the community team.

Colleagues were positive and willing to discuss challenges faced. The walkaround provided the safety champions with the opportunity to learn more about enhanced maternity support worker role as well as participating in the culture awareness tombola organised as part of the ongoing work the service is doing to improve its culture. Issues around the maternity estate in particular antenatal clinic and antenatal day unit were discussed. There were no urgent matters for escalation.

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 December 2024 539 triage attendances were recorded on the BadgerNet patient record system. This shows sustained attendance levels throughout 2024 with an average 18.45 attendances per day Jan-Dec 2024.

Triage attendances Jan 24 - Dec 24		
Month	**Attendances**	**Ave per day**
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
October	545	17.5
November	539	17.9
December	531	17.1

- 18.8% of attendees were seen immediately on arrival.
- The longest wait recorded for initial review was 35 minutes.
- 97% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes and an improvement from previous months.

- 99% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this is beyond the KPI which stipulates 95% review within 30 minutes.
- 1.9% of attendees were categorised as red on arrival. All were seen within 15 minutes of arrival for initial triage. Once identified as red, appropriate ongoing care was provided in all cases.
- 24.6% of attendees were categorised orange on arrival. This is a significant increase from November when the number of attendees categorised as orange was 18.5%. This change in the number of women being categorised as orange will be monitored to ascertain whether it required further exploration.

Recruitment processes are underway to recruit to the additional triage staffing establishment, in the interim, the Triage Task & Finish Group will continue to collaborate with the team to optimise the service and improve performance.

7. INDUCTION OF LABOUR (IOL)

Trust Board will be aware the service has been identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes.

A transformation project is underway to improve performance across the induction of labour pathways. A review of data quality is underway to confirm WHH is reporting in the same way as other providers and a task and finish group is in place with an identified lead midwife to support the workstream. This work will be informed by a new regional IOL guideline due to be ratified in January 2025.

The WHH maternity service is also participating in an LMNS led improvement project related to IOL and in a randomised control trial study related to IOL and dose of induction agent.

As part of the work already underway, the team have reviewed 12 months of WHH data and benchmarked this to similarly sized providers. This will allow the service to formalise some specific targets for improvement.

In 2024 WHH had an average delay rate across the IOL pathways of 33.2%, similarly sized provider Mid Cheshire Hospital Trust and Countess of Chester had delay rates of 15.7% and 17.7%, respectively.

It is proposed WHH aim for an initial target of 25% with sustained improvement. To achieve a reduction of 8.2% would be significant.

This proposal will be taken to the next IOL task and finish improvement group for discussion and agreement. Once the target is formally agreed delays will be reported monthly to QAC and Trust Board via an SPC chart.

In the interim the task and finish group have instigated a number of actions to gain additional insight into pathways and contributory factors to delays. These are detailed below:

Monthly IOL Audit:

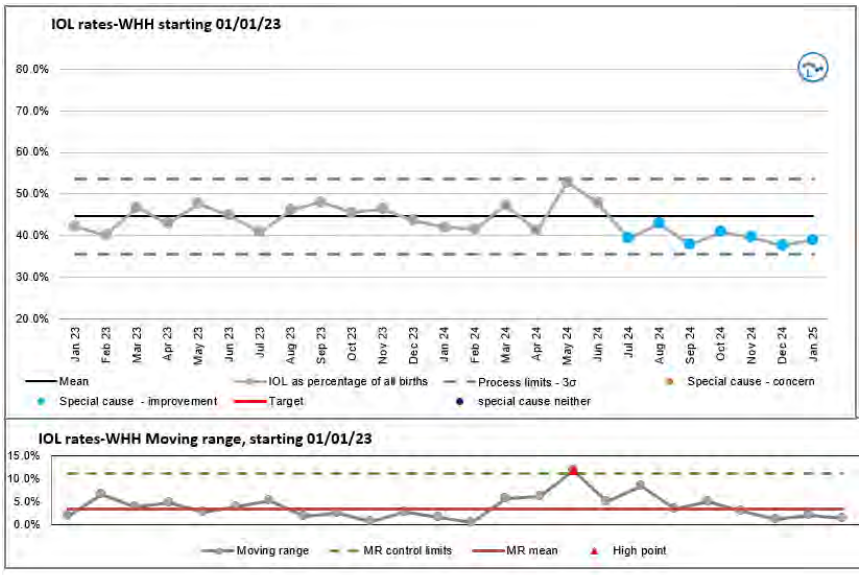
- Length of stay during the induction process.
- Number of outpatient inductions conducted.
- Duration of delays experienced during the induction process.
- Inappropriate inductions.

These audits are already highlighting new workstreams, for example in December 2024, 15% of IOLs were booked inappropriately. In addition, in triangulating quantitative data with qualitative feedback from women has highted a lack of clarity for women regarding the process of induction both prior to commencing the process and once within the pathway.

As a result, actions have already been implemented as follows.

- Ongoing development of education materials for patients and staff. Emphasising clarification of term gestation (37 vs 39 weeks): Explaining the physiological impact on neonatal outcomes of earlier inductions within the term window. Risks and benefits for both mothers and babies to support decision-making and shared understanding for IOL before 39 weeks without medical indication.
- Informing women about the IOL process, expected length of stay, and ensuring informed consent throughout.
- Review of current guidelines to clarify criteria for offering IOL, including for VBAC, diabetes, LGA and polyhydramnios cases.
- Develop a comprehensive booking flowchart for IOL, incorporating a triage system to prioritise appropriately.
- Review midwifery led pathways and outpatient induction pathways to increase midwifery led births on the Nest, with a separate booking system for these patients.
- Ongoing exploration of a dedicated IOL triage system to ensure inductions are booked appropriately. The aim is to align closely with the ELCS triage process, introducing a 24-hour triage service to streamline patient prioritisation and reduce delays. Implementation of the triage system is dependent on the development of robust IOL guidelines.
- A business case is under development to assess the introduction of Dilapan to reduce the duration of the IOL process. Further evaluation of its cost-effectiveness for use in all women is ongoing.

A potential factor in overarching rates of IOL is inappropriate IOL which will contribute to flow and lack of capacity. A target for IOL rates is under discussion which will consider the potential impact of the new regional guideline. Once agreed this will be shared to next QAC and Trust Board. In the interim, the SPC chart shows improvement in the position since avoidance of inappropriate IOL and wider work around IOL has become a focussed workstream.



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.

8.2 Current position

In the period February 2024 – January 2025, MNSI have accepted seven cases for investigation. Position as at 31/1/2025 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	07/11/2024	25/11/2024	10/12/2024
25/08/2024	MI-038061	HIE/Cooling	In progress	Awaiting	Awaiting	Awaiting	
25/11/2024	MI-039124	HIE/Cooling	In progress	Awaiting	Awaiting	Awaiting	

One case was referrred to MNSI in January but this case was rejected by MNSI following review of the criteria and discussions with the family. An MDT Initial Safety Review ahs alraedyt been completed into this event. As the case will not now be

explored via MNSI, an After Action Review (AAR) will be completed which will take account of any questions from the family.

8.3 Reports received

No reports were received in January 2025.

8.4 Overview of all MNSI cases in Maternity Services for Board oversight

To further ensure Quality Assurance Committee and Trust Board have effective oversight of MNSI investigations, there is an expectation an annual report is provided to provided the committee with an overview of all MNSI referrals.

The 2024 report is attached in appendix three for information. The reporting period is in line with the requirement of MIS year 6 reporting.

9. UPDATE ON OTHER WORKSTREAMS

9.1 Perinatal Cultural Leadership Programme (PCLP)

Work is ongoing across the maternity and neonatal services to further improve workplace culture.

As part of this, and as reported previously, a series of ideas events with clinical teams has been completed. Whilst staff who have attended the sessions have been positive and solution focussed it is clear there is work to do across the service in particular in relation to improving relationships between clinical areas and in ensuring that systems and processes are supportive in this.

Feedback from these events is being collated and formal next steps being developed. It is anticipated this will be a significant and multi-faceted MDT workstream for 2025/26. These actions once formalised will be incorporated into the PCLP action plan. The PCLP action plan as at 31st January 2025 (prior to these new actions being agreed) is included in appendix three for information.

10. COMPLAINTS

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

Specialty	Description	Complaint Opened
Maternity	Patient had C-section but wound was not sutured correctly leaving raw exposed edge, leaving patient with disfigured scar.	03/12/2024

The other complaints received related to care within the gynaecology service (three complaints) and Paediatric Urgent Care (one complaint).

11. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

12. RECOMMENDATIONS

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

Appendix two – Overview of MNSI cases in Maternity Services

Author	Lisa Davies, Integrated Governance Quality Lead
Report Title	Maternity & Newborn Safety Investigations (MNSI) (previously Healthcare Safety Investigation Branch - HSIB) Reports during period 08.12.2023 – 30.11.2024
Purpose	Overview of all MNSI cases in Maternity Services for Board oversight
Date	11th February 2025

Overview and Background

Trust Board to be provided with an overview of all MNSI referrals in Maternity Services during period 3 December 2023 to 30 November 2024.

Background, Key Issues and Risks

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

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

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

- No family consent or consent withdrawn.
- MRI brain normal following therapeutic cooling
- Does not meet MNSI criteria (As per appendix 2i)

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

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

- A term baby has been therapeutically cooled, however MRI brain outstanding (MRI brain is normally conducted >72 hours once the baby has been re-warmed, and dependent upon babies' condition may only occur some weeks after the event).
- The mother has attended with contractions and further clarification needed surrounding if she perceived herself to be in labour.

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

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

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

Table of WHH MNSI Referrals Accepted for Full Investigation **6 December 2023 – 30 November 2024**				
Date of MNSI opening investigation and MNSI Reference Number	**Summary of Incident**	**MNSI Criteria Met**	**WHH Initial Safety Review**	**Status**
08/03/2024 MI-036897	Low risk intrapartum care. Baby born in poor condition	Potential severe brain injury – therapeutic cooling	MI-036897 ISR.pdf	MI-036897 Final Report.pdf Report received and case closed
11/03/2024 MI-036905	Intrapartum stillbirth during the inpatient induction of labour process	Intrapartum stillbirth	MI-036905 ISR.pdf	MI-036905 Final Report.pdf Report received and case closed
07/05/2024 MI-037420	Presented to maternity triage with fetal death in utero (FDIU)	Intrapartum stillbirth	MI-036420 ISR.pdf	MI-037420 Final Report.pdf Report received and case closed

07/05/2024 MI-037421	Presented to maternity triage with fetal death in utero (FDIU)	Intrapartum stillbirth	MI-037421 ISR.pdf	MI-037421 Final Report.pdf Report received and case closed
28/08/2024 MI-038061	Baby born in poor condition at home	Potential severe brain injury – therapeutic cooling	MI-038061 ISR.pdf	In progress. Awaiting draft & final report.
05/12/2024 MI-039124	Pathological CTG - Misclassified	Potential severe brain injury – therapeutic cooling	MI-039124 ISR.pdf	In progress. Awaiting draft & final report.

Finalised MNSI reports can take up to six months.

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

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

The WHH MNSI **rejected** case for the past 12 months is detailed below:

Table of WHH MNSI Rejected Cases Past 12 Months				
Case date and Referral Reference Number	**Summary of Incident/Reason for referral**	**Reason Rejected**	**Comments**	**Initial Review**
03/07/2024 MI-037622 (Harris)	Potential severe brain injury – therapeutic cooling	Criteria NOT met	Low risk born at home with meconium aspiration at birth. Transferred out - Not cooled	MI-037622 ISR.pdf

Recommendations and next steps

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

Governance Quality Lead for Women's and Children's CBU along with the Director of Midwifery to undertake a Cluster Review of completed case for the period 1 January 2024 to 31 December 2024 for identification of themes and richer learning opportunities.

Appendices

Appendix 2i

MNSI (HSIB) Reporting Criteria

Our maternity programme investigates cases of:

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

Babies

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

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

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

The definition of labour used by HSIB includes:

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

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

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

Intrapartum stillbirth

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

Early neonatal death

- When the baby died within the first week of life (0-6 days) of any cause.
- Potential severe brain injury
- Potential severe brain injury diagnosed in the first seven days of life, when the baby:
- Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.
- Was therapeutically cooled (active cooling only). This is where the baby's body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
- Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

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

Maternal deaths

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

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

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

Direct deaths

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

Indirect deaths

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

Appendix 2ii

PMRT Reporting Criteria

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

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g.
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g.
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g.
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

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

- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

Appendix 3 - 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	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		30th April 2025	
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 March 2025	
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 March 2025	
PCLP4	Development of a programme of "Meet the Quad" Teams sessions to share key updates	Quad/ Emma Bentham		31st March 2025	
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	DOM	Sessions completed. Feedback being collated and new actions identified	31st October 2024	
PCLP6	Maternity & Neonatal Working group to be established focus on wellbeing, emotional recovery, and burnout	CBU MGR		31st March 2025	

PCLP7	Communication to be completed to clarify leadership structure	DOM		28th February 2025	
PCLP8	To use the "You said, we did" feedback tool quarterly to demonstrate progress against actions from the culture workstreams (from Q3 2024)	Quad/ Emma Bentham		28th February 2025	
PCLP9	To engage fully with the Trust culture plan and communicate this to the maternity and neonatal team	All		31st March 2025	
PCLP10	To implement system to capture/triangulate staff satisfaction/culture related learning and ensure oversight via the Quad and Maternity & Neonatal Safety Champions	DOM	Underway. Formal process and escalation to be finalised	31st March 2025	
PCLP11	To ensure feedback from exit interviews is captured and used to support improvement activity	Dep DoM		15th March 2025	
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. PEF gathering informal feedback from student midwives for data triangulation. Next step to develop formal programme to share with staff	31st March 2025	

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	Work ongoing. Survey of staff completed, and initial shadowing schedule being mapped. Workforce development guideline in development	30th April 2025	
PCLP15	To review PCLP action plan as part of Quad/NED meetings	Quad/ Emma Bentham	Agenda item for Quad meet 5/11/2024, 11/2/2025	Ongoing	
PCLP16	To report progress against PCLP quarterly to QAC	DOM	Next report to QAC 11/2/2025	12th November 2024	
PCLP17	To meet with Trust colleagues to align activity with wider Trust culture plan	DOM	Meeting held 17/10/2024.	Complete	
PCLP18	Feedback from ideas events to be collated, shared with Quad and actions identified	DOM	Ideas events complete. Feedback being collated to share.	28th February 2025	
PCLP19	Quad to meet with Health Innovation NW to identify plan for ongoing support	Quad	Meeting held 9/10/2024.	Complete	
PCLP20	PMA team to develop an action plan with a focus on supporting improved culture.	Quad	PMA planning completed 27/2/2025. Next step meeting with SLT to finalise and agree programme	31st March 2025	

To: Ali Kennah, Chief Nurse
Ailsa Gaskin-Jones, Director of Midwifery

Cc: Tina Moors, Deputy Director of Midwifery

Piccadilly Place
Manchester
M1 3BN
Tel: 07730381653

4th February 2025

Dear Ali and Ailsa

Thank you so much for hosting the Regional Maternity Team annual visit on the 29 January 2025. It was a fantastic opportunity for us to hear directly from the team about your journey over the last 12 months, celebrate improvements in your services and discuss your plans for the coming year.

It is clear from your presentations there have been significant improvements throughout the maternity services at the Trust. We were particularly impressed with the work shared around improving culture that you having been doing and consider that the tombola exercise is a really unique initiative to increase awareness of poor behaviours and supporting colleagues from different disciplines to start having conversations about culture and its impact. We are keen that you consider how the impact of this initiative can be measured and how it can be shared more widely.

It was also great to see the improvement in the estates and how this is impacting on the experiences of your service users during their pregnancy and birth journey. The changes in Triage, both in the estates and the systems and processes were evident and it was excellent to see the demonstrable impact these improvements are having on the 15-minute triage compliance.

The presentation from Team Rivers team leader, Jonathan, demonstrated the impact enhanced continuity of carer has in supporting women and their families from the most deprived areas and those with the most complex social needs. Through our discussions it was recognised that achieving 24-hour cover for intrapartum is not possible without increasing the establishment of the team. However, the team are working to ensure intrapartum care is in place for the highest risk or most vulnerable women. Therefore, we suggested seeking feedback from women who do not receive intrapartum care from Team River to assess the impact this has had. The feedback received through this exercise can then inform potential next steps for Team River.

We were grateful that Lisa and Collette, your MNVP leads, were able to join us for the day as well. Ensuring that service users are at the heart of everything we do is key, and it was good to hear directly from Lisa and Collette, especially regarding the plans to embed neonatal service user voices into their MNVP work.

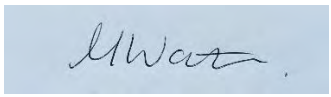
During our feedback we shared how positive the visit had been. It was clear from the interactions we had with the front-line staff and all of the presentations we heard that the maternity and neonatal workforce are proud of the care and services they provide.

Thank you again for sharing all the excellent initiatives and improvements, and please thank all the team members that took the time to share their work with us. We were really impressed with all the hard work, dedicated and passion from the leadership team and this is reflected in staff we had the pleasure to meet on the day.

Thank you also for sharing your presentation from the day for our records, and I look forward to receiving the translated flash cards, so they can be shared more widely. Please do not hesitate to contact the team is there is anything we can do to support you and your team.

With best wishes

Yours Sincerely



Michelle Waterfall
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/10 appendix 1c**	
SUBJECT:	**Maternity & Neonatal Quality Review – January 2025**	
DATE OF MEETING:	2 April 2025	
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)***	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.	

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: 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.

	Yes	No	N/A
2. Advance equality of opportunity between people who share a relevant 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.

	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 to the Board of Directors on Maternity and Neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and the Trust Board of Directors. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Maternity & Neonatal Safety Investigations (MNSI) update • Complaints • Coroner Regulation 28 position There were three moderate harm events in January 2025. One related to a baby transferred to another provider for cooling. Two related to incidence of Obstetric Anal Sphincter Injury (OASI (3rd /4th degree tear)). There were no severe or fatal harm events in January 2025. Themes from Maternity/Neonatology patient safety events in January 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 with regular updates provided to Quality Assurance Committee (QAC) and Trust Board.

	Good compliance with Maternity specific training standards is being sustained. Compliance with K2 (fetal surveillance competencies) has moved below target for Obstetric Consultants. A plan is in place to achieve compliance by the end of March 2025. Representatives from Cheshire and Mersey Local Maternity and Neonatal System (LMNS) conducted an annual assurance visit on the 16 December 2024 and 22 January 2025. There were no urgent concerns raised as part of the visits. Analysis of the 2024 CQC maternity survey has now been completed and was reported in detail to QAC in agenda item QAC/25/03/267v. Feedback from the idea's sessions held with is included in detail. This includes a thematic analysis of the feedback. With regard to the potential areas for improvement these can be categorised into a number of themes with the highest number of concerns relating to the following: • Care Pathways – 13% • Poor culture – 17% • Workforce models (including staffing) 25%: A series of next steps and actions are being developed. It is anticipated this will be a significant and multi-faceted MDT workstream for 2025/26. The service continues to achieve its KPIs for Maternity Triage. WHH continues to perform less well than other providers in relation to timeliness of induction of labour (IOL). A transformation piece of work is underway to improve the position. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight.

	The 2023 MBRRACE-UK perinatal mortality rates report was received on 6 February 2025. This report concerns stillbirths and neonatal deaths among the 2,454 babies born at the Trust in 2023. For most measures WHH rates are around average for similar Trusts & Health Boards. The only area where WHH highlighted is outside of the average is the stabilised & adjusted Neonatal mortality rate excluding deaths due to congenital anomalies. The WHH rate is 0.73 per 1,000 live births. This is more than 5% higher than the average for similar Trusts & Health Boards. The Q3 cluster review of postnatal readmissions has been completed. The readmission rate for Q3 was 4.2%. This is an increase of 0.65% from Q2; however, remains 0.67% lower than Q1. An overview of activity underway to improve the position is included in the paper. No complaints were received in the Maternity or Neonatal Services in January 2025. 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/25/03/267iv**	
	Date of meeting	11 March 2025	
	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 – January 2025	AGENDA REF:	BM/25/04/10 appendix 1c

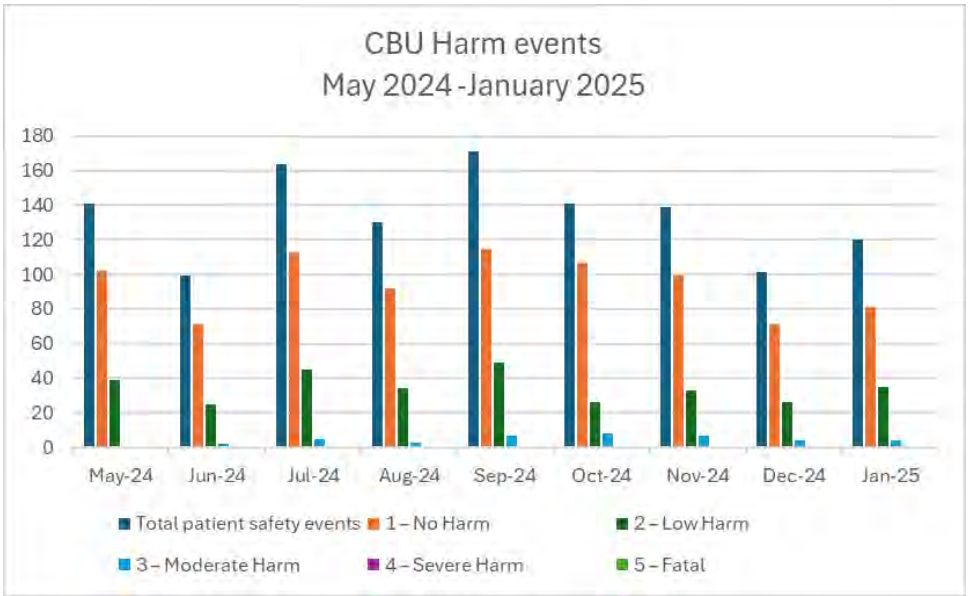
1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month January 2025.

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 for the period May 2024 – January 2025:

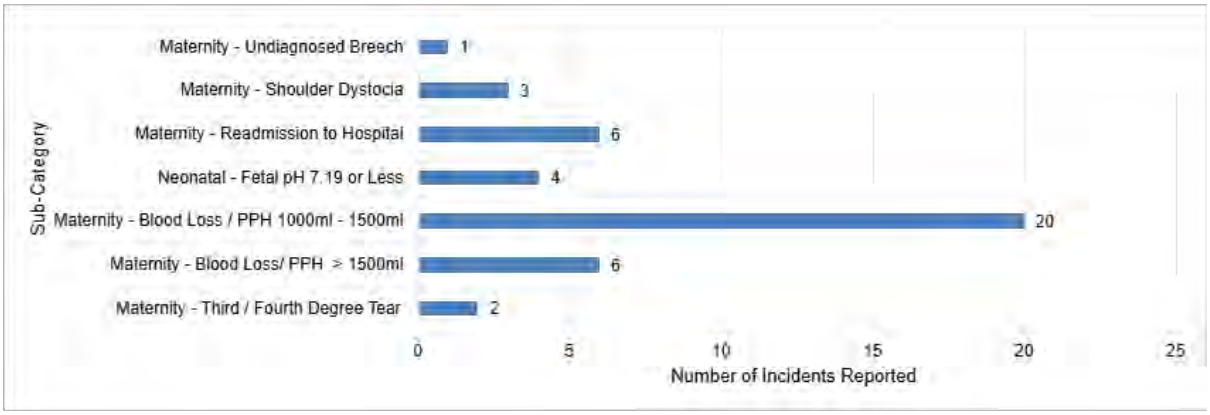


There were 120 patient safety events reported across the CBU in January 2025.

There were no severe harm or fatal events in January 2025. There were three moderate harm events within the Maternity Service. One case related to a term baby born in poor condition following placental abruption. This baby was transferred to another provider for cooling. The case was referred to MNSI for review and this has been rejected following their triage process. The case will be presented through the Maternity Service's Perinatal Meeting to facilitate an MDT review. An Initial Safety Review (ISR) was completed. The remaining two moderate incidents were OASI. These cases were reviewed by the Maternity MDT through Intrapartum Review Group (IRG).

This is a downward trend in cases of OASI from four in December 2024 and six in November 2024.These cases were reviewed in IRG and learning from the IRG reviews will feed into the existing workstream related to OASI.

Themes from Maternity/Neonatology in January 2025 are detailed in the table below:



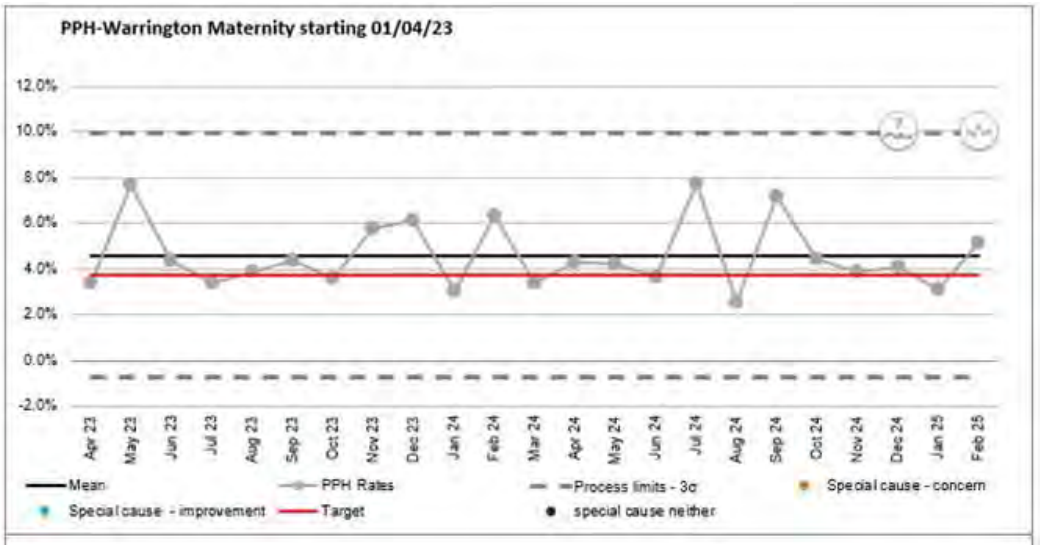
6 postnatal readmissions were reported in January 2025. Work remains ongoing to reduce avoidable readmissions through a number of workstreams. In particular workstreams related to reducing wound infections and management of hypertension. Further detail regarding these workstreams is included in section 11 of this paper.

There were 20 cases of PPH 1000ml-1500ml. This is an increase from 13 cases in December 2024. All cases of PPH 1000ml-1500ml are reviewed and learning shared.

It should be noted, there was a reduction in the number of cases of PPH ≥1500mls in January 2025 which will have partly contributed to the increase in the lower rates of PPH in that earlier recognition and management of PPH 1000ml-1500ml is preventing these cases developing into PPH ≥1500mls.

However, this does not account for the total increase in PPH 1000ml-1500ml. Should this increase in rates of PPH 1000ml-1500ml persist in February 2025 a cluster review will be conducted to ensure all learning has been captured.

The SPC chart for PPH ≥1500mls to end of February continues to show common cause variation.



Five term babies were admitted to the Neonatal Unit (NNU) in January 2025. All cases of term admission are reviewed via ATAIN which reports quarterly to QAC and Trust Board.

3. WORKFORCE METRICS & MEASURES

Work remains ongoing across the Maternity and Neonatal Teams to sustain compliance with mandatory training and completion of staff appraisals.

At the end of January compliance for mandatory training across maternity and child health colleagues is 89.46% for Trust mandatory training (including safeguarding training), 87.02% 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 is 81.19% at the end of January 2025. A targeted piece of work is underway to improve compliance above the Trust target.

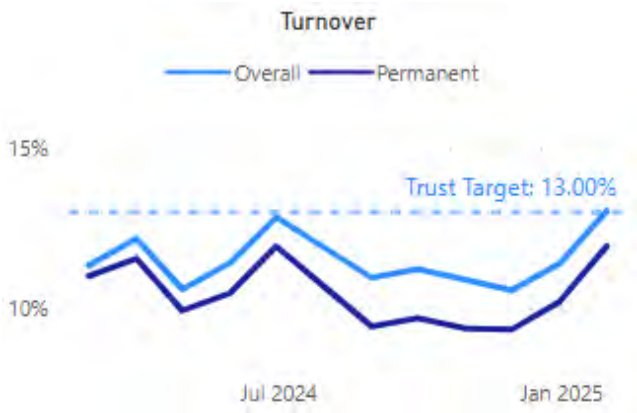
Good compliance with maternity specific training standards is being sustained. Compliance with K2 (fetal surveillance competencies) has moved below target for Obstetric Consultants. A plan is in place to achieve compliance by the end of March 2025. Two other Obstetric doctors have not achieved compliance; however, they are new to the service and within the agreed grace period. Again, a plan to meet compliance is in place.

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
Midwives	99%	100%	91.1%	100%	97.7%
Obstetric Consultants	100%	100%	83.3%*	n/a	n/a
Other Obstetric	100%	100%	77.7%**	n/a	n/a
Obs Anaesthetic	96.5%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	100%
Neonatal medical and ANNP	n/a	n/a	n/a	94.4%	n/a

*two Obstetric Consultants not compliant – plan in place
** two new members of the medical team – within 6 month grace period. Plan in place

Turnover for Maternity and child health staff (permanent staff) in January is 11.935% 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:



A deteriorating position can be noted. Some of this is due to a number of staff taking flexible retirement in December 2024 and January 2025. However there have been resignations for other reasons. Exit interviews have been completed and feedback/learning is being incorporated into the retention workstream and the wider work around culture.

The vacancy rate for Maternity and child health staff remains positive and is significantly below the Trust target. This is illustrated in the graph below:

4. EXTERNAL FEEDBACK

Representatives from Cheshire and Mersey Local Maternity and Neonatal System (LMNS) conducted an annual assurance visit on the 16 December 2024 and 22 January 2025. There were no urgent concerns raised as part of the visits.

Formal written feedback was received on 14 February 2025 and is included as Appendix one for information.

Many of the areas highlighted within the feedback as 'Actions & Next Steps' relate to existing workstreams within the service. Those not already captured are being formulated into a formal action plan which will be presented to April QAC for approval.

5. SERVICE USER FEEDBACK

Analysis of the 2024 CQC maternity survey has now been completed and was reported in detail to QAC in agenda item QAC/25/03/267v.

In summary:

- There has been a significant improvement in the Trust score in 2024 compared to 2023.
- WHH is one of two Trusts in the Northwest to have scored within the top ten nationally.
- The 2024 survey results have recognised improvements in the five areas rated as worse than expected in 2023.
- The five areas where WHH scored the lowest have been explored and when compared to national averages, WHH performance is 'about the same' as the national average score in all of these measures. Work is underway to improve performance.
- A comparison of the demographic of those who responded to the survey has been completed to ensure this reflects those receiving care. Work is underway to improve response rates for the 2025 survey particularly amongst those groups where response rates are not reflective of numbers receiving care.

6. STAFF FEEDBACK

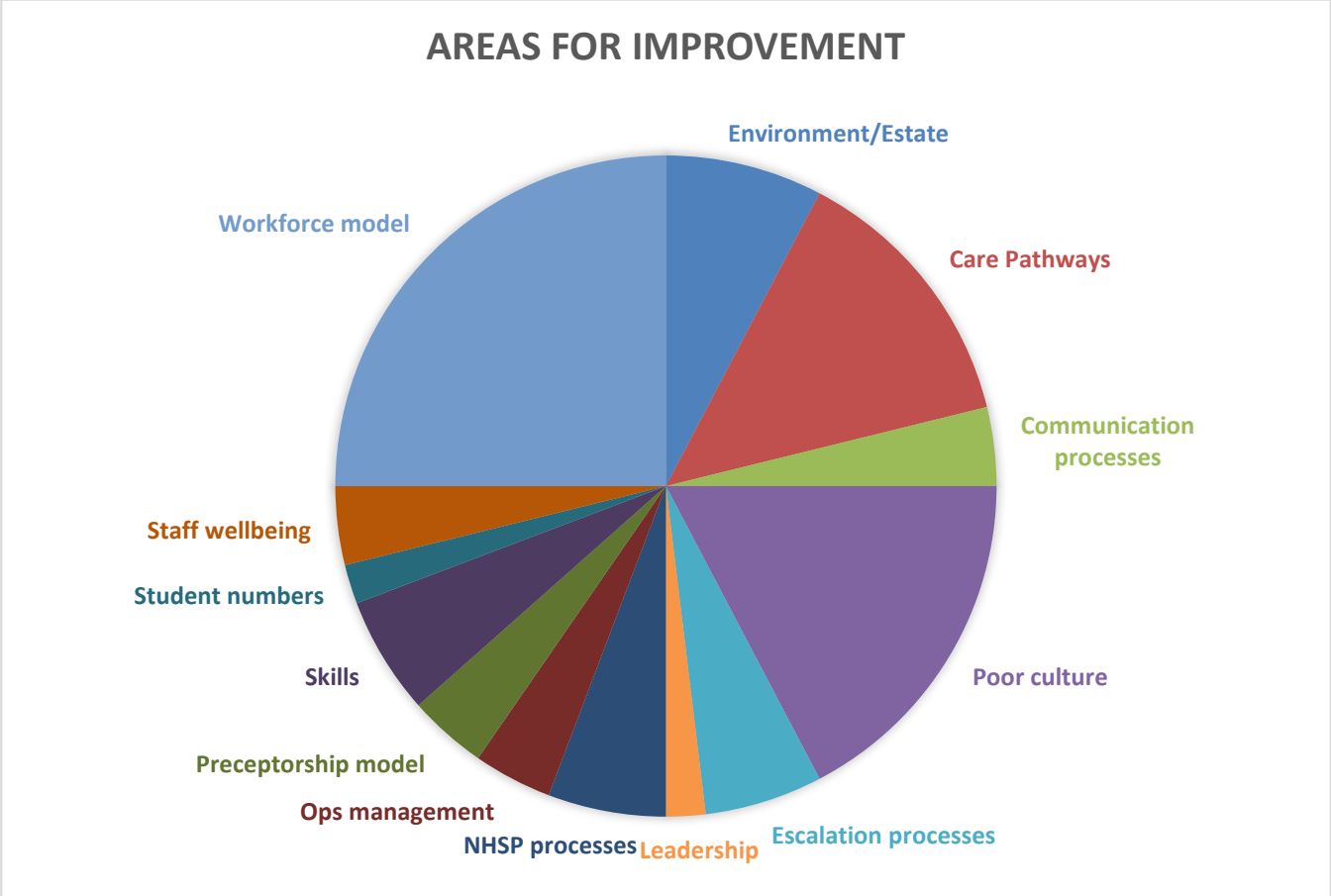
Trust Board have been sighted on a programme of work is ongoing across the Maternity and Neonatal Services to further improve workplace culture.

As part of this, and as reported previously, a series of ideas events with clinical teams has been completed. Whilst staff who have attended the sessions have been positive and solution focussed it is clear there is work to do across the service. A thematic analysis of this feedback has been completed with 87 individual pieces of feedback collated. These can be categorised as follows:

- 52 related to areas for improvement
- 23 related to positive feedback.
- 12 related to specific improvement ideas

With regard to the potential areas for improvement these can be categorised into a number of themes with the highest number of concerns relating to the following:

- Care Pathways – 13%
- Poor culture – 17%
- Workforce models (including staffing) 25%:



The sessions have provided rich learning for the Senior Leadership Team and a series of next steps and actions are being developed. It is anticipated this will be a significant and multi-faceted MDT workstream for 2025/26. Details of this workstream will be presented to QAC in April and will be incorporated into both the Perinatal Cultural Leadership Programme (PCLP) action plan which reports regularly to QAC/Trust Board and other clinical action plans as appropriate.

7. 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 January 2025 621 triage attendances were recorded on the BadgerNet patient record system. This is an increase of 16% from December and shows sustained attendance levels throughout 2024 with an average 18.64 attendances per day December 2024 – January 2025.

Triage attendances Dec 24 – Jan 25		
Month	**Attendances**	**Ave per day**
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
October	545	17.5
November	539	17.9
December	531	17.1
January	621	20

- 18.3% of attendees were seen immediately on arrival.
- The longest wait recorded for initial review was 60 minutes.
- 92% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes and an improvement from previous months.
- 98% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this is beyond the KPI which stipulates 95% review within 30 minutes.
- 1.7% of attendees were categorised as red on arrival. 91% were seen within 15 minutes of arrival for initial triage. Once identified as red, appropriate ongoing care was provided in all cases.
- 23.5% of attendees were categorised orange on arrival. This maintains the increase seen in December from November when the number of attendees categorised as orange was 18.5%. This change in the number of women being categorised as orange will be monitored to ascertain whether it required further exploration.

Recruitment processes have been completed for the additional triage staffing establishment, 2.5 WTE Midwives and 2.69 WTE Maternity Support Workers have been recruited and are progressing through HR appointment processes.

8. INDUCTION OF LABOUR (IOL)

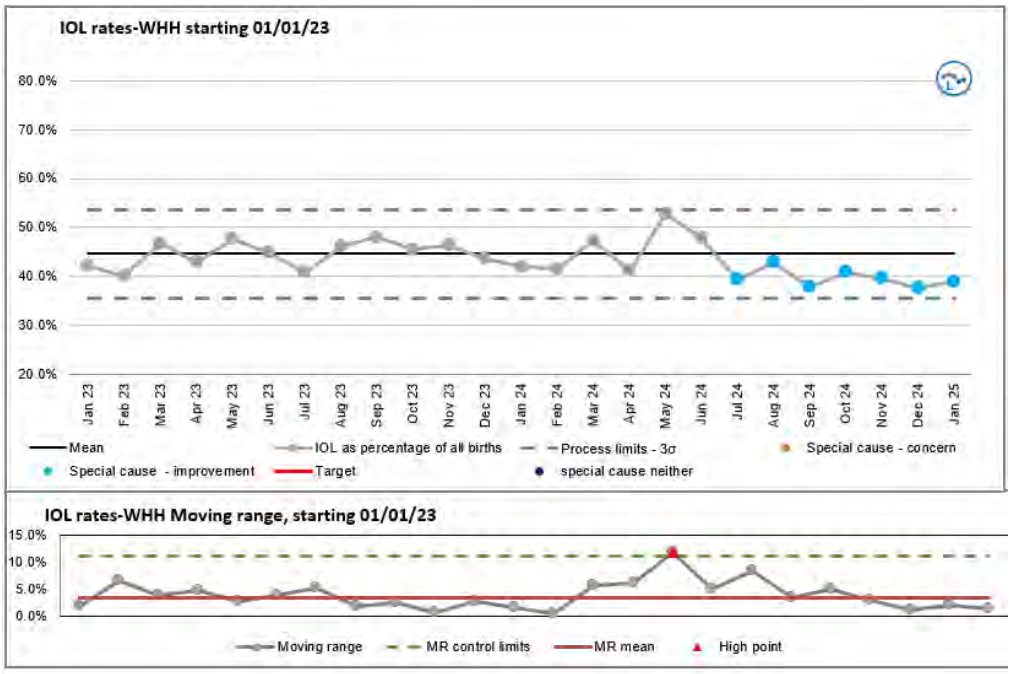
Trust Board will be aware the service has been identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes.

A transformation project is underway to improve performance across the induction of labour pathways. As described previously, the Triage task and finish group have instigated a number of actions to gain additional insight into pathways and contributory factors to delays. This includes a monthly audit of the following:

- Length of stay during the induction process.
- Number of outpatient inductions conducted.
- Duration of delays experienced during the induction process.
- Inappropriate inductions.

The February audit has identified eight inductions were booked inappropriately. Work is ongoing with the team including development of education materials for patients and staff. Emphasising clarification of term gestation (37 vs 39 weeks). This will explain the physiological impact on Neonatal outcomes of earlier inductions within the term window alongside risks and benefits for both mothers and babies of IOL before 39 weeks gestation when there is no medical indication. It is anticipated this will support improved risk assessment and decision-making.

A potential factor in overarching rates of IOL is inappropriate IOL which will contribute to flow and lack of capacity. A target for IOL rates is under discussion which will consider the potential impact of the new regional guideline. The SPC chart to end of January 2025 shows improvement in the position since avoidance of inappropriate IOL and wider work around IOL has become a focussed workstream.



9. MNSI POSITION AND REPORTS RECEIVED

9.1 Background

To ensure QAC and Trust Board have oversight of the sevice's position with regard to cases being investigated by MNSI an update will provided each month.

9.2 Current position

In the period March 2024 – February 2025, MNSI have accepted seven cases for investigation. Position as at 28/2/2025 is as follows:

9.3 Reports received

No reports were received in February 2025.

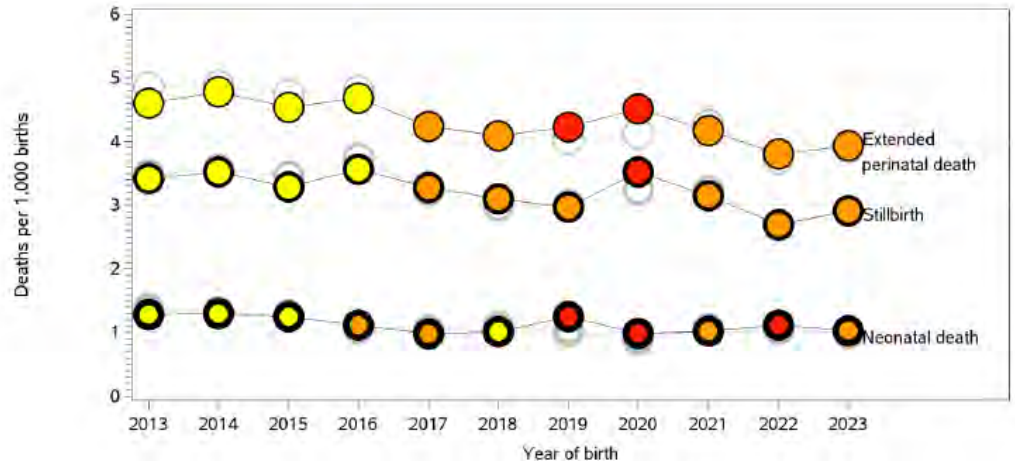
Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
28/02/2024	MI-036897	HIE/Cooling	Complete	31/07/2024	10/09/2024	30/09/2024	N/A
10/03/2024	MI-036905	Stillbirth	Complete	25/06/2024	25/07/2024	17/09/2024	08/10/2024
04/02/2024	MI-037420	Stillbirth	In progress	29/08/2024	09/10/2024	04/11/2024	12/11/2024
05/02/2024	MI-037421	Stillbirth	In progress	23/09/2024	07/11/2024	25/11/2024	10/12/2024
25/08/2024	MI-038061	HIE/Cooling	In progress	Awaiting	Awaiting	Awaiting	
25/11/2024	MI-039124	HIE/Cooling	In progress	Awaiting	Awaiting	Awaiting	

10. MBRRACE-UK PERINATAL MORTALITY REPORT: 2023 BIRTHS

The 2023 MBRRACE-UK perinatal mortality rates report was received on 6 February 2025. This report concerns stillbirths and neonatal deaths among the 2,454 babies born at the Trust in 2023. It includes details of the stillbirths and Neonatal deaths for births that occurred in the Trust in 2023, as well as background information on all births.The full report is included in Appendix two for information.

Key matters to note are as follows:

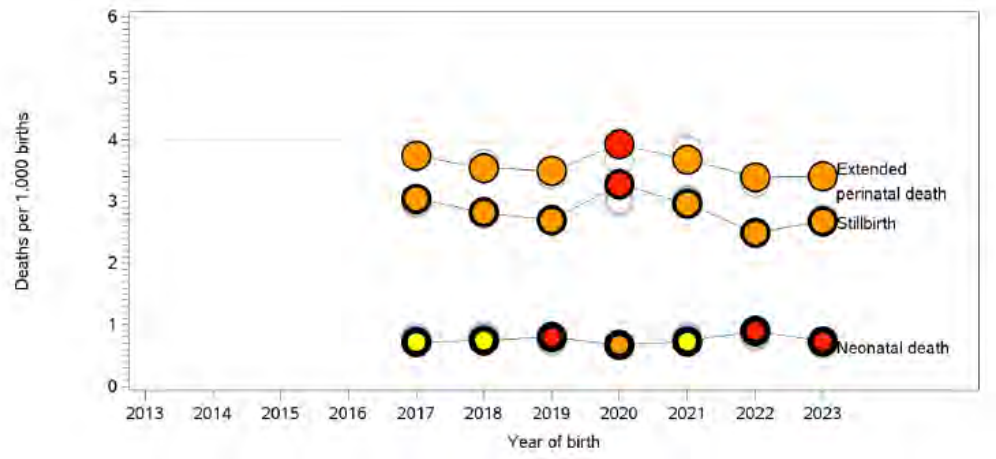
All deaths



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

- WHH stabilised & adjusted stillbirth rate is 2.91 per 1,000 total births. This is around the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted Neonatal mortality rate is 1.03 per 1,000 live births. This is around the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted extended perinatal mortality rate is 3.94 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies



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

- WHH stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is 2.68 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

- WHH stabilised & adjusted Neonatal mortality rate excluding deaths due to congenital anomalies is 0.73 per 1,000 live births. This is more than 5% higher than the average for similar Trusts & Health Boards.
- WHH stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is 3.41 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

The report suggests where mortality rates are up to 5% higher or up to 5% lower than the average for the group or more than 5% higher than the average for the group, the service should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. This work will now be commenced.

Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards are advised to use the national PMRT process to review all their stillbirths and neonatal deaths. This is fully emebedded at WHH.

11. UPDATE ON OTHER WORKSTREAMS

11.1 Postnatal readmissions

The Q3 cluster review of postnatal readmissions has been completed. For the period 1 October 2024 to the 31 December 2024, 25 patients were readmitted to the Maternity Unit following 600 births. This provides a readmission rate of 4.2%. This is an increase of 0.65% from Q2; however, remains 0.67% lower than Q1.

Of the 25 patients readmitted, 20 were deemed unavoidable (80%) and 5 were deemed avoidable (20%). This is a 25% decrease in avoidable admissions from Q2.

Four of the five avoidable readmissions were due to management of hypertension. The theme noted within this cluster review was not noting upward trends on the MEOWS chart. This provided insight that although a blood pressure can be within normal parameters, an upward trend should trigger a review for possible medication or a more robust care plan post discharge.

Trust Board will be aware a Hypertension Working Group has been established with all relevant professionals. A new regional guideline is expected from NICE which will support more consistent pathways. Learning form the Q3 cluster review has been fed into the working group who will review current trends and monitor causes of readmissions to facilitate streamlined management. A further update will be provided to Trust Board as part of the Q4 cluster review.

An isolated avoidable readmission was due to a post birth plan to recheck haemoglobin level on day 7 not being followed. HB was subsequently found to be 89 and the patient was symptomatic of anaemia which required admission. This has been fed back to the relevant team to avoid future reoccurrence.

There were three readmissions for wound related reasons of which all three were unavoidable. 12% of the re-admissions were wound related which is a significant decrease from 50% in Q2. The MDT Wound Surveillance Group remains in place.

The second most prevalent reason for readmission in Q3 was Mastitis which equated to six readmissions (24%), Mastitis had not previously been a common reason for readmission but appears to have peaked during Q3.

All women admitted for mastitis were beyond the community discharge from Midwifery Services, with readmissions occurring between three- and six-weeks post birth. All were deemed unavoidable as care provided prior to discharge met expectations and community care had been taken over by Health Visiting Teams. Findings from the audit will be shared with the 0-19 service to ascertain if there is collaborative work the service can do to reduce future cases.

12. COMPLAINTS

No complaints were received relating to care in the maternity and neonatal services in January 2025.

13. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

14. RECOMMENDATIONS

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

29th January 2025

PRIVATE & CONFIDENTIAL
Ms Ailsa Gaskill-Jones
Director of Midwifery
Warrington and Halton Hospital Trust

Dear Ailsa

Re: LMNS Annual Visit to Warrington and Halton Hospital Trust 16th December 2024 and 22nd January 2025

Thank you for hosting the LMNS Annual visit to your trust. It was a pleasure to meet with you and your teams and we are most grateful for the time given and the very generous hospitality provided.

As outlined in our presentation the visit was a follow on from the original NHSE led Ockenden visits to Trusts in 2022. The role and remit of both NHSE Regional team and the LMNS has changed over this time, and we are now responsible for oversight, support and assurance on behalf of Cheshire and Merseyside ICB.

The annual visit will form part of this role and provides an opportunity to build relationships and to see firsthand the services you provide for the mothers and babies in your care.

Although I did provide some feedback at the end of the day, I am also setting out the comments from the wider visit team below:

Strengths captured by LMNS Team

- Equity focus and Equalities Dashboard
- Workforce improvements – Sickness now below Trust Target of 13% and vacancy rate reduced from 17.2% to 2% by culture of listening and support with staff
- Award from Perinatal Institute for Neonatal Team
- Bereavement service with 24/7 cover by 3 x MWs and Birth Trauma advocacy training with Silver Birch Maternal Mental Health Team
- CQC survey – Good and one of only two in the NW with ‘Better than Expected’.
- Estate and environment for Triage and MLU fantastic
- Proactive around QI for maternity
- Team is responsive and works well with LMNS
- Neonatal Team work well and family Feedback is very positive for Family Integrated Care
- Strong relationships with MNVPs
- NED very engaged and meets regularly with the DOM and Quad, monthly walkarounds and staff feedback they are visible and approachable
- CNST reinvestment for medics on rota
- Immense work on Immunisations and Vaccinations to be commended and good practice should be shared across C&M
- PMA support for Trainee Midwives
- PMRT and PSIRF processes well embedded with dedicated PAs for attendance at PMRT

Strengths captured by LMNS Clinical Lead

- **Leadership:** Division has good understanding of improvements required and plans are in place for phased actions
- **Caesarean section lists** are staffed by Obstetric Consultant and there are plans to increase from 2 ½ days to 3 full day lists
- **Anaesthetic Consultant** presence on Delivery Suite
- **Training:** Good evidence of use of SIMS, training for neonatal collapse on postnatal ward in place and there is a robust process for ensuring staff complete fetal monitoring training within timeframes to stop their competence expiring
- **Culture:** Good feedback on clinical supervision; Consultants come in or stay on site when on-call; RCOG rules and responsibilities document firmly embedded in practice and Band 7 will call Consultant if needed
- **Communication with Neonatal team:** there is a ward clerk specifically for updating BadgerNet and the Neonatal calendar for high-risk babies due to be born
- **Triage:** BSOTS used well with electronic board monitoring and ability to perform daily audits to monitor breaches
- **Bereavement suite:** Warm pleasant space bereavement rooms; plans to have a separate space of post-bereavement counselling follow-up funded through charitable funds

Challenges captured by LMNS Team

- ECOC Team for Halton as an area of greatest need which should be prioritised
- GMC Survey Results but acknowledge response to this
- Outlier for Induction of Labour delays
- Outlier for Diverts
- Need for greater forward planning and anticipated peaks in acuity and activity
- Cluster of stillbirths – being reviewed
- Attain rates high
- Postnatal Readmissions
- Postnatal Estate
- Better use of Triage and MLU estate as a great asset but underutilised – could this also provide EPAU out of hours?
- Outdated MNVP posters
- Estate areas could be adapted for increased activity, especially to aid Elective CSs
- Relatively new midwifery leadership team could do with more mentoring and support
- Neonatal visibility within the Quadrumvirate
- Atain is an issue with high separation levels
- Transitional Care funded but not deemed as suitable 24/7 offer by NWODN

Challenges captured by LMNS Clinical Lead

- No blood fridge in the Neonatal Unit which can delay access to O neg blood when needed in an emergency such as vasa praevia. Blood must be ordered from the lab and if they are busy in the main hospital this can cause delays. Clinical Lead for Neo says would be much better if there was fridge
- **TC:** Neonatal nurse-led, no MSW input. Needs to have more MatNeo approach. No specific area for TC
- 24 hours telephone triage staffing is a challenge. Specialist Midwives can be deployed to cover. It is separate to main triage but can be pulled in if in escalation. Telephone triage is then diverted to Delivery Suite

- **Triage:** There is daily overflow of patients from the ANDU (Day Unit) which can lead to long patient waits
- **ANDU:** The Division plans to improve the system for ANDU after it completes proposed estate changes to the antenatal/postnatal ward C23
- **ANDU:** there is a proposal to develop virtual clinics for women needing scan reviews to reduce the impact on patient experience, efficiency, waiting times/ANDU and triage

Specific issue: GMC survey

Rota is more service provision than training. College Tutor thinks that rota coordinator staffing instability has contributed. There is resident doctor input into the rota now which should improve things

- Handover has been improved
- Protected sessions monthly for teaching
- Resident doctors can come in on post on-call rest and get time back in lieu
- Good feedback on clinical supervision
- Consultants come in or stay on site when on-call.

RCOG rules and responsibilities document firmly embedded in practice and Band 7 will call Consultant if needed

Actions & Next Steps

- Review JD and Evaluation of non-clinical role for population health with Clare Fitzpatrick, LMNS Lead Midwife
- Explore improved engagement with NWAS
- Work with LMNS team on forward planning to avoid volume of mutual aid requests
- Maternity Team to explore if 'peep for 30' project impacts on IOL
- Discuss with NWODN psychology neonates
- Share progress on Birth Trauma Hub with LMNS
- Explore opportunities for increased use of triage/MLU estate especially pregnant ladies accessing A&E and EPAU
- NWOD to support business case for Neonatal TC Lead Nurse
- Engage MNVPs in adding warmth to the IOL area
- Invite MNVP to safety Champion Walkarounds
- Share with LMNS EXAMPLE OF MNSI report on a page
- Share Equity dashboard and plan with LMNS
- Explore translation offer for Neonatal
- Share outcome of Task and Finish Group to review Interpreting Services
- LMNS to review support for Board level safety champions across C&M
- Division has clear plan for improvement of estates and pathways.
- ANDU/Triage overflow issues should be prioritised
- Regular Divisional catch-up sessions with resident doctors
- Regular Communication – Communication and support will be provided via established LMNS meetings and forums, at the request of the Trust and in response to any other requests from NHSE and/or ICB.

I hope that the above feedback is helpful, and the actions reflect your expectations from the feedback session at the end of the visit.

Once again thank you for your support and cooperation and I look forward to working with you and your teams in the future.

Please do not hesitate to contact me with any questions.

Yours sincerely

Catherine McClennan
LMNS SRO & Programme Director for Women's Health & Maternity Programme
Cheshire & Merseyside ICB

Cc: Tina Moors (Head of Midwifery)
Cc: Alison Kennah (Chief Nurse)
Cc: Dr Rita Arya (Clinical Lead)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

MBRRACE-UK perinatal mortality report: 2023 births

This report concerns stillbirths and neonatal deaths among the 2,454 babies born within your Trust in 2023. It includes details of the stillbirths and neonatal deaths for births that occurred in your Trust in 2023, as well as background information on all births.

- Birth numbers are obtained from routine data sources and may not match locally recorded numbers.
- Births before 24 completed weeks gestational age and all terminations of pregnancy are EXCLUDED.
- Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births.

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **2.91 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **1.03 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **3.94 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **2.68 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.73 per 1,000 live births**. This is more than 5% higher than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.41 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Recommended actions

As the neonatal mortality rate calculated excluding deaths due to congenital anomalies has been highlighted this year, it is important to: a) review the data that was entered locally about your Trust to ensure it is accurate and complete; and b) ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

Definitions

Late fetal loss:	A baby born between 22 and 23 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby born at or after 24 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died up to 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

1. Your perinatal mortality rates

The mortality rates are reported for babies born within your Trust at 24 completed weeks gestational age or later, excluding terminations of pregnancy. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2023. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies. The **stabilised & adjusted mortality rate** provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Trust in 2023.

To account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision; (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 22 weeks or later; (iv) 2,000-3,999 births per annum at 22 weeks or later; (v) under 2,000 births per annum at 22 weeks or later**.**

Your Trust has been included in the comparator group with 2,000-3,999 births per annum.

Perinatal mortality (all deaths)

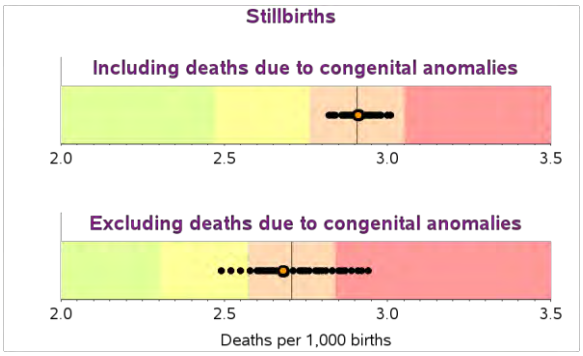
Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**7**	**2.85**	**2.91**	**(2.39 to 3.54)**	**Up to 5% higher or up to 5% lower**
Neonatal	**3**	**1.23**	**1.03**	**(0.64 to 1.71)**	**Up to 5% higher or up to 5% lower**
Extended perinatal	**10**	**4.07**	**3.94**	**(3.39 to 5.03)**	**Up to 5% higher or up to 5% lower**

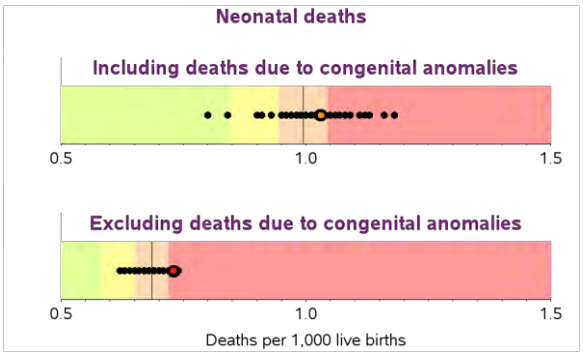
Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**6**	**2.45**	**2.68**	**(1.91 to 3.79)**	**Up to 5% higher or up to 5% lower**
Neonatal	**3**	**1.23**	**0.73**	**(0.50 to 1.17)**	**More than 5% higher**
Extended perinatal	**9**	**3.67**	**3.41**	**(2.63 to 4.66)**	**Up to 5% higher or up to 5% lower**

Comparisons with similar Trusts and Health Boards

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a coloured circle:





- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

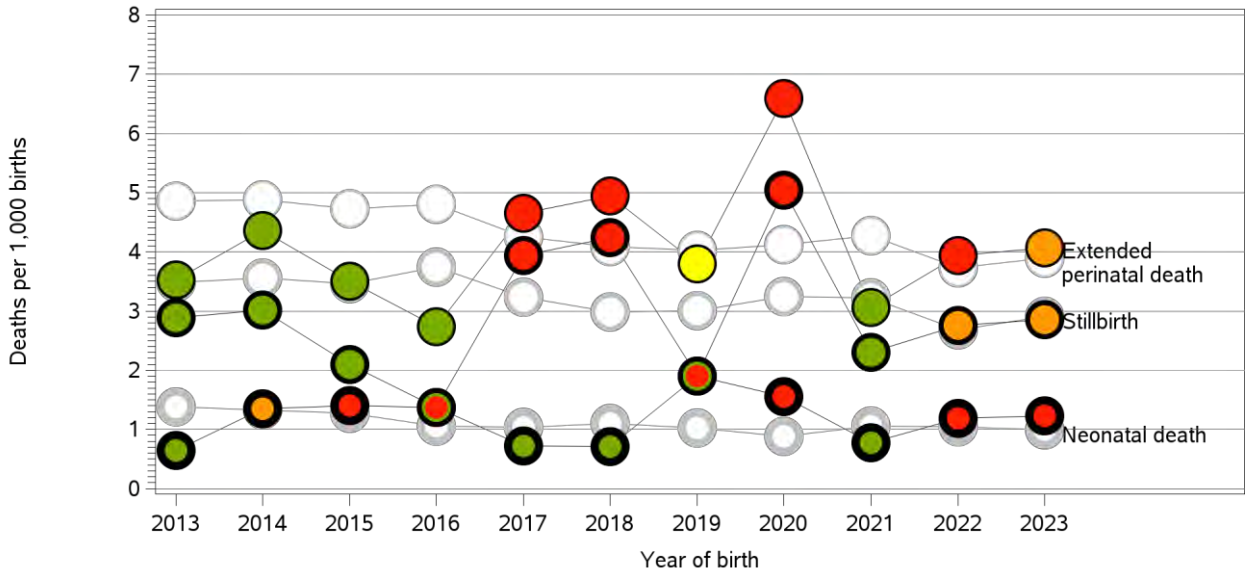
Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

2. Mortality rates over time

Crude mortality by year of birth (all deaths)

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

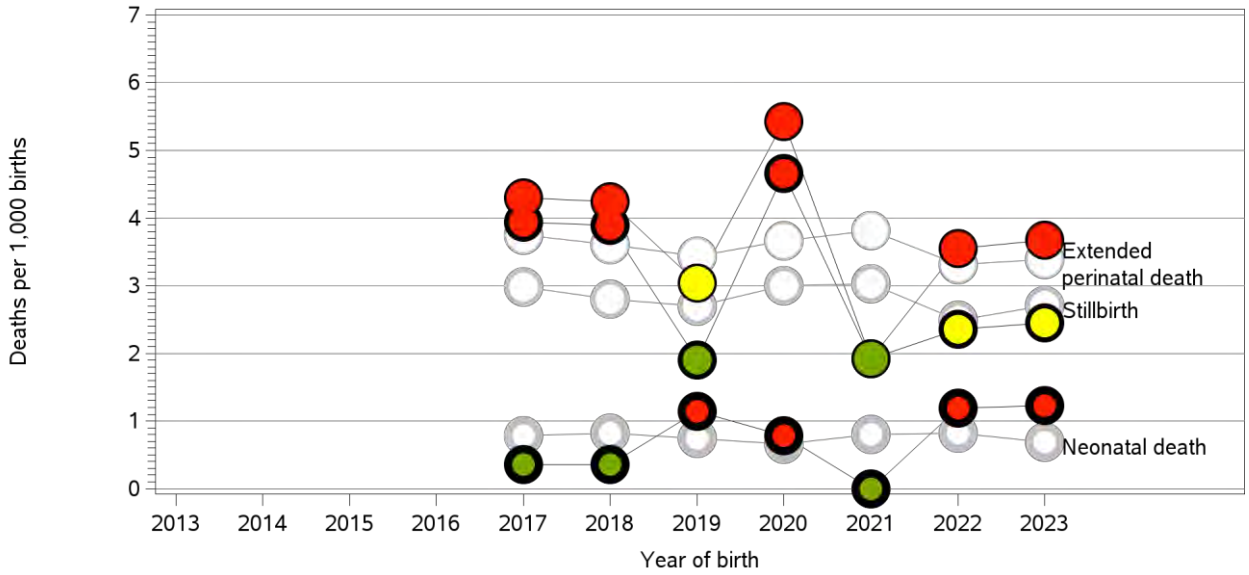
Due to updates to the data, these results might differ slightly from those in previous reports.



Crude mortality by year of birth (excluding deaths due to congenital anomalies)

Crude mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data, these results might differ slightly from those in previous reports.

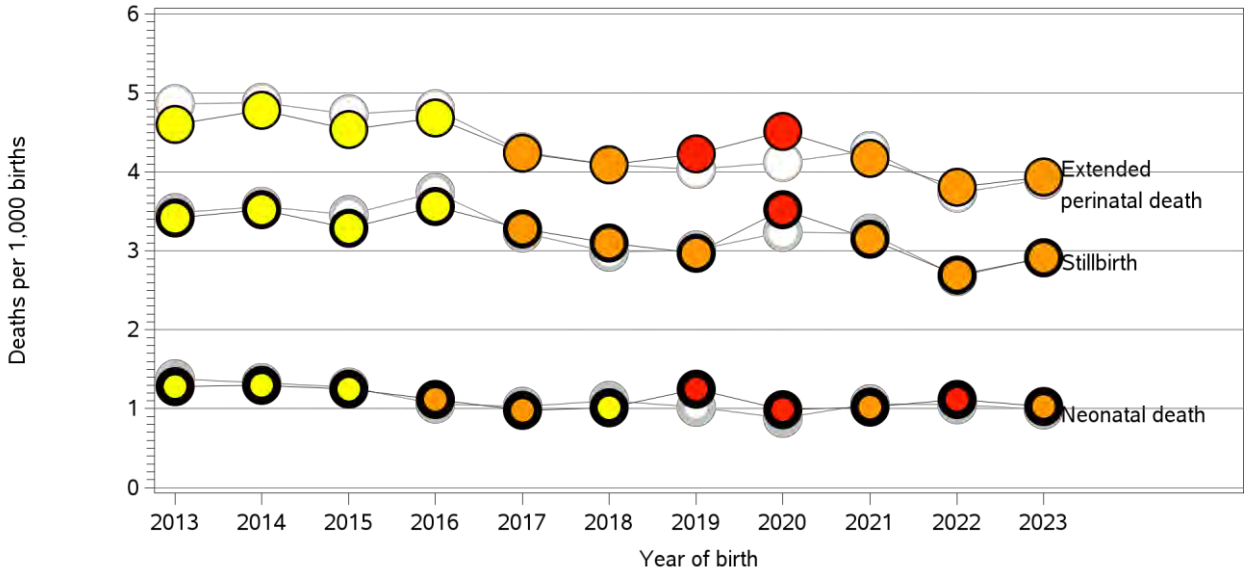


Mortality rates over time *continued*

Stabilised & adjusted mortality by year of birth (all deaths)

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

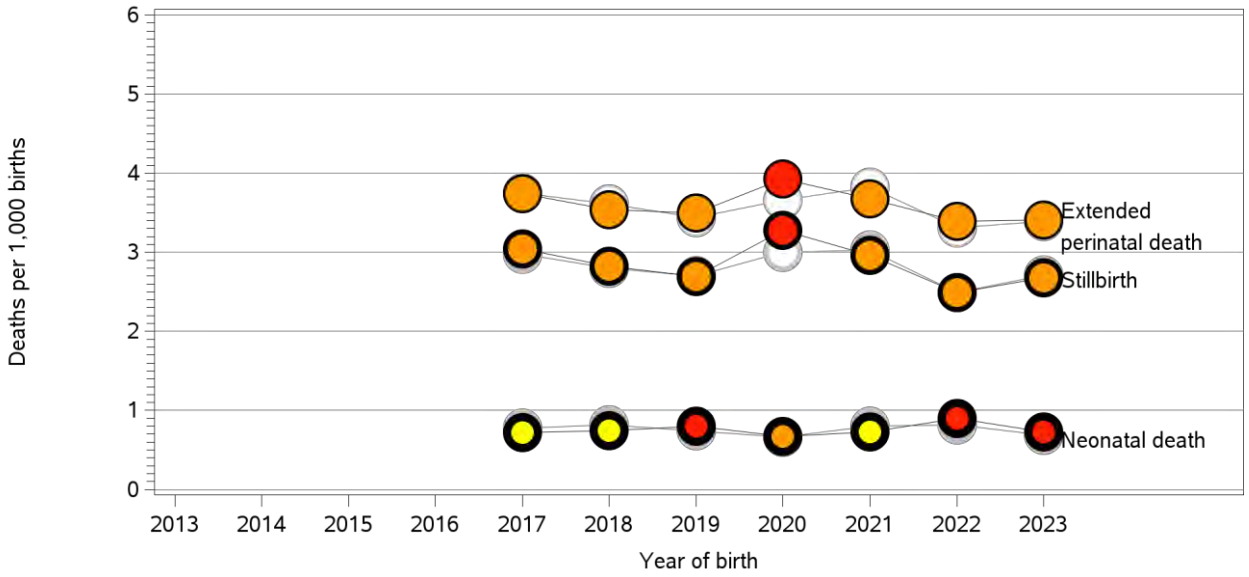
Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth (excluding deaths due to congenital anomalies)

Stabilised & adjusted mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

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



3. Your perinatal deaths

Deaths of babies born within your Trust

The crude mortality rates reported here are for babies born within your Trust, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 2 which provide more reliable estimates of the underlying (long-term) mortality rates for your Trust.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your Trust	*Rate (N)*	2.4	(6)	0.4	(1)	0.0	(0)	0.8	(2)	0.4	(1)	4.1	(10)
UK-wide	*Rate*	2.8		0.3		0.1		1.0		0.6		4.8	

The rates of extended perinatal death for your Trust, by gestational age at delivery, are shown below. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Your Trust	*Rate (N)*	250.0	(1)	208.3	(5)	18.3	(3)	0.4	(1)	0.0	(0)
UK-wide	*Rate*	323.3		98.4		17.4		1.6		2.1	

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of live born babies who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Within your Trust	*% (N)*		(0)	0%	(0)	0%	(0)	100%	(1)		(0)
Outside your Trust	*% (N)*		(0)	100%	(1)	100%	(1)	0%	(0)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere.

For births within your Trust, a post-mortem was offered for 100% of stillbirths and 100% of neonatal deaths, compared with 97% and 91% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your Trust	*% (n/N)*	100%	(7/7)	100%	(1/1)
Outside your Trust	*% (n/N)*	Not applicable		100%	(2/2)
UK-wide	*%*	97%		91%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You should ensure that the cause of death on the MBRRACE-UK data reporting system is updated once the post-mortem results are known.

Cause of death		Post-mortem			
		Offered		Consent obtained	
Unknown	*% (N)*				

Your perinatal deaths *continued*

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Trust and for neonatal deaths of babies who were born in your Trust. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.

			Infection		Neonatal		Intrapartum		Congenital anomaly		Fetal	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	14.3%	(1)	14.3%	(1)	14.3%	(1)
	UK-wide	%	2.8%		1.2%		1.3%		8.4%		5.0%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	66.7%	(2)	0.0%	(0)	0.0%	(0)	33.3%	(1)
	UK-wide	%	8.2%		40.1%		1.2%		35.0%		3.5%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	42.9%	(3)	14.3%	(1)	0.0%	(0)	0.0%	(0)
	UK-wide	%	5.6%		35.3%		3.4%		34.3%		2.9%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	0.0%		2.1%		0.8%		7.3%		1.9%	

Babies born at 22 to 23 weeks gestational age

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is essential that your Trust ensures that there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Trust for babies born in 2023 was 4. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

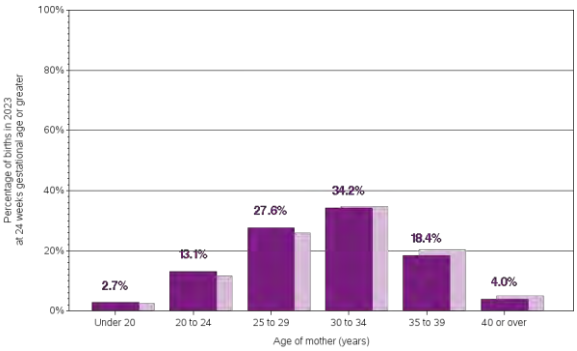
		Deaths of babies born at 22 to 23 weeks gestational age	
		Late fetal losses	Neonatal deaths
Your Trust	*N*	4	1

4. Your births

Age of mother

The proportion of mothers aged 35 years old or older was lower than that of the UK as a whole: 22.4% versus 25.4%.

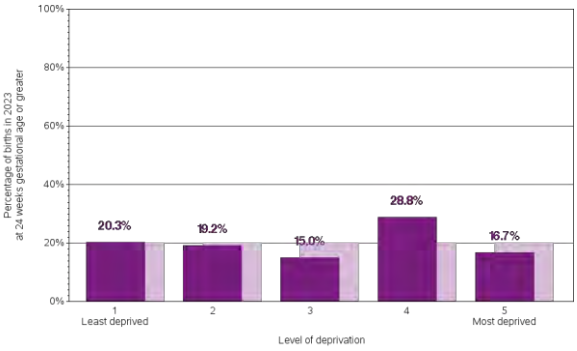
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

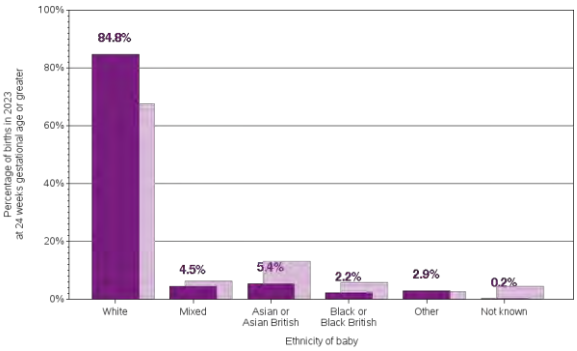
The mothers giving birth in your Trust lived in areas of similar deprivation to those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 15.1% versus 28.0%.

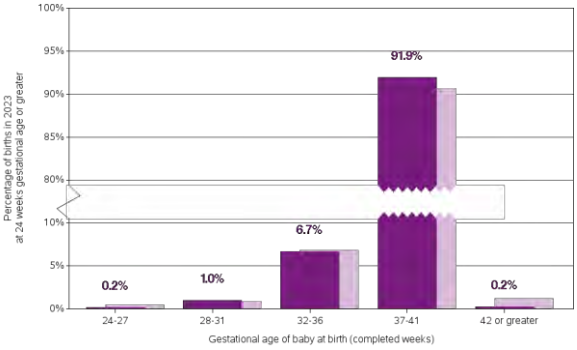
Across the UK the babies were of the following ethnicities: 67.5% White; 6.2% Mixed; 13.2% Asian or Asian British; 5.8% Black or Black British; 2.8% other; 4.4% not known.



Gestational age

In your Trust, 4 babies (0.2%) were born at 24 to 27 weeks gestational age, lower than the 0.4% seen in the UK as a whole. However, the percentage of babies born at 28 to 31 weeks was similar to the national average: 1.0% versus 0.8%.

In addition, 6 babies (0.2%) were born post-term (42 weeks or greater), a lower percentage than the UK average of 1.2%.

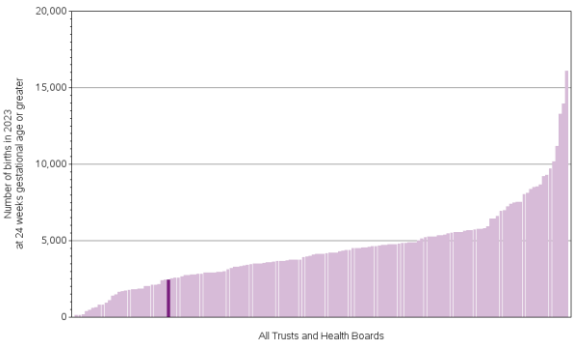


Your births *continued*

Number of births

There were 2,454 births in your Trust at 24 weeks gestational age or later, excluding terminations of pregnancy.

The purple line in the graph opposite shows that the number of births in your Trust puts you in the lowest third of all Trusts and Health Boards in the UK.



Percentage of births taking place in your Trust by commissioning organisation

The table below provides the percentage and number of births in your Trust at 24 weeks gestational age or later from each of the commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Trust. These organisations are Sub-Integrated Care Boards (Sub-ICBs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

In total, the births from these organisations accounted for 96.4% of your births at 24 weeks gestational age or later in 2023.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. NHS Cheshire and Merseyside ICB - 02E	90.4% (1635)	2. NHS Cheshire and Merseyside ICB - 01F	26.3% (306)
3. NHS Cheshire and Merseyside ICB - 01X	9.0% (159)	4. NHS Greater Manchester ICB - 02H	5.2% (170)
5. NHS Greater Manchester ICB - 01G	2.9% (96)		

5. Data reporting

Completeness of key data items for DEATHS AT YOUR TRUST

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2023, we received 100% of information on key data items for the deaths which occurred within your Trust.

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Trust, these tables show the overall completeness of data for **deaths at your Trust no matter where they were born**. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- less than 70.0% complete
- 70.0% to 84.9% complete
- 85.0% to 96.9% complete
- 97.0% to 99.9% complete
- 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Trust. We are pleased to report that 100% of the data items were completed for deaths reported by your Trust. Thank you for help and support.

Mother's details	Completeness	
Name	100.0%	♦
UK-wide	100.0%	
Postcode of residence	100.0%	♦
UK-wide	100.0%	
Ethnicity	100.0%	♦
UK-wide	97.0%	
Age	100.0%	♦
UK-wide	100.0%	

Birth	Completeness	
Type of onset of labour	100.0%	♦
UK-wide	98.8%	
Actual place of birth	100.0%	♦
UK-wide	99.5%	
Date and time of birth	100.0%	♦
UK-wide	99.4%	
Final mode of birth	100.0%	♦
UK-wide	99.4%	

Booking and antenatal care [note 1]	Completeness	
Smoking	100.0%	♦
UK-wide	97.6%	
Body mass index	100.0%	♦
UK-wide	100.0%	
Intended type of care at booking	100.0%	♦
UK-wide	95.5%	
Estimated date of delivery	100.0%	♦
UK-wide	100.0%	

Baby's outcome	Completeness	
Date death confirmed [note 2]	100.0%	♦
UK-wide	100.0%	
Whether alive at onset of care [note 2]	100.0%	♦
UK-wide	95.4%	
Whether admitted to NNU [note 3]	100.0%	♦
UK-wide	99.6%	
Main cause of death	100.0%	♦
UK-wide	97.4%	

Baby's characteristics	Completeness	
Birth weight	100.0%	♦
UK-wide	98.9%	
Gestational age at birth	100.0%	♦
UK-wide	99.2%	

Note 1: Excluding mothers reported as never booked.
Note 2: This data item is collected for stillbirths only.
Note 3: This data item is collected for neonatal deaths only.

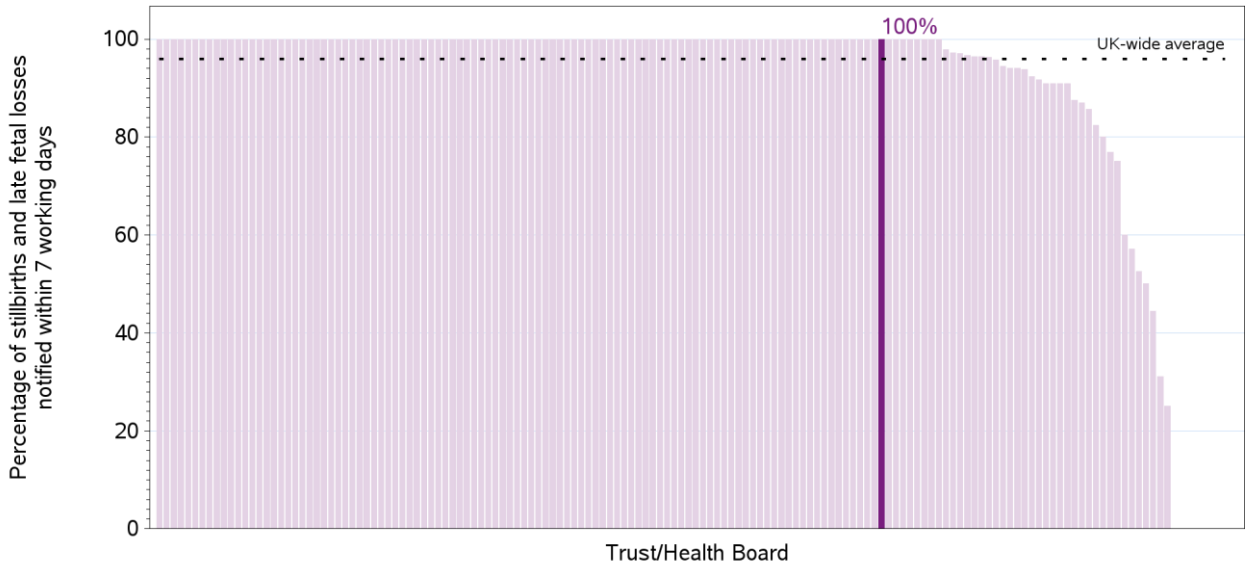
Percentage of deaths notified by your Trust within 7 working days

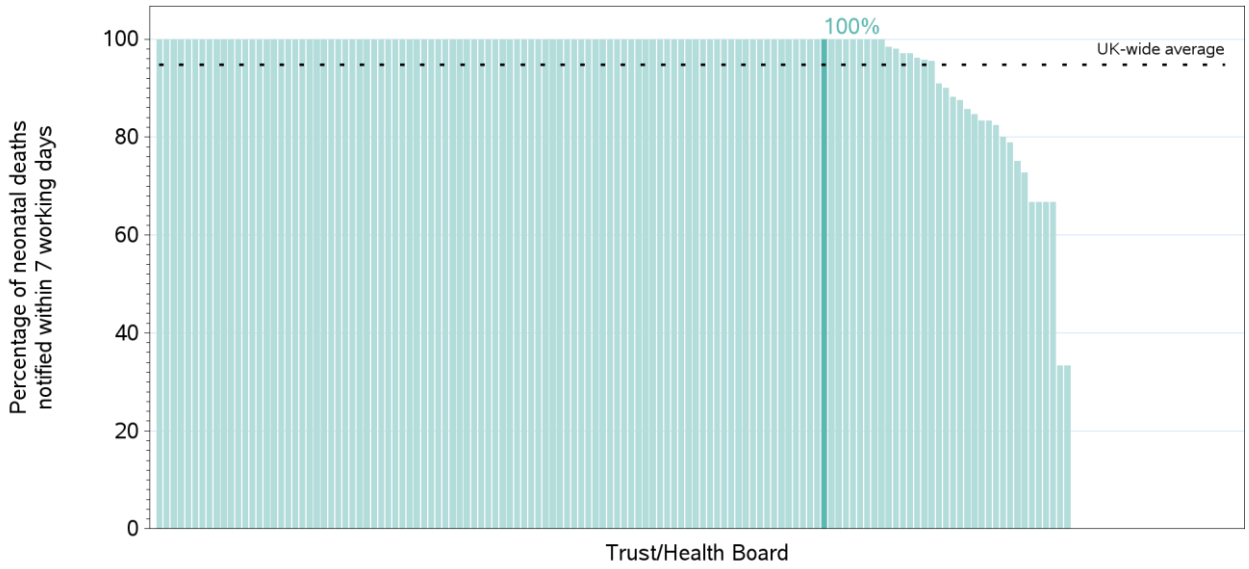
The MBRRACE-UK timeliness benchmarks for the notification of deaths and completion of surveillance data are:

1) All deaths should be **notified** to MBRRACE-UK within 7 working days of the death occurring. The full surveillance data does not have to be complete at this point.

2) Trusts and Health Boards should aim to **complete** surveillance data entry for each death within 90 days of the death occurring. The final cause of death can be updated at a later date, if necessary.

The graphs below show the percentage of stillbirths & late fetal losses and neonatal deaths notified by your Trust within the 7 working days benchmark period.





About this report

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford, with members from the University of Leicester (who lead the perinatal aspects of the work), University of Birmingham, Chelsea and Westminster Hospital NHS Foundation Trust, The Newcastle upon Tyne Hospitals NHS Foundation Trust, National Maternity Voices and Sands.

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England, the Welsh Government and, with some individual projects, other devolved administrations and Crown Dependencies.

Data sources

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics, Personal Demographics Service, National Records of Scotland, Public Health Scotland, Northern Ireland Maternal and Child Health, States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2024.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other locally or nationally reported rates, as births before 24 weeks gestational age have been excluded from most tables due to differences in reporting by Trusts and Health Boards. Further details on the methods we have used are included in the Technical Manual.

Deaths included in this report

The MBRRACE-UK real-time data monitoring tool (RTDM) can be used to identify the deaths included in this report by selecting "Born within your trust/HB" as the trust/health board of birth. The RTDM uses live surveillance data on perinatal deaths where the baby was born at, or died at your Health Board, and is available to anyone registered to use the MBRRACE-UK reporting system.

Data viewer

The MBRRACE-UK Data Viewer can be used to view data on a map and compare perinatal mortality rates for the organisations responsible for the commissioning and provision of care.

MBRRACE-UK, Department of Population Health Sciences, University of Leicester, George Davies Centre, Leicester, LE1 7RH.

Tel: +44 (0)116 252 5425 **Email:** mbrracele@npeu.ox.ac.uk **Web:** http://www.npeu.ox.ac.uk/mbrrace-uk

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/10 appendix 2a**			
SUBJECT:	**Maternity Incentive Scheme Year 6 Update – February 2025**			
DATE OF MEETING:	2 April 2025			
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: 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.			
	2. Advance equality of opportunity between people who share a relevant 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.			
	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. Regular meetings are held with the LMNS to review in detail progress against Saving Babies Lives Care Bundle v.3 (SBLCBv3). The latest review of SBLCBv3 took place on 4 December 2024. Following that review, the LMNS confirmed 100% compliance overall for the 6 elements. The reporting period for MIS Year 6 is to 30th November 2024. An assurance process in relation to Safety Actions 3, 4, 5, 6, 7, 8 and 9 has been undertaken by the Cheshire & Mersey Local Maternity and Neonatal System (LMNS) who have deemed WHH as compliant against these actions. Other safety actions (1, 2 and 10) are externally validated but internal review would suggest WHH will also be deemed as meeting these standards. The internal WHH assurance processes were completed during week 3rd February 2025. The formal signed Board Declaration Form will now be submitted to the Cheshire & Mersey ICB Chief Executive for countersigning. On receipt of this, the finalised Board Declaration Form must be submitted to NHSR by 12 noon on 3rd March 2025.		
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/25/02/243ii**	
	Date of meeting	11 February 2025	
	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 – February 2025	AGENDA REF:	BM/25/04/10 appendix 2a

1. BACKGROUND/CONTEXT

NHS Resolution (NHSR) 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 2nd April 2024. Trusts are required to complete their Board declaration form and submit to NHSR by 12 noon on 3rd 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.

The reporting period for MIS Year 6 is to 30th November 2024. The LMNS has a key role in reviewing provider evidence and obtaining assurance against the MIS Year 6 requirements. This process was completed by the LMNS in late November/early December 2024 when evidence uploaded to the NHS Futures portal to demonstrate compliance with Safety Actions 3, 4, 5, 6, 7, 8 and 9 was reviewed. Findings of the review team were shared with the LMNS Assurance Board on 27th January 2025 (the LMNS presentation is included in appendix one for information). Feedback in relation to individual Trust compliance was provided to Trusts on 30th January 2025. This is included in appendix one for information.

WHH Compliance level agreed by LMNS Assurance Board is as follows:

- Safety Action 3 - Transitional Care - compliant
- Safety Action 4 - Clinical workforce - compliant
- Safety Action 5 - Midwifery staffing - compliant
- Safety Action 6 - SBLv3 - compliant
- Safety Action 7 - Listening to women, parents and families - compliant
- Safety Action 8 - Multi professional training – compliant
- Safety Action 9 - Board Oversight and Assurance – compliant

Safety Actions 1, 2 and 10 are externally validated via a cross reference of data between by MBRRACE-UK, the National Neonatal Research Database (NNRD) and NHS Resolution. This process is underway. The current WHH position is as follows:

- Safety Action 1 - Use of the National Perinatal Mortality Review Tool – email assurance received from MBRRACE-UK national team 31st January 2025 - WHH meet the standard
- Safety Action 2 - Submitting data to the Maternity Services Data Set - no external review process prior to February 2025 however “Clinical Negligence Scheme for Trusts: Scorecard” evidences achievement of 12/12 Quality Improvement Metrics
- Safety Action 10 - Reporting of all qualifying cases to HSIB/MNSI and NHS Resolution Early Notification Scheme – no external review process prior to February 2025

In line with the year 6 guidance, a presentation was made to the WHH Chief Executive, Chief Operating Officer and Chief Nurse on 4th February 2025 to share evidence of how the service is meeting the requirements of MIS year 6. A further presentation was made to Trust Board on 5th February 2025 to provide assurance to Board. This allowed Trust Board to confirm they are satisfied the evidence provided meets the required safety actions’ sub-requirements as set out in the safety actions and technical guidance and facilitates the signing of the Board declaration form.

3. NEXT STEPS

Following discussion at Trust Board on 5th February 2025, the Board declaration form will be signed and submitted to the C&M ICB Chief Executive to be countersigned no later than 17th February 2025.

Once countersigned by the C&M ICB Chief Executive, the form will be returned to WHH. The form will then be submitted to NHSR no later than 3rd March 2025.

4. 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 February 2025.

5. RECOMMENDATIONS

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

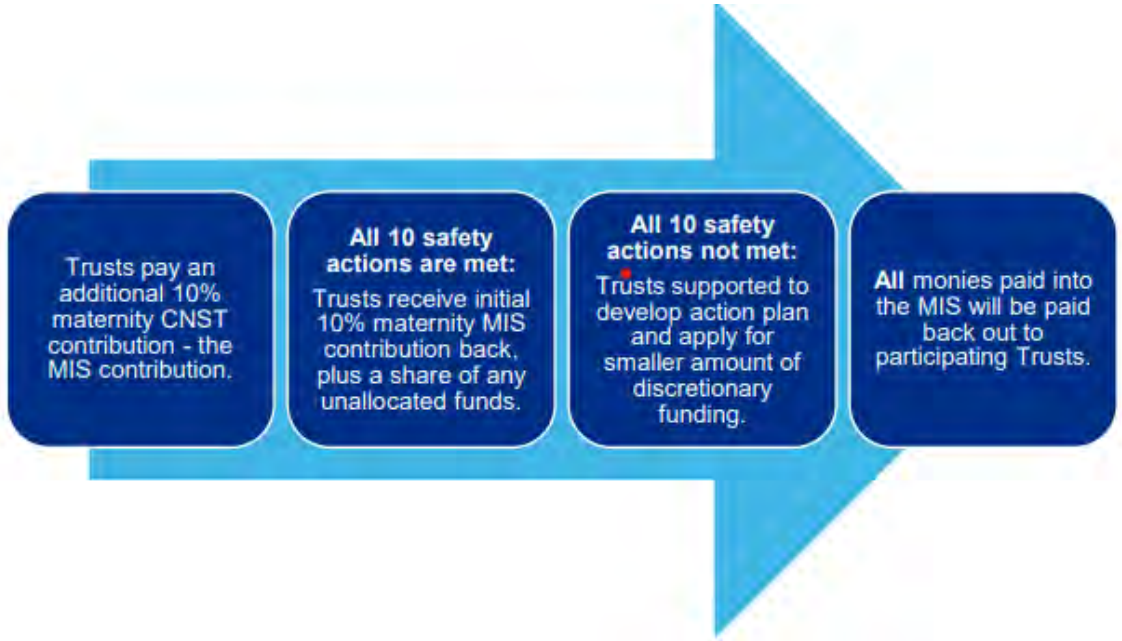
Women's Health and Maternity (WHaM) Programme

Maternity Incentive Scheme Year 6 (MIS yr 6) Progress Update

15th January 2025

MIS Yr 6 Background

- 6th year of operation 24/25 there is likely to be a 7th year in 25/26 (details expected April 2025)
- Supports 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***.'
- MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:



LMNS Oversight and Assurance Processes

It is important to note that **MIS yr 6 remains a self-verifying process for Providers and Trust Boards**. The LMNS are required to assure that the quality of the evidence from Providers meets the MIS year 6 standards. Please note that Safety Actions 1, 2 and 10 are externally validated.

The LMNS put the following support processes in place :-

- ✓ Quarterly meetings with all Providers for SBLv3 to review evidence and give feedback. MIS has been discussed at these meetings since June 2024.
- ✓ Process for LMNS assurance agreed at LMNS Assurance Board ending on **21st February 2025**, to give sufficient time prior to 3rd March 2025 for the ICB Accountable Officer to give their assurance and return to Providers to submit.
- ✓ Reminder email outlining submission requirements to the LMNS Portal on NHS Futures Website sent to Providers 1st November 2024 with closing date of 8th November 2024 (Note this is prior to closing date for reporting period of scheme which is 30th November 2024. Some Providers were still compiling evidence.
- ✓ Evidence review started by the LMNS team w/c **4th November 2024** where information was already available and continued through to date with on-going support and advice being given to Providers to meet requirements (2 clinicians per safety action to ensure transparency).
- ✓ Safety Action 3 and 7 – this is being undertaken in conjunction with the Neonatal Operational Delivery Network and evidence reviewed with the NODN Team. The NODN reports to Quality Safety and Surveillance Group include updates and oversight on reducing term admissions to neonatal units.
- ✓ East Cheshire has been part of the Greater Manchester and East Cheshire LMNS (GMEC) assurance process throughout MIS yr 6 time period and their evidence review has been undertaken by GMEC. C+M LMNS has been invited to the pre check point review and final review. This is a shadow oversight role as the CEO of C+M ICB needs to sign off East Cheshire's MIS Yr 6 submission. GMEC will confirm level of assurance of evidence to C+M LMNS after their review on 23rd January 2024 and before 12th February 2024.

MIS Year 6 compliance and submission timeline

Cheshire and Merseyside

Date	Actions
13 Sept 2024	LMNS Assurance Board- **MIS SA 7 MNVP updated Action Plans and confirmation of all requirements of SA 7 are complete**
15th Nov 2024	• **LMNS Assurance Board**-sign off SA 7 (if not submitted in time for September Assurance Board) • SBLv3 Q3 evidence submission deadline
W/C 4th Nov 2024	LMNS commence reviewing evidence for MIS yr 6
18th Nov-29th Nov 2024	LMNS reviewing SBLv3 Q3 and MIS year 6 (SA 3,4,5,6,7,8,9) evidence on NHS Futures platform
w/c 2nd Dec 2024	LMNS have scheduled 1:1 MIS/SBL Provider assurance meetings to feedback on SBL v3 evidence only
24th Dec 2024	• 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 & Trust Boards (COCH have requested a December date as no Board in Jan 25). • 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.
17th February 2025 to 3 March 2025 12 noon.	• The final MIS declaration must be completed in full in line with the published MIS guidance. It must be signed by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer. Once complete it must be sent to nhsr.mis@nhs.net between **17 February 2025 and 3 March 2025 by 12 noon**.
21st Feb 2025	Completed Trust submission form signed by Trust CEO to be sent to CEO of ICS for sign off.
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**

Safety Action 3: Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Relevant time-period - 2 April 2024 to 30 November 2024

Cheshire and Merseyside Health and Care Partnership

Required Standard

a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice

Or

Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.

b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.

Minimum Evidence Requirement for Trust Board

Evidence for standard a) to include:

For units with TC pathways

- Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04.

For units working towards TC pathways

- An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.

Evidence for standard b) to include:

1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.
2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.

Technical Guidance for Safety Action 3	
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and LMNS Boards before the submission deadline
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the safety champion minutes.
What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with safety champions and noted in the minutes at least once before the end of the reporting period.

Trust / Site	COCH	LWH	MCHT	MWL Whiston*	MWL Ormskirk*	WHH	WUTH
Safety Action 3 Transitional Care Compliance (TC) (This was reviewed with the NODN) Reporting period 2nd April to 30th November 2024	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

MWL are submitting as one Trust (2 sites) – Both are compliant but MWL Whiston does have a transitional care but it does not fully meet the required standard. However, there is an action plan in place which meets the requirements for MIS year 6.

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Reporting period 2 April 2024 to 30 November 2024

Cheshire and Merseyside Health and Care Partnership

Required Standard

a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

   a. currently work in their unit on the tier 2 or 3 rota
   <u>or</u>
   b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
   <u>or</u>
   c. hold a certificate of eligibility (CEL) to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.
   rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**
   rcog-guidance-on-compensatory-rest.pdf

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

<u>or</u>

the standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

<u>or</u>

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Reporting period 2 April 2024 to 30 November 2024

Cheshire and Merseyside Health and Care Partnership

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should audit their compliance via Medical Human Resources.

   Information on the CEL for short term locums is available here: www.rcog.org.uk/cel

   This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk)

   A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance.

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations.
   NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG

4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020).
For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Trust / Site	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
Safety Action 4:Can you demonstrate an effective system of clinical workforce planning to the required standard? Reporting period 2nd April to 30th November 2024	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? Reporting period 2nd April to 30th November 2024

Cheshire and Merseyside Health and Care Partnership

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

Minimum Evidence Requirement for Trust Board

The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement.

It should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.
- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.
- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
    - The midwife to birth ratio.
    - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

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

Cheshire and Merseyside Health and Care Partnership

Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard. If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.

What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Trust	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
Safety Action 5 Midwifery Staffing Reporting period 2nd April to 30th November 2024	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of Saving Babies' Lives Care Bundle Version Three? Reporting Period 2nd April to 30th November 2024

Cheshire and Merseyside rtnership

Required Standard

Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.

Minimum Evidence Requirement for Trust Board

Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following:

- Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
- Progress against locally agreed improvement aims.
- Evidence of sustained improvement where high levels of reliability have already been achieved.
- Regular review of local themes and trends with regard to potential harms in each of the six elements.
- Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.

The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.

Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net. Some data items are or will become available on the National Maternity Dashboard (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries, please email nhsr.mis@nhs.net
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.

Trust	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
Safety Action 6 Implementing Saving Babies Lives v3 Care Bundle	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Next steps:

- SBLv3 ongoing review cycles have continued in 24/25 and are scheduled into Q4 of 24/25 to support Providers to achieve 100% implementation
- Quarterly Improvement meetings held in 2024 with all Providers, all Providers attended
- Audit compliance confirmation on-going within LMNS
- Work closely with NODN – SBLv3 dashboard is being developed by NODN

Current C&M Overall Position (December 2024)

Trust	COCH	LWH	MCHT	ORMSKIRK	WHISTON	WHH	WUTH
Element 1 Smoking in pregnancy	70%	90%	80%	100%	80%	100%	80%
Element 2 Fetal Growth Restriction	85%	95%	90%	100%	90%	100%	95%
Element 3 Reduced Fetal Movement	100%	100%	100%	100%	100%	100%	100%
Element 4 Fetal Monitoring	100%	60%	80%	80%	100%	100%	80%
Element 5 Preterm Birth	89%	100%	100%	81%	81%	100%	85%
Element 6 Diabetes	100%	83%	100%	100%	100%	100%	100%
Overall *(RAG indicates change in position since September 2024)*	87% ↓	93% ↑	93% ↑	91% ↓	87% ↓	100% ↑	89% ↓

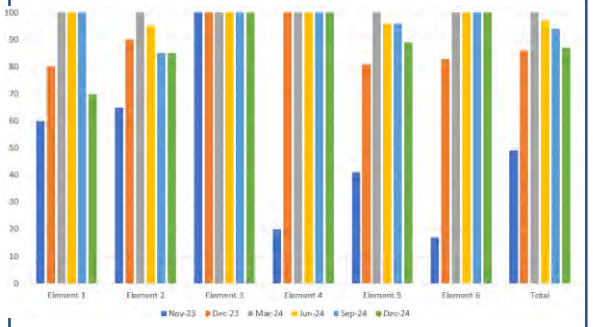
MIS Year 6 requirement: The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all **best endeavours – and sufficient progress** – have been made towards full implementation, in line with the locally agreed improvement trajectory. LMNS Senior Leadership team have confirmed all providers in C+M are compliant.

Benchmarking: Improvement Graphs December 2024

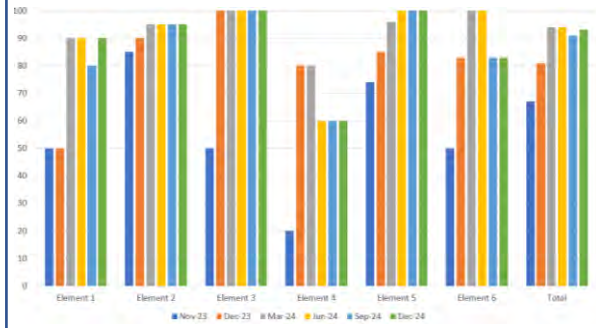
% of Interventions Fully Implemented (Normal variation expected)

NHS Cheshire and Merseyside

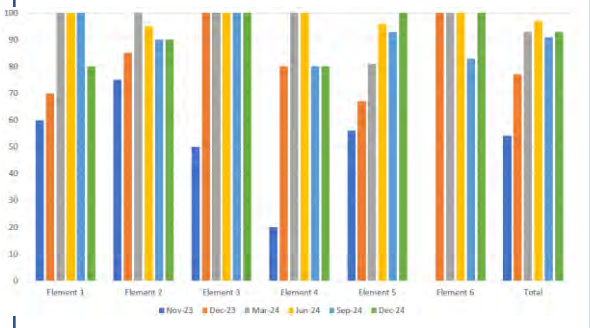
COCH



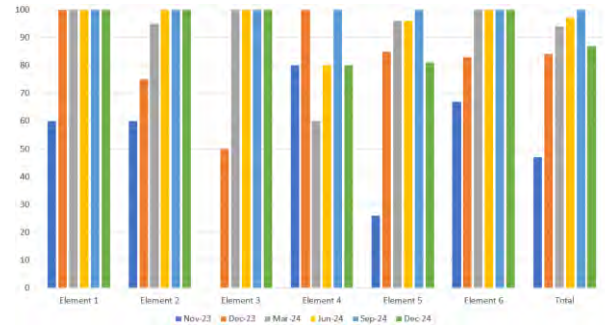
LWH



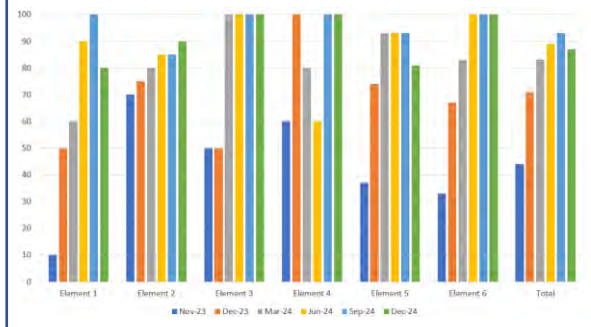
MCHT



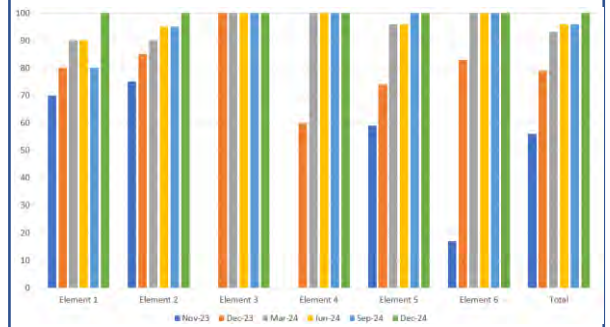
MWL Ormskirk



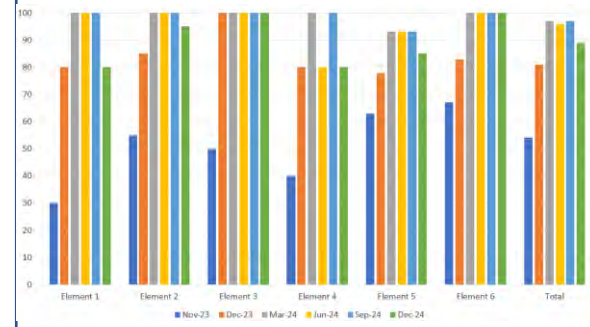
MWL Whiston



WHH



WUTH



Improving me
Women's health and maternity experiences

NB: The green bar indicates compliance in December 2024

Safety Action 7: Listen to women, parents and families using maternity and neonatal services, and coproduce services with users. Reporting period from 2 April 2024 to 30 November 2024

Cheshire and Merseyside Health and Care Partnership

Required Standard

1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

   a) Engagement and listening to families.

   b) Strategic influence and decision-making.

   c) Infrastructure.

2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such **as:**

- Safety champion meetings
- Maternity business and governance
- Neonatal business and governance
- PMRT review meeting
- Patient safety meeting
- Guideline committee

c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs
- If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.

Trust	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
Safety Action 7 Listen to women, parents and families using maternity and neonatal services, and coproduce services with users. **Reporting period from 2 April 2024 to 30 November 2024**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

LMNS have evidence that ICB Finance team have sent relevant monies to Providers via PLACE to support compliance with SA 7. This is reflected in the minutes of LMNS Assurance Board November 2024.

Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data where available, and progress monitored by Safety Champions and LMNS Board.

- Evidence has been submitted to the LMNS demonstrating regular monitoring by QUAD and maternity safety Champion.
- MNVP Action Plans submitted (and reviewed by LMNS team) to the LMNS Assurance Board July as evidence for MIS Yr 6.
- Confirmation of MNVP renumeration (plus additional birth trauma additional monies) from ICB finance team to LMNS Assurance Board November 2024.
- Chair of MNVP Provider leads has a standing agenda item to update the LMNS Assurance Board on progress of Provider action plans, including any barriers the LMNS will need to support the MNVP to overcome and ensure voices of all service users are heard.

Safety Action 8:Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Reporting period 1st December 2023 to 30th November 2024.

Cheshire and Merseyside
Health and Care Partnership

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 1 December 2023 to 30 November 2024

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal Life Support Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor). • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees

Safety Action 8:Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? Reporting period 1st December 2023 to 30th November 2024.

Cheshire and Merseyside Health and Care Partnership

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal Life Support Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor). • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees

Trust	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
Safety Action 8:Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? Reporting period 1st December 23 to 30th November 2024	Compliant	Compliant	Compliant–	Compliant	Compliant	Compliant	Compliant

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?

Cheshire and Merseyside
Health and Care Partnership

Required Standard

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

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? Reporting period 2nd April to 30th November 2024

Cheshire and Merseyside
Health and Care Partnership

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.

- Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Trust	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
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? Reporting period 2nd April to 30th November 2024	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Technical guidance 'If the Board or appropriate sub-committee do not meet monthly, it is the expectation that maternity and neonatal quality and safety will be discussed every time the Board or sub-committee meet.' page 51

MIS Yr. 6 Overall Compliance as of 15th January 2025

Trust	COCH	LWH	MCHT	MWL Whiston	MWL Ormskirk	WHH	WUTH
Safety Action 1							
Safety Action 2							
Safety Action 3	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Safety Action 4	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Safety Action 5	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Safety Action 6	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Safety Action 7	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Safety Action 8	Confirmed	Compliant	Compliant	Compliant	Compliant	Compliant	Complaint
Safety Action 9	Compliant	Compliant	Compliant	Compliant	Complaint	Compliant	Compliant
Safety Action 10							

Next Steps

- Reflective session planned with LMNS team and there will be further feedback to Providers on lessons learnt and priorities going forward.
- The LMNS oversight and assurance will continue quarterly for MIS year 7 once it has been released (anticipated Q1 2025/26).

Improving me
Women's health and maternity experiences

Cheshire and Merseyside
Health and Care Partnership

Thank you for listening

www.improvingme.org.uk
info@improvingme.org.uk
twitter.com/Improvingme1
www.facebook.com/Improvingme1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/10 appendix 2c**			
SUBJECT:	**Maternity Incentive Scheme Year 6 Update – March 2025**			
DATE OF MEETING:	2 April 2025			
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: 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.			
	2. Advance equality of opportunity between people who share a relevant 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.			
	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. Regular meetings are held with the LMNS to review in detail progress against Saving Babies Lives Care Bundle v.3 (SBLCBv3). The next review of SBLCBv3 will take place in March 2025. The reporting period for MIS Year 6 is to 30th November 2024. The external assurance process in relation to Safety Actions 3, 4, 5, 6, 7, 8 and 9 has been undertaken by the Cheshire & Mersey Local Maternity and Neonatal System (LMNS) who have deemed WHH as compliant against these actions. Other safety actions (1, 2 and 10) are externally validated The internal WHH assurance processes were completed during week 3rd February 2025. The formal signed Board Declaration Form has been signed and finalised. The formal Board Declaration Form was submitted to NHSR on 27th February 2025 prior to the deadline of 12 noon on 3rd March 2025. MIS year 7 will launch on 2 April 2025.

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this paper.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/03/267ii**	
	Date of meeting	11 March 2025	
	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 – March 2025	AGENDA REF:	BM/25/04/10 appendix 2c

1. BACKGROUND/CONTEXT

NHS Resolution (NHSR) has 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 in Spring 2024. Specifications and timelines were released on 2nd April 2024. Trusts were required to complete their Board declaration form and submit to NHSR by 12 noon on 3rd 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

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.

The reporting period for MIS Year 6 is to 30th November 2024. The LMNS reviewed evidence uploaded to the NHS Futures portal to demonstrate compliance with Safety Actions 3, 4, 5, 6, 7, 8 and 9 and deemed the service compliant with the recommendations.

Safety Actions 1, 2 and 10 are externally validated via a cross reference of data between by MBRRACE-UK, the National Neonatal Research Database (NNRD) and NHS Resolution. This process is underway.

A presentation was made to Trust Board on 5th February 2025 to provide assurance against the recommendations within MIS year 6. This allowed Trust Board to confirm they were satisfied the evidence provided met the required safety actions' sub-requirements as set out in the safety actions and technical guidance and facilitated the signing of the Board Declaration Form.

Following discussion and approval at Trust Board on 5th February 2025, the Board Declaration Form was signed by the WHH Chief Executive and C&M ICB Chief Executive. Subsequently the finalised Board Declaration Form was submitted to NHSR on 27th February 2025 prior to the deadline of 12 noon on 3rd March 2025.

Regular meetings are held with the LMNS to review in detail progress against Saving Babies Lives Care Bundle v.3 (SBLCBv3). The next review of SBLCBv3 will take place in March 2025. Feedback from this review will be shared to April QAC.

3. NEXT STEPS

Submission of the finalised Board Declaration Form marks the end of the process for MIS Year 6.

MIS year 7 will launch on 2 April 2025 with a national launch event planned for 28th April 2025.

4. MONITORING/REPORTING ROUTES

Progress with 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 March 2025.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/10 – Appendix 3**	
SUBJECT:	**2024-2025 Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**	
DATE OF MEETING:	2 April 2024	
AUTHOR(S):	Ails Gaskill-Jones, Annabel Grossmith, Emma Bentham	
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: 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.

2. Advance equality of opportunity between people who share a relevant 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.

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):***	• Q3 2024/25 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 6.17%, this is beyond the national target (6%) and the NWNODN target (5.6%), however is an improvement of 0.44% on the last quarter. • All admissions including those <6 hours have been included as this is the national and regional expectation. • All term admissions in Q3 were reviewed and learning from these cases informs the ATAIN action plan. • Significant improvement has been seen in Q3 2024/25 in the proportion of admissions assessed as avoidable had care been optimal. • An ATAIN action plan is in place to improve the service position against ATAIN standards. • The ATAIN action plan is monitored at the monthly Women's & Children's (WCH) Governance Meeting. • 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 content of this paper.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.	**QAC/25/03/267i**	
	Date of meeting	11 March 2025	
	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 3 Avoiding Term Admission into Neonatal Unit (ATAIN)	AGENDA REF:	BM/25/04/10v

1. BACKGROUND/CONTEXT

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. Northwest 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 ATAIN standards.

2. KEY ELEMENTS

2.1 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 Q3 reporting period from 1 October 2024 to 31 December 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 of Directors 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.

2.2 Summary of unexpected term admissions to NNU

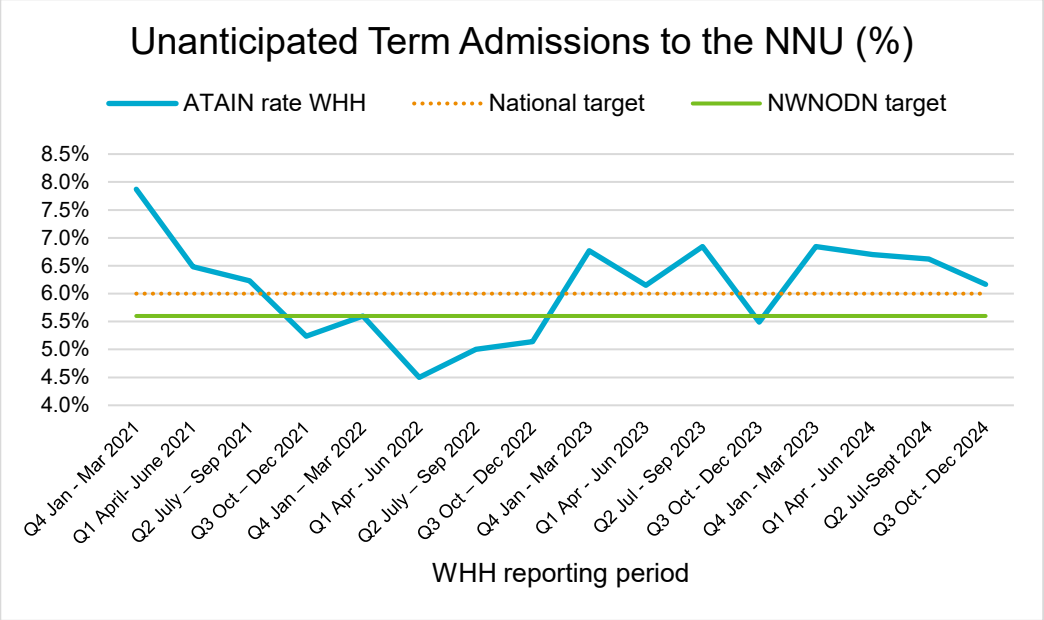
The Q3 ATAIN rate was 6.17% which is higher than the national and NWNODN targets but a decrease of 0.44% on the last quarter.

As per the previous report, other Trusts exclude Neonatal Unit admissions of less than six hours duration from ATAIN data. However, WHH continues to report on these cases and work is ongoing through the ODN to align other Trusts to also report all admissions.

Of the 37 term admissions, two did not require review as part of the ATAIN process as the baby was well and admitted for social reasons. It should be noted, if these admissions were not included, this would reduce the WHH ATAIN rate for Q3 to 5.8%.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	Total Number of term admissions as a % of live births (babies with <6 hrs admission)	National target 6%	NWNODN Target 5.6%
Q1 Apr – Jun 2024	612	42	6.86%	5.8%		
Q2 Jul – Sept 2024	680	45	6.62%	5.6%		
Q3 Oct – Dec 2024	600	37	6.17%	6.0%		

Below is a summary of unanticipated term admissions to Neonatal Unit from July 2022 – December 2024. From Q1 2024-25 this data will be reported via an SPC chart to better understand the position and progress.



As part of the ATAIN review, the team will consider whether an admission to NNU was avoidable if care had been optimal. Significant progress can be seen in this measure. From Q3 2023/24 to Q2 2024/25 the average avoidable was 34.5% of admissions. In Q3 2024/25 the proportion avoidable was 21.6%.

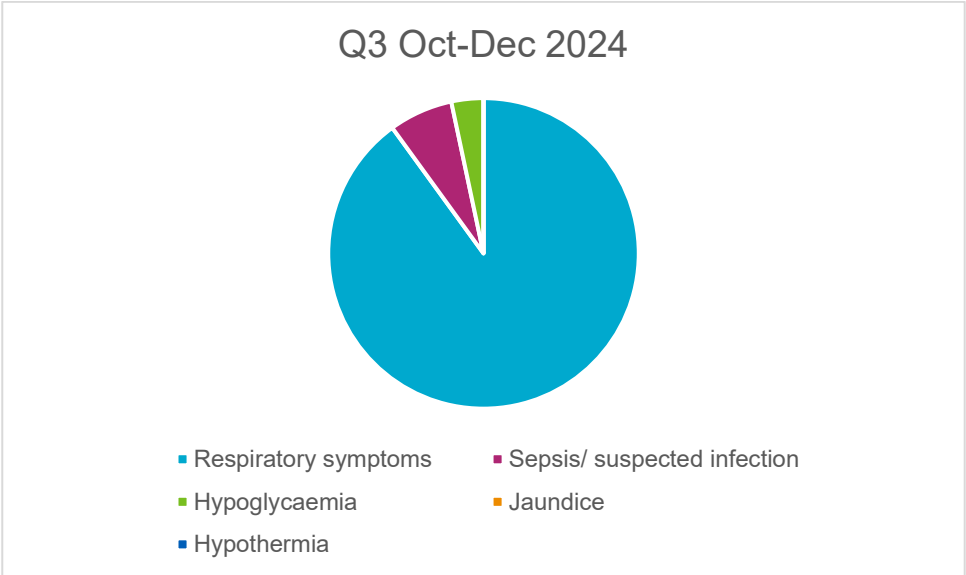
WHH Oct 2022 - Mar 2024	Number of Term Admissions	Outcome of ATAIN review		% avoidable
		Avoidable Admissions	Unavoidable Admissions	
Q3 Oct – Dec 2023	34	12	22	35.2%
Q4 Jan – Mar 2024	41	13	28	31.7%
Q1 Apr – Jun 2024	42	15	27	35.7%
Q2 Jul – Sept 2024	45	16	38	35.5%
Q3 Oct – Dec 2024	37	8	27	21.6%

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

73% (27) of term admissions were for management of a respiratory problem requiring observation. This may include signs of respiratory distress (including grunting) and low oxygen saturation (SATs or oxygen requirement). Only five of these cases were deemed avoidable even if care had been optimal.

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 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	2.4%	0	0%
Q2 Jul-Sept 2024	680	45	6.62%	26	58%	1	2.2%	2	4.4%	3	6.7%	2	4.4%
Q3 Oct-Dec 2024	600	37	6.17%	27	73%	2	5.4%	1	2.7%	0	0%	0	0%

The below table details primary reasons for term admissions to NNU at WHH:



2.4 Themes and Learning: Outcomes of ATAIN review

Reasons for categorising term admissions as avoidable included:

- PEEP for 30 minutes may have avoided admission
- Care could have been provided on Transitional Care
- Earlier delivery could have been facilitated
- Early term caesarean section should not have been facilitated

2.4.1 Good Practice:

- Examples of good communication and excellent documentation from the MDT team
- Timely step down of baby from NNU to Transitional Care
- Intubation prevented by use of less invasive surfactant administration

2.4.2 Learning Points/Themes/Actions:

- Simulation training to be implemented to support the team in the care of the deteriorating baby
- Use of life start trolley in caesarean sections where general anaesthetic is used to be considered. This will require training and simulations.
- Gestational Diabetes Mellitus (GDM) guideline to provide further guidance in relation to timing of birth (depending on different treatments) to support decision making and risk assessment as to whether reasonable to delay delivery.

Individualised learning and facilitated reflection have taken place as appropriate with the support of colleagues/supervisors.

2.4.3 Recommendations:

- Continuation of facilitating reflective discussions with staff as required from cases requiring individualised learning.
- Continue regular ATAIN Meetings ideally involving rotation of obstetric trainees to participate in the meetings.
- 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 and Trust Board.

4. RECOMMENDATIONS

Members of the Trust Board are requested to receive and discuss the findings of this paper for information and to share the report with the Trust Board as per Safety Action 3 of the Maternity Incentive Scheme.

ATAIN ACTION PLAN

ONGOING ATAIN ACTIONS						
	Action	**Owner**	**Next Review Date**	**Target Completion Date**	**Update**	**RAG**
1	NEWTT audit every month to ensure compliance with neonatal observations	Ward Managers	28/02/2025	Ongoing	25/09/2024 – Awaiting implementation of NEWTT2, prior to commencement of audit as this will provide clear parameters for staff.	
2	Development of Transitional Care offering to further reduce term admissions and separation of mothers and babies.	Clinical Director	28/02/2025	Ongoing	02/12/24 – TC working group ongoing	
3	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	28/02/2025	Ongoing	02/12/2024 – Review of maternity ward shift leader roles and responsibility underway to provide support to this 02/12/24 – Plans to facilitate MDT simulation training in different settings in dept re: deteriorating baby, and to ensure there is specific guidance regarding this (resuscitation will be different to initial resuscitation at birth)	
4	Introduction of Intelligent Intermittent Auscultation (IIA) across the NEST and homebirth service	Consultant Midwife, Maternity Matrons	15/1/2025	Ongoing	02/12/24 – Training is ongoing to ensure rolled out across all staff 24/01/25 – Training still being rolled out to all staff	
5	CTG workshop to be recommenced, to share weekly learning on the shop floor in relation to fetal surveillance.	Fetal Surveillance Consultant & Fetal Surveillance Midwife	15/1/2025	Completed	C-Shop posters now displayed – MDT CTG teaching workshops to restart Dec 2024 led by Specialist RM – Fetal surveillance and Obstetric Lead for Fetal Surveillance from Jan 2025. Regular workshops have recommenced. Action completed and closed.	

	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/25/04/10 Appendix 4**	
SUBJECT:	**Quarter 3 2024/25 Transitional Care (TC) Report**	
DATE OF MEETING:	2 April 2025	
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery, Erica Wiles – Neonatal Matron	
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: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.			
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. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.			

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="3">The paper provides an overview of babies who required Transitional Care (TC) in the period October - December 2024. An audit of babies who received TC within Q3. 2024/25 has been undertaken and results of this will be described within this paper along with any identified learning.

Following the CQC inspection of Maternity Services at WHH in September 2023, a full review of the current Transitional Care (TC) Model has taken place. A multidisciplinary (MDT) Working Group was created with representatives from both Maternity and Neonatal Services.

The Q3 Transitional Care audit has identified the following:
18 babies who met the broad admission criteria for TC in Q3.
One baby was admitted directly to TC from birth.
Five babies were suitable to receive TC from birth, however this was not facilitated due to staffing on the Neonatal Unit (NNU)
One term baby who initially stayed with their mother received TC for poor feeding.
The majority of babies who met the broad TC criteria in Q3 required some level of respiratory support and were initially provided with care via NNU.
The audit has identified learning, action to resolve have been added to the TC action plan.
The action plan is monitored via Women’s & Children’s Governance (WCH) and the Neonatal Oversight Meeting.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to note the content of this report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">QAC/25/03/267iv</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">11 March 2025</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Quarter 3 2024-25 Transitional Care (TC) Report	AGENDA REF:	BM/25/04/10 Appendix 4

1. BACKGROUND/CONTEXT

"Neonatal transitional care (NTC) is additional to normal care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals" (BAPM 2017).

Transitional Care (TC) is embedded in the Maternity Incentive Scheme, Year 6, Safety Action 3. Transitional Care is not always a physical location but a pathway involving more frequent observations and coordinated care between the Neonatal and Midwifery Team. TC is for babies who need a little more nursing care and monitoring and is provided by the team on the Neonatal Unit (NNU), Birth Suite and Postnatal Ward.

The aim of TC is to keep parents and babies together in a neonatal transitional care setting and to support the resident birthing parent as primary care provider for their babies more than normal newborn care. The pathway provides additional support for small and/or late preterm babies and their families to facilitate a smooth transition to discharge baby home and prevent neonatal admission.

Following the CQC inspection of Maternity Services at WHH in September 2023, a review of the current transitional care model has taken place, from this a working group was created and a robust action plan developed. Alongside this, an audit of babies who received TC within Q3 2024/25 has been undertaken and results of this will be described within this paper.

2. KEY ELEMENTS

2.1 WHH Transitional Care Position

The findings of this report have been collated from a review of all babies who met the criteria for TC during the Q3 reporting period from 1 October 2024 to 31 December 2024.

Each case has been reviewed utilising the BadgerNet and Lorenzo database system to ensure any learning is identified and shared in a timely manner.

W**HH Transitional Care Criteria**

- Gestational Age 34+0 to 35+6 weeks
- Birth Weight of >1.6kg to <2.0kg

Any baby requiring one or more of the following:

- Infants requiring intravenous antibiotics with risk factors.
- Additional support with feeding via nasogastric tube
- Haemolytic disease requiring phototherapy and assessment of serum bilirubin 4-6 hourly.
- Infants with Neonatal Abstinence Syndrome requiring medication on a weaning regime and on regular observations (4 hourly or more frequently)
- Babies requiring observations more frequently than four hourly.
- Management of hypoglycaemia to be controlled with a minimum of two hourly feeding

2.2 Summary of Babies who met the Transitional Care Criteria

During Q3, 18 babies met the criteria for TC. An audit of these cases has identified the following:

Admitted direct to TC	1
Appropriately received NNU care and stepped down to TC when well enough	2
Allocated to PEEP for 30 pathway	5
Term baby requiring feeding support	1
Term baby requiring double phototherapy	1
Did not received TC	8

Of the 18 babies who met the criteria in Q3, one baby was admitted to TC from birth and remained on TC for 4 days. Four babies were suitable to receive TC from birth however NNU were unable to staff TC due to high acuity and acute staff sickness. One baby was suitable to step down to TC at day two of life however their mother discharged home after 24 hours.

Two babies were potential for TC at time of birth, NNU could not staff TC and they should have been admitted to NNU however they both remained with their parents for a period. During this time one baby became cold and the other was fed a large volume causing possible aspiration leading to this baby requiring ventilation. A baby of 35+6 gestation did not receive TC care as was not identified as meeting the criteria however at 2 day of life was noted to be jaundiced and required admitting to NNU for treatment.

A cluster review of these patient safety events will be carried out to identify learning. An immediate safety alert has been sent to all maternity and neonatal teams reminding teams of criteria and highlighting if a TC is unable to be provided the baby must be admitted to NNU.

The other 10 babies who met the broad TC criteria in Q3 required some level of respiratory support and were initially provided with care via NNU. Of these:

- Three babies were appropriately stepped down to TC when clinically indicated.
- One term baby required double phototherapy, and IV fluids however could have received double phototherapy on TC had staffing allowed.
- One babies did not meet TC criteria once medically fit for discharge from NNU.
- Five followed the PEEP for 30 pathway. However, one of these babies did not receive TC. This pathway is part of a QI project the neonatal team are undertaking where babies, who at 30 minutes post birth are still requiring respiratory support, will go to NNU and be commenced on high flow with NO formal admission for the first hour. This is to

establish if they can be weaned quickly. If successful, the baby will then go back to mum with a TC plan to establish feeding alongside regular observations.

Reasons for admission to the NNU are highlighted in the table below, it is to be noted that significant improvements in relation to the timely step down of these babies to TC have been seen this quarter due to continuous education and collaboration between the midwifery and neonatal services.

	Reason baby admitted to NNU	Actions to reduce occurrence
1	Babies requiring respiratory support	• Repeat audit to be undertaken to review length of time baby required respiratory support
3	Staffing	• Review staffing

2.3 Good Practice:

- Utilising TC to support infants who require support with feeding, rather than admitting to NNU.
- Excellent Neonatal Care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Sharing of audit outcomes across the MDT with both Midwifery and Neonatal Teams to ensure learning is communicated.
- Significant improvements in relation to the timely step down of these babies to TC
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Unavailability of TC now added to terms of reference for Operational Review Group to ensure senior oversight and review

2.4 Recommendations:

- Time to be given to the Midwifery Lead for TC to complete the TC training programme.
- An immediate safety alert to all maternity and neonatal teams reminding teams of criteria and highlighting if a TC is unable to be provided the baby must be admitted to NNU (complete)
- Review of “Think TC” boards to ensure staff in all areas can identify babies who meet TC criteria.
- Education regarding importance of ensuring babies receive adequate thermoregulatory care.
- Focussed learning from TC review to be included on Neonatal Natter and OWL
- Staffing – Continue to ensure neonatal staff are allocated to TC babies.
- NNU Matron to review occasions where NHSP has been utilised to support TC staffing to support long term staffing plan.
- Following NHSP review, finance to provide costings for Band 4 Nursery Nurses to support long term staffing plan and inform a potential future revenue request.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

2.5 Outstanding actions from action plan

- Ongoing TC audit which will be reported through this committee.
- Review of IV policy required to enable midwifery staff to undertake IV antibiotics on babies, pharmacy input required.
- TC Bay on C23 to be established now induction of labour activity transferred to new space on Birth Suite.

3. MONITORING/REPORTING ROUTES

The services progress in relation to TC was presented to the Local Maternity and Neonatal System (LMNS) as part of the external assurance processes for Maternity Incentive Scheme, Year 6, Safety Action 3. The LMNS were satisfied with the service's project to continuously improve the transitional care offer. The presentation provided to the LMNS is included in appendix 1 for information.

The TC action plan is monitored at both the Women's and Children's Clinical Business Unit Governance Meeting and Neonatal Oversight meeting which take place monthly, prior to reporting to the Quality Assurance Committee. This report will be shared at both meetings.

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/10 appendix 5**	
SUBJECT:	**Quarter 3 2024-25 Perinatal Mortality Review/Audit**	
DATE OF MEETING:	2 April 2025	
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:

	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: 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 3 (Q3) PMRT report for the period covering 01/10/2024 – 31/12/2024. During Q3, no babies met the criteria for reporting to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): WHH stillbirth rate for Q3 2024/25 was 0.0 per 1000 births. The MBRRACE-UK national stillbirth rate for 2023 is 4.0/1000 births. WHH Neonatal mortality rate during Q3 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births. During Q3, WHH undertook one PMRT review panel of a stillbirth (a baby born at 32+2 weeks). Parental perspective of the care they received was sought in this case. The panel review of the stillbirth case graded care as A. There were no issues with care identified for the mother and baby up to the point that the baby was confirmed to have died. There were no issues identified with the care of the mother following confirmation of the death of her baby. 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/25/02/243i**	
	Date of meeting	**11 February 2025**	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Quarter 3 2024-25 Perinatal Mortality Review/Audit	AGENDA REF:	BM/25/04/10 appendix 5

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 3 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 3 2024/25 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.

There were no cases to report to MBRRACE-UK during Q3 reporting period.

2.1 Quarter 3. WHH Stillbirth Rate:

- WHH Q3 stillbirth rate for 2024/2025 is 0.0 per 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. Rolling year Q4 2023/24-Q3 2024/25 rate is 2.82 per 1000 births. The MBRRACE-UK national rate is 4.0 per 1000 births.

Table 1: WHH Stillbirth Data Over 12-month Period:

Metric	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	12-month total
Number of live births	591	615	676	600	2482
Total number of stillbirths >24 weeks	5	1	1	0	7
Total Stillbirth Rate >24 weeks (per 1000 births)	**8.50**	**1.60**	**1.50**	**0.0**	**2.82**
Number of intrapartum still birth rate	1	0	0	0	1
Number of stillbirths >37 weeks	2	1	0	0	3

2.2 Q2. WHH Neonatal Mortality Rate:

- WHH neonatal mortality rate during Q3 2024/2024 was 0.0 per 1000 live births.
- The MBRRACE-UK national rate is 2.7/1000 live births.

3. QUARTER 3 2024/25 PMRT REVIEW FINDINGS

3.1 Quarter 3 PMRT Review Panel Key Findings

Synopsis of Findings

One baby born at 32+2 weeks gestation was a stillbirth. The cause of death was confirmed as placental abruption and chorioamnionitis.

Surveillance Findings:

- Singleton pregnancy.
- Aged between 35-40 years.
- White ethnicity and spoke English as the first language.
- No communication problems because of learning difficulties/hearing problems.
- Smoker who declined smoking cessation support.
- Unbooked pregnancy.

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 Q3 one PMRT review panel took place. Parental perspective of the care they received were sought. In this case, care was graded A. In this case there were no issues with care identified for the mother and baby up to the point that the baby was confirmed to have died. In this case there were no issues identified with the care of the mother following confirmation of the death of her baby.

3.2.2 PMRT Grading of Care – Neonatal Death

During Q3 there were no PMRT review panels required

3.2.3 PMRT reporting for Saving Babies Lives Care Bundle v3- Q3 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 Q3 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 was one PMRT panel review in Q3 which was attended by multidisciplinary internal and external panel members.

Table 6: Q3 WHH PMRT Panel Attendance

Number of participants involved in PMRT reviews. Total number of reviews from 01/10/2024 – 31/12/2024 = 1			
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	1	0	1
Admin/Clerical	0	0	0
Bereavement Midwife	1	0	1
External Rep	1	0	1
Management Team	1	0	1
Midwife	1	0	1
Neonatal Nurse	0	0	0
Neonatologist/Paediatrician	0	0	1
Obstetrician	1	0	1
Other	0	0	0
Governance Manager	1	0	1
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

- Parental involvement was sought in all cases as part of PMRT panel review.

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 no actions recorded from the Q3 2024/25 PMRT review panel.

4. SUMMARY

WHH Q3 PMRT audit recorded no babies reported to MBRRACE born between 01/010/2024 and 31/12/2024.

- WHH stillbirth rate for Q3 2024/25 was 0.0 per 1000 births. Rolling year Q4 2023/24-Q3 2024/25 stillbirth rate is 2.82 per 1000 births. This is below the 2023 MBRRACE-UK national rate of 4.0 per 1000 births.
- WHH Neonatal mortality rate during Q3 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- One PMRT review panel was held in Q3 which was attended by multidisciplinary internal and external panel members. This case related to a stillbirth. In this case care was graded as A.
- Parental perspective of the care they received were sought in this case.

- There were no actions required following the review panel findings. PMRT action plans are monitored at Women's and Children's Governance Committee.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

5. MONITORING/REPORTING ROUTES

This report was shared at the Women's and Children's Clinical Business Unit Governance Meeting in March 2025.

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/25/04/10 appendix 6**	
SUBJECT:	**CQC Maternity Survey Results 2024**	
DATE OF MEETING:		
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery, Helen Wall – Compliance & Improvement Manager	
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:			
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 provides an overview of the CQC Maternity Survey results for 2024.The information provides the Quality Assurance Committee (QAC) with an analysis of the responses of people who have given birth at the Trust between January and February 2024.

	There has been a significant improvement in the Trust score in 2024 compared to 2023. The Trust are one of two Trusts in the North West to have scored within the top ten nationally. The 2024 survey results have recognised improvements in the five areas rated as worse than expected in 2023. All are now regarded as '**about the same'** as the national Trust average. The five areas where WHH scored the lowest are as follows: • Were you involved in the decision to be induced? • Did the Midwife or Midwifery Team that you saw or spoke to appear to be aware of the medical history of you and your baby? • During your pregnancy did Midwives provide relevant information about feeding your baby? • After your baby was born, did you have the opportunity to ask questions about your labour and the birth? • Thinking about your antenatal care, were you spoken to in a way you could understand? When compared to national averages, WHH performance is 'about the same' as the national average score in all of these measures. A comparison of the demographic of those who responded to the survey has been completed to ensure this reflects those receiving care. Work is underway to improve response rates for the 2025 survey particularly amongst those groups where response rates are not reflective of numbers receiving care.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this paper.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/03/267v**	
	Date of meeting	11 March 2025	
	Summary of Outcome		

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

REPORT TO TRUST BOARD

SUBJECT	CQC Maternity Survey Results 2024	AGENDA REF:	BM/25/04/10 appendix 6

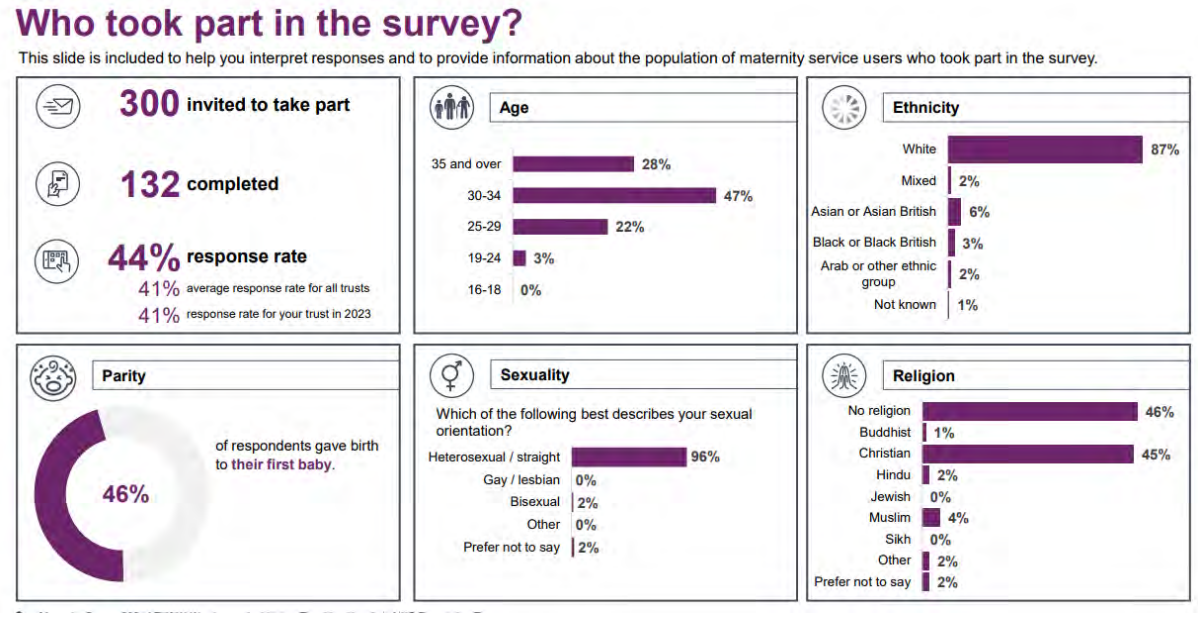
1. BACKGROUND/CONTEXT

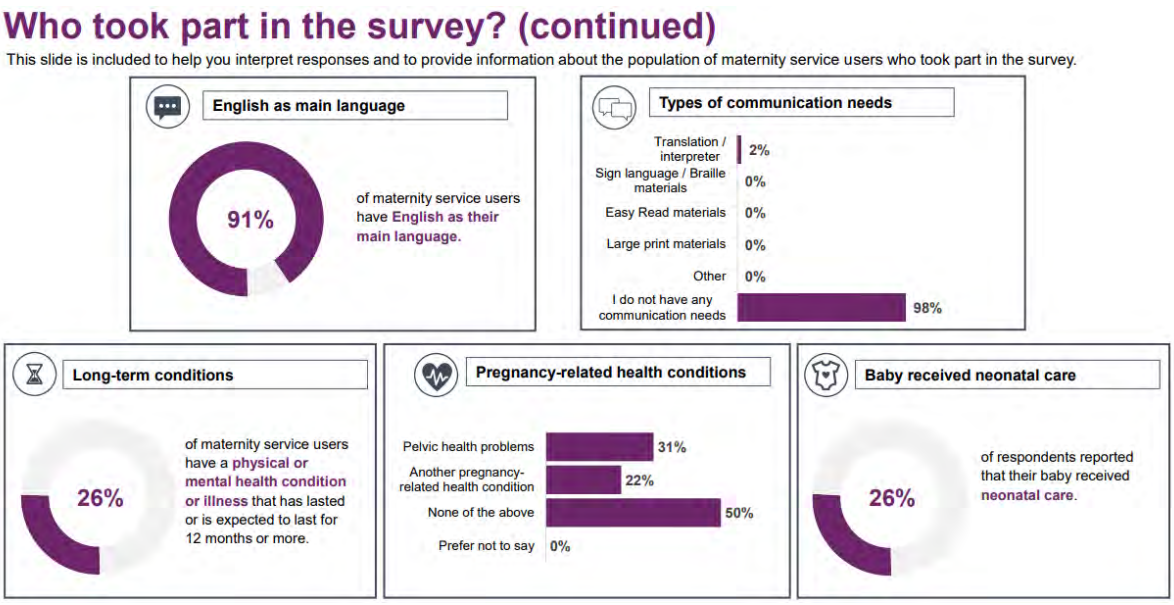
This paper provides an overview of the results of the CQC Maternity Survey 2024.

Service users were eligible to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 29 February 2024. If there were fewer than 300 people within an NHS Trust who gave birth in February 2024, then births from January were included. As there were 186 people who gave birth in February 2024, births from January 2024 will also have been included.

2. RESPONSE RATES

Response rate for WHH was 44% which is above the average national response rate of 41% and is an increase from the WHH response rate in 2023 (41%).





It is acknowledged there is significant scrutiny of Maternity Services in relation to reducing health inequalities with particular attention to those most at risk of poor outcomes. To support this, it is important that the voices of these groups are captured as part of the CQC Maternity Survey.

- On average 9% of those who book for Maternity care at WHH are from BME backgrounds. Response rate for this group was 13%.
- On average 3.9% of those who book for Maternity care at WHH do not have English is not their main language. Response rate for this group was 9%.
- On average 6% of those who book for Maternity care at WHH are aged under 24. Response rate for this group was 3%. This learning will be shared with both the Maternity and Neonatal Voices Partnership and other partners to improve response rates from this group for 2025 survey which will commence its data collection shortly. We will also ensure we are capturing the voices of this cohort via other activity.

Further analysis of the demographic of those who responded is underway paying particular attention to those whose baby received Neonatal care as evidence suggests experiences of maternity services can have a long-term impact on this cohort.

3. RESULTS

3.1 Overall results

The overall survey results for the Trust were rated as '**better than expected.'** This places the Trust in the top eight Trusts across the country and one of only two in the Northwest whose results were awarded this rating. This means families' experiences of using Maternity Services were substantially better than the national average. 'Better than expected' was the highest overall rating awarded for any Trust.

In the 2024 survey 57 questions were attributed a score. This is an increase from the 54 scoreable questions in 2023.

In five of the questions, the Trust achieved a score which was '**better than expected**' compared to the national Trust scores.

- C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?
- C10. Did the staff treating and examining you introduce themselves?
- C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?
- C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?
- D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

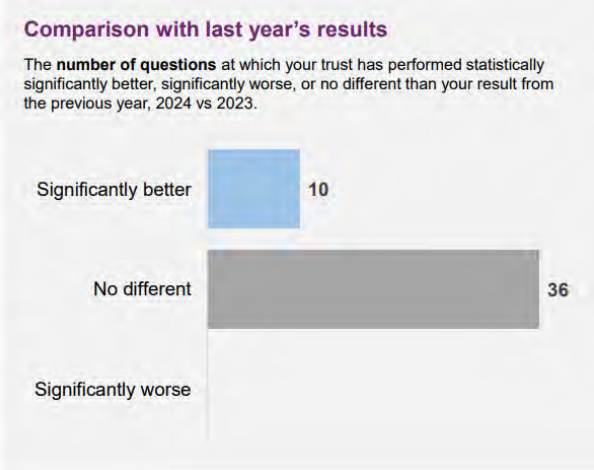
In **3** of the questions, the Trust achieved a score which was '**somewhat better than expected**' compared to the national Trust scores.

- C11. Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- C18. Did you have confidence and trust in the staff caring for you during your labour and birth?
- F11. Were you given information about any changes you might experience to your mental health after having your baby?

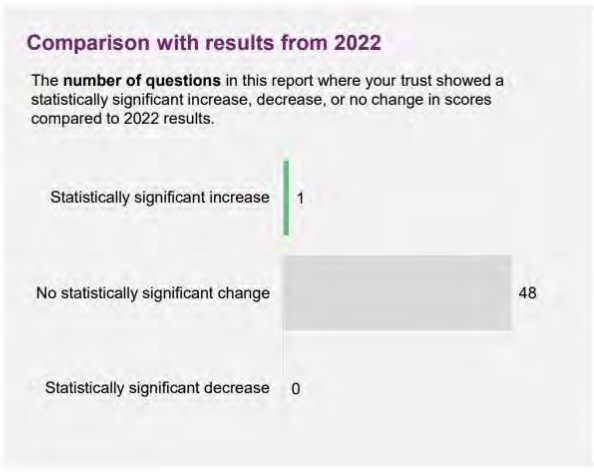
In the remaining **49** questions, the Trust achieved a score that was '**about the same**' compared to the national Trust scores.

3.2 Score comparison to 2023.

2024 Survey results



2023 Survey results



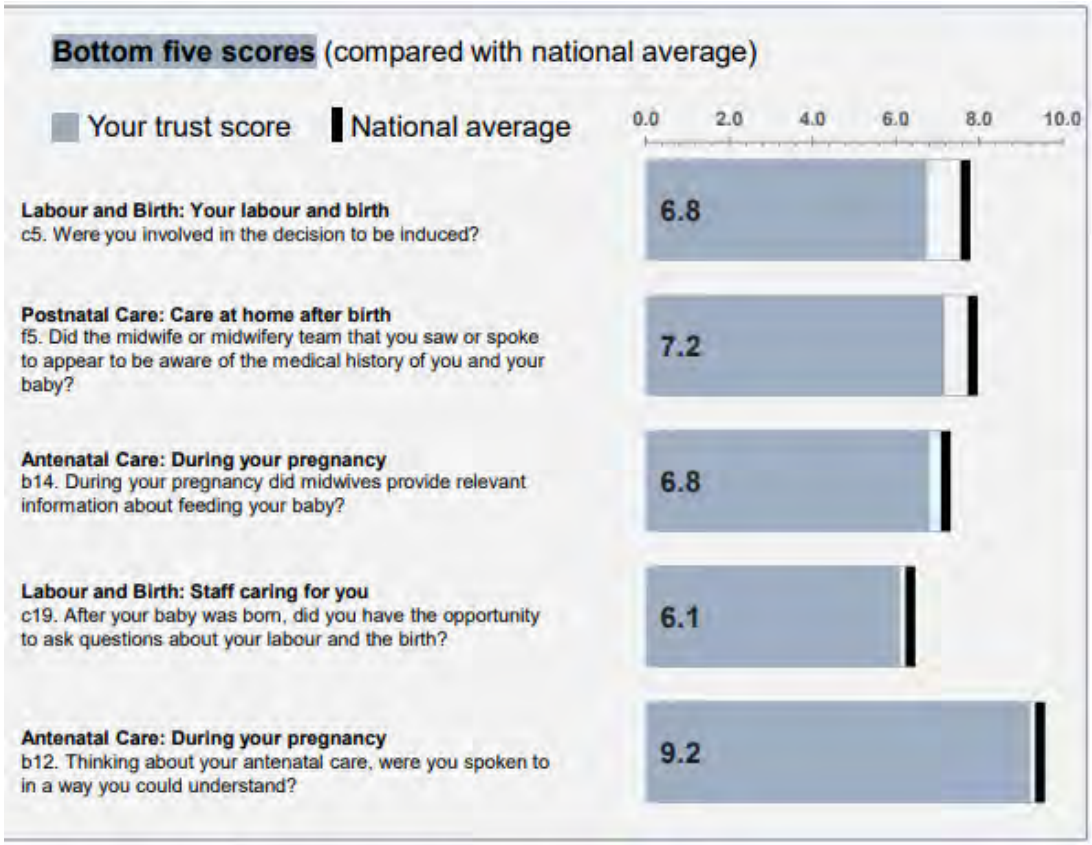
The 2023 survey results identified five areas for improvement based on the experience of those birthing in January and February 2023 which were:

- Were you offered a choice about where to have your baby? (somewhat worse)
- Did you get enough information from either a Midwife or Doctor to help you decide where to have your baby? (worse)
- During your antenatal check-ups, did your Midwives or Doctor appear to be aware of your medical history? (worse)
- During your pregnancy did midwives provide relevant information about feeding your baby? (worse)
- Did you have confidence and trust in the staff caring for you during your antenatal care? (somewhat worse)

The 2024 survey results have recognised improvements in all five of these areas and all are now regarded as '**about the same'** as the national Trust average.

The results also show where there have been statistically significant changes in the scores. There have been no statistically significant decreases in any of the scores within the survey. There have been 10 statistically significant increases in scores and the remainder have had no change of significance.

3.3 Areas for improvement



The bottom five scores for 2024 are listed above. Although these are our 'bottom' scores, all have been assessed as aligning with the national trust comparisons.

- C5. Were you involved in the decision to be induced?
- F5. Did the Midwife or Midwifery Team that you saw or spoke to appear to be aware of the medical history of you and your baby?
- B14. During your pregnancy did Midwives provide relevant information about feeding your baby?
- C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?
- B12. Thinking about your antenatal care, were you spoken to in a way you could understand?

The bottom five scores for 2024 do not highlight any areas of significant concern as they are all 'about the same' as the national average score. However, it is important the team are aware of these areas in order to target any potential areas for improvement.

4. DISCUSSION/NEXT STEPS

It is encouraging to see the improvements in the Maternity Survey results for 2024 and demonstrates positive feedback from people giving birth at Warrington and Halton.

All the areas where improvements were identified as being required in 2023 have seen improvements. There are eight areas where the service has scored higher than expected compared to other Trusts.

The team have measures in place to target improvements in the 'bottom scores. The team have also conducted additional analysis and compared the data held by the Trust from the time of the survey (January to February 2024) and more recently (December 2024 and January 2025) in relation to the induction of labour.

4.1 Were you involved in the decision to be induced?

Jan – Feb 2024

- 40/40 (100%) of women had documentation in their record to show that an IOL plan had been discussed with them.
- 36/40 (90%) of women had documentation in their record to show that they had agreed to the IOL. Four women had no documentation to support this.

Dec 2024 – Jan 2025

- 37/40 (92.5%) of women had documentation in their record to show that an IOL plan had been discussed with them. Three women did not.
- 38/40 (95%) of women had documentation in their record to show that they had agreed to the IOL. Two women had no documentation to support this.

As a result of this review, the team have updated BadgerNet to make these mandatory fields to complete to provide further assurance.

4.2 During your pregnancy did midwives provide relevant information about feeding your baby?

The improvement in the responses regarding infant feeding information is encouraging and there is ongoing work around information being automatically shared with people at set gestations. This will also ensure the service have documentation to reflect this information being shared. A new infant feeding support worker has been recently recruited who will continue to drive the support in infant feeding.

4.3 After your baby was born, did you have the opportunity to ask questions about your labour and the birth?

The Consultant Midwife takes the lead on the birth reflections service which offers people the opportunity to come and talk about their birth. A survey is currently being prepared to capture the feedback from people and further develop this service.

Thinking about your antenatal care, were you spoken to in a way you could understand?

It is vital that the team continue to communicate with people in a way that they understand. Where there are language barriers Team River have developed flash cards to assist communication. This resource has also been shared with the LMNS to support communication improvements across the network. Information leaflets are also available in other languages. The Badger app provides people the ability to record any questions they may have for their next appointments. The Antenatal Team will continue to encourage the use of the app to drive understanding.

There is also a task and finish group in place reviewing processes across the pregnancy continuum to support assurance that people who need an interpreter service are being offered and have support around them to understand the information that is being shared. This group was established following learning captured as part of a cluster review into poor outcomes which identified the challenge faced by women navigating Maternity Services for whom English is not their first language but ordinarily would not consider themselves to need interpreting services.

4.4 Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby? / During your labour and birth, did your midwives or doctor appear to be aware of your medical history?

Team River, the enhanced continuity of care team, continue to receive positive feedback about engagement and support.

The Badger app supports people to share information to support the team.

The team will continue to seek feedback from people using services through surveys and MNVP to ascertain how performance against this metric can be improved.

5. RECOMMENDATIONS

Members of the Trust Board are requested to note the contents of this paper.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/10 appendix 7**	
SUBJECT:	**Midwifery Summary Safe Staffing Report**	
DATE OF MEETING:	2 April 2025	
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: 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.

	Yes	No	*N/A*
2. Advance equality of opportunity between people who share a relevant 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 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.

	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 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 January 2025 and red flag position for the period October - December 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 January 2025 was 130.28fte. The vacancy rate for registered staff is 7.1%. Recruitment to vacancies is ongoing with 5.1fte midwives in the pipeline. Vacancy rate for registered staff not yet recruited to is 3.2%. Midwifery retention rates show a deteriorating position with a rate of 12.33% at the end of January 2025. Exit interviews have been completed and feedback/learning is being incorporated into the retention workstream. Sickness rates for January 2025 for registered midwifery staff were 11.59%, this is an increase and significantly higher than the Trust target. Proactive management of matters relating to workforce are ongoing. 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 October 2024 – 31st December 2024 there were 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 October 2024 – 31st December 2024 there was no episodes flagged where a woman in active labour did not receive one-to-one care. An action plan is attached for information. Review of the maternity workforce using the Birthrate Plus® workforce planning tool is required every three years and the latest assessment process is currently underway. The outcome of the assessment will be reported to Strategic People Committee in May 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**	Strategic People Committee	
	Agenda Ref.	**SPC/25/02/186**	
	Date of meeting	19 February 2025	
	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/25/04/10 appendix 7

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 31st January 2025 and red flag position for the period October - December 2024 alongside other key workforce metrics.

2. MIDWIFERY ESTABLISHMENT

This report summarises the current funded and actual staffing establishment as of the 31st January 2025 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 as per the workforce dashboard at the 31st January 2025 is 130.28fte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The variance against the position in January 2022 is the result of the addition of a number of new full time and part specialist midwifery roles to the midwifery establishment since that time 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 and is therefore due. The assessment process is currently underway, and the outcome of the assessment will be reported to Strategic People Committee in May 2025.

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 Q3 2023/24.

Table 1 - Midwifery Red Flags reported (October - December 2024)

	Number of Red Flags raised		
Red Flag Reason	Oct 2024	Nov 2024	Dec 2024
Delay in med review triage >30min	28	33	18
Delay in review of CTG	0	1	0
Delay in triage >15min	1	5	1
Delay in triage >30min	0	1	0
Delayed IOL	1	2	1
Delayed MEOWS	0	0	0
Delayed >30min Pain relief	0	0	0
Full clinical examination not carried out when presenting in labour.	0	0	0
Inadequate Triage	0	0	0
Missed Medication	0	0	1
Delay in administration of analgesia	0	0	0
Missed/Delayed Observation	0	0	1
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	0	0	0
Delay in ongoing IOL	4	3	6
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0
Shortfall in RM Time	36	15	16
Birth Suite Coordinator NOT supernumerary	0	1	0
AMBER Alert - Staffing	1	0	1
AMBER Alert - Acuity	0	0	0
IOL Handover to C23	0	0	0
Time critical activity	0	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 October – 31st December 2024 there is one episode recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary.

This occurred at a time of red escalation and the unit was deflecting to other providers. This was for a short period of time.

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 October – 31st December 2024 there are no episodes recorded in SafeCare where a woman in active labour is **NOT** receiving one-to-one care.

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 timely recruitment processes to all midwifery vacancies	Tina Moors	1/7/2024	Ongoing	
Submit revenue request to increase midwifery establishment to support triage staffing and release capacity elsewhere	Ailsa Gaskill-Jones	1/8/2024	Complete	
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	Complete and ongoing	
Clarify the responsibility of Specialist Midwives to be available to work clinically when required to do so	Tina Moors	1/10/2024	Complete	
Work with team to clarify when red flags should be raised and ensure consistency of reporting	Kim Farrell	1/11/2024	28/2/2025	
Complete recruitment of additional staffing resource following approval of Triage establishment revenue request	Kim Farrell	1/11/2024	31/3/2025	

This will be complimented by the wider work being undertaken within the service as a result of earning from recent service diverts which highlighted the need for more effective systems to horizon scan for potential issues with regard to acuity and staffing and ensure appropriate mitigation is implemented.

4. WORKFORCE METRICS

4.1 Vacancy rate

The vacancy rate for registered staff is 7.1%. This includes the additional establishment approved in November 2024 to support maternity Triage. Recruitment to vacancies is ongoing with 5.1fte midwives in the pipeline. Vacancy rate for registered staff not yet recruited to is 3.2%. Seven newly qualified midwives have now commenced with the organisation, with one further due to complete their induction in February 2025. 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 show a deteriorating position with a rate of 12.33% at the end of January 2025. Some of this is due to a number of staff taking flexible retirement in December and January. However there have been resignations for other reasons. Exit interviews have been completed and feedback/learning is being incorporated into the retention workstream.

4.3 Sickness absence

Sickness rates for January 2025 for registered midwifery staff were 11.59%, this is an increase and significantly higher than the Trust target. Proactive management of matters relating to workforce are ongoing.

5. RECOMMENDATIONS

Trust Board is requested to receive and discuss the findings of this paper with regard to midwifery staffing.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/11**	
SUBJECT:	Compliance Update Q3 2024/25	
DATE OF MEETING:	**2 April 2025**	
AUTHOR(S):	Felicia 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)*	**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 resulting in an overcrowded Emergency Department. **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. **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. **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:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides compliance updates for Quarter 3 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. The report provides oversight of discussion topics that were outlined from the QCOG Meeting that took place on 11 November 2024, and the 30 January 2025. Oversight of the CQC Engagement Meetings held with the WHH Executive Team and Senior Colleagues on 13 November are also featured where key quality updates were discussed. The report advises on WHHs changed approach to the Single Assessment Framework (SAF) where a triangulation of evidence will be utilised to offer assurance on compliance, along side Ward Accreditation, Quality metrics and other data sources. This will commence in Q4. Future Mock Assessment plans are noted also to be linked to the key themes of Safeguarding and Medicines compliance. These assessments will be supported by external experts and will take place in Q4. It is noted WHH received an Environmental Health Assessment in December 2024. The Trust received a rating of 4. An action plan has been completed and will be monitored by the Health and Safety Subcommittee. The Report also provides full oversight of all CQC enquiries since Q2. noting 9 enquiries are closed, 6 enquiries remain open and are being progressed. The Report highlights a RIDDOR event relating to a Microbiology sample that was labelled incorrectly (19 November 2024). The Health and Safety Executive has since held telephone calls with senior teams to seek assurance and requested associated policies. Feedback was positive noting appropriate policies are in place. A follow up visit is expected, the date of this is yet to be confirmed.			

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/25/03/262**	
	Date of meeting	11 February 2025	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Compliance Update Q3 2024/25	AGENDA REF:	BM/25/04/11

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 are one of the key bodies responsible to 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.

Monitoring, measuring and assessing levels of service is necessary, not only to gain the assurance required for WHH to meet all regulatory objectives, but in addition, to provide appropriate assurance in the form of evidence, to support other inspections and assessments, as well as seek to gain accreditations, re-accreditations, and quality standards of excellence recognitions.

To monitor overall performance in relation to the Trust's compliance and assurance objectives, a Quality Compliance Oversight Group (QCOG) was formed. The last meeting in Q3 took place on 11 November 2024. The meetings are scheduled bi-monthly, with a further meeting taking place on 30 January 2025 (Q4).

1. QUALITY COMPLIANCE OVERSIGHT GROUP UPDATES

Items reported to the QCOG Meeting, held on 11 November 2024, reflected the quality compliance and assurance work being undertaken, as well as outlining health and safety compliance visits from other agencies. The updates are as follows:

- CQC Engagement Mtg of November 2024 Update
- Update on Single Assessment Guide and Communications Plan
- Update on Warrington Theatres Mock Assessment
- Single Assessment Framework progress
- IPC Pillars of Assurance
- CQC Enquiries
- Health and Safety Inspections

A further QCOG Meeting was held on 30 January 2025. Full details will feature in the Q4 QAC Compliance update. The meeting in January provided oversight of the following areas:

- CQC General Update
- Single Assessment progress update
- Mock Assessment plans for Safeguarding, Medicines Managements and Well Led.
- Previous inspection Must Do's and Should Do's
- CQC Enquiries
- Policy Progress Regulation 17 Update

2.1 CQC ENGAGEMENT MEETING OF NOVEMBER 2024 UPDATE

A CQC Engagement Meeting took place on 13 November 2024. In addition to the standard agenda items (which were outlined in the Q2 Compliance report), the CQC added more specific topics to their agenda, under three of the five quality update sections. These were.

Quality Updates - Safe

- IPC: Discussion on WHH 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: Discussion around how WHH is responding to MUST compliance.
- Mandatory Training (MT): WHH's consistent high performance in MT noted, discussion on what is considered mandatory training and how WHH is achieving sustained compliance.
- Supervision and Appraisal: Appraisal rates appear consistently below the Trust's target. Discussion around how WHH monitors appraisals and when the Trust expects to achieve 85%.
- Mental Health Act Compliance: Tracy Fenell, Deputy Director of Nursing & Patient Experience, had the opportunity to describe how WHH monitors compliance of the Mental Health Act, and it monitors quality and performance in the Psychiatric Laison Services.

Quality Updates – Responsive

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

There is a section in the CQC Engagement Meeting agenda called "Service Highlight Discussion" and the focus on the August 2024 visit was Urgent and Emergency Care (UEC). For this November visit, wards B19 and A7 were selected. An informal visit was undertaken, so the CQC Team could see the environment, hear about the quality initiatives being undertaken, and initiate their own discussions directly with the staff. The visits to both areas were positive, and the CQC Team noted staff were confident when discussing Ward Accreditation and quality initiatives. The CQC identified a positive learning culture.

The next CQC Engagement Meeting was anticipated to take place in February 2025. However, due to existing diary commitments for both WHH teams and the CQC Team, it was not possible to find a mutually convenient date during the month of February. It was therefore agreed that the next Engagement Meeting would take place on 31 March 2025. An overview of Planned Care will be delivered at this forthcoming meeting. Other agenda items will be sent through to the Compliance Team from the CQC Team no later than 10 March, so that the required updates can be prepared.

2.2 UPDATE ON SINGLE ASSESSMENT GUIDE AND COMMUNICATIONS PLAN

The intranet has been updated with a section for CQC and compliance. The Compliance Communications Guide was reviewed and finalised. It has been publicised, along with an update to staff about the former Moving to Outstanding items, which are now being referred to as "Making a Difference".

Making a difference has become a dedicated space to share good news or describe how staff have made a difference to patients. The aim is to familiarise staff with the concept, encourage them to share good news stories and create new media work. The relevant CQC Quality Statements are also being linked to articles.

During Q3 a review has taken place to identify the different CQC promotional posters currently being displayed in and around the Hospitals. This was undertaken to determine whether the current materials displayed were still fit for purpose, and to evaluate whether any changes and/or additional CQC rating information materials should be used. A WHH proposal for future promotional CQC rating materials was drafted, and the CQC were approached for further guidance and confirmation that the Trust's promotional plan was fit for purpose. Confirmation that the proposal was suitable has been received. The proposal will now be shared internally and a timeline for implementation will be agreed.

2.3 UPDATE ON WARRINGTON THEATRES MOCK ASSESSMENT

A Theatre mock assessment took place in September at Warrington only (as Halton theatres were not in operation at the time of the assessment). A summary was provided in the last Q2 briefing paper. An action plan was formulated following the assessment and progress is being made to address issued raised. Regular monitoring is taking place, with targets for actions to be completed by 31 March 2025. Part of the review highlighted the need to move policy documents across to the central policy library. Considerable work has taken place to critically review all Theatres documentation which was held locally, and determine appropriate actions required.

- 82 documents that were stored locally, have now been archived.
- 21 Policies have been reformatted to the revised policy document style and uploaded onto the central store.
- 6 policies have been reviewed and updated and are going through the policy ratification process.
- 20 remain outstanding (15.5%) with a target completion date of 31.3.25.

2.4 UPDATE ON THE MOCK ASSESSMENT PROGRAMME

At the last QCOG Meeting, the Head of Compliance advised that other Trusts in the Cheshire and Merseyside region had paused their mock assessments programmes, with a view to resuming assessment work when the CQC assessor roles and operational changes come into effect during 2025.

WHH Compliance Team have now initiated a review to examine the Ward Accreditation process and assess whether information gained for the mock assessment process can be pulled from other WHH audits, data and inspections, to give a triangulated approach and a greater level of assurance. The timeline for completion and launch of the new process is 31 March 2025.

Whilst the above review is ongoing WHH has planned themed mock inspections of Medicines Management and Safeguarding during Q4. These inspections will be supported by external experts

within the fields of Pharmacy and Safeguarding. These services have been selected, as wherever the CQC might choose to undertake an assessment, these 2 elements of always form part a key part of assessment process. Medicines management is always thoroughly checked, and as our patient profile changes, ensuring appropriate safeguarding measures are in place, and requirements are being met, is critically important. It seems prudent to undertake mock assessment, and examine performance across the Trust, in relation to these two specific elements.

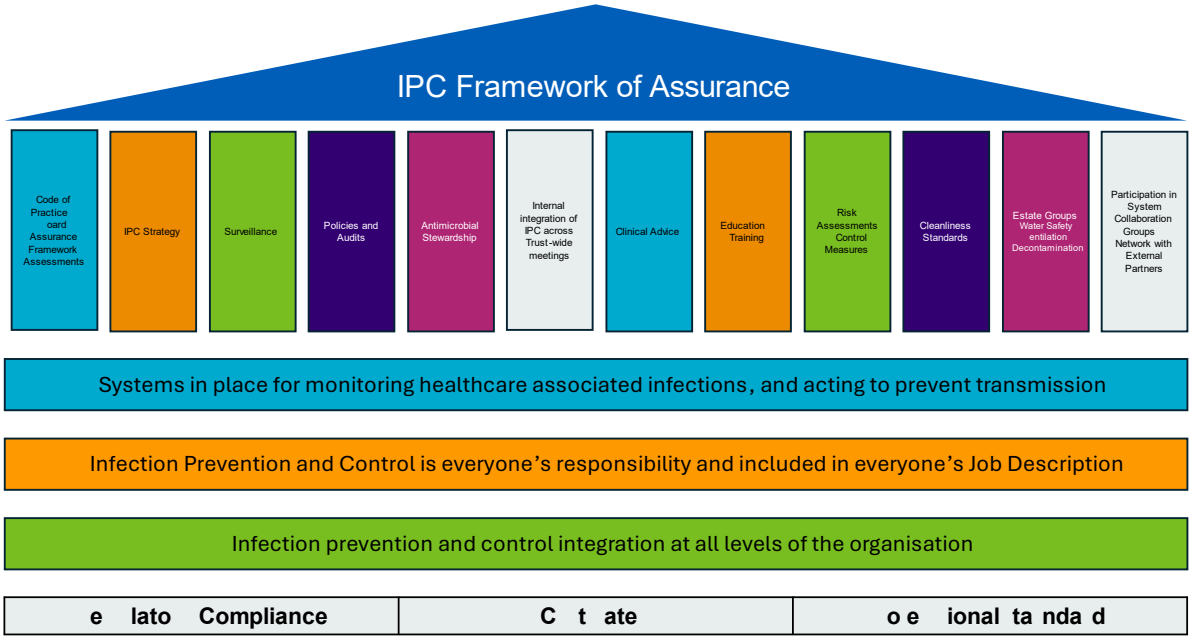
2.5 SINGLE ASSESSMENT FRAMEWORK (SAF) PROGRESS

Work continues to ensure all departments have self-assessed their evidence against the CQC Quality Statements. The evidence now needs to be scrutinised, and the self-assessment score needs to be validated/amended depending on the evidence review. A task team will be set up to undertake the reviews. It is anticipated that the reviews will be stepped and undertaken by each domain, starting with statements in relation to SAFE during Q4. This is a necessary action to ensure a consistent approach.

In addition to this internal exercise, other SAFE score benchmarking with partner services including the CQC is planned during Q1 of 25/26. The aim is to provide assurance that the score allocated against the evidence collated for each quality statement, is in line with the CQC scoring approach.

2.5 IPC PILLARS OF ASSURANCE

Infection Prevention and Control presented their Pillars of Assurance at the last QCOG Meeting. This design mirrors the Compliance Pillars model, and clearly illustrates all aspects under the management of IPC and how the systems in place support the Trust in meeting its IPC regulatory and professional standards compliance.



Pillar of Support	Description
Code of Practice & Board Assurance Framework Assessments	Biannual compliance assessments and action plans in place to address areas of non-compliance with the Code of Practice on Prevention of HCAIs and the IPC Board Assurance Framework
IPC Strategy	2022 – 2025: 4 objectives: Prevention of HCAIs, Strengthening Antimicrobial Stewardship; Improving Cleanliness, Greening the NHS including waste management
Surveillance	Mandatory reported infections: CDT, GNBSI, MSSA, MRSA ; Alert organism; Covid-19, Swarm huddles and cluster/outbreak meetings Orthopaedic mandatory surveillance: Surveillance of surgical site infection – starting with Maternity C. section
Policies and Audits	Policies as defined by the Code of Practice, aligning to National IPC Manual. Auditing programme to ensure compliance; Joint Matron and IPC Ward and Department visits, visibility of the IPC Team, local audits including peer audit SOP (high impact interventions, hand hygiene, PPE, Mattress audits
Antimicrobial Stewardship	Antibiotic Ward rounds; Quarterly point prevalence audits; IVOS CQUIN; 24 hour on-call access to Microbiology advice
Internal integration of IPC across Trust-wide meetings	IPC representation across internal meetings
Clinical Advice	Patient care and management for 'Alert organisms'; isolation priorities; integration with operational teams for safe patient placement
Education & Training	Induction training, mandatory training, single point lessons, Grand Round presentations; Matron masterclasses
Cleanliness Standards	Commitment to cleanliness charter; Cleanliness monitoring and action to rectify; roles and responsibilities included; introduction of efficacy audits, PLACE assessments; Deep cleaning programme, Standardisation of cleaning terminology and terminal cleaning standards sign off
Risk Assessments and Control Measures	Incident reporting system. Risk recognition and recording; control measures implemented and action planning ; action plans on healthcare associated infection prevention (MRSA/MSSA and GNBSI) and brilliant basics in IPC campaign, aligning PSIRF to HCAI events
Estate Groups: Water Safety; Ventilation; Decontamination	Participation in capital projects planning; Water testing and results review; Ventilation testing and upgrades; decontamination on (endoscopy) and off-site (surgical instruments)
Participation in System Collaboration Groups & Network with External Partners	Priority action areas aligned to mandatory HCAI reporting; shared learning across systems aligned to PSIRF ICB System collaborative on Infection Prevention; C&M CDT collaborative – diarrhoea management NHSE – HCAI Group

2.6 CQC ENQUIRIES AND NOTIFICATIONS

Closed Enquiries since Q2 Report

Category	Query	Comments
Opened 2.8.24 CAS-511021 Monitor PSIRF Data – Severe Physical Harm	Review of 12 incidents to understand the grading process and be assured that when the decision is made to downgrade, it is appropriate. This issue was initiated as a result of the CQC having access to the LFPSE system and noting that incidents start as "severe" and then after initial review, can often change to a lower level of risk.	All questions relating to the individual IR's have now been addressed and assurances provided. **Closed 25.11.24**
Opened 15.4.24 191846 Never Event Enquiry (1 of 2 in the same enquiry)	Surgical swab left in situ post operatively. PSII completed, 4/5 identified actions for improvement completed. PSII report presented to SOM on 21st October – approved. Shared with patient and family.	**Closed 28.10.24**
Opened 15.4.24 191564 Never Event Enquiry (2nd of 2)	Retained mayo needle tip (broke off during procedure) left in situ postoperatively. Report presented to SOM, 3/3 identified actions completed – approved. Agreed to de-escalate from a Never Event. This incident has consistently been classed as "no harm" and this remains the case	CQC satisfied with the decision to de-escalate and have accepted the final report.

	following discussion and on completion of the investigation.	**Clo e d 19.12.24**
Opened 20.9.24 CAS-573937 Maternity Care concern	Concerns about retained products following a neonatal death and a data breach query.	Comprehensive timeline of events was shared and explanation around processes and options relating to retained products. Confirmation that no data breaches had been recorded. **Clo e d 7.10.24**
Opened 26.9.24 CAS-582631 Discharge prescription concern	PRN and oral presentation of the same medicine was prescribed. This was queried.	Deliberately dispensed both forms. The oral medication was described as "anticipatory medication", so it was available to the patient if they were able to convert back to taking the medication orally, as opposed to by Continuous Subcutaneous Infusion (CSCI). **Clo e d 8.10.24**

Ongoing Enquiries from Q2

Category	Query	Comments
Opened 30.7.24 CAS-506098 Complaint – ISR	196155 (2232/22151) Concerns re: patient care in ED	Draft report was presented to the Safety Oversight Meeting (SOM) w/c 27.1.25. Amendments are being completed and will presented to SOM for final sign off. The finalised copy will be sent to the CQC. **Target date for completion 12.2.25**

Enquiries logged in Q3

Opened 1.11.24 CAS-631161 Concerns raised by a CQC employee who was the attending relative of a patient	Concerns re: Delays for patients being cared for on the ED corridor impacting on level of support offered to patients.	A full investigation took place, and all issues raised were addressed. During the specified dates, there were capacity challenges including multiple enhanced care patients requiring L3 and L4 care. A full break down of activity over the 3 dates was provided, as well as a detailed narrative, along with Ambulance Handover and Corridor policy SOPs. **Clo e d 11.12.24**
Opened 18.12.24 CAS-682855 Discharge concerns	**Relating to a patient who had been on A10 (reference 200204)** – Query about medications that were sent to the Nursing Home, lack of catheter passport and discharge handover.	Having received a completed "Concerning Discharge" form from the Care home, the matter had already been raised as an incident and investigated when the enquiry came through.

		The CQC were provided with an immediate response, which gave a comprehensive explanation if all events. **Closed the same day 18.12.24**
Re-opened 21.11.24 Care concern	**IR (311869: Reference – 177919)** – Serious incident involving a 3-month baby from 2023, missed opportunities and safeguarding.	All associated information had been sent to the CQC previously. Additional information was provided, following a further request received from the CQC on 21/11/24. **Awaiting confirmation of closure**
Opened 1.11.24 CAS – 624859 T&O Staff concerns	Concerns about staffing on the Trauma & Orthopaedics Ward and a question about whether staff are suitably trained to deal with the level of acuity of patients.	Several internal meetings took place, and the Executive Medical Director wrote a comprehensive position update for the CQC response. **Closed 19.12.24**
Opened 12.12.24 CAS-684771 Care Concerns A5	Request for information in wound management, training compliance levels, patient hygiene audits and discharge process.	Information provided within the stipulated timeframe and the CQC have responded, acknowledging the improved training compliance percentages for the ward. **Closed 22.12.24**
Opened 15.11.24 CAS-649204 Care Concern	Care concern made by the son of an elderly inpatient. He has raised a formal complaint and alerted the CQC, who have requested a copy of the final response.	The Deputy Director of Nursing & Patient Experience made direct contact with the patient's son, and his mother's care was escalated to the Gastroenterology Team for review. **Final complaint response letter due to be finalised by 13.2.25**

New Q4 enquiries to date

Category	Query	Comments
Opened 2.1.25 CAS-696630 Care Concern	A formal complaint has been submitted and the CQC would like a copy of the final response. The issue relates to CPAP equipment delays and the management of patients currently waiting for CPAP equipment.	Complaint fully investigated and a copy of the final response has been sent to the CQC on their request. **Awaiting CQC response**
Opened 21.1.25 CAS-727657 Covid Care Concern	Anonymous concern that staff on a post-surgery ward are working whilst having tested positive for covid/flu.	IPC Lead will submit relevant policy documentation and provide a response. **Target date for completion is 12.2.25**
Opened 21.1.25 CAS-731775	Anonymous concern about level of care being shown to patients on EAU.	Investigation underway. Safeguarding Team have also received this concern via the local authority.

Staff behaviour issues on EAU		**Target date for completion is 12.2.25**

RIDDOR Notification

Microbiology	On the 19 November 2024 Microbiology received a sample (an aspirate from a spinal abscess) that was not labelled as hazardous, and the sample was processed as any other sample on an open bench.	An investigation was completed with actions. The omission was to fail to label the sample with the bright yellow warning label. **CQC informed.** **Enquiry number assigned CA - 703643-G4Z4W8.** **Clo e d 24.12.24**
Additional information	There was a call with the HSE on 8.1.25. The Trust was represented by the Head of Health & Safety, the Senior Chief Biomedical Scientist and the Associate Director of Infection Control. The Inspector was happy that Pathology had reviewed documentation such as SOPs, Risk Assessments and training for Medical Staff. The incident was discussed, and lab processes were described. Documents requested: Investigation Report Safety Brief following the incident. Comms to Microbiology staff following the incident. Revised SOP's. Revised Risk Assessments. Training Materials. Following review of the documents, a visit will be arranged to see systems used in Microbiology. Date to be arranged.	

Never Event Notification

Opened 13.1.25 CAS-722985 Theatres 31.12.24	81-year-old female admitted 30/12/2024 following a fall and sustaining a right intracapsular #NOF.	During a a Hemi Hip Arthroplasty on 31/12/2024, it was recognised by the surgeon that the wrong stem was implanted with cement. The surgeon intended to use a standard offset stem but implanted a high offset stem. No harm came to the patient. After discussion at Safety Oversight Meeting (SOM), a Never Event was declared on 6.1.25, due to the unintended prosthesis. • Patient Safety Incident Investigation (PSII) lead has been identified. • Duty of Candour completed.

		• Reported using Strategic Executive Information System (StEIS). **PSII outcome to be shared with CQC. Target date for completion 13.7.25**

2.7 HEALTH & SAFETY INSPECTIONS

Environmental Health conducted an inspection on the Warrington Site on the 13 December 2024.

Three areas were assessed. These are:

- how hygienically the food is handled – how it is prepared, cooked, cooled, stored, and what measures are taken to prevent food being contaminated with bacteria
- the condition of the structure of the premises including cleanliness, layout, lighting, ventilation, equipment and other facilities
- how staff manage and record what is done to make sure food is safe using a system like Safer food, better business

The Site has a newly renovated kitchen in which the Inspector spent most of the inspection looking at the equipment, documentation, and cleaning products.

The Inspector visited Ward C21 to ensure Wards had allergen information available for patients and to ensure the kitchens were clean and no out-of-date food was stored.

Prior to the visit there was a rigorous audit regime in place completed by the Matrons, Lead Nurses, Infection Control and Prevention and Health and Safety.

The outcome of the assessment was WHH was provided a rating of 4.

An action plan has been completed, this will be monitored by the Health and Safety Subcommittee with any escalations to the Quality Assurance Committee.

3.0 Q3 POSITIVE TRUST NEWS (TO BE SHARED WITH THE CQC PRIOR TO THE 31.3.25 ENGAGEMENT MEETING)

PAEDIATRIC AUDIOLOGY SERVICE QUALITY ASSESSDMENT TESTING (PASQAT)

The Integrated Care oard (IC) want to move Warrington and ridgewater servic es to “low risk”, and in line with this, a visit by the NHS England (NHSE) Team will not be until March or April 2025. There are 4 remaining elements to this for WHH namely, peer review, team training, continuous audit and Improving Quality in Physiological Services Accreditation (IQIPS). The ICB are satisfied with all the work WHH have completed since the incident, and the peer reviewer from the Countess of Chester Hospitals is assured and ready to step down WHH from having all ABR traces peer reviewed. A CPD programme for the team has been developed. An audit plan is in place, supported by the clinical audit tool. The audits will continue to follow the BSA guidance. Progress in respect of IQIPS accreditation is monitored through the Quality Contract processes and updates are provided through CQPG.

CERVICAL SCREENING QA PRIORITISATION

The Screening Quality Assurance Service (SQAS) recently completed its annual quality review of all cervical screening services. Based on the evidence assessed by the QA Team, SQAS does not plan to undertake a specific QA activity of WHH screening services during the 2025/26 financial year.

The letter has been sent to the Regional Public Health Commissioning Team and the WHH Screening & Immunisation Team separately. The teams have been congratulated for their hard work that has led to this outcome.

DONATION TO TRANSPLANT PATHWAY LETTER OF RECOGNITION AND THANKS

A letter of commendation has been received in November 2024 from the Director of Organ and Tissue Donation and Transplantation, which outlines the tremendous work WHH have undertaken between April 2024 and September 2024 in relation to organ and tissue donation & transplant activity, as well as quality of care in organ donation.

2. NEXT STEPS

- Self-assessment ratings for Safety Oversight Framework continues.
- 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 commenced in Q3; the Compliance Team have agreed to support this work stream.
- Reduce the number of outdated policies, weekly reports to the Care Groups – full oversight is provided by the Safety Oversight Meetings. Current compliance is noted to have improved to 82.6% (February 2025)
- Plan and execute both Safeguarding and Medicines Management mock assessments and report on findings. Work with the teams on any action plan requirements.
- Continue the QCOG work.
- Plan and prepare for the next CQC Engagement Meeting scheduled to take place on 31 March 2025.
- Submit the updated CQC previous inspection “Should Do and Must Do” report to the March QCOG meeting for discussion.
- Manage all CQC Enquiries.

3. RECOMMENDATIONS

The Board of Directors are asked to note the contents of this report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/12**	
SUBJECT:	**Proposed Quality Strategy 2025-2027**	
DATE OF MEETING:	**2 April 2025**	
AUTHOR(S):	Ernesto Quider, Associate Director of Quality Tracy Fennell, Deputy Chief Nurse/Director of Clinical Governance	
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)***	**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 resulting in an overcrowded Emergency Department. **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. **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. **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	**Yes**	**No**	***N/A***
		✓		

	characteristic and those who do not			
	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 paper provides the Board of Directors with an update on the consultation process of developing a new Quality Strategy in line with Trust Strategy and linked with domains of quality and defined in our Annual Quality Priorities 24/25. 1. Patient Safety 2. Clinical Effectiveness 3. Patient Experience			
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note and approve the contents of this report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/25/03/262**		
	Date of meeting	11 March 2025		
	Summary of Outcome	approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO TRUST BOARD

SUBJECT	Quality Strategy Update 2025-2027	AGENDA REF:	BM/25/04/12

1. BACKGROUND/CONTEXT

This paper provides the Board of Directors with an update on the development a new Quality Strategy 2025-2027 to be aligned with the Trust Strategy, as well as linked with domains of quality and defined in our annual Quality Priorities 2025/26.

1. *Patient safety* – quality care is care which is delivered so as to reduce the risk of avoidable harm to patients and a culture of support, openness and honesty when something has gone wrong.

2. Patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The patient experience domain of quality also embraces accessibility, understood in the sense that we must provide services in an inclusive way that recognises the diversity of our population.

2. *Clinical effectiveness* – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.
3.

4. KEY ELEMENTS

The Quality Strategy 2025-2027 (see separate document) outlines our commitment to prioritise quality and safety above all else. In line with the recommendations presented to the Quality Assurance Committee in Quarter 2 by the Strategy Team, the strategy will be refreshed with 'light touch' update for the new financial year.

Historically WHH has identified several areas of focus however the alignment has not been clear, and this has caused confusion in reporting for frontline teams.

These areas of reporting have included.

- Quality Strategy
- Business Planning
- CQUINs
- Quality Account
- Quality Priorities

The Board of Directors are requested to support the proposal to use the key areas identified within the new Quality Strategy to inform WHHs Quality Priorities for 2025-2027. This will be reported in the annual Quality Account.

It is recommended WHH will not identify further Quality Strategic Goals in addition to Quality Priorities as in previous years. This will enable clear focus on a smaller number of areas that are focused and aligned to the Trust's Quality Strategy and key areas of risk and continuous improvement.

It is also proposed that CQUINs will continue to be monitored separately via the CQUINs Meeting and report to Patient Safety and Clinical Effectiveness Sub-Committee quarterly (no change).

The proposed Quality Priorities (see separate report) which have been thematically reviewed from previous stakeholders' consultation surveys and discussed with senior leaders in Care Groups and Corporate services in various meetings are aligned with the domains of quality and CQC key lines of enquiry in order to build on the progress made with the National Quality Board's (NQB) Shared Commitment to Quality and the improvements we have achieved for the past three years. These will be integrated in Quality Strategy and renamed as the Quality Priorities. These priorities will be reviewed annually as per Quality Account reporting and various engagement meetings.

We have expanded our engagement in Q4 to gain further views of Care Groups and CBUs leaders. This engagement will continue through the annual business planning process, and we will engage our commissioners and regulators regarding this strategy.

This Quality Strategy will set out the approach and help shape the direction of quality and safety improvements in achieving our ambition to become an outstanding for our patients, staff and communities.

What are we aiming to achieve:

The vision for quality for the next three years and beyond in line with our integration plan with Bridgewater Community Healthcare NHS Foundation Trust:

1. Improving our people's health outcomes and enhancing their quality of care,
2. Ensuring care is safe and effective, with support available when and where it is needed most,
3. Delivering a caring and responsive patient experience every time.

What will this mean for our patients, people and system partners:

The overarching vision of this new Quality Strategy will be based on the life stage framework (i.e.., start well, live well and age well) as highlighted in the NHS Long Term Plan to better meet the needs of patients and their families as we implement our bold vision supported by specific programmes of work within domains of quality, which will be linked to Quality Priorities and other regional and national strategic context:

- Improving Patient and service users experience (to be aligned with our Patient Experience and Inclusion strategy)
- Improving safety culture in line with national Patient Safety Strategy
- Improving value by utilising quality improvement (QI) methodology and establishing high-impact priority programmes
- Enhancing quality of care by addressing health inequalities
- Improving staff experience making WHH a great place to work and receive high quality and exemplary safe services.

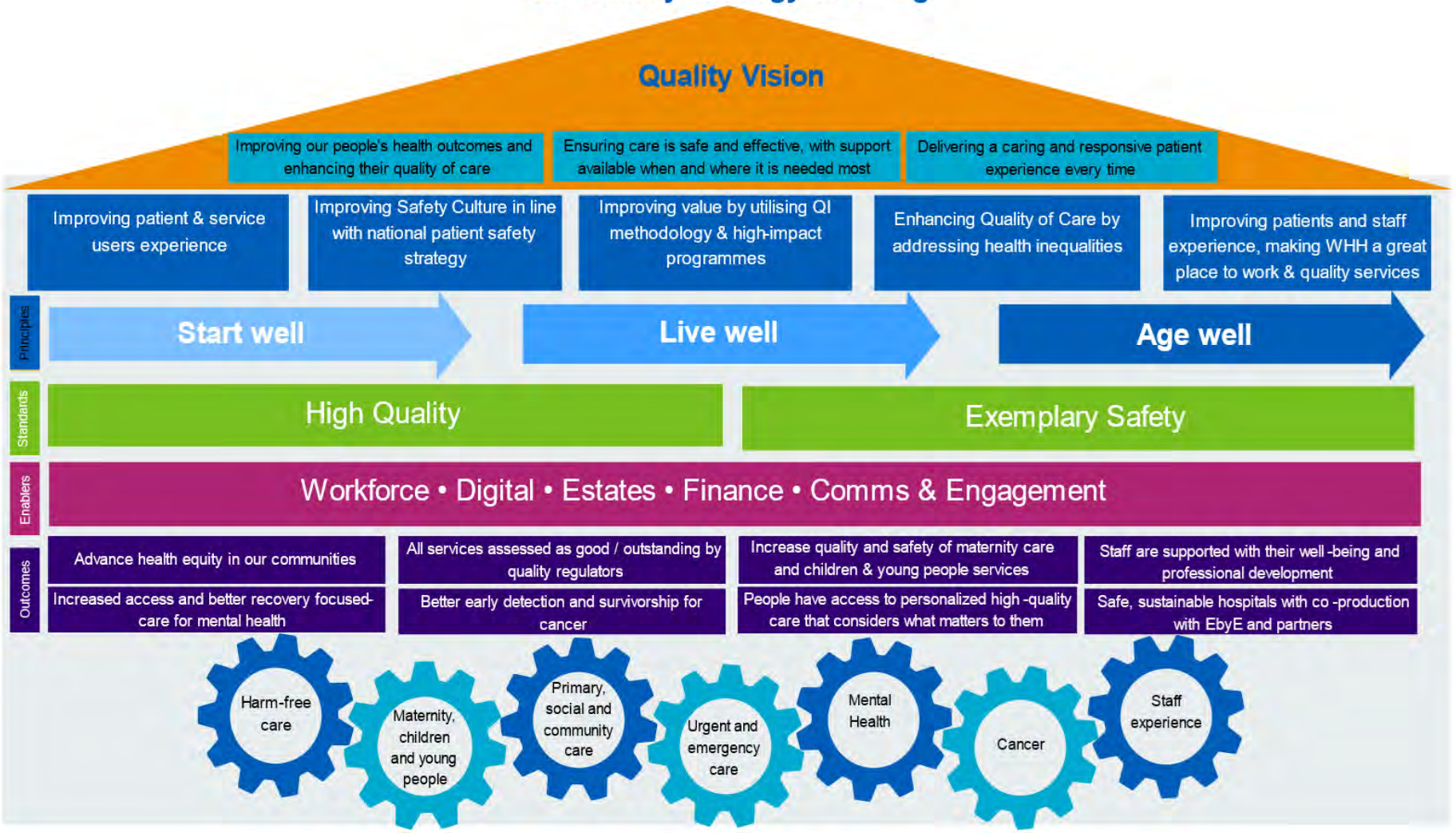
The collaborative approach of developing this strategy will ensure that there are links to the Trusts' enabling strategies and corporate support- People, Digital, Estates, Finance and Communications and Engagement teams. The Quality Strategy is summarised further within this document (see ***figure 1. Quality Strategy on a Page below***).

5. RECOMMENDATIONS

The Board of Directors are asked to receive, note the information contained in this paper and approve the draft Quality Strategy 2025-2027.

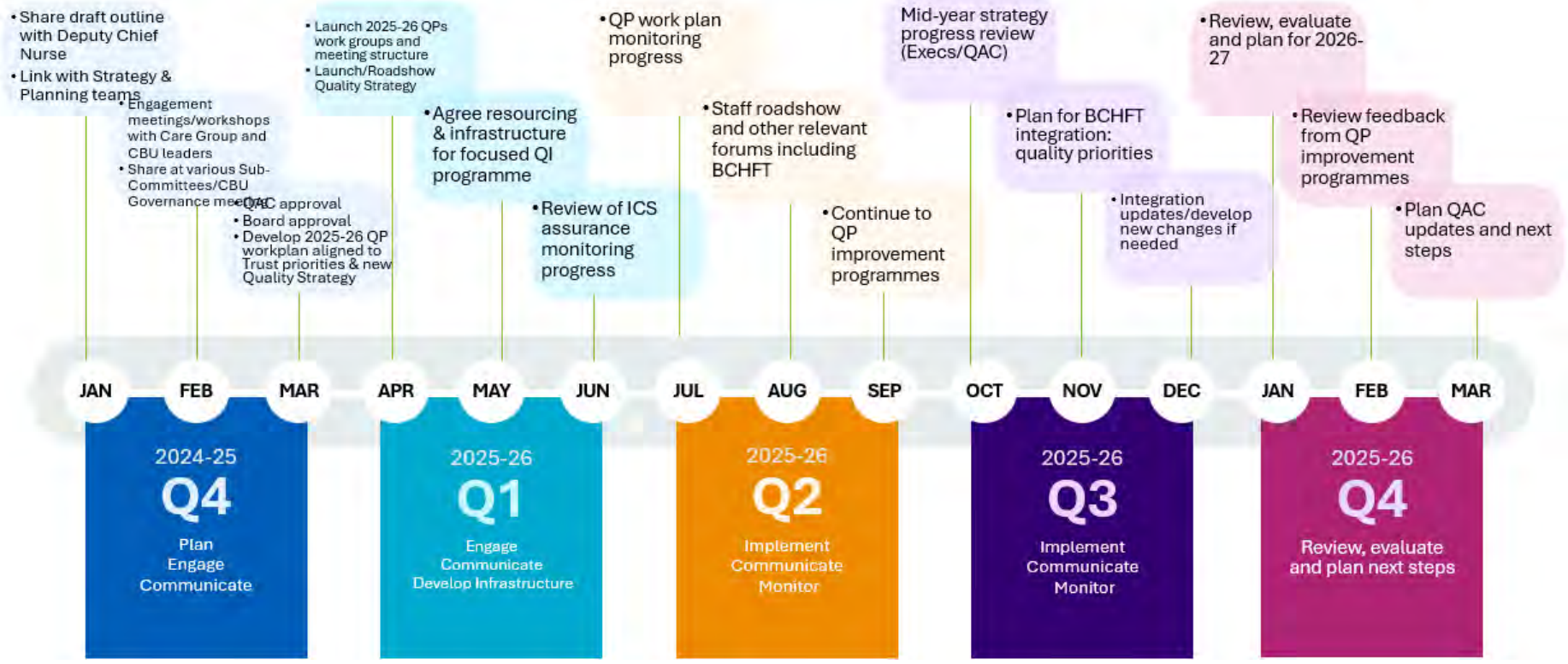
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Quality Strategy on a Page



Delivering Quality Strategy:

Quality Strategy engagement High Level Plan



Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/13**			
SUBJECT:	**Annual Equality, Diversity and Inclusion Report (2024-2025)**			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	Adam Harrison-Moran, Head of Strategic Workforce Development & Culture			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People 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: ***This report includes information associated with the Equality, Diversity and Inclusion Annual Report which is written to address the general aims of the public sector equality duty.***			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information: ***This report includes information associated with the Equality, Diversity and Inclusion Annual Report which is written to address the general aims of the public sector equality duty.***			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information: ***This report includes information associated with the Equality, Diversity and Inclusion Annual Report which is written to address the general aims of the public sector equality duty.***			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an overview of the Equality, Diversity and Inclusion Annual Report for 2024/25. As public sector			

<table>
<tr><td></td><td colspan="3">organisations, all NHS Trusts are required to demonstrate how they meet the general and specific duties of the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010. As part of the requirements, organisations are required to demonstrate how they are actively working to reduce health inequalities by promoting equality and working to eliminate discrimination, whilst maintaining a commitment to respect human rights.

To comply with this, Warrington and Halton Teaching Hospitals NHS Foundation Trust completes an Equality, Diversity and Inclusion Annual Report. The report for 2024/25 was approved by the Strategic People Committee on behalf of the Trust Board on 19 March 2025.

The report includes the following sections:
• NHS EDI Improvement Plan implementation updates
• How the organisation is meeting the equality duty
• An overview of WHH Staff Networks and their role
• Health inequalities and its approach within the organisation (patients, public and workforce)
• Equality Delivery System (patients and workforce)
• External accreditations
• Key achievements for 2024/25
• EDI workforce statistics including gender, ethnicity and disability pay gap reporting
• EDI patient statistics
• Governance and accountability overview.

Aligned with the national reporting requirements, the Trust must publish their annual report on its website by 30 March 2025.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board are asked to receive the Equality, Diversity and Inclusion Annual Report (2024/25), as approved by the Strategic People Committee on behalf of the Trust Board in March 2025.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Strategic People Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">SPC/25/03/202</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">19 March 2025</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Approved for publication with delegation of authority from the Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
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REPORT TO TRUST BOARD

SUBJECT	Annual Equality, Diversity and Inclusion Report (2024-2025)	AGENDA REF:	BM/25/04/13

1. BACKGROUND/CONTEXT

Public sector organisations have been required to demonstrate how they are actively working to reduce health inequalities by promoting equality and working to eliminate discrimination, whilst maintaining a commitment to respect human rights. Moreover, they need to demonstrate the outcomes of this work showing how they have assessed the impact of policies, strategies and action plans on the local population and its workforce. This is demonstrated through the publication of the Equality, Diversity and Inclusion Annual Report each March.

The Strategic People Committee holds the delegated authority on behalf of the Trust Board for the approval of all equality, diversity and inclusion reporting. The Equality, Diversity and Inclusion Annual Report (2024/25) was approved by the committee on 19 March 2025. This report provides a high-level analysis of the key findings of the report.

A copy of the full report for review can be found on the Trust website by clicking here.

2. KEY ELEMENTS

The report includes information focused on local implementation of national standards, such as the NHS EDI Improvement Plan. Additionally it highlights the role of WHH Staff Networks and actions taken to address health inequalities within the Trust. The report also includes the Equality Delivery System for both patients and staff, as well as external accreditations and achievements. Workforce and patient statistics, including gender, ethnicity, and disability pay gap reporting, are included as sections, demonstrating how the Trust aims to meet the needs of its local population. An overview of governance and accountability is also included.

Section three provides an overview of actions taken to meet the general and specific duties of the public sector equality duty, including consultation, engagement, the staff survey and patient/service user responsibilities.

Section four provides an overview of staff network performance and achievements in the previous year. This includes achievements in external accreditations, engagement with staff, policy and strategy development and celebration events.

Section five incorporates the new requirements under the Health and Care Act 2022 to report on health inequalities performance. This highlights where health inequalities reporting is aligned with the equality, diversity and inclusion portfolio.

Section nine highlights some of the Trust's key achievements in 2024/25. This includes:

- The achievement of external acknowledgements and accreditations.
- An increased number of Experts by Experience, part of our commitment to meaningful co-production and co-design.
- Review and refresh of the Trust equality objective action plans, in line with the specific duties of the public sector equality duty.
- Continued investment in health inequalities, notably working with the local communities and focused action for workforce health and wellbeing.
- Introduction of the Equality and Health Inequalities Impact Assessment, aligning with best practice to improve the access and experience of patients, the public and workforce.

Section 10 then provides a protected characteristic breakdown of the workforce profile for the Trust as of 31 October 2024, with both substantive and bank staff included. The report demonstrates:

- A year-on-year increase for race and disability. Presenting a positive impact against both the local population and the Trust's Model Employer strategy targets.
- An improvement in the unknown declaration reporting for disability and sexual orientation.

Additionally, the report includes the gender, ethnicity and disability pay gap reporting for the Trust, effective 31 March 2024. It is noted that disability pay gap reporting is new for 2024/25 and highlights that the mean hourly rate and median hourly rate for staff that have disclosed as having a disability are both lower than the rates for those that have disclosed as not having a disability. The difference in mean hourly rate was £3.20 for March 2024, with disabled members of staff more likely to be in the lower pay bands (Q1 and Q2) than higher pay bands (Q3 and Q4). In comparison, non-disabled staff are evenly distributed across all pay bands.

3. MONITORING/REPORTING ROUTES

Equality, diversity and inclusion reporting is overseen by the Strategic People Committee on behalf of the Trust Board.

4. TIMELINES

The report has been published on the Trust website as per requirements by 30 March 2025.

5. ASSURANCE COMMITTEE

Strategic People Committee holds the delegated authority on behalf of the Trust Board for the oversight and approval of equality, diversity and inclusion reporting.

6. RECOMMENDATIONS

The Trust Board are asked to receive the Equality, Diversity and Inclusion Annual Report (2024/25), as approved by the Strategic People Committee on behalf of the Trust Board in March 2025.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/14**			
SUBJECT:	**Freedom to Speak Up**			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	Alison Jordan Freedom to Speak up Guardian			
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 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):***	In 2024/25 April to December Freedom to Speak up (FTSU) has managed sixty six cases of disclosure. For the same period in 2023/24 FTSU managed twenty one cases and thirty five in 2022/23. Most issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU guardian continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that are highlighted.			

	A draft FTSU strategy for 2025 - 2027 has been circulated to the Executive and non-Executive Lead for FTSU and can be found at **Appendix 1**. The FTSU team continues to engage with colleagues across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to raise awareness of FTSU. In February 2025 the FTSU guardian attended the Your Future Your Way programme to deliver an awareness session. The information was well received and positive suggestions made around increasing the diversity of the FTSU champions group were made. In February 2025, a new FTSU Guardian commenced in post working two days a week.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the progress of Freedom To Speak Up.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPC/25/03/207**	
	Date of meeting	19 March 2025	
	Summary of Outcome	Noted.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/25/04/14

1. BACKGROUND/CONTEXT

In 2024/25 April to December Freedom to Speak up (FTSU) has managed sixty six cases of disclosure. For the same period in 2023/24 FTSU managed twenty one cases and thirty five in 2022/23. Most issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU guardian continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that are highlighted.

The FTSU team continues to engage with colleagues from across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU.

On the 1st February 2025 a new FTSU Guardian commenced in post working substantively two days per week. This represents a commitment by the organisation to the FTSU process undertaken to support colleagues in the organisation to raise awareness of any concerns in relation to work. The previous Guardian had been working to build the champion network of whom there are now fifty four champions, and a further eighteen staff have expressed an interest in becoming Champions. To increase the diversity across the Champions group and build the network to cover all areas of the organisation the guardian will link with Trust staff networks.

2. KEY ELEMENTS

Table 1 sets out the number of disclosures for the last 3 years and up to Q3 of 2024/25:
The table represents the number of disclosures by individual so even if several themes form the disclosure this is counted as one.

Table 1 Number of disclosures by individual

	2021/22	2022/23	2023/24	2024/25
Quarter 1	4	17	6	15
Quarter 2	8	5	6	15
Quarter 3	6	13	9	36
Quarter 4	2	7	10	
Total	**20**	**42**	**31**	**YTD 66**

Table 2 includes the themes contained within an individual disclosure. From Q1-Q3 2024/25 there have been sixty six individual disclosures containing overall ninety six recorded themes. This equates to thirty of those individual disclosures including more than one of the six listed recordable themes.

Table 2 Themes from disclosures

	2021/22 Q1 – Q4	2022/23 Q1 – Q4	2023/24* Q1 - Q4	24/25* Q1-Q3
Behaviour, culture and relationships	15	31	26	61
Process	2	3	1	
Patient safety/Quality	1	5	7	10
Staff levels / patient care	2	2	1	7
Communication		1		
Worker Safety/Wellbeing			6**	18

*In Q4 2023/24 national reporting changes were made to allow for more than one area of disclosure to be reported per case, and worker safety was also included.
**introduced in Q4 23/24.

The Freedom to Speak up Guardian (FTSUG), and Champions continue to present at events across the Trust, in particular to the medical students, rotational doctors, preceptorship staff and international nurses. More recently the Guardian has presented an awareness session to the most recent Your Voice Your Way cohort. The Guardian is planning a series of walk arounds to speak directly to staff and raise awareness of FTSU and the value that the organisation places upon this.

In 2025/26, the Trust Board will receive two updates on FTSU as well as take part in a Board development session to undertake a review of the FTSU reflection and planning tool which will incorporate the Trust Board's views. This will be used by the Guardian to develop the FTSU development plan that will support the delivery of the FTSU strategy.

The FTSU Guardian has undertaken the national training and both existing and new champions have been requested to complete the Electronic Staff Record (ESR) FTSU training and all existing Champions have successfully completed this. Support from the workforce data team will be required to monitor the uptake of this training more widely across the organisation as this training does not form part of the mandatory training offering.

National Update

In 2023/24 data submitted by Freedom to Speak Up guardians, 4% (1285) of cases indicated workers believed they experienced some form of disadvantageous and/or demeaning treatment as a result of speaking up. This has resulted in a new National Guardians office detriment guide being produced.

The detriment guidance discusses the benefit of completing a detriment risk assessment. Protect has given Freedom to Speak Up Guardians access to its risk assessment which can support those responding to reports of detriment following speaking up. **For more information you can read the detriment guidance**.

All resources and information is available via the NGO's website News - National Guardian's Office.

3. DEVELOPMENTS

In response to the local and national disclosures and the publication of a number of reports which recommend the FTSU route to support organisations to influence culture change, investment has been made into the FTSU team. This will enable more engagement with staff across the Trust and provide opportunities bring about improvement and culture change.

One of the ways in which FTSU has influenced cultural change positively is through initiating cultural reviews into areas of our organisation that has an increase in number of FTSU disclosures and employee relations issues.

- A cultural review took place in a service of the Trust in January 2024. The results of this have proven to be a success with the recommendations of the review have been implemented over 2024/25.

- The area reviewed has increased the supervision in place for trainee posts and reports from new starters on the unit are positive. Several successful workplace mediations have also been completed. Staff who had been displaced as a result of work related stress caused by the issues in the area have now made plans to return to their substantive work roles.

Currently there is another cultural review underway in the organisation and an Executive lead piece of work to support cultural improvement across the Trusts Theatres provision.

Supporting sexual safety in the workplace

In response to staff survey results and triangulation of FTSU disclosures. Awareness raising sessions have commenced.

1. To understand the importance of sexual safety in healthcare, aligned with key UK policies and healthcare frameworks
2. To be aware of the recent changes in law and guidance, including the Worker Protection Act (2023), Good Medical Practice (January 2024) and NHS Sexual Safety Charter
3. Discuss the connection between survey findings and speaking up
4. Encourage an open dialogue on workplace sexual safety – through the lens of the NHS Staff Survey 2023
5. Empower people with strategies to prevent, report and respond to incidents of sexual misconduct
6. Promotion of the Trusts sexual safety in the workplace resource and guidance booklet

4. RECOMMENDATIONS

The Trust Board is asked to note the report and the information provided regarding the developments and progress of Freedom To Speak Up within the organisation.

Appendix 1

Draft FTSU strategy 2025-2027

FTSU Strategy 2025-2027 0v1.docx

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Freedom to Speak Up Strategy 2025 – 2027

(Approved Strategic People Committee)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Freedom to Speak Up Strategy

Mission and Vision

Our mission is to develop an open and learning culture and make Freedom to Speak Up (FTSU) part of the usual way we work together in the Trust and support the development of FTSU across our developing Better Care Together programme.

Our vision is that everyone, regardless of their role, feels that they have a voice and therefore feel safe to raise a concern with anyone, and know that they will be listened to, taken seriously and that the issue will be acted upon appropriately.

Voice is one of the three main pillars of the NHS People Plan. Listening and acting upon matters raised means that Freedom to Speak Up delivers on the ambitions set out in the Trust People Strategy and the promise of the NHS as the best place to work and will also support the delivery of the Trust's Strategic Objectives.

How will we do this?

Our most immediate concern is ensuring that speaking up works well now so that our health and care workforce feels empowered and listened to.

We have a clear ambition to support the continued development of a speaking up culture across the Trust. To deliver our vision we will:

- Ensure all staff are aware of FTSU provisions, understand the role of FTSU and their responsibility to speak up.
- Promote the variety of ways that staff can speak up about any concerns they may have and encourage a culture of accountability and openness.
- Promote FTSU e-learning for all staff and enhanced FTSU training for leaders.
- Ensure managers and leaders are clear about their roles and responsibilities when handling concerns, and receive appropriate support to do so effectively.
- Provide communication on FTSU in a variety of ways, ensuring materials are accessible to all and have maximum reach and impact.
- Continue to develop the FTSU Champions Network, led by the FTSU Guardian.
- Ensure robust governance and assurance processes to ensure that matters raised are consistently and thoroughly investigated through the appropriate processes.
- Encourage feedback and take appropriate action to facilitate and share learning across the Trust to support the development of an open culture.

- To ensure reporting of FTSU data (anonymised) and triangulation with other business intelligence to inform actions to promote patient and staff safety and quality of clinical services.

How will we know that we're making progress?

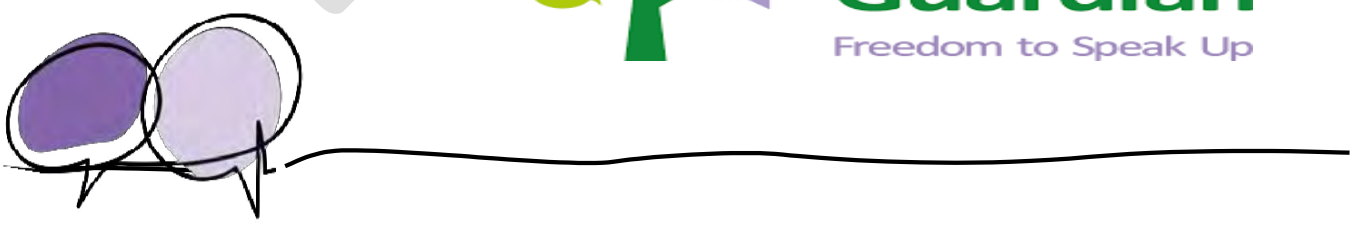
We will monitor a variety of key people metrics and use staff engagement channels, including Pulse Surveys, National Staff Survey, Staff Engagement Forum, and Staff Networks to ensure regular feedback.

FTSU assurance reports are routinely reported to the People Committees (as part of the Committee Work Plan) with bi annual reporting to the Board. High level reporting and updates will also be provided to staff to support learning and promote an open and learning culture. The Trust will report it's FTSU data nationally via the National Guardian Office (NGO).

Each year an action plan will be produced to look at implementation of actions gained from triangulation of data both internal and externally including the National Guardian's Office.

Outcomes and Impact – what will be different?

- The learning from FTSU concerns will be incorporated with other business intelligence to inform actions to promote patient and staff safety and quality of clinical services.
- Learning from concerns will be shared with all staff in an open and transparent manner (while respecting confidentiality) to support the development of an open and learning culture across the Trust.
- Improvement in staff survey response and therefore National Guardians Office Index.



National Guardian
Freedom to Speak Up

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/15**			
SUBJECT:	**NHS Staff Survey 2024 Results and Analysis**			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	Adam Harrison-Moran, Head of Strategic Workforce Development & Culture			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People 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: This report includes a section which focuses on reviewing data by bullying, harassment or abuse. The organisation has a risk (ID: 2103) which monitors the disparity of different protected groups using the data provided in the Staff Survey 2024.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information: This report includes a section on the workforce race and workforce disability equality standard which highlights the Trust performance in equality of opportunity. This data is used as one source, whilst qualitative information is sourced through engagement sessions.			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information: This report includes reference to how the data is utilised with Staff Networks and wider organisation to reduce disparity and improve the experience of the whole workforce.			

EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an overview of the annual NHS Staff Survey results for the organisation from 2024, which are aligned to the NHS People Promises as set out in the NHS People Plan. The survey took place between September and November 2024, with a 52% participation rate equating to 2,409 members of staff having their say. Equating to one in two staff in the organisation. This demonstrates a more accurate reflection on the survey findings. The results show that the organisation is better than the Acute Trust average in all nine elements of the NHS Staff Survey. The report highlights that the Trust improved in two elements of the survey, but a slight deterioration in seven, when compared with the 2023 results. The paper provides an overview of the engagement with the wider organisation to prioritise and enable meaningful change as a result of staff feedback, including next steps to ensure the voice of our workforce is utilised as intelligence for learning in the year 2025/26. This aligns with the We are WHH: Culture Plan reporting cycle.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the 2024 Staff Survey results for Warrington and Halton Teaching Hospitals NHS Foundation Trust and priorities to respond to staff feedback and experience.		
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 TRUST BOARD

SUBJECT	NHS Staff Survey 2024 Results and Analysis	AGENDA REF:	BM/25/04/15

1. BACKGROUND/CONTEXT

The NHS Staff Survey is a nationally mandated survey across all NHS organisations to inform local improvement in staff experience and wellbeing. It is a national measure against the pledges set out in the NHS Constitution and provides useful intelligence to the Care Quality Commission and local commissioners. Data from the survey is also used to inform other statutory reports, including the Workforce Equality Standards.

The 2024 survey took place between September and November 2024. The Trust commissions IQVIA Quality Health to administer the survey process as an approved NHS survey provider. The Trust undertakes a mixed mode approach to the survey with the majority of staff receiving a digital questionnaire. For staff who do not have regular access to computers, paper copies were provided.

A full communications plan was implemented during the field work for the survey which included Staff Survey cafés, walkabouts and a series of 'You Said, We Did' messages to encourage participation.

The Staff Survey is made up of several questions split into nine elements, seven of which represent the NHS People Promise[1] as outlined below and in **Diagram One**:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff engagement
- Morale

Diagram One: NHS People Promise

The results of the survey provide the Trust with the opportunity to understand staff experience, what is going well and the areas which require further improvement and intervention. This is used as the main intelligence form for the We are WHH: Culture Plan. This paper provides a high-level overview of the results for the 2024 survey,

[1] NHS People Promise: https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/the-promise/

including the governance for monitoring of organisational and directorate action plans to respond to staff feedback.

2. KEY ELEMENTS

2.1. Response Rate

A total of 2,409 staff members completed the 2024 survey, which equates to 52% of the eligible workforce. This is a 7% improvement in comparison to the 2023 survey and **Diagram Two** highlights this is the best response rate for the Trust since the COVID-19 pandemic.

The results also highlight that the Trust performed 3% better than the national average response rate of 49%, as demonstrated in **Diagram Two**.

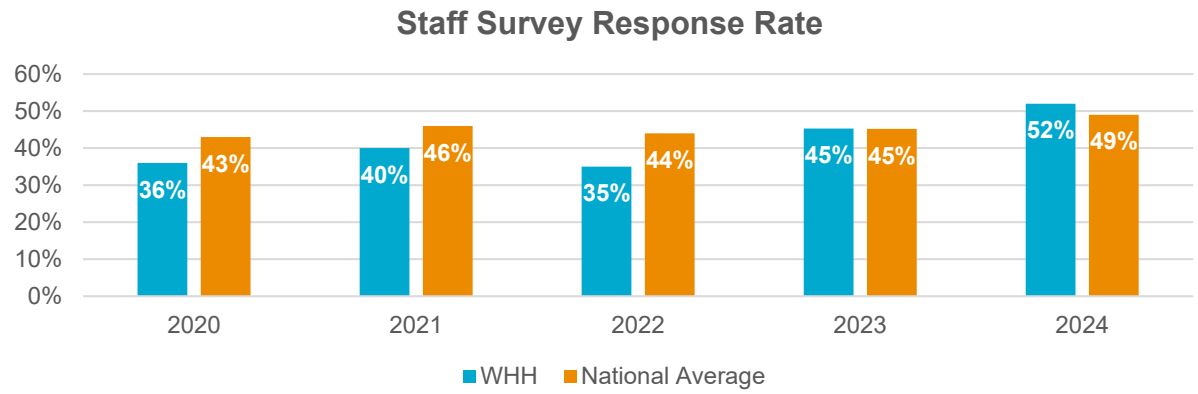


Diagram Two: Staff Survey Response Rate (2020 to 2024)

2.2. Overview of Results

The 2024 NHS Staff Survey results highlight that the Trust saw a positive improvement in two elements of the survey in comparison with 2023 results, specifically for:

- We are always learning
- We work flexibly

Although the Trust score deteriorated in seven elements, the highest difference was at 0.07%. When benchmarked against other Acute and Acute & Community Trusts WHH performed better than the average Trust for all nine elements of the 2024 NHS Staff Survey for the second year running.

The survey contains 108 questions which are grouped into sub-sections within the nine elements of the survey. **Table One** highlights the 10 questions where there has been a significant difference in response, either through improvement or deterioration, since 2023.

Sub-section	Question	Percentage difference	2024 score
Compassionate culture	Q25d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	-3.3%	58.1%
Diversity and equality	Q16a) In the last 12 months, I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	+1.9%	6.6%
We are recognised and rewarded	Q4a) I am satisfied with the recognition I get for good work.	-3.0%	53.1%
Health and safety climate	Q3h) I have adequate materials, supplies and equipment to do my work.	-3.9%	59.1%
Burnout	Q12e) I often / always feel worn out at the end of my working day / shift.	-3.5%	35.5%
Burnout	Q12g) I do not have enough energy for family and friends during leisure time.	-2.7%	26.7%
Negative experiences	Q13a) In the last 12 months, I have personally experienced physical violence at work from patients / service users, their relatives or other members of the public.	+2.4%	16.9%
Appraisals	Q23b) The appraisal / review helped me to improve how I do my job.	+3.1%	28.4%
General questions	Q10c) I work additional UNPAID hours for this organisation, over and above my contracted hours.	-5.2%	46.4%
General questions	Q18) In the last month, I have seen an error, near miss, or incident that could have hurt staff and / or patients / service users.	+3.0%	35.6%

Table One: Significance testing by question (2023 v 2024)

Significance testing highlights that staff report a slight decrease in satisfaction with the standard of care provided (-3.3% difference), while there is an increase in staff experiencing discrimination at work (+1.9%). Issues such as satisfaction for the recognition of good work (-3.0%) and a lack of adequate materials or supplies for tasks (-3.9%) are also noted, alongside challenges related to burnout, with staff feeling worn out or lacking energy for personal time. With the survey being administered in a period of sustained operational and financial pressures for the organisation and wider NHS this is reflected in the national scores, all seeing a deterioration in the same themes.

Positively, appraisals performance has improved and are importantly perceived as helpful in improving job performance (+3.1%) and there is a slight increase in the reporting of incidents that could harm staff or patients. Overall, these insights provide

a snapshot of employee satisfaction, challenges and areas needing attention within the Trust in 2025/26.

Additionally, the survey provided analysis at question level on the experience of our internationally educated staff (staff recruited from outside the UK), this particularly allows for any disparities in experience to be identified. Positively, the 2024 results indicate a slight improvement in staff recruited from outside the UK stating that the Trust respects individual differences, for example cultures, backgrounds, ideas etc. when compared with 2023. This is a 7.4% improvement from 2022.

Appendix One provides an overview of the survey results by theme, compared against the national best results, average results and worst results.

2.2.1. Sexual Misconduct and Harassment

In 2023, for the first time, the survey included questions about sexual harassment and safety, revealing significant findings. Approximately 6.29% of staff at the Trust reported experiencing unwanted behaviour of a sexual nature from patients or members of the public in the past year, while 3.75% reported similar experiences involving staff and colleagues.

For the 2024 survey, the results show that there has been a 1.38% increase to 7.75% in the percentage of staff who reported experiencing unwanted behaviour of a sexual nature from patients or members of the public. 3.39% reported experiencing unwanted behaviour from other staff members, this is a 0.38% improvement in comparison to 2023. **Diagram Three** highlights the estimated number of staff members who reported experiencing unwanted sexual behaviours, based on question response numbers. This highlights that although there is a reduction in the percentage of incidents reported (staff on staff), with an increased response rate in 2024, this indicates a higher number of estimated reports in comparison to 2023.

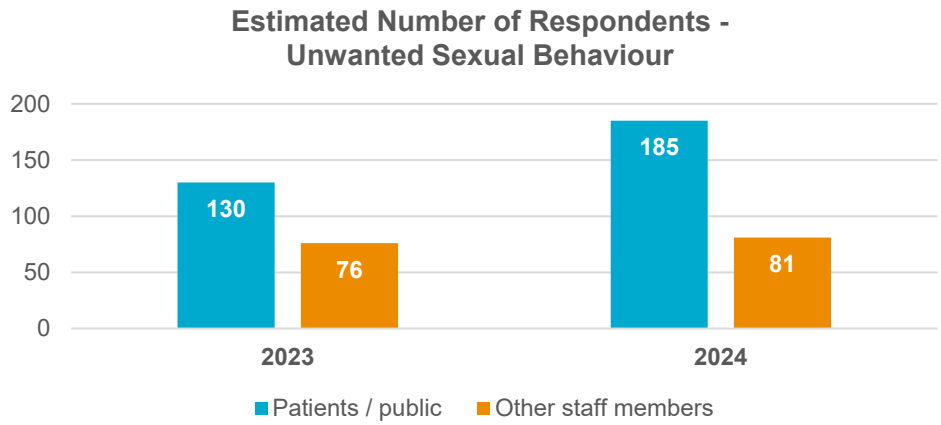


Diagram Three: Unwanted Sexual Behaviour Responses by Number of Staff

A series of interventions, targeting specific staff groups has been completed. This has included the rollout of a ‘Sexual Safety: Resource and guidance document’ in June 2024, the introduction of a ‘Sexual Misconduct in the Workplace’ policy in February 2025 and the promotion of the national NHS e-learning package.

To support additional training, workshops have commenced in collaboration between the People Directorate and Freedom to Speak Up. This will continue throughout 2025/26 in line with the organisation's commitment to the NHS Sexual Safety Charter.

2.2.2. Freedom to Speak Up

The 2024 Staff Survey includes four questions which provides intelligence for staff reporting on unsafe clinical practice and their experience of the organisation addressing concerns. The questions are:

- **I would feel secure raising concerns about unsafe clinical practice** – this demonstrated the same response as 2023 with 73% of staff reporting positive responses.
- **I am confident that my organisation would address my concern** – 60% of staff felt the organisation would respond if concerns were raised regarding unsafe clinical practice. This was a deterioration of 1% compared with 2023 but an increase in comparison to 2022.
- **I feel safe to speak up about anything that concerns me in this organisation** – 62% of staff reported feeling safe to speak up at the Trust, although an improvement from 2022, this does demonstrate a 2% deterioration from 2023.
- **If I spoke up about something that concerned me, I am confident my organisation would address my concern** – 52% of staff felt confident that the organisation would address concerns raised, a 2% deterioration in comparison to 2023 whilst remaining a 3% improvement compared to 2022.

This data highlights a deterioration in results compared to 2023, there is however no statistical difference with the Trust still performing better than the national average in all four questions. This highlights that there still remains significant work to be done in ensuring all staff feel they can speak up at the Trust. In addition, closing the loop on staff feeling that when they speak up, their concerns will be listened to and acted on.

To support this, analysis is being undertaken, in conjunction with the Freedom to Speak Up Guardian and Champion Network to encourage staff to speak up at work. Data will be analysed by departments to identify opportunities for targeted action.

2.2.3 Patient Safety Incident Response Framework (PSIRF)

The 2024 Staff Survey includes four questions which provides intelligence on how the organisation addresses how staff will be treated should they reporting on errors, near misses or incidents and whether they will receive feedback should they raise a concern. The questions are:

- **My organisation treats staff who are involved in an error, near miss or incident fairly** – this demonstrated the same response as 2023 with 63% of staff stating they believed the Trust treats staff fairly.
- **My organisation encourages us to report errors, near misses or incidents** – there was a 1% improvement in this score compared to 2023 with 88% of staff feeling encouraged to report errors, near misses or incidents.
- **When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again** – there was a 2%

improvement since 2023 with 73% of staff agreeing that the Trust takes action to ensure than an incident does not happen again.

- **We are given feedback about changes made in response to reported errors, near misses and incident** – this demonstrates the same response as 2023 with 65% of staff indicating that they have received feedback.

This data highlights an overall moderate improvement in comparison to the 2023 survey results, however, highlights that there are improvements required in how staff feel they will be treated should they report an incident and whether they will receive feedback on any lessons learned should they report. In comparison to the national average, the Trust performed better for all four questions associated with the Patient Safety Incident Response Framework.

2.2.4 Bullying, Discrimination and Harassment

The 2024 Staff Survey includes six questions which provide intelligence for violence and aggression and staff experiencing bullying, discrimination and harassment in the organisation. Overall the questions demonstrate an increase in incidents of bullying, discrimination and harassment.

Table Two provides an overview of the questions and variations to 2022 and 2023.

Question	2022	2023	2024	Variation (2023 – 2024)
Q13) In the last 12 months how many times have you personally experienced physical violence at work from...?				
a) Patients / service users / public	13.98%	14.81%	16.96%	+2.15%
b) Managers	0.48%	0.41%	0.29%	-0.12%
c) Other colleagues	1.36%	1.49%	1.18%	-0.31%
Q14) In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...?				
a) Patients / service users / public	24.28%	22.46%	22.79%	+0.33%
b) Managers	10.84%	7.43%	7.62%	+0.19%
c) Other colleagues	19.35%	15.99%	16.38%	+0.39%

Table Two: Violence, aggression, bullying, harassment or abuse questions and variation (2022 to 2024)

The table demonstrates that although there has been a slight increase in questions associated with bullying, harassment or abuse between 2023 and 2024, there remains a significant variation between scores reported in 2022.

Questions associated with violence and aggression have reduced for staff on staff and with managers demonstrating a positive improvement in cultural transformation programmes. There has however been an increase in incidents from patients, this will

be reviewed and addressed through the Violence and Aggression Task and Finish Group.

2.3. Local and Regional Benchmark

The Health Service Journal (HSJ)[2] reported that WHH scored in the top five Trusts in the North West for recommending the organisation as a place to work, as highlighted in **Diagram Four**.

Organisation	2020	2021	2022	2023	2024	Change 2023-24	Response rate 2024
Alder Hey Children's	78%	70%	67%	71%	74%	2.8	62%
Mid Cheshire Hospitals	73%	66%	64%	68%	67%	-1.6	43%
Mersey and West Lancashire Teaching Hospitals				68%	65%	-3.1	37%
East Cheshire	66%	57%	60%	62%	62%	0.2	60%
Warrington and Halton Teaching Hospitals	68%	60%	56%	63%	61%	-1.3	52%
Bolton	67%	63%	60%	59%	60%	1.3	48%
Manchester University	65%	54%	50%	57%	60%	2.3	45%
Stockport	55%	55%	53%	61%	60%	-1.1	45%
Wrightington, Wigan and Leigh Teaching H	67%	63%	61%	63%	59%	-4.2	35%
Tameside and Glossop Integrated Care	58%	49%	56%	57%	57%	-0.1	43%
East Lancashire Hospitals	72%	65%	64%	62%	57%	-5.2	42%
Liverpool University Hospitals	64%	48%	46%	54%	56%	1.9	33%
Blackpool Teaching Hospitals	68%	64%	60%	62%	56%	-6.0	47%
Northern Care Alliance			55%	58%	56%	-2.4	55%
Wirral University Teaching Hospital	62%	56%	55%	56%	53%	-3.4	47%
Lancashire Teaching Hospitals	64%	56%	57%	59%	50%	-9.7	39%
Countess of Chester Hospital	65%	49%	43%	45%	48%	2.6	45%
University Hospitals of Morecambe Bay	66%	56%	54%	57%	47%	-9.8	41%

Diagram Four: North West Trusts – ranked in order of staff "agreeing" or "strongly agreeing" they would recommend it as a place to work (2024 Staff Survey)

In addition, across the nine elements of the survey, WHH outperformed local neighbouring Trusts[3] in eight areas, as highlighted in **Table Three**.

	Warrington and Halton	Mersey and West Lancashire	Countess of Chester	Wirral University	Liverpool University Hospitals
We are compassionate and inclusive	**7.42**	7.37	6.96	7.14	7.08
We are recognised and rewarded	**6.09**	5.95	5.53	5.71	5.72
We each have a voice that counts	**6.85**	6.77	6.34	6.46	6.52
We are safe and healthy	**6.32**	6.28	5.79	5.91	6.07

[2] HSJ: Revealed: The best and worst trusts to work at

[3] Neighbouring Trusts are those in the same benchmark group and include Mersey and West Lancashire Teaching Hospitals / Countess of Chester / Wirral University and Liverpool University Hospitals Group

We are always learning	**5.83**	5.61	5.13	5.38	5.28
We work flexibly	**6.39**	5.98	5.60	6.07	5.88
We are a team	**6.94**	6.74	6.45	6.62	6.54
Staff engagement	**6.92**	6.94	6.48	6.56	6.62
Morale	**6.16**	6.08	5.53	5.66	5.77

Table Three: Comparison with local neighbouring Trusts (acute comparison) – 2024

2.4. Workforce Equality Standards (Staff Survey Analysis by Protected Characteristic)

The Staff Survey is used as a core element for the workforce equality standard reporting on an annual basis. From March 2024, Trusts were required under the EDI Improvement Plan[4] to report and set targets for year-on-year improvements in bullying, discrimination and harassment related questions. This was approved by the Strategic People Committee on 20 March 2024 as risk 2103.

Following analysis of the 2024 Staff Survey by protected characteristic, discussions will be held and reported through the Workforce Inclusion and Culture Sub-Committee on next steps and recommendations to address the findings of the results.

This will be completed in conjunction with the leadership of the WHH Staff Networks which represent:

- Multi-Ethnic Staff Network
- Progress LGBTQ+ Network
- Disability Awareness Network
- Armed Forces and Military Veterans Community Network
- Women's Staff Network

Actions to inform improvement for the results of the survey by race, disability and sexual orientation will also form part of the annual Workforce Race, Disability and Sexual Orientation Equality Standard action plans, which will be presented to the Strategic People Committee for ratification in August 2025.

[4] NHS EDI Improvement Plan - https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/

2.4.1. Workforce Race Equality Standard

Table Four highlights the results of the Workforce Race Equality Standard metrics associated with the NHS Staff Survey in 2024.

Question	All Other Ethnic Groups			White			Variation from previous year (Ethnic Groups)
	2022	2023	2024	2022	2023	2024	
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25.5%	28.2%	**29.5%**	21.2%	19.7%	**19.7%**	+1.3%
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	30.8%	21.9%	**26.0%**	21.8%	17.6%	**17.8%**	+4.1%
Q15) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	40.8%	51.0%	**52.5%**	61.7%	64.9%	**63.4%**	+1.5%
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	18.9%	13.3%	**15.4%**	4.7%	5.35%	**4.7%**	+2.1%

Table Four: Workforce Race Equality Standard Results

2.4.2. Workforce Disability Equality Standard

Table Five highlights the results of the Workforce Disability Equality Standard metrics associated with the NHS Staff Survey in 2024.

Question	Staff With a LTC or Illness			Staff Without a LTC or Illness			Variation from previous year (LTC)
	2022	2023	2024	2022	2023	2024	
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	26.6%	25.7%	**25.0%**	19.9%	18.8%	**20.1%**	-0.7%
Q14b) Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	17.9%	11.5%	**10.1%**	8.0%	5.7%	**6.6%**	-1.4%
Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	24.4%	22.7%	**18.9%**	15.7%	12.5%	**14.4%**	-3.8%
Q14d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	43.0%	53.9%	**49.8%**	49.5%	48.7%	**50.3%**	-4.1%

Question	Staff With a LTC or Illness			Staff Without a LTC or Illness			Variation from previous year (LTC)
	2022	2023	2024	2022	2023	2024	
Q15) Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	54.0%	58.0%	**57.8%**	61.0%	64.8%	**62.4%**	-0.2%
Q11e) Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	26.9%	22.7%	**21.5%**	18.3%	15.6%	**14.8%**	-1.2%
Q4b) Percentage of staff satisfied with the extent to which their organisation values their work	34.0%	40.8%	**38.5%**	45.6%	50.7%	**47.5%**	-2.3%

Table Five: Workforce Disability Equality Standard Results

3. NEXT STEPS

3.1. Staff Survey Priorities

The 2024 Staff Survey results were released on 13 March 2025 and provide the Trust with the opportunity to directly respond to staff feedback through robust assurance and priority setting, both at organisational and local departmental level. Following their release, the results have been shared with the wider organisation in a variety of accessible methods that capture all staff by utilising existing engagement approaches and communication channels. This includes verbal, written text and infographics, as illustrated in **Appendix Two**.

3.1.1. Setting Priorities for Improvement and Shared Learning

Following release of the results, all Care Groups and Corporate Services received their results by People Promise theme and statistical difference. Further work to develop local action plans for improvement are currently underway led by the Culture, Engagement and Inclusion Team and HR Business Partners. Service leads will work with the People Directorate to develop key priorities against their local results to deliver during 2025/26. This will be supported by the We are WHH: Culture Plan.

Services based on their staff survey performance have been categorised as one of the following:

- Developing
- Achieving
- High-performing
- Exemplar

Dependent on the categorisation of the service follows a bespoke offer of support to ensure that all staff who work at WHH have ‘a good day at work’.

Local actions to support this will be presented and monitored through the Workforce Inclusion and Culture Sub-Committee, reporting to the Strategic People Committee. All Care Groups and corporate services will have priority actions in place by mid Q1 2025/26 to make reasonable improvements towards completion, in preparation for the opening of the 2025 survey from September 2025.

In addition to local priorities, the Culture, Engagement and Inclusion Team are collaborating with Trade Unions, Staff Networks, Culture Champions and Clinical Leads to identify organisational priorities which demonstrate how the Trust are responding to feedback.

4. MONITORING/REPORTING ROUTES

Reporting of Staff Survey action plans at Care Group, CBU and Corporate Service level will be reported through the Workforce Inclusion and Culture Sub-Committee, chaired by the Chief People Officer. Actions will be monitored and shared learning cascaded through the Committee’s Cycle of Business.

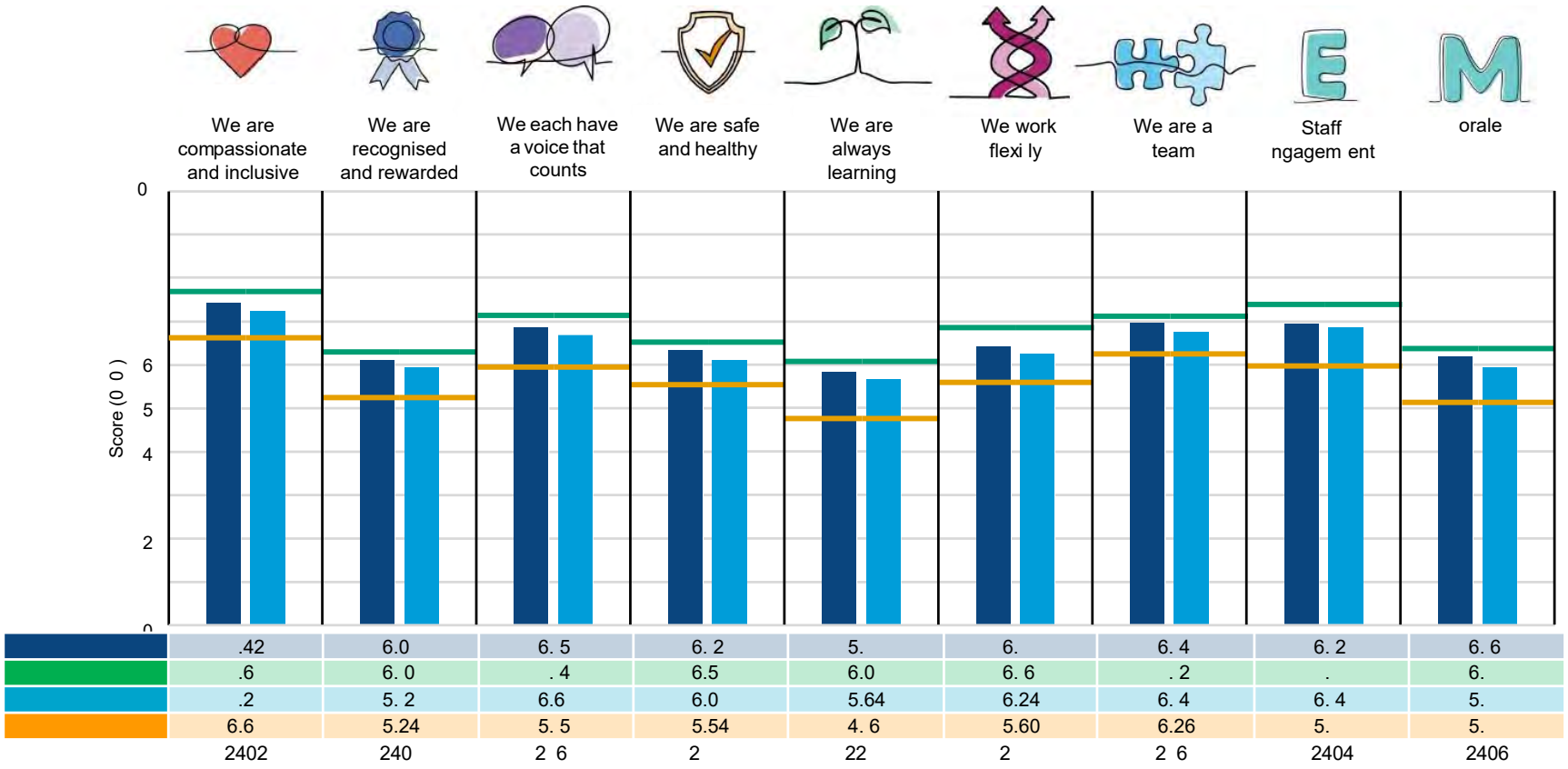
5. ASSURANCE COMMITTEE (IF RELEVANT)

Assurance for the Staff Survey is via the Strategic People Committee. Updates on localised action plans will be presented through the Chairs Logs for Workforce Inclusion and Culture Sub-Committee on a bi-monthly basis.

6. RECOMMENDATIONS

The Trust Board are asked to note the 2024 Staff Survey results for Warrington and Halton Teaching Hospitals NHS Foundation Trust and priorities to respond to staff feedback and experience.

Appendix 1: Overview of Survey Results by Survey Theme



	.42	6.0	6. 5	6. 2	5.	6.	6. 4	6. 2	6. 6
	.6	6. 0	. 4	6.5	6.0	6. 6	. 2	.	6.
	.2	5. 2	6.6	6.0	5.64	6.24	6. 4	6. 4	5.
	6.6	5.24	5. 5	5.54	4. 6	5.60	6.26	5.	5.
	2402	240	2 6	2	22	2	2 6	2404	2406

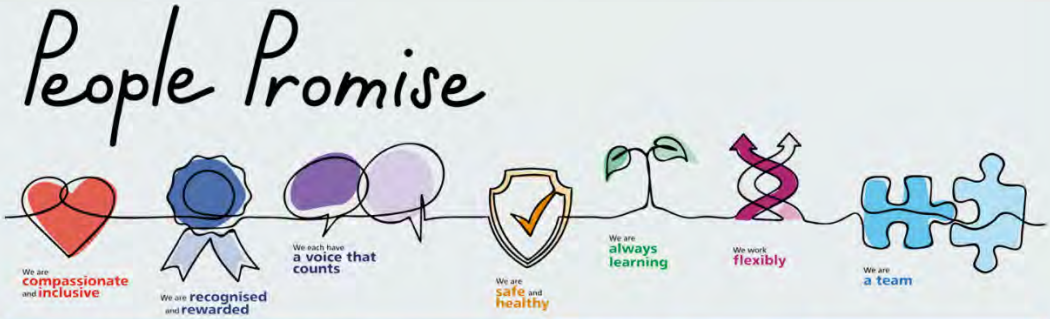
Appendix 2: NHS Staff Survey Results Infographic

Our staff survey results

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our response rate increased to 52% compared to 45% in 2023, with 2,409 colleagues completing the survey – the highest number of responses WHH has ever received!

We are proud to have achieved above the national average for **all nine elements** of the survey and improved our performance from 2023 in two of the elements.



We are compassionate and inclusive

- 89% say their role makes a difference to patients and service users

WHH scored higher than average in the areas of compassionate leadership, diversity and equality and inclusion

We are safe and healthy

- 64% feel that WHH takes positive action on health and wellbeing

Staff reported feeling that they have more energy and work / life balance than previous years

We are recognised and rewarded

- 74% felt that their immediate manager values their work
- 69% say that the people they work with show appreciation to one another

We are always learning

- 86% of staff reported having an appraisal review in the past 12 months, performing better than 2023 and the national average

We each have a voice that counts

- 91% feel that they are trusted to do their job

WHH scored higher than average in the areas of autonomy and control and raising concerns

We work flexibly

- 60% of staff say they can achieve a good balance between work and home life

WHH scored higher than average and better than the 2023 results in the areas of support for flexible working and work-life balance

We are a team

- 75% feel their immediate manager encourages them at work with 67% saying they give them clear feedback
- 81% say they enjoy working with their colleagues with 74% saying they understand each other's roles at WHH

Staff engagement

- 62% would recommend WHH as a place to work
- 72% feel they can make suggestions to improve the work they do with 60% saying they can make the improvements happen

Morale

- WHH scored better than the average Trust in the areas of work pressure and stressors at work

Results have been taken from the 2024 NHS Staff Survey, published on 13 March 2025. Comparisons are benchmarked against acute and acute and community trusts.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/16**	
SUBJECT:	Bi-monthly Strategy Highlight Report	
DATE OF MEETING:	2 April 2025	
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):***	• WHH and BCH's respective Trust Boards have now approved the intention for WHH to formally acquire BCH and become one single integrated organisation. These approvals trigger the start of a transaction process and it is anticipated that the single organisation will take effect from 1st April 2027, pending approvals. Work continues across all ten workstreams and the process of developing the strategic business case has commenced. The Clinical and Operational services group have facilitated two clinical summits to consider pathways within services identified as priorities for integration • The Living Well Hub has recently celebrated its first full year in operation. During that time, over 15,200 visitors have been through the doors with around 50% of these attendances from people "dropping in" to access a service, and the other 50% attending for pre-booked appointments. • Over 89,000 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. • The brand-new Living Well on-line in Warrington (virtual health and wellbeing hub) is due to go-live in March. The new digital platform continues the pioneering collaborative work across Warrington place under the Living Well programme. • The new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is embedded and work continues to implement the new post menopausal bleeding pathway within the CDC in Halton. This will enable women to access a one stop clinic for diagnosis of gynaecological cancers.		
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):	Choose an item.		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Strategy update
January-February 2025

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	Stephen Bennett	
Slide 8-9	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 10-11	Community diagnostic centre	Lefteris Zabatis/Stephen Bennett	
Slide 12-13	New hospitals programme and strategic estates	Carl Mackie	
Slide 14-15	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 16	Completed projects	Strategy team	

Section 4 - Other trust strategic updates	
Slide 17-18	Summary of other Trust strategy related updates
Section 5 - Cheshire and Merseyside strategic updates	
Slide 19	Summary of strategic updates from Cheshire and Merseyside

Key messages

- WHH and BCH's respective Trust Boards have now approved the intention for WHH to formally acquire BCH and become one single integrated organisation. These approvals trigger the start of a transaction process and it is anticipated that the single organisation will take effect from 1st April 2027, pending approvals. Work continues across all ten workstreams and the process of developing the strategic business case has commenced. The Clinical and Operational services group have facilitated two clinical summits to consider pathways within services identified as priorities for integration
- The Living Well Hub has recently celebrated its first full year in operation. During that time, over 15,200 visitors have been through the doors with around 50% of these attendances from people "dropping in" to access a service, and the other 50% attending for pre-booked appointments.
- Over 89,000 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.
- The brand-new Living Well on-line in Warrington (virtual health and wellbeing hub) is due to go-live in March. The new digital platform continues the pioneering collaborative work across Warrington place under the Living Well programme.
- The new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is embedded and work continues to implement the new post menopausal bleeding pathway within the CDC in Halton. This will enable women to access a one stop clinic for diagnosis of gynaecological cancers.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme and Virtual Hub
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates
Naz Ghodrati	CEO, Warrington Voluntary Action	Warrington Virtual Hub, UEC Steering group, Warrington Poverty Conference
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
Alex Katz Sara Suarez	Director, Frontier Economics Associate Director, BMG Research	Living Well Hub – MHCLG project evaluation team
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities and prevention programme in Halton
Peter Bryant Christine Doyle Zoe Bond	Mergers and acquisitions team, NHS England	Support with / insight into integration options appraisal
Rob Cooper	Managing Director, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Tom Roberts	Operational Lead, Kier Construction	CDC phase 3 programme plan
Rick Howell	Lead Commissioner, Adult Social Care, Warrington Borough Council	Living Well Hub - strategic oversight group
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Lee Bloomfield	Associate Director of Strategic Operations, Merseycare NHSFT	Living Well Hub - strategic oversight group
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 and integration programme
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
Cllr Tony Higgins	Elected member, Warrington Borough Council	Central 6 delivery board – update re: virtual health and wellbeing 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 Sunil Sharma	Alder Hey Children's Hospital, Paediatric Surgical team	Paediatric hub project team meeting
Paul Marsh	Regional Health Sector Lead, Kier Construction | North and Scotland	New Hospitals Programme and Strategic Estates

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Steve Park	Director of Growth, Warrington Borough Council	Living Well Hub – MHCLG evaluation, Warrington Town Deal Board
Chris Woodforde	GP- Halton	CYP CDC Respiratory diagnosis pathway
Debbie Watson	Director of Public health, Warrington Borough Council	Living Well Virtual Hub – exec oversight, Warrington Poverty Conference
Michael Bell	Planning Policy and Programmes Manager	Strategic Estates Programme South Warrington urban Expansion
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
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.

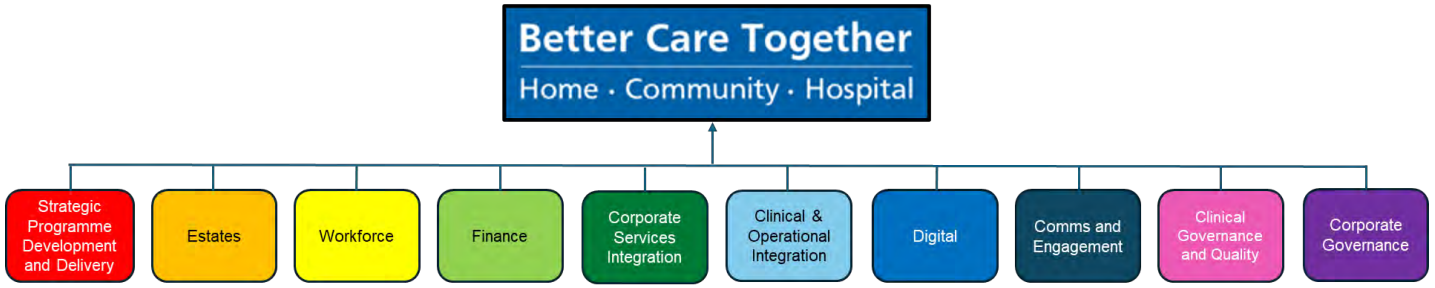
The integration programme- “Better Care Together” has been established with 10 workstreams: Strategic Programme Development, Estates, Workforce, Finance, Corporate Service Integration, Clinical and Operational Services Integration, Digital Services, Communication and Engagement, Clinical Governance and Quality, and Corporate Governance. Each workstream is developing a detailed delivery plan and working with partners to deliver objectives.

What does this mean for WHH?

The formal acquisition of BCH by WHH has now been approved by both Trust Boards and the organisations are now working towards coming together to form a single legal entity wef 1st April 2027. Work is well underway across all ten workstreams to develop the clinical, operational and corporate models, structures and processes that will deliver the best possible care for the populations of Warrington and Halton, both in hospital and out in the community.

Progress:

- New organisational name now agreed and set to be widely communicated imminently.
- Clinical summits have now commenced, designed to bring together clinical teams from both organisations to help design the future plans for clinical services.
- The specific requirements of the corporate services workstream have now been agreed and work is due to commence to start to design the future service delivery models in April.
- Committees in common between the two partner organisations are due to commence in April.
- Organisational change framework and managers toolkits are currently in development to help support managers through a complex change process.
- Work is underway to develop the strategic business case to set out the high level plans for the acquisition alongside indicative benefits and risks.



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
Corporate services integration workstream – deliverables agreed and communicated	April 2025
Communication of new name for integrated organisation following consultation	March 2025
Development of clinical model/clinical strategy	July 2025
Single organisation commences operation	1st April 2027

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 Gardner
Chief Strategy and Partnerships Officer WHH
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Hayley Heard
Deputy Director of Strategy and Partnerships
Hayley.heard@nhs.net

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

- Construction contract awarded
- Timetable development sub-group established
- Collaboration and Contribution Agreement agreed

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
Build commencement	April 2025
Lease heads of terms agreed	April 2025
Construction complete	Oct 2025

Contact details
Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

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 83,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023.
- Early handover of the MRI area is now completed. Final handover day is planned for May 2025.
- Completion of the final phase of the programme is planned for May 2025 with clinical activity scheduled to commence from June 2025.
- New pathway for paediatric respiratory diagnosis has now commenced and new gynae bleeding pathway approved by national team.
- Activity plan for 25/26 is being agreed and calculations suggest the activity should make a significant contribution to the Trust's financial position again next year.

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
Installation of new CT and MRI scanners	May 2025
Completion of new build CDC (phase 3)	May 2025

Contact details
Lefteris Zabatis
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

- Discussions ongoing with construction partners on development of masterplanning for new hospitals programme
- Plans for an urgent treatment centre in development

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	March 2025

Contact details
Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Living Well Virtual Hub- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- To lead the development of new Living Well Virtual Hub for Warrington place in partnership with stakeholders across Warrington.
- To replace previous council run “Mylife” service directory with a modern, accessible multi-functional online platform that serves as a one stop shop for many more service providers from across the borough ranging from small grassroots organisations to larger statutory providers.
- The new virtual hub will form part of a growing programme of work at Place to strengthen the offer around prevention, early intervention and empowering self-care through a “community-led” approach.
- The new platform will empower users to navigate their health and wellbeing journey more independently and would become the single digital entry point for any health and wellbeing-related enquiries for the public of Warrington and also for any staff working across the local system.
- Phase 2 will focus on growing the network and providing tools (such as online social prescribing) and actionable insights to professional working within Warrington for better targeting and supporting health needs of local population groups.

What does this mean for WHH?

- Delivery of a new digital product under the Living Well umbrella which supports the shift from analogue to digital, from hospital to community and from sickness to prevention.
- Longer term, the online platform will support improving health outcomes, reducing inequalities and help reduce future demand and pressure on statutory health and care services across the Borough.

Progress since last report

- Further stakeholder engagement, networking and system mapping of support services across Warrington. Project presented at multiple board meetings across Place.
- Crowd sourcing imagery for website including completion of a public photo competition. Prizes to be presented by The Mayor of Warrington on 20th March.
- Migration of MyLife data completed and soft launch of Living Well Warrington.
- End user testing workshops completed in Feb and design updates to design in progress based on feedback.
- UKSPF allocated funds final spend agreed and deployed.

Living Well Virtual Hub- part 2

NHS
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
Soft Launch of platform	5th March 2025
Photo competition presentation and project delivery group event	20th March
Platform go live to public	26th March
Ongoing network development and onboarding to platform. Evaluation and impact measurement planning.	April-Sept 25

LIVING WELL IN WARRINGTON

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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.
- As October 2024, more than 50,000 patient contacts have occurred at the hub.

Warrington Living Well Hub

- The Living Well Hub has recently celebrated its first full year in operation. During that time, over 15,200 visitors have been through the doors with around 50% of these attendances from people “dropping in” to access a service, and the other 50% attending for pre-booked appointments.
- The service model continues to evolve with the following new services commencing during the report period:
    - Signing Solutions now host sessions to train staff and the public in basic British Sign Language
    - Unify credit union drop-in
    - Expanded phlebotomy service
- The Living Well Hub has been selected as one of twenty Town Deal-funded projects nationally to be evaluated for impact and future learning by the Ministry for Housing, Communities and Local Government. The evaluation took place during February. The final report (covering all twenty national projects) is expected in early 2026.

Other Trust 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. The length of time patients are being nursed on the A&E corridor has reduced from 13 hours in April 2024 to 7 hours in February 2025. Activity in the Same Day Emergency Unit (SDEC) remains consistently above target at 1,180 attendances in February. Bed occupancy rates remain a challenge as do the 4 and 12- hour waiting time targets for the emergency department. Targeted work is ongoing to address these issues and includes the development and expansion of hot clinics and a call before convey (CB4C) pilot.

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

- Construction works complete. All areas handed over to operational teams

Theatre 3 at Nightingale Building, Halton

- Currently in full construction – plan in place with operational teams for phased handover of department
- WHH Project Team working closely with contractors to manage early warning notices and compensation events

Upgrade to Ward B2 at Nightingale Building, Halton

- Construction works complete. All areas handed over to operational teams

Other Trust strategic updates

Digital Projects

EPCMS Update

- Joint Procurement Delivery Group ToR and Partnership Procurement and Deployment Agreement endorsed. Both Trust agreed to work towards single Pre-Market Engagement (PME) in April. Following Exec to Exec and NHSE/ICB 10th March meeting work continues in finalising the procurement/deployment plans and finding a solution to funding issue.
- Bridgewater inclusion in EPR procurement Option 3 Two Phase ITT WHH/MWL Acute EPR ITT followed by WHH/BW Community EPR ITT.

PEP Update (Stats from Feb 2025)

- 58% of patient letters have been read digitally reducing the need for printing and postage of letters.
- 61% of our local population are registered with the NHS App (58% Halton, 63% Warrington)
- 117k notification messages have been sent to our patients
  - 67k (58%) were sent via the NHS App
  - 25k were read on the NHS App –reducing SMS messages by 22%
- Radiology Appointment Letters are now being digitally uploaded to either the NHS App or via the Dr Doctor portal. Anyone wishing to receive paper copies can choose to opt out
- The Trust is now live with appointment letters directly into the NHS App.
- A number of pilots are underway with departments giving good initial feedback on patient messaging functionality

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. A “helicopter team” is being established to drive implementation and will link closely with the local WHH team and the regional pathology collaboration team working on the hub model to ensure alignment.

Pathology collaboration

- Work continues to develop the East Pathology Hub and an outline business case was approved by WHH Trust Board in November 2024. Detailed work is ongoing to develop a full business case which will be presented to Trust Board. The full business case will detail the proposal to develop a hub at Whiston hospital and essential services laboratories in Warrington, Halton, Southport, Ormskirk and St Helens. The WHH team are working closely with the team at MWL to ensure development of a high- quality service that delivers the needs of our population and staff.

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. Demand and capacity planning data has been considered, and a project plan is being developed. The Alder Hey team will be visiting the Halton site in the spring to discuss mobilisation of the plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/18**			
SUBJECT:	Performance Assurance Framework (PAF) Refresh			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	Bethan Thompson, Senior Performance and Systems Development Lead			
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 RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**all**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually. Proposed updates to the PAF for 2025/26 are:			

	• Amendment to the content and purpose of the Quality People and Sustainability (QPS) Review. • Updates to reflect changes to the organisation including team names and job titles.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	The Trust Board is asked to support the amendments to the PAF as part of the annual refresh.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/25/03/290	
	Date of meeting	25/03/2025	
	Summary of Outcome	Supported by Committee to go to Trust Board.	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication		

REPORT TO TRUST BOARD

SUBJECT	Performance Assurance Framework (PAF) Refresh	AGENDA REF:	BM/25/04/18

1. BACKGROUND/CONTEXT

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing, and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.

The Executive Team has considered the effectiveness of the PAF and current accountability structure. A number of amendments have been proposed to the current PAF. These changes are laid out in section 2 of the report.

2. KEY ELEMENTS

The following amendments are being proposed to the PAF and have been incorporated as track changes into the draft updated PAF in **Appendix A**.

- Amendments have been made to the content and purpose of the Quality People and Sustainability (QPS) Quarterly Performance Review (section 3.1.4). This includes amendments to the content of QPS including additional inclusion of IPR Performance reporting by Exception to highlight key concerning metrics for the Care Group to action.

- The PAF has been updated to reflect changes to the organisation including team names and job titles.

3. RECOMMENDATIONS

The Trust Board is asked to approve the amendments to the PAF as part of the annual refresh.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix A

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Performance Assurance Framework – Update for April ~~2024~~2025

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework (PAF) sets out principles of accountability and the commitment by Warrington & Halton Teaching Hospitals NHS Foundation Trust to establish, maintain and provide assurance of effective systems and processes for managing and improving performance across all levels of the Trust. The PAF was developed to provide clarity of accountability and subsequently assurance from 'Ward/Department to Board'. This is underpinned by a focus on health outcomes for patients and the community. The PAF supports the Trust's ambition of being "Outstanding".

1.2 What is Performance Measurement?

The Trust has many different processes for measuring performance at every level of the organisation. Measuring performance via dashboards, reports and systems is vital for ensuring our services are operating in line with National and Local standards. Measuring performance gives an early indicator of potential risks which can be resolved before they become an issue.

1.3 What is Performance Management/Improvement?

Performance management is about ensuring the delivery of timely, high quality, effective and safe patient care by using Trust resources in an efficient manner. This includes understanding how the Trust is performing, reasons for variation, and barriers to improvement. Once this is understood, actions can be planned and delivered in order to make improvement.

1.4 Scope

The PAF covers all performance requirements set out in the Trust's Operational Plan, NHSE~~/I~~ System Oversight Framework, NHS Standard Contract, NHS Operational Planning Guidance, by the CQC and the Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff make to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust performance management policy/incremental pay progression policy.

1.5 Dependencies

The successful implementation of the PAF is dependent upon the production of information dashboards and reports by the Trust's Digital Analytics Team as well as Operational services who managed their own reporting processes (e.g., Theatres, Pathology, Radiology) and the timely supply of data by the Trust's Finance, Quality and HR teams.

1.6 Associated Polices and Strategies

Whilst the PAF incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures in place that will contribute to the delivery of this Framework.

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This PAF sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate actions will be implemented to bring performance back to an acceptable level. The PAF:

- Sets out clear lines of accountability and responsibility for delivery of performance from 'Ward/Department to Board'.

- Supports the principle that all staff have a responsibility to contribute towards improving performance of the organisation and everybody should take ownership.
- Creates clear understood accountabilities and oversight.
- Ensures performance objectives are agreed and transparent measurements are set to monitor performance against objectives.
- Ensures performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
- Provides assurance to the Board, Governors, Regulators, Stakeholders/Partners and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Supports the achievement of the Trust objectives.
- Supports the delivery of the requirements of the Trust Foundation Licence, NHSE System Oversight Framework and the NHS Standard Contract.
- Provides focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
- Supports the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
- Recognises good performance and improvement and share good practice.
- Set out the process for managing performance risks/issues with a balance between challenge and support.

~~In 2023/24, as the Integrated Care Systems & Boards (ICSs) & (ICBs) develop and mature, additional changes to the PAF may be required.~~

3. Our approach to Performance Management

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from "Ward/Department to Board" and "Board to Ward/Department" as set out in **Appendix 1** and is detailed as follows:

3.1.1 Trust Board Level

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with an explanation about performance issues from relevant Executive Directors. The Trust Board may subsequently request one or more performance improvement actions (see 3.3.2) where there is variation with any area of performance.

The Integrated Performance Report (IPR) and the Care Group/CBU IPR are produced by the Trust Contracts & Performance Team with support from Finance, Quality, Governance, Digital Analytics and HR. The format of the IPR and Care Group performance reports have been designed to ensure:

- That information is presented in a way which supports an informed discussion by the Board about achieving improvement.– This will include the triangulation of data to identify trends and areas considered to be an outlier in terms of performance.
- That the commentary presented by the respective Executive, along quantitative performance data, both explains current performance and identifies the actions that are being taken to provide assurance of continual improvement in quality, safety and performance.

KPIs within the Board IPR are reviewed and agreed at least annually by Board Committees with final approval from the Trust Board. KPIs may be changed in year with the minuted support of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

- Exception Report – the front section of the document is an exception report which summarises all KPIs by both Assurance and Variation Category. This is followed by a report of KPIs consistently failing to meet set targets, and KPIs indicating special cause variation of a concerning nature~~.~~. This section also contains additional information around the Trust's Financial Performance including the capital programme.
- Assurance and Variation Movements – this section details areas of special cause variation across all KPIs using Statistical Process Control (SPC) Assurance and Variation Icons (supported by NHSE~~/I~~ as part of the "Making Data Count" initiative). Also detailed is whether KPIs are achieving their set Targets.
- Dashboard – The dashboard details current and historic levels of performance, reasons for underperformance and/or performance deterioration and detail of actions and investigations underway in order to improve performance against the KPI. Wherever possible KPIs are presented as ~~The dashboard contains~~ Statistical Process Control charts which look at data over time to determine if a process is within control or not, or whether there is special cause variation which requires action.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by the Mersey Internal Audit Agency (MIAA).

3.1.2 Board Committees (Finance & Sustainability, Quality Assurance, Strategic People)
Executive Directors and Senior Managers will present updates on performance relative to the Committee remit as appropriate and in addition to the bi-monthly IPR discussed at the Board. The Committee may request one or more performance improvement actions (see 3.3.2) where there is a variation with any KPI. The Committee will escalate any performance variation or highlights to the Trust Board as appropriate via the committee Chair's 'Issues' report.

Each Committee receives regular performance reports as part of its agenda. The KPIs contained in the Committee reports can be changed by approval of Committee members as there may be occasions where the Committee wants to report at a more granular level of detail. Any changes to KPIs need to triangulate to the Trust Board IPR. ~~–~~All changes must be minuted to include the rationale for the change.

3.1.3 QPS Quarterly Performance Review at Care Group Level

The Quality Performance and Sustainability (QPS) Executive Team Review is chaired by the Chief Executive~~EO~~ where a Quarterly review of each Care Group's performance ~~–~~is undertaken.

The Care Group Triumvirate will be required to attend this forum four times per year and present their position alongside their CBU IPR Dashboard, which will highlight any declining variation and/or assurance by exception to the Executive Team. In addition, a summary of Quality, Access and Performance, Workforce and Financial Sustainability performance will be presented alongside relevant KPIs. Prior to the quarterly QPS review, the Care Group Triumvirate will review and update the IPR by exception report and in-year business plan progression in relation to Quality & Governance, Operational Performance, Strategy, Improvement, People, and Finance.

Discussions will take place to understand any barriers to performance improvement or reasons for variation against signed off Business Plans and will look at any additional support required to address barriers preventing strategic priorities from delivery. The Care Group will also

address ongoing revenue requests and benefits realisation against historic revenue requests. ~~The Care Group Triumvirate will be required to attend this forum four times per year and present their position alongside a 'QPS Performance Dashboard', which will highlight key Care Group priorities set at business planning, as well as performance~~.
~~Alongside the dashboard~~In addition, the Care Group Triumvirate will present on areas of improvement and good practice which can be shared across the Trust. This will form part of the Trust Learning Framework. Actions from the forum will be recorded by a member of the Performance Team. If urgent actions are required, the Care Group will provide an update to the next available Executive Team meeting and will not wait until their next quarterly review.

~~Prior to the QPS review, the Care Group Triumvirate will review and update 'Business Planning Dashboards' in relation to Quality & Governance and Operational Performance (Quality and Performance), People (People) and Finance (Sustainability) that have been created based on the priorities set out at Business Planning. The Dashboards will monitor achievement against priorities, and will track Care Group delivery against Quality, People and Finance goals and targets.. The dashboards will also include progress around priorities identified in business plans which in turn supports delivery of the CBU/Care Groups Strategy.~~

The Executive Team may request one or more performance improvement actions (see 3.3.2) where there are any areas of variance. The Executive Team will escalate to the appropriate Board Committee or the Trust Board if it feels necessary to do so.

The Executive Team may ask Care Groups to attend Executive Team meetings at any time outside of the review process where there is a potential performance issue.

3.1.4 Leadership Observational Rounds
Non-Executive & Executive Leadership Observational rounds have been in place since 2022/23, and focus on positive interactions, celebrating success, and utilising CQC Red Flags to guide key lines of enquiry with the goal of improvement. Leadership Observational Rounds may also utilise performance variation to guide key lines of enquiry. The Leadership Observational Rounds take place 6 times per year and feedback will be collated as evidence as part of the CQC well led domain.

3.1.5 Care Group/CBU Level
The Care Group & CBU Triumvirate is expected to manage the performance of their services and have appropriate structures/forums in place to do so. The Care Groups & CBUs will be able to access performance information to enable them to monitor and manage performance in real time. Care Groups & CBUs are required to take corrective action to improve areas of underperformance, working with corporate services and other Trust departments as appropriate. Care Groups & CBUs should escalate any areas of performance variance to the appropriate forum. The Care Groups & CBU Triumvirates may request one or more performance improvement actions (see 3.3.2) for an individual Ward, Department, Service or Team where there are any areas of variation.

3.1.6 Ward, Department, Service or Team Level
Ward/Department/Service/Team managers will be able to access appropriate performance reports at that level in order to ensure they are managing day to day performance. Wards/Departments/Services/Teams are accountable to the CBU Triumvirate, who will provide any support, along with corporate services as necessary.

The production of quality, meaningful and timely performance information is fundamental to the delivery of the PAF. Information must be timely, accurate and complete; and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

3.2 Roles & Responsibilities

Specific roles and responsibilities in relation to the ongoing monitoring, management, and improvement for the performance of the Trust are as follows:

3.2.1 Chief Executive
The Chief Executive has overall corporate responsibility for performance across the Trust.

3.2.2 Executive Directors
Executive Directors have delegated authority, responsibility, and accountability for the areas within their portfolio for ensuring effective performance management structures, systems and processes are in place for reporting, managing and improving performance with robust arrangements in place for addressing performance concerns.

3.2.3 Chief Finance Officer ~~& Deputy Chief Executive~~
In addition to responsibilities outlined in 3.2.2, The Chief Finance Officer ~~& Deputy Chief Executive~~ has delegated authority for ensuring the overarching Performance Assurance Framework is in place and Executive oversight of the Performance Team activities outlined in 3.2.4.

3.2.4 Contracts, Performance and Commercial Developments Team
The Contracts, Performance and Commercial Developments Team is responsible for the management, production and development of the Trust and Care Group/CBU IPR as well as the management of the QPS Executive Team Review process. The Performance ~~Team~~ Lead is the gatekeeper of the IPR and is responsible for ensuring any changes are approved via the appropriate governance process and once approved are actioned.

The Contracts, Performance and Commercial Developments Team will provide training to the Care Groups & CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.2.5 Digital Analytics Team
The Digital Analytics Team will develop, generate and publish the necessary local reports and dashboards to enable the Care Group/CBU/Teams to monitor and manage performance and will provide data for the Trust and Care Group/CBU level IPRs.

3.2.6 Corporate Services
Corporate services (Finance, Governance, HR, IM&T, Strategy) has responsibility for the production and validation of data for Trust, Care Group & CBU IPR dashboards. Corporate services will provide the necessary support to Care Group/CBUs in order to improve performance in their area.

3.2.7 Care Group Triumvirates
The Care Group Triumvirates has responsibility and accountability for the management and improvement of performance for their CBUs and will implement appropriate performance improvement actions (see 3.3.2). Care Group Triumvirates will hold CBU Triumvirates accountable for the delivery of performance KPIs at CBU level.

3.2.8 CBU Triumvirates
The CBU Triumvirates has responsibility and accountability for the management and improvement of performance for their CBU and will implement appropriate performance improvement actions (see 3.3.2). Each CBU triumvirate will, in turn, hold individual service managers, clinical matrons, specialty leads and, where applicable, Professional Heads of Service, accountable for the delivery of performance KPIs at specialty and service level.

3.2.9 Ward/Department/Service/Team Managers

The Ward/Department/Service/Team managers have responsibility for the management and improvement of performance for their Ward/Department/Service/Team and will implement any improvement actions requested by the CBU Triumvirate.

3.2.10 All Staff

All members of staff contribute to managing and improving performance and are encouraged to suggest areas for improvement and ideas on how improvement can be made. All staff should have an understanding of how their role contributes to performance of the Trust and the impact this has on patient care.

3.3 Performance Risks/Issues

Where there is a risk to the Trust achieving a standard or target or where performance has deteriorated or is an outlier against a benchmark , this should be highlighted as a performance risk/issue and must be detailed as necessary on relevant risk registers All actions and interventions relating to performance risk/issues will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support, recognising any organisation wide resource needs.

3.3.1 Identification and Management

A performance risk/issue can be identified by any member of staff at any level of the organisation ("Ward/Department to Board").

Where a performance risk/issue has been identified, it is the responsibility of the Performance Oversight Group outlined below to oversee appropriate actions in order to resolve the issue as soon as possible.

Performance Issue/Risk Area	Performance oversight Group	Support
Ward, Department, Service or Team Level	CBU Triumvirate	Corporate Services
CBU Level	Care Group Triumvirate Quality, People & Sustainability Executive Team	
Trust Level	Executive Team Finance & Sustainability Committee Strategic People Committee Quality Assurance Committee ~~Clinical Oversight Recovery Committee~~ Trust Board	

3.3.2 Performance Improvement Actions

A. Informal

Some low/medium level performance issues/risks may be managed locally by reviewing processes and making the necessary operational changes. These performance risk/issues may be as a result of a temporary local issue such as a staff shortage or an unexpected increase in demand. In the first instance, these performance issues should be managed and resolved locally with the appropriate authority to do so.

B. Remedial Action Plan

Where a performance risk/issue cannot be resolved in the short term and it is likely to have a medium to long term impact on Trust performance, the Performance Oversight Group may

request a Remedial Action Plan. The Remedial Action Plan will outline actions to be taken, impact, timescales and review timescales and will be reviewed at an appropriate forum each month. Once the performance oversight group is satisfied that the actions are complete and performance has returned to a satisfactory level, the Remedial Action Plan will be closed.

C. Deep Dive Review

The relevant Performance Oversight Group may request at any time a deep dive into areas where there is a continued performance concern. The Performance Oversight Group will set out terms of reference including timescales. Once the review has been concluded, the Performance Oversight Group will agree next steps this may include setting quality improvement metrics, trajectories for improvement, further investigations, the implementation of a Remedial Action Plan or the establishment of an Improvement Group.

D. Improvement Group

Where performance issues/risks need additional support in order to return to satisfactory levels, a time limited Improvement Group will be established. The Improvement Group will be made up of representatives from corporate and clinical services as appropriate and will be sponsored by an appropriate Executive Director or Senior Manager and will report progress to the Performance Oversight Group.

E. Intensive Support

Where performance has not returned to a satisfactory level after the required support has been provided, the Performance Oversight Group may place a Care Group, CBU or Team into Intensive Support. Intensive Support is a recovery planning and delivering procedure and is a mechanism to direct additional management focus. The performance oversight group will write to the Care Group/CBU/Team to inform them of the decision and will outline the reasons this action has been taken. The Care Group/CBU/Team will be expected to report weekly to the Performance Oversight Group actions taken to improve performance and the impact this has had. This effort will be supported by appropriate corporate resources. The Care Group/CBU/Team will remain in Intensive Support until the performance issue has been resolved. Once the performance oversight group is satisfied that the performance issue has been sufficiently addressed, the performance oversight group will write to the Care Group/CBU/Team to inform them of the decision to bring them out of Intensive Support.

The Intensive Support procedure may be deployed in the following circumstances:

- Where there are continued and persistent performance issue in one or more areas.
- Where there is an ongoing risk to patient safety which has not been addressed, effective delivery of services or any other reasons where it is judged that the level of support is justified by the performance oversight group.
- Where delivery levels against operational performance targets is inadequate as determined by the Performance Oversight Group, where no robust plan has been agreed.
- Failure to operate within the financial parameters outlined without a legitimate reason or evidence of lack of financial controls.
- Any other circumstances where it is assessed that a risk exists which cannot be resolved via normal line management actions or where less intensive recovery actions have failed.

A summary of improvement groups and intensive support provision will be reported to the relevant board committee.

4. Structure and Governance to ensure delivery

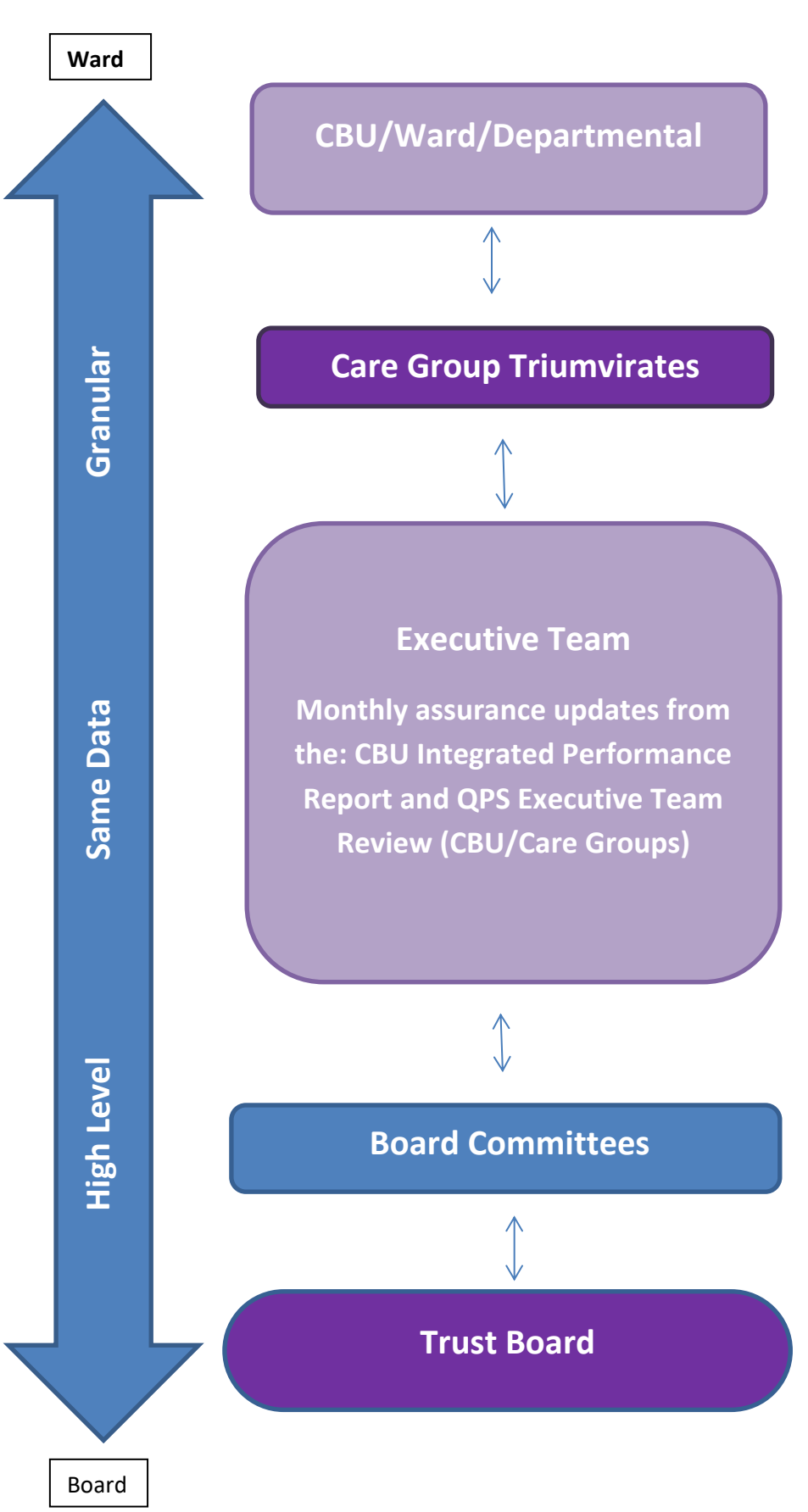
4.1 Accountability, Responsibility and Reporting Structure

Appendix 1 sets out the Trust's Accountability, Responsibility and Information reporting structure. Each meeting will have a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

5. Next Steps

This Performance Assurance Framework will be reviewed in April ~~2025~~ 2026 as part of the annual planning cycle. The PAF will be reviewed and updated as appropriate as new guidance emerges in year.

Appendix 1 - Trust Accountability, Responsibility and Information Reporting Structure – "Ward/Department" to Board



CBU/Ward/Departmental	• CBUs/Wards/department leaders. • Review performance and identify risk at granular level weekly and take corrective action as appropriate. • CBU Triumvirates report up Care Group Triumvirates.
Care Group Triumvirates	• Full review of performance at CBU level. • Review, confirm and identify any risk/issues with agreement of remedial action plans. Risk to be reported through Risk Review Group. • Support CBUs to improve performance in identified areas. • Monitoring of remedial actions arising from QPS.
Executive Team Monthly assurance updates from the: CBU Integrated Performance Report and QPS Executive Team Review (CBU/Care Groups)	• Executive Committee holds Care Groups to account via the QPS. • Provide support to Care Groups to address identified performance issues.
Board Committees	• Executive Director/Senior Leaders attend committee meetings. • Board Committees review their performance reports/dashboards. • Deep dives requested by Committee where there is variation in performance. • Relevant committees assure Board through key issues reports and escalates any issues to Trust Board.
Trust Board	• Integrated Performance Report presented by Executive Directors. • Receiving concerns raised by Committee Chairs. • Board request additional actions and assurance where necessary. • Bi-Monthly meeting.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/19**			
SUBJECT:	Integrated Performance Report Refresh			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	Jane Hurst, Chief Finance Officer Daniel Moore, Chief Operating Officer & Deputy Chief Executive Zoe Harris, Director of Operations and Performance and Deputy Chief Operating Officer Ali Kennah, Chief Nurse Jennie Dwerryhouse, Deputy Chief People Officer Paul Fitzsimmons, Executive Medical Director			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance Officer Daniel Moore, Chief Operating Officer & Deputy Chief Executive Ali Kennah, Chief Nurse Michelle Cloney, Chief People Officer 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):	**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:			

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">The Trust Integrated Performance Report (IPR) Dashboard is reviewed at least annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date.

This paper outlines the recommended updates, including metrics to be removed and included in the Trust Board's IPR from 2025/26.</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:

1. Approve the proposed amendments to the IPR Dashboard for 2025/26.
2. Note the contents of this report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Finance + Sustainability Committee
Quality Assurance Committee – circulated virtually with committee
Strategic People Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">FSC/25/03/290
SPC/25/02/185</td></tr>
<tr><td>Date of meeting</td><td colspan="3">25/03/2025
19/02/2025</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">KPI adjustments approved by all corresponding committees.</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Whole FOIA Exemption</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Annual IPR Refresh	AGENDA REF:	BM/25/04/19

1. BACKGROUND/CONTEXT

In April 2017, the Trust Board approved the implementation of the Performance Assurance Framework (PAF) which sets out the approach for ensuring effective systems are in place for monitoring, managing, and improving Trust performance.

As part of the introduction of the PAF, the Trust implemented the Integrated Performance Report (IPR) dashboard which brings together indicators from a range of sources including Contractual Standards, CQC Insight Indicators and Indicators relating to the NHSE/I System Oversight Framework. This dashboard provides assurance and oversight of performance at Trust Board level.

All IPR indicators are reviewed at least annually to ensure they remain relevant and up to date and to introduce any new indicators which are required.

This paper outlines recommendations for updates to indicators relating to Quality, Access and Performance, Workforce and Finance. Following support from the relevant subcommittees (QAC, FSC and SPC), the Trust Board is asked to support these changes.

2. KEY ELEMENTS

The Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators. In addition, the 2025/26 draft NHS Standard Contract and NHSE Oversight Framework have been reviewed to understand changes which may affect performance monitoring. The recommendations outlined have been supported by the relevant committees and are show in Tables **1**-**5**.

Removed Indicators

Table 1 proposes the removal of Trust Indicators.

Table 1: Indicators to be Removed

KPI	Rationale
Quality	
2. Duty of Candor (Serious Incidents)	Duty of Candor has remained at 100% for over 2 years. Duty of Candor is discussed at the Safety Oversight group. Any deviations from 100% target will be escalated to Trust Board.
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	Any cases of COVID-19 are recorded and tracked by Infection Prevention Control. Any increase in COVID-19 cases will first be escalated to QAC, then Trust Board.
15. Staffing – Care Hours per Patient Day (CHPPD)	CHPPD is monitored via Strategic People Committee. Any statistical deviations from the target will be escalated to the Trust Board via Strategic People Committee.
18. NICE compliance	NICE compliance has remained above target for over 2 years. NICE compliance is monitored by patient safety and any deviation in target will be raised to QAC via Patient Safety.
27. Ward Moves between 10pm and 6am with a dementia,	Ward moves is monitored within the Corporate Performance Report which is produced monthly which feeds into FSC.

LD and/or Mental Health alert	
Access & Performance	
44. Discharge Summaries - % sent within 24hrs	Performance has consistently exceeded the target for 2+ years. Deviations in performance are to be escalated to Trust Board via PRG if required.
45. Discharge Summaries - Number NOT sent within 7 days	
48. Urgent Operational cancelled for 2nd time	Performance has been consistently at 0 for 2+ years. Deviations in performance are to be escalated to Trust Board via PRG if required.
56. % patients referred to long COVID service not assessed within 15 weeks	The long COVID service has been decommissioned.
60. Virtual Outpatient Appointments	Virtual Outpatients no longer requires ongoing monitoring at Trust Board level. This is monitored via PRG.
61. Uncapped Theatre Utilisation	Uncapped Theatre Utilisation is no longer monitored; however, capped theatre utilisation will continue to be monitored via the IPR.
Workforce	
64. Retention	KPI not to be reported to Trust Board as a similar measure to Turnover. Continue to be reported to Strategic People Committee for triangulation purposes.
66. Bank and Agency Reliance	KPI is reported with the Finance KPIs for Trust Board so not to be included in the People KPIs to Trust Board due to duplication. Continue to be reported to Strategic People Committee for triangulation purposes.
Finance	
There are no Finances indicators to be removed at this time.	

Updated Indicators

Table 2 provides details of updates required to Trust Indicators.

Table 2: Indicators to be Updated

KPI	Proposed Change	Rationale
Quality*		

1.Incidents (over 40 days)	Removal of the following supporting evidence charts: • Prevention of future deaths PSII Actions breached	This supporting evidence can be managed locally. Due to low quantity of these incidents, it will be more effective to raise these by exception. PSII actions are picked up by patient safety/QAC. PSII actions can be escalated via QAC to Trust Board
11.Inpatient Falls & harm levels	Removal of supporting evidence 'Falls - avoidable harm' Moderate and above harm to be grouped together	This KPI has remained at 0 since being recorded in December 2023. Any increase will be escalated to QAC via the Patient Safety team.
13.Medication safety – Reconciliation within 24 hours	Removal of the following supporting evidence charts: • Medication safety – controlled drug incidents Medication safety – incidents with harm	This supporting evidence for Medication is monitored through PSCESC and QAC.
19.Complaints	Removal of the following supporting evidence charts: • Complaints Closed in month • Complaints – Responded in time frame Complaints - PHSO	These aspects of Complaints are monitored through the Patient Safety Committee. In addition, there is an annual complaints report which goes to the WAC for escalation. Complaints will also be monitored weekly from 1st April 2025 at Safety Oversight Group.
Access & Performance		
There are no Access & Performance indicators to be updated at this time.		
Workforce		
63. Supporting attendance	Change from Annualised to monthly reporting in line with best practice SPC chart reporting. Target increase from 4.2% to 5.0% in line with clinical budget setting and regional benchmarking.	Accurate SPC analysis requires non-annualised (monthly) data.
Finance		
75. Agency Ceiling	Agency ceiling KPI proposed to be amended to: **75.** Agency Reduction **Target:** 30% reduction of 2024/25 plan	The previous KPI was Agency Ceiling (with a 2024/25 ICS target of 3.2%) this has been achieved throughout 2024/25. This KPI will now be renamed **Agency Reduction** to ensure that Agency usage is in line with the operational planning guidance to reduce agency by 30% of the 2024/25 plan. The Agency 2025/26 target has been agreed as part of operational planning

		sign off; the Trust Board will sign off the 2025/26 trajectory on 20th March 2025. This Agency trajectory will be used within the IPR.

New Indicators

Table 3 provides details of a newly proposed Trust Indicators.

Table 3: New Indicators

KPI	Measurement Criteria	Rationale
Quality		
There are no new Quality indicators recommended at this time.		
Access & Performance		
There are no new Access and Performance indicators recommended at this time. Typing Turnaround Times will be introduced as a KPI in 2025/26 following the establishment of reporting requirements.		
Workforce		
There are no new Workforce indicators recommended at this time		
Finance		
Bank Reduction	Bank usage as a % of staffing at the Trust. **Target:** 10% reduction of 2024/25 plan	The metric has been included in the 2025/26 IPR proposal for Board oversight of this metric. This KPI will monitor bank reduction to ensure that bank usage is in line with the operational planning guidance to reduce bank by 10% of the 2024/25 plan. The Bank 2025/26 target has been agreed as part of operational planning sign off. This Bank trajectory will be used within the IPR.

Presentation Amendments to Indicators

Table 4 proposes the presentational amendments to Trust Indicators.

Table 4: Presentational Amendments to Indicators

KPI	Proposed Change
Quality	
There are no presentational amendments recommended at this time.	
Access & Performance	
35. A&E Waiting Times - % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC) **76.** A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC)	The UEC KPIs will be grouped together in the IPR to ensure associated KPIs are reported on together.

36. Average time in department ED **37.** A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge **41.** Ambulance Handovers within 15 minutes **42.** Ambulance Handovers within 30 minutes **57.** Type 5 attendance	
The following KPIs will be grouped together in the IPR to ensure associated KPIs are reported on together: **32.** Diagnostic Waiting Times (within 6 weeks) **33.** Referral to Treatment – Open Pathways **34.** Referral to Treatment – Number of patients waiting 52+ weeks **51.** Elective Recovery Activity (Grouped SPCs) **52.** Elective Recovery Diagnostic Activity (Grouped SPCs) **58.** Reduction in Outpatient Follow Ups compared to 19/20 activity	The DM01 KPIs will be grouped together in the IPR to ensure associated KPIs are reported on together.
The following KPIs will be grouped together in the IPR to ensure associated KPIs are reported on together: **46.** Cancelled Operations on the day for a nonclinical reason **47.** Cancelled Operations on the day for a nonclinical reason - Not offered a date for readmission within 28 days of the cancellation **62.** Capped Theatre Utilisation	The Theatre-related KPIs will be grouped together in the IPR to ensure associated KPIs are reported on together.
Workforce	
There are no presentational amendments recommended at this time.	
Finance	
There are no presentational amendments recommended at this time.	

The proposed changes will result in a decrease of the KPIs from 75 to 63 as follows:

	2024/25	2025/26
Quality	31	26
Access & Performance	31	25
Workforce	6	4
Finance	7	8
Total	**75**	**63**

Updated IPR Targets

Table 5 provides an overview of the IPR metrics with the current 2024/25 and 2025/26 proposed targets/trajectories.

Table 5: 2025/26 KPIs and Targets

Quality KPIs		2024/25 Target or Threshold	2025/26 Target or Threshold
1	Incidents	0	0
2 REMOVED	Duty of Candour (serious incidents)	100.00%	NA
3	Healthcare Acquired Infections (MRSA)	0	0
4	Healthcare Acquired Infections (MSSA)	No threshold set	Thresholds not yet received for 2025/26
5	Healthcare Acquired Infections (CDI)	Less than 60 for 2024/25	
6	Healthcare Acquired Infections (Ecoli)	Less than 79 for 2024/25	
7	Healthcare Acquired Infections (Klebsiella)	Less than 28 - 2024/25	
8	Healthcare Acquired Infections (PA)	Less than 10 - 2024/25	
9 REMOVED	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	NA
10	VTE Assessment	95.00% (quarterly position)	95%
11	Inpatient Falls & harm levels	20% or more decrease from previous year	10% reduction
12	Pressure Ulcers	10% reduction	20% reduction
13	Medication Safety Reconciliation within 24 hours	80.00%	80.00%
14	Staffing - Average Fill Rate	90.00%	90.00%
15 REMOVED	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	NA
16	Mortality ratio - HSMR	No target set	No target set
17	Mortality ratio - SHMI	No target set	No target set
18 REMOVED	NICE Compliance	90.00%	NA
19	Complaints	Zero complaints open over 6 months old/in the backlog	0
20	Friends and Family (Inpatients & Day cases)	95.00%	95.00%
21	Friends and Family (ED and UCC)	87.00%	87.00%
22	Mixed Sex Accommodation Breaches (ITU Only)	0	0
23	Sepsis - % screening for all emergency patients.	90.00%	90.00%
24	Sepsis - % screening for all inpatients	90.00%	90.00%

25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	90.00%
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	90.00%
27 REMOVED	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	NA
28	Acute Kidney Injury	Less than previous month	Less than previous month
29	Maternity Postpartum Haemorrhage	3.70%	3.70%
30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	Best Practice Tariff
31	MUST nutritional assessment completion	above 85%	above 85%
Access and Performance KPIs		**2024/25 Target or Threshold**	**2025/26 Target or Threshold**
32	Diagnostic Waiting Times 6 Weeks	95.00%	95.00%
33	Referral to treatment Open Pathways	92.00%	92.00%
34	RTT - Number of patients waiting 52+ weeks	0	Less than 1 % of the total waiting list by March 26
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	75%	78% (national aspiration)
76	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	75%	78% (national aspiration)
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	2% or less
37	Average time in department ED	No Target	No Target
38	28 Day Faster Cancer Diagnosis Standard	75%	75%
39	Cancer 31 Day Wait	96%	96%
40	Cancer 62 Day Wait	85%	75% national target by March 2026, with a Trust stretch target of 77%. Operational standard of 85%
41	Ambulance Handovers within 15 minutes	65%	65%
42	Ambulance Handovers within 30 minutes	95%	95%
43	Ambulance Handovers within 60 minutes	100%	100%
44 REMOVED	Discharge Summaries - % sent within 24hrs	95%	NA
45 REMOVED	Discharge Summaries - Number NOT sent within 7 days	0	NA
46	Cancelled Operations on the day for a non-clinical reason	Less than 2%	Less than 2%
47	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation.	0	0

48 REMOVED	Urgent Operations Cancelled for 2nd Time	0	0
49	Super Stranded Patients	Trajectory	Trajectory
50	No Criteria to Reside (NCTR)	No Target set	No Target set
51	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in previous year	Target/Trajectory to be finalised in 2025/26.
52	Elective Recovery Diagnostic Activity (Grouped SPCs)		
53	Elective Outpatient Activity	0%	0%
55	Patients seen in the Fracture Clinic within 72 hours	95%	95%
56 REMOVED	% patients referred to long COVID service not assessed within 15 weeks	No Target set	No Target set
57	Type 5 attendances	No Target set	No Target set
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	No Target set
59	% Patients discharged to their usual place of residence	No Current Threshold	No Current Threshold
60 REMOVED	Virtual Appointments	No Target set	NA
61 REMOVED	Uncapped Theatre Utilisation	85%	NA
62	Capped Theatre Utilisation	85%	85%
Workforce KPIs		**2024/25 Target or Threshold**	**2025/26 Target or Threshold**
63	Supporting Attendance	<4.2%	<5%
64 REMOVED	Retention	>85%	>85%
65	Turnover	<13%	<13%
66 REMOVED	Bank & Agency Reliance	<9%	<9%
67	Core/Mandatory Training	>85%	>85%
68	Performance & Development Review (PDR)	>85%	>85%
Finance KPIs		**2024/25 Target or Threshold**	**2025/26 Target or Threshold**
69	Trust Financial Position	Plan	Plan
70	Cash Balance	Plan	Plan
71	Capital Programme	Plan	Plan
72	Better Payment Practice Code	>95%	>95%
73	Cost Improvement Programme – In year	>90% plan	>90% plan
74	Cost Improvement Programme recurrent – In year	>90% plan	>90% plan
75 UPDATED	Agency Reduction	N/A	Reduction of 30% of 2024/25 plan
NEW	Bank Reduction	N/A	Reduction of 10% of 2024/25 plan

The Trust Board is asked to approve the proposed amendments to the IPR Dashboard for 2025/26.

If approved by the Trust Board, these changes will be implemented from the June 2025 Board report (April 2025 data).

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. Approve the proposed amendments to the IPR Dashboard for 2025/26.
2. Note the contents of this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/20**			
SUBJECT:	**Board Cycle of Business**			
DATE OF MEETING:	2 April 2025			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive and Steve McGuirk Chair			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All✓			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board are required to review their Cycles of Business on an annual basis. The proposed amended Cycle of Business is attached for review and approval by the Trust Board. Once approve this will guide the planned business for Trust Board Agendas throughout 2025/26.			
PURPOSE: *(please select as appropriate)*	**Approval** ✓	**To note**	**Decision**	

RECOMMENDATION:	The Trust Board is asked to approve the Cycle of Business for 2025/26.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Cycle of Business 2025-26										
	Frequency		Lead	02-Apr	04-Jun	06-Aug	01-Oct	03-Dec	28-Feb	
				2025					2026	
Engagement Story	**Standing Item**	**Sup Pack**	**Chief Nurse Head of Patient Experience and Inclusion**	X	X	X	X	X	X	
Opening Business										
Chairman's Welcome, Apologies & Declarations	Standing Item		**Chair**	X	X	X	X	X	X	
Minutes of Previous Meeting(s) & Action Log	Standing Item		**Chair**	X	X	X	X	X	X	
Chief Executive's Report	Standing Item		**Chief Exec**	X	X	X	X	X	X	
Chairman's Report	Standing Item		**Chair**	X	X	X	X	X	X	
QPS Assurance										
Integrated Performance Dashboard inc Monthly Nurse staffing report	Standing Item		**Execs**	X	X	X	X	X	X	
Refresh of Trust Integrated KPIs (formal signing in May)	Annually		**Chief Finance Officer**	X						
Performance Assessment Framework (PAF)/ Review (formal signing in May)	Annually		**Chief Finance Officer**	X						
Quality										
Complaints Report	Annually		**Chief Nurse**			X				
Learning From Experience Summary Report	Quarterly	✓	**Chief Nurse**	XQ3	XQ4		XQ1	XQ2		
Health & Safety Report	Annually	✓	**Chief Nurse**			X				
Director of Infection Prevention & Control Annual Report (DIPC)	Annually	✓	**Chief Nurse**			X				
Infection Prevention & Control Update	Quarterly	✓	**Chief Nurse**	XQ3	XQ4		XQ1	XQ2		
Infection Prevention and Control Board Assurance Framework Compliance	Bi-Annually	✓	**Chief Nurse**			X			X	
Safeguarding Report	Annually	✓	**Chief Nurse**			X				
Compliance Update (was M2O)	Quarterly		**Chief Nurse**	XQ3	XQ4		XQ1	XQ2		
Learning from Deaths	Quarterly	✓	**Executive Medical Director**	XQ3	XQ4		XQ1		XQ2	
Medicines Management	Annually	✓	**Executive Medical Director**		X					
Controlled Drugs Annual Report	Annually	✓	**Executive Medical Director**		X					
Safe Nurse Staffing	Bi-Annually	✓	**Chief Nurse**			X			X	
Violence Reduction Strategy	Bi-Annually	✓	**Chief Operating Officer**		X				X	
Patient Experience Strategy 6 monthly report	Bi-Annually	✓	**Chief Nurse**		X			X		
In Patient Survey	Annually		**Chief Nurse**		X					
Fragile Clinical Services Update	Bi-Monthly		**Chief Nurse & Executive Medical Director**	X	X	X	X	X	X	
Quality Strategy Update	Annually		**Chief Nurse**		X	X				
Quality Strategy Revised 2025-27	3-yearly		**Chief Nurse**	X						
Quality - Maternity Papers										
Maternity and Neonatal Summary Report (to cover the scheduled papers below)	Bi-Monthly		**Director of Midwifery**		X	X	X	X	X	
Monthly Maternity & Neonatal Review	Bi-Monthly			X	X	X	X	X	X	
Maternity Self-Assessment Tool Report	Bi-Annually				X			X		

Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report	Quarterly		**Chief Nurse & Director of Midwifery**	Q3	Q4		Q1	Q2	
Perinatal Mortality Report	Annually				X				
Maternity Incentive Scheme Yr 6 Submission	Annually								X
MIS year 5 - Safety Action 4b - Anaesthetic, Neonatal and Medical Workforce overview	Annually								X
Maternity Incentive 5-Year Update including Saving Babies Lives Care Bundle V3 Update	bimonthly			X	X	X	X	X	X
Safe Staffing Report (QAC)	Bi-Annually				X				X
Midwifery Safe Staffing Report (SPC)	Quarterly			Q3		Q4	Q1	Q2	
Avoiding Term Admissions into Neonatal units (ATAIN)	Quarterly			Q3		Q4		Q1	Q2
Transitional Care Audit	Quarterly			Q3		Q4		Q1	Q2
Review of Harm	bi annually				X			X	
Maternity Review of Year Progress Report (2023/24)	Annually		**Director of Midwifery & NED Maternity Safety Champion**		X				
CQC Maternity Surney	Annually		**Chief Nurse & Director of Midwifery**	X					
People									
NHS National Staff Opinion Survey	Annually		**Chief People Officer**	X					
GMC Re-validation Annual Report inc Statement of Compliance	Annually	✓	**Executive Medical Director**				X		
Communications & Engagement Dashboard Report	Quarterly		**Director of Comms & Engagement**		Q4	X Q1		X Q2	xQ3
Guardian of Safe Working Report	Quarterly	✓	**Executive Medical Director**	XQ3	X Q4		X Q1	XQ2	
Guardian of Safe Working Annual Report	Annually	✓	**Executive Medical Director**			X			
Freedom To Speak Up Guardian Report	Bi-Annually		**Freedom to Speak Up Guardian**	X			X		
Hospital Volunteer Report	Annually		**Chief Nurse**		X				
Gender Pay Gap Annual Report	Annually		**Chief People Officer**		X				
Health & Wellbeing Report	Annually		**Chief People Officer**		X				
Finance & Sustainability									
Operational Plan & Budgets Approval	Annually		**Chief Finance Officer**	X					
Cash Support (within IPR)	Bi-Monthly		**Chief Finance Officer**				X	X	X
Capital Programme	Annually		**Chief Finance Officer**	X					
Emergency Preparedness Report	Annually		**Chief Operating Officer**			X			
EPRR Assurance Letter/Statement of Compliance	Annually	✓	**Chief Operating Officer**				X		
EPPR Compliance Update following Dec 2023 Report	one off		**Chief Operating Officer**		X				
Strategy Programme Highlight Report	Bi-Monthly		**Director of Strategy & Partnerships**	X	X	X	X	X	X
Strategy Bi-annual Delivery Report	Bi-Annually		**Director of Strategy & Partnerships**			X			X
Senior Information Risk Owner Report	Annually	✓	**Chief Information Officer**				X		
Digital Strategy Group Update	Bi-Monthly	✓	**Executive Medical Director**	X	X	X	X	X	X
Use of Resources Annual Report (on hold see FSC CoB)			**Chief Finance Officer**						
Committee Assurance Reports									
Audit Committee	Bi-Monthly		**Company Secretary**	X	X		X	X	
Quality Assurance Committee	Bi-Monthly		**Chief Nurse**	X	X	X	X	X	X
Finance & Sustainability Committee	Bi-Monthly		**Chief Finance Officer**	X	X	X	X	X	X

Strategic People Committee	Bi-Monthly		**Chief People Officer**	X	X	X	X	X	X
Charitable Funds Committee	Quarterly		**Director of Comms and Engagement**	X		X	X		X
Year End									
Code of Governance Compliance & Compliance with Licence Annual Return – completion of Cos7	Annually		**Company Secretary**		X Cos7				
Code of Governance Compliance & Compliance with Licence Annual report (for Year End / Audit Committee)	Annually				Yr End Audit				
Governance									
Strategic Risk & BAF	Bi-Monthly		**Company Secretary**	X	X	X	X	X	X
Annual Review of BAF & Risk Appetite Statement	Annually								X
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	Annually		**Chief Finance Officer**					X	
Risk Management Strategy Report	Annually		**Chief Nurse**			X			
Board Cycle of Business	Annually		**Company Secretary**	X					
Board Sub-Committee Cycle of Business and Terms of Reference	Annually		**Company Secretary**	QAC & SPC, FSC					
Charitable Funds Committee Governing Document & Cycle of Business	Annually	✓	**Chair/Company Secretary**	X					
Charities Commission Checklist	Annually		**Director of Comms & Engagement**						X
WHH Charity Annual Report	Annually		**Director of Comms & Engagement**				X DRAFT	X	
Board Effectiveness Review (end of Financial Year April 2025, report in June 2026)	Annually		**Chair/Company Secretary**		X				
Fit and Proper Persons Test - Annual Report on Board Members (audit)	Annually		**Chair/Company Secretary**		X				
Trust Senior Management Organograms	Bi-Annually	✓	**Chair/Company Secretary**			X			X
Committee Chairs Annual Reports									
Quality Assurance Committee	Annually		**Chair**			X			
Finance & Sustainability Committee	Annually		**Chair**			X			
Audit Committee	Annually		**Chair**				X		
Strategic People Committee	Annually		**Chair**		X				
Closing Business									
Review of Meeting	Standing Item		**Chair**	X	X	X	X	X	X
Any other Business & Date of next meeting	Standing Item		**Chair**	X	X	X	X	X	X

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/21**			
SUBJECT:	**Committee Terms of Reference and Cycles of Business**			
DATE OF MEETING:	3 April 2025			
AUTHOR(S):	John Culshaw, Company Secretary			
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):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The proposed amended Terms of Reference and Cycle of Business for the: I. Quality Assurace Committee II. Finance & Sustainability Committee III. Audit Committee IV. Strategic People Committee Are attached for consideration and approval. Key updates include amendments to:			

i. Quality Assurace Committee (QAC)

It is proposed that the Terms of reference for 2025/26 remain consistent with 2024/25, there have been some minor amendments to:

4. Membership – updates to some role titles of core members

6. Reporting – some names of groups and sub-committees have been updated

It is proposed that the QAC Cycle of Business 2025/26 remain consistent with 2024/25, with some minor formatting changes, and removal of any papers that were for a limited time only during the previous year.

Three additional maternity papers have been added to the 2025/26 CoB, these are:

- CQC Maternity Survey
- MNVPO Report
- Birth Trauma Position (limited time)

ii. Finance & Sustainability Committee (FSC)

It is proposed that the Terms of reference for 2025/26 remain consistent with 2024/25, with no proposed amendments, the ToR for the committee were last updated in October 2024.

As with QAC, It is proposed that the FSC Cycle of Business 2025/26 remains consistent with 2024/25, with some minor formatting changes only,

There are no significant changes being proposed to QAC and FSC at this stage as it is expected there will be a full governance review of the Committees Terms of Reference and Cycle of Business, led by the Executive Leads and Company Secretary prior to the initiation of **QAC and FSC Committees in Common** with Bridgewater Community Healthcare NHS Foundation Trust during Q1 of 2025/26. As part of the planned integration work.

iii. Audit Committee

Following a robust review in 2024/25, there are no proposed amendments to the CoB and ToR for 2025/26.

The Trust Board is asked to note the amendment to the June Committee meeting date, which will now take place on Monday 23rd June, to fit in with the External Auditors schedule.

iv. Strategic People Committee

This report seeks approval from the Trust Boards of WHH for the establishment of the Strategic People Committee in Common (the "Committee"), as detailed in the attached Terms

	of Reference (Version 1, effective April 2025). The Committee is proposed to enhance collaboration, align people strategies, and support the Trusts' journey toward integration by April 2027, while ensuring compliance with NHS regulations and local priorities. Each of the proposed changes above have been reviewed and agreed by the respective Committees and are presented to the Trust Board for ratification.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	The Trust Board is asked to review and approve the Committee Terms of Reference and Cycles of Business		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, , Finance & Sustainability Committee, Audit Committee and Strategic People Committee	
	Agenda Ref.	**QAC/25/03/266**, **FSC/25/03/295**, **AC/25/02/97, SPC/25/03/201,**	
	Date of meeting	QAC – 12.03.24, FSC – 24.03.25, AC – 27.02.25, SPC – 19.03.25,	
	Summary of Outcome	Supported	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

The purpose of the Quality Assurance Committee (the Committee) is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety.

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks in relation to Quality are managed appropriately in line with professional and regulatory standards.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

Quorum shall be seven members, of which at least one should be a Non-Executive Director.

4. MEMBERSHIP

The Committee shall be composed of two Non-Executive Directors, one of whom is the Maternity Board Safety Champion, and one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- ~~Deputy Director of Integrated Governance & Quality~~
- Chief Finance Officer
- Director of Strategy & Partnerships
- Chief People Officer
- Deputy Chief Nurse & Director of Clinical Governance
- Deputy Medical Director
- Company Secretary
- Chief Pharmacist
- Director of Midwifery & Associate Chief Nurse /Midwifery Safety Champion Lead
- Associate Director of Quality

Attendees

- Chief Executive
- Obstetrics/Obstetrics Safety Champion Lead & Governance Lead
- Associate Chief Nurse (Planned Care)
- Associate Chief of Nursing (Unplanned Care)

- Head of Therapy / Lead AHP
- Associate Medical Director - Patient Safety
- Associate Medical Director - Clinical Effectiveness
- Associate Chief Nurse/Associate DIPC
- Senior Information Risk Owner

Observers

- Governor

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- The Chair of the Committee will provide a written committee assurance report to the Board bi-monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented to the Board meeting on its work and performance in the preceding year.

The sub committees listed below are required to submit high level briefing papers to the Committee

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience and Inclusion Sub-Committee
- Health & Safety Sub-Committee
- Information Governance and Corporate Records Group
- Adult & Child~~ren~~ Safeguarding Sub Committee
- Risk Review Group
- ~~Complaints Quality Assurance Group~~
- Quality Academy Sub-Committee
- Infection Prevention and Control Sub Committee
- Palliative Care and End of Life Sub Committee
- ~~Patient Equality, Diversity, and Inclusion Sub-Committee~~
- Medicines Governance Group

-
- IG & Records Group
- ~~Moving to Outstanding Group~~Compliance Oversight Group
- ~~Strategy and a Greener WHH Sub-Committee (by exception)~~

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Monitor the quality objectives as set out in the Trust Strategy on the agreed success/KPIs for each objective and the underpinning priorities.
- Oversee the development and implementation of the Trust's enabling strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;
- Overseeing 'Deep Dive Reviews' of risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented;
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.

- Ensure that the Trust has effective communication channels in place forward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has concerns about standards of care or safety.

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected.

Members unable to attend must send a deputy who is able to make decisions on their behalf. Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Tuesday preceding the Quality and Assurance Committee.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

The Cycle of Business will be reviewed by the Committee every 12 months.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality Assurance Committee
Version:	V5.1 DRAFT
Implementation Date:	April 2022
Review Date:	April 2022
Approved by:	Quality Assurance Committee
Approval Date:	QAC 05.04.2022 Trust Board 25.05.2022

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
V3 6 December 2016	5 - Membership	Revised to include Non-Executive Directors to be amended to read **two** Core Attendees – to read **Core Members** Delete Divisional Operational Directors from the Core Membership **ADD Transformation Director** **ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety. Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from each Division.**	QAC 6.12.2016
	10 – Administrative Arrangements	The Committee will be supported by the Secretary to the Trust Board.	QAC 7.2.17
V3 10 January 2017	5 - Membership	Membership further reviewed to include Head of Midwifery and Associate Director Infection Control + Prevention.	QAC 7.2.17
V3 7 February 2017	5 – Membership	Delete Director of IM&T	QAC 7.2.17

V3 02 January 2018	4 – Membership	Delete Chief Pharmacist, Chiefs of Service, Surgery, Women's & Children and Acute Care Services, Associate Directors of Nursing, Associate Director of Infection Control.	QAC 09.01.2018
V3 02 January 2018	2 – Frequency of Meetings	Meetings to move from monthly to bi-monthly	QAC 09.01.2018
V3 02 January 2018	6 – Reporting	Removal of Infection Control Committee, medicines management, Inclusion of Risk Review Group, Complaints Quality Assurance Group, Research and Development Sub Committee and Safeguarding Committee,	QAC 09.01.2018
V3 04 May 2018	4 – Membership	Add Audit and Governance Lead for Women's Health	QAC 03.08.2018
V3 08.01.2019	4 – Membership	**Add** CEO DoF + Commercial Development Chief Pharmacist AHP Lead **Replace Deputy HRD with** Director of HR + OD **Replace Deputy DoIM&T with** Chief Information Officer Change in titles of Director of Strategy, Associate Medical Directors and Associate Chief Nurses **Move** Audit and Governance Lead for Women's Health to attendee section	QAC 08.01.2019 + Trust Board 29.05.2019
V3 08.01.2019	6 – Reporting	**Add** Infection Prevention + Control SC End of Life Steering Group Divisional Governance Medicines Governance	QAC 08.01.2019 Trust Board 29.05.2019
V3 08.01.2019	10– Review/Effectiveness	**Add** Cycle of business reviewed annually	QAC 08.01.2019 Trust Board 29.05.2019
V4 07.01.2020	4 – Membership	**Add** Director of Medical Education Observer section – Public Governor **Remove** CEO **Amend** Assistant Chief Nurses to Associate Chief Nurses	QAC 07.01.2020 Board 29.01.2020

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		Medical Director Strategy to Interim Associate Medical Director Innovation and Improvement Obstetrics/ Obstetrics Safety Champion Lead add and Governance Lead	
V4 07.01.2020	6 – Reporting	**Remove** Divisional Governance Medicines Governance	QAC 07.01.2020 Board 29.01.2020
V4.1 03.11.2020	6 – Reporting	**Add** Equality Diversity & Inclusion and change in titles CFO, Chief Nurse and CPO	QAC 03.11.2020 Board 25.11.2020
V5 05.10.2021	4 - Membership Core Members	**Amendments to titles**: Director of Strategy & Partnerships. Deputy ~~Assistant~~ Chief Nurse - Patient Safety & Clinical Education Director of Midwifery & Associate Chief Nurse ~~Head of Midwifery~~/Midwifery Safety Champion Lead & Governance Lead ~~Chief Information Officer~~ Senior Information Risk Owner **Delete:** Assistant Chief Nurse - Clinical Effectiveness	QAC 05.10.2021 Trust Board 24.11.2021
V5 05.10.2021	6 - Reporting	**Amendments**: Health & Safety ~~& Risk~~ Sub-Committee Quality Academy Committee ~~Research and Development Sub Committee~~ Palliative Care and End of Life Steering Group. **ADD** Patient Equality, Diversity and Inclusion Sub Committee, Medicines Governance Group, Moving to Outstanding Group, Strategy and a Greener WHH Sub-Committee (by exception) **REMOVE** Equality Diversity & Inclusion Sub Committee	QAC 05.10.2021 Trust Board 24.11.2021

V5.1 05.04.2022	4 - Membership Core Members	**Amendments to titles**: • Director of Integrated Governance & Quality • Assistant Chief Nurse (Planned Care) • Assistant Chief of Nursing (Unplanned Care) • Head of Therapy / Lead AHP	QAC 05.04.2022 Trust Board 25.05.2022
V5.1 05.04.2022	6 - Reporting	**Amendments:** • Information Governance and Corporate Records Group • Adult & Children Safeguarding Sub Committee	QAC 05.04.2022 Trust Board 25.05.2022
V5.2 04.10.2022	4 - Membership Core Members	Amendments to titles:	Trust Board 25.01.2023
V5.2 04.10.2022	6 - Reporting	Updated reference to Committee Assurance Report	Trust Board 25.01.2023
V5.2 04.10.2022	9 – Administrative Arrangements	Removal of outdated guidance	Trust Board 25.01.2023
v5.3 13.06.2023	4 - Membership Core Members 11. Duties & Responsibilities	Amendments to job tiles - Company Secretary Addition of: - Associate Director of Quality **ADD** Monitor the quality objectives as set out in the Trust Strategy via bi-annual reporting on the agreed success/KPIs for each objective and the underpinning priorities.	QAC 13.06.2023
V6 12.03.2024	Section 3 – Quorum	Amend to require one NED for quoracy	
V6 12.03.2024	Section 4 – Membership	• Move some roles from core members to attendees • Update reference to Public Governor to Governor	
V6 12.03.2024	Section 7 – Duties & Responsibilities	Remove reference to QAC as the Committee responsible for oversight of the Strategic Risk Register	
V6.1 11.03.2024	Section 4 – Membership Section 6 - Reports	Change of role name to Deputy Chief Nurse and Director of ~~Integrated~~Clinical Governance Remove	

		• Patient Equality, Diversity, and Inclusion Sub Committee • Moving to Outstanding Group • Complaints Quality Assurance Group • Strategy and a Greener WHH Sub-Committee (by exception) • Add • Patient Experience and Inclusion Sub-Committee • IG & Rrecords group • Compliance Oversight Group	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
07.01.2020	**V3 – replaced with Version 4**	QAC 07.01.2020 Trust Board 29.01.2020
24.11.2021	**V4 – replaced with Version 5**	QAC 05.10.2021 Trust Board 24.11.2021
05.04.22	**V5 – replaced with Version 5.1**	QAC 05.04.2022 Trust Board 25.05.2022
25.01.2023	**V5.1 – replaced with Version 5.2**	QAC 04.10.2022 Trust Board 25.01.2023
13.06.2023	**V5.2 – replaced with Version 5.3**	QAC 13.06.2023
03.04.2024	**V5.3 – Replaced with Version 6**	QAC 12.03.2024 Trust Board 03xx.04xx.2024xxxx
XXXXXXX	**V6 – Replaced by version 6.1**	QAC 11.03.2025 Trust Board XX.XX.2025

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMMITTEE
CYCLE OF BUSINESS 2025-2026

CALENDAR YEAR (APRIL 2025 - MARCH 2026)				2025										2026		
Item	**Reporting Frequency**	**Process**	**Lead**	**08-Apr**	**13-May**	**10-Jun**	**08-Jul**	**12-Aug**	**09-Sep**	**14-Oct**	**11-Nov**	**09-Dec**	**13-Jan**	**10-Feb**	**10-Mar**
STANDING AGENDA ITEMS															
Welcome, apologies, declarations, cycle business, rolling attendance log	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Minutes and Action Log	Monthly	**Approval**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
OPENING AGENDA ITEMS															
Patient Story	Bi-Monthly	**Noting**	Dep Chief Nurse	✓			✓		✓		✓		✓		✓
Deep Dive	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Compliance Update	Quarterly	**Assurance**	Chief Nurse/Dep Dir Gov		✓**Q4**			✓**Q1**			✓**Q2**			✓ **Q3**	
Hot Topics	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
COMPLIANCE & OVERSIGHT															
Quality IPR Metrics	Bi-Monthly	**Discuss & Assurance**	Chief Nurse	✓		✓		✓		✓		✓		✓	
UEC Update	Monthly	**Assurance**	Chief Strategy & Partnerships Officer								✓	✓	✓	✓	✓
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	Chief Nurse						`						✓
MATERNITY UPDATE															
Cheshire & Merseyside Perinatal Mortality Report (PMRT)	Quarterly	**Assurance**	Director of Midwifery		✓**Q4**			✓**Q1**			✓**Q2**			✓ **Q3**	
Avoiding Term Admission into Neonatal Unit (ATAIN)	Quarterly	**Assurance**	Director of Midwifery			✓**Q4**			✓**Q1**			✓**Q2**			✓ **Q3**
Perinatal Mortality Report	Annually	**Assurance**	Director of Midwifery	✓											
Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maternity Self Assessment Tool	Bi-Annually	**Assurance**	Director of Midwifery		✓						✓				
Maternity & Neonatal Quality Review Report	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of Harm Events	Bi-Annually	**Assurance**	Director of Midwifery	✓						✓					
Transitional Care Audit (limited time)	Quarterly	**Assurance**	Director of Midwifery			✓**Q4**			✓**Q1**			✓**Q2**			✓ **Q3**
Post Partum Haemorrhage (Audit)	Bi-Annually	**Assurance**	Obstetric Governance Lead						✓					✓	
CQC Maternity Survey	Annually	**Assurance**	Director of Midwifery												✓
MNVP biannual report	Bi-Annually	**Assurance**	Director of Midwifery				✓						✓		
Birth Trauma position (limited time)	Annually	**Assurance**	Director of Midwifery				✓								
SAFETY															
Mental Health Update	Quarterly	**Assurance**	Chief Nurse		✓			✓			✓			✓	
Safeguarding Update Report (inc Annual Report)	Bi-Annually	**Assurance**	Dep Chief Nurse			✓						✓			
Medicines Management Report	Annually	**Assurance**	Exec Med Director		✓										
Controlled Drugs Report	Annually	**Assurance**	Exec Med Director		✓										
CIP/GIRFT Quality Impact Assessment Compliance (Finance)	Bi-Annually	**Assurance**	Exec Med Director / Chief Finance Officer & Deputy CEO		✓						✓				
Learning from Experience Report	Quarterly	**Assurance**	Director of Integrated Governance & Quality		✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**	
Staffing report - Safe Nurse Staffing	Bi-Annually	**Assurance**	Chief Nurse			✓	`						✓		
Director of Infection Prevention & Control (DIPC) Report	Quarterly	**Assurance**	Associate Director Infection Prevention and Control		✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**	
DIPC Report	Annually	**Assurance**	Associate Director Infection Prevention and Control				✓								
Infection Prevention and Control BAF	Bi-Annually	**Assurance**	Associate Director Infection Prevention and Control				✓						✓		
Mortuary Licensed Activity Report (Including Fuller update)	Bi-Annually	**Assurance**	Chief Nurse				✓						✓		
Violence Reduction Strategy Update	Bi-Annually	**Assurance**	Chief Nurse		✓							✓			
Health and Safety Report	Annually	**Approval**	Director of Integrated Governance & Quality				✓						✓		
Sepsis High Level Update	Quarterly	**Assurance**	Dep Chief Nurse		✓**Q4**			✓**Q1**			✓**Q2**			✓ **Q3**	
Cardiopulmonary Resuscitation (CPR) Decisions and Discussions (Adults) Position Report	Bi-Annually	**Assurance**	Exec MD / Dep Chief Nurse	✓						✓					
CLINICAL EFFECTIVENESS															
Learning From Deaths Review	Quarterly	**Assurance**	Exec Med Director			✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**
Clinical Audit Forward Plan	Annually	**Assurance**	Director of Integrated Governance & Quality	✓											✓
Clinical Audit Report (inc Annual Report)	Bi-Annually	**Assurance**						✓					✓		
PATIENT EXPERIENCE															
Dementia Strategy Review	Annually	**Approval**	Dep Chief Nurse			✓									
Dementia Strategy Report	Bi-Annually	**Assurance**	Dep Chief Nurse								✓				
Patient Experience & Inclusion Sub Committee Bi-annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓						✓					
Complaints Report	Annually	**Approval**	Director of Integrated Governance & Quality			✓									
COMPLIANCE & OVERSIGHT															
Board Assurance Framework/Corporate Risk Register	Bi-Monthly	**Approval**	Company Secretary	✓		✓		✓		✓			✓		✓
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	CFO & Deputy CEO												✓
Quality Priorities Report	Quarterly	**Assurance**	Deputy Chief Nurse			✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**
Quality Priorities 2023-24	Annually	**Approval**	Chief Nurse												✓
Quality Account	Annually	**Approval**			✓ **DRAFT**	✓ **FINAL**									
Quality Strategy Update	Annually	**Assurance**				✓									✓
Quality Strategy Refresh 2024-27	3-yearly	**Assurance**													✓
Risk Management Strategy Report	Annually	**Assurance**				✓									
Nursing & Midwifery Strategy Update	Annually	**Approval**	Dep Chief Nurse			✓									
ED Improvement Programme Update	Monthly	**For assurance**	COO/EDM/CN& Dep CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Improvement Progress Report	Bi-Annually	**Assurance**	Chief Nurse & Dep CEO					✓					✓		
Enabling Strategy Alignment Progress report	Bi-Annually	**Assurance**	Director of Strategy & Partnerships		✓						✓				
Patient Safety & Clinical Effectiveness Sub Committee Exception Report	Monthly	**Assurance**	Exec Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Palliative and End of Life Care Report (strategy updates)	Bi-Annually	**Assurance**	Cons Palliat Med /Dir Med Educ	✓										✓	
Information Governance + Corporate Records Group	Quarterly	**Assurance**	Chief Information Officer		✓				**Q1**				✓**Q2**		✓**Q3**
Patient Experience & Inclusion Sub Committee Bi-annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓						✓					
Quality Management System (paused awaiting **Impact**)	Annually	**Assurance**	Director of Integrated Governance and Quality												
In-Patient Survey	Annually	**Assurance**	Chief Nurse	✓											
Ward Accreditation Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓						✓					
Claims Report	Bi-Annually	**Assurance**	Chief Nurse	✓						✓					
GOVERNANCE															
Terms of Reference	Annually	**Approval**	Chair/Co Secretary												✓
Cycle of Business	Annually	**Approval**	Chair/Co Secretary												✓
Committee Effectiveness Annual Review	Annually	**Assurance**	Chair/Co Secretary	✓											
Committee Chair's Annual Report	Annually	**Assurance**	Chair/Co Secretary				✓								
Committee Effectiveness Action Update	Annually	**Assurance**	Chair/Co Secretary							✓					
High Level Enquires & External Assessment / Inspections (when notified)	Monthly	**Assurance**	Director of Integrated Governance & Quality	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MATTERS TO NOTE FOR ASSURANCE															
Minutes from the Quality Academy Sub-Committee	Bi-Monthly	**Assurance**	Chief Nurse		✓			✓			✓		✓		
CLOSING MEETING															
Items for Escalation to the Trust Board	Monthly	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of Meeting	Monthly	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

A quorum shall be two (2) members, one of who must be a Non-Executive Director. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non-Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

4. MEMBERSHIP

The Committee shall be composed of two (2) Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Core Members
The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Chief Finance Officer
- Chief Nurse
- Chief Operating Officer & Deputy CEO
- Executive Medical Director
- Chief People Officer
- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Deputy Chief Finance Officer
- Company Secretary & Associate Director of Corporate Governance
- Associate Director of Estates and Facilities Management
- Chief Information Officer

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

Observers

- Governor

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting; and/or
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have; and/or
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- Financial Resources Group
- Digital Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group
- Improvement & Productivity Group

7. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the NHS Provider License
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- Overseeing the development and subsequent monitoring of an operational plan including activity, workforce, finance, annual budget, annual capital programme and cashflow for approval by the Trust board.
- To ensure that appropriate triangulation across portfolios in the medium and long term financial models is
  provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- Consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Committee Assurance Report.
- To monitor compliance with NHSE requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- Benchmark financial and operational performance within the Integrated Care System, regionally and nationally
- Approve capital expenditure up to £5m on behalf of the Trust Board
- To oversee the Trust's Emergency Preparedness and Response (EPRR) Framework

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £5m or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	V11 **FINAL**
Implementation Date:	01.04.25
Review Date:	12 months from final approval
Approved by:	Finance & Sustainability Committee
Approval Date:	FSC 24 March 2025, Trust Board 02.04.25

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
22 March 2017	**3 – Reporting arrangements**	- There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.	
22nd March 2017	**4. Duties and Responsibilities**	- To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement	
22 March 2017	**6 - Attendance**	- Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy. - Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance	
22 March 2017	**9. Reporting Groups**	Two groups removed: - The Business Planning sub Committee (strategic). - Strategic & Annual Planning Steering Group. One Group added: - Pay Spend and Review Committee minutes to reporting groups.	
22 March 2017	**10 Administrative Arrangements**	- Due to change in administrative support to the Committee - Agreement with the Chair and Director of Finance to amend the timescale for circulating papers	

18 October 2017	**4. Duties and responsibilities** **6. Core attendees** **9. Reporting Groups**	- Delete items relating to Estates and IM&T - Delete Director of IM&T Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records	
22 November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21 March 2018	**Core Attendees**	Addition of Medical Director	Trust Board 29.5.2019
19 September 2018	**Core Attendees**	Remove Director of Transformation	Trust Board 29.5.2019
20 March 2019	**Section 6: Core Attendees**	Remove Medical Director Add Head of Corporate Affairs	Trust Board 29.5.2019
20 March 2019	**Section 9: Reporting**	Add Financial Resources Group Remove Out Patient Turnaround Remove ICIC	Trust Board 29.5.2019
18 March 2020	**Section 6: Core Attendees**	ADD Medical Director Amend Title of Head of Corporate Affairs to read Trust Secretary Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development ADD Director of Strategy (when required)	FSC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 9: Reporting**	Remove Urgent & Emergency Care Improvement Committee	FSC 18.03.2020 Trust Board 25.03.2020
23 September 2020	**Section 4 Duties and Responsibilities**	Addition of reports from Digital Services	FSC 23.09.2020 Trust Board 25.11.2020
23 September 2020	**Section 6: Core Attendees**	Amend the titles of three Directors Add Chief Information Officer	FSC 23.09.2020 Trust Board 25.11.2020

23 September 2020	**Section 9: Reporting**	Add Digital Board	FSC 23.09.2020 Trust Board 25.11.2020
22 September 2021	**Section 6: Core Attendees** **Section 9: Reporting**	Amend title of Deputy Director of Finance & Commercial Development and Delete post of Chief Information Officer **Add Medical Staffing Review Group and Strategy & Sustainability Review Group**	FSC 22.09.2020 Trust Board 24.11.2020
21st September 2022	**Section 4: Duties & Responsibilities**	Updated reference to Committee Assurance Report and amended NHSI to NHSE following NHS Improvement becoming part of NHS England in July 2022	
21st September 2022	**Section 9: Reporting Groups**	Addition of GIRFT/Clinical productivity Group Amend title of Digital Board to Digital Management Group	
26th April 2023	**Section 4: Duties & Responsibilities**	• Updated reference to new Provider Licence • Re-instated review of performance following dis-establishment of Clinical Recovery Oversight Committee • Addition of oversight of annual operational plan • Removal of duplicate responsibility • Updated Committee Capital Spend limit • Remove reference to MTFM and LTFM	
26th April 2023	**Section 6: Core Attendees**	• Addition of Chief Executive and Associate Director of Estates & Facilities Management	
26th April 2023	**Section 9: Reporting Groups**	• Update of Report Group titles	
27th March 2024	**Section 4 - Membership**	• Update titles of members and add Chief Information Officer	
27th March 2024	**Section 6 - Reporting**	• Addition of Improvement & Productivity Group • Confirmation that the Committee oversees EPRR arrangements	
27th March 2024	**Section 9 – Administrative Arrangements**	• Affirmation of the Committee's duty ro review the Terms of Reference and Cycle of Business annually	

28th August 2024	**Section 4: Membership Core Members**	• Addition of Director of Communications and Engagement as a core member of the committee	

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TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
20 March 2020	**V5 to be replaced by V6**	FSC 18.03.2020
23 September 2020	**V6 to be replaced by V7**	FSC 23.09.2020
22 September 2020	**V7 to be replaced by V8**	FSC 22.09.2022
21st September 2022	**V8 to be replaced by V9**	FSC 21.09.2022
26th April 2023	**V9 to be replaced by V10**	FSC 26.04.2023 Trust Board 07.06.2023
3rd April 2024	**V10 to be replaced by V10.1**	FSC 27.03.24 Trust Board 03.10.24
2nd October 2024	**V10.1 to be replaced by V10.2**	FSC 28.08.24 Trust Board 02.10.24
2nd April 2025	**V10 tto be replaced by V11**	FSC 24.03.25 Trust Board 02.04.25

Warrington and Halton Teaching Hospitals NHS Foundation Trust

FINANCE & SUSTAINABILITY COMMITTEE CYCLE OF BUSINESS 2025/26														
CALENDAR YEAR (APRIL 25 - MARCH 26)				2025									2026		
AGENDA ITEM	Reporting Frequency	Process	LEAD	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
INTRODUCTION & ADMINISTRATION															
Apologies for Absence	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the Last Meeting & Action Log	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Rolling attendance log + cycle of business	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
GOVERNANCE & COMPLIANCE															
Hot Topic	Monthly Standing Item or as required	For Approval	**Chair/CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Deep Dive	Monthly Standing Item or as required	For Approval	**Chair/CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Committee Terms of Reference	Annually	For Approval	**Company Sec**												√
Committee Cycle of Business	Annually	For Approval	**Company Sec**												√
Pay Assurance Report	Monthly	For assurance	**CPO**	√	√	√	√	√	√	√	√	√	√	√	√
Board Asssurance Framework & Risk Register	Monthly	For Approval	**Company Sec**	√	√	√	√	√			√		√		√
Annual Review of BAF & Risk Register	Annually	For Assurance	**Company Sec**		√										
PAF Review and Refresh of Trust KPIs	Annually	For Assurance	**CFO**												√
Committee Effectiveness Review and follow up report	Annually	For Assurance	**Chair/Company Sec**	√						√					Advise of survey
Annual Chair's Report to the Board	Annually	For Assurance	**Chair/Company Sec**				√								
Sustainability Strategic Priorities Update	Bi-Annually	For Assurance	**Chief Strategy & Partnerships Officer**		√						√				
Emergency Preparedness Annual Report (EPRR) & Annual Assurance Letter Statement of Compliance	Annually	For Assurance	**COO**				√								
Minutes/Action Log of the Event Planning Group meeting	Monthly	For Assurance	**COO**	√	√	√	√	√	√	√	√	√	√	√	√
PERFORMANCE															
Corporate Performance Report	Monthly	For Assurance	**COO**	√	√	√	√	√	√	√	√	√	√	√	√
Winter Plan	Annually	For Assurance	**COO**						√						
Estates Strategy 2024-29 Progress Report	Bi-Annually	For Assurance	**COO**		√						√				
Recovery Updates	Monthly	For Assurance	**COO & CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Digital Services HLB & Digital Board minutes	Monthly	For Assurance	**CIO&SIRO**	√	√	√	√	√	√	√	√	√	√	√	√
SIRO (Senior Information Risk Owner) Report	Annually	For Assurance	**CIO&SIRO**						√						
FINANCIAL ASSURANCE															
Monthly Finance report, Finance + Resources Group Minutes & Capital Planning Group Minutes	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Cost Pressures	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Capital Planning Group Annual Report	Annually	For Assurance	**COO/Dep CEO**				√								
Monthly CIP	Monthly	For Assurance	**CFO/EMD/DofS&P**	√	√	√	√	√	√	√	√	√	√	√	√
Monthly Productivity Improvement Update	Monthly	For Assurance	**DCFO**	√	√	√	√	√	√	√	√	√	√	√	√

Indicative Financial cost of harm annual report	Annually	For Assurance	**EMD/CS&PO**		√									
Capital Expenditure Approvals (schemes above £500k) wef May	Monthly	For Assurance	**Exec Lead**	√	√	√	√	√	√	√	√	√	√	√	√
Cash Support Update	Quarterly	For Assurance	**CFO**		Q1			Q2				Q3			Q4
Elective Restoration Update	Quarterly	For Assurance	**COO**				Q1			Q2			Q3		
Benefits Realisation Quarterly Report	Quarterly	For Assurance	**CFO**		Q4			Q1				Q2		Q3	
Costing Update	Quarterly	For assurance	**CFO**				Q4					Q1 & Q2 Bi Annual			Q3
Medical Workforce Review Group Quarterly Report	Quarterly	For Assurance	**EMD**		Q4			Q1			Q2			Q3	
Use of Resources Annual Report	**on hold**		**CFO**												
INVESTMENT															
Annual Capital Programme	Annually	For Assurance	**CFO**											√	
PLANNING															
Operational Plan & Budgets	Annually	For Approval	**CFO**	**X** Final 2024/25										**X** Draft 2025/26	**X** Final 2025/26
MISC															
Integration Update	Monthly	For Noting	**Chief Strategy & Partnerships Officer**	√	√	√	√	√	√	√	√	√	√	√	√
CLOSING															
Items for Escalation to the Trust Board &	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Review of Meeting	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Any Other Business	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Next Meeting Date & Time	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√

TERMS OF REFERENCE

Audit Committee

1. PURPOSE

The Audit Committee has primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement. In addition the Audit Committee shall:

- provide assurance of independence for external and internal audit;
- ensure that appropriate standards are set and compliance with them monitored in all areas that fall within the remit of the Audit Committee ; and
- monitor compliance with corporate governance requirements (e.g. compliance with the terms of the Licence; Constitution; codes of conduct; standing financial instructions; maintenance of registers of interest).

2. FREQUENCY OF MEETINGS

Meetings shall be held at least five times per year with additional meetings where necessary.

The internal auditor and external auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

3. QUORUM

The quorum necessary for the transaction of business shall be two members.

4. MEMBERSHIP

The Committee shall be composed of all (7) the Trust's independent non-executive directors, at least one of whom should have recent and relevant financial experience (Monitor Code C.3.1), as follows:

- at least one member of the Trust's Quality Assurance Committee will be a member of the Trust's Audit Committee
- the Chair of the Trust shall not be a member

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

The Trust Chair may be invited to attend meetings of the Audit committee if required

The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed.

Only members of the Audit Committee have the right to attend meetings, but the following individuals shall normally be in attendance:

- Chief Finance Officer
- Director of Integrated Governance and Quality
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider
- Company Secretary & Associate Director of Corporate Governance
- Head of Financial Services
- Governor Observer
- Associate Director of Finance – Operational

The Chief Executive may also be invited to attend and should in any case, attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

The Audit Committee may require individual Trust Directors to attend in respect of specific agenda items and, in addition, will normally extend an open invitation to all Trust Directors to attend all meetings.

5. AUTHORITY

The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have any executive powers in addition to those delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice on any matter within its Terms of Reference and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

6. REPORTING

The Committee shall report to the Board of Directors and Council of Governors annually on how it discharges its responsibilities; specifically on its work in support of the annual governance statement, commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements

- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements
- The robustness of the processes behind the quality account

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The minutes of the Committee meetings will be formally recorded. The Chair of the Audit Committee shall draw to the attention of the Board any issues that require disclosure or require executive action via a Committee Assurance Report.

7. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following areas:

Integrated Governance, Risk Management, and Internal Control

Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring there is scrutiny and oversight of the Strategic Risk Register and Board Assurance Framework

The Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality Assurance Committee) so that it understands processes and linkages. However, these other committees must not usurp the Audit Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and governing body. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Liaising with the Committee Chairs and the Trust's Executive Team to plan and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, including areas identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation after taking briefings from Committee Chairs or the Executive Team

The Committee will also periodically review the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Standards of Business Conduct (Managing Conflicts of Interest) and examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference to the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances.

Other

Review performance indicators relevant to the remit of the Audit committee.

Examine any other matter referred to the Audit Committee by the Board of Directors, the Chairs of the Committees of the Board or the Executive Team and initiate investigation as agreed with the members of the Audit Committee.

Develop and use an effective assurance framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health [and social care] sector and professional bodies with responsibilities that relate to staff performance and functions.

8. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent out 5 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board and the Trust Secretary.

9. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements and report on this to the Trust Board.

These terms of reference will be reviewed every two years by the Council of Governors and the Trust Board.

Date: 27.02.2025 DRAFT V4.3
Approved: AC XX.XX.XX Trust Board XX:XX:XXXX
Review Date: (12 months from date of approval)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Audit Committee
Version	V4.3
Implementation Date	Immediate
Review Date	27.02.2025
Approved By	Audit Committee – 27 February 2025

REVISION			
Date	**Section**	**Reason for change**	**Approved by**
16.1.2017	10	- Review date amended from at least annually to every 2 years - Committee to be supported by the Secretary to the Trust Board.	Audit Committee 16.01.2017
22.2.2018	4 5 6	- Change Quality Committee to Quality Assurance Committee - Internal Audit to include liaison with the Trust's Q&A and TOB committees - Audit Committee to review SORD, SFIs, Standards of Business Conduct (MCoI) arrangements - Review Freedom to Speak Up Register - Review performance indicators relevant to remit of AC - Commission any investigations or 'deep dives' or request any other committee to do so - Develop and use an effective assurance framework to guide the audit committee's work - Review the work of the Trust Board's other Committees - Consider any external reviews by regulators and/or professional bodies that relate to staff performance and functions. Membership - The Trust Chair may be invited to attend meetings of the Audit committee if required - The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are	Audit Committee 22.02.2018

	10	being addressed Attendance – to include: - Director of Integrated Governance - Head of Corporate Affairs - Secretary to the Board - A minimum of 75% attendance is required by members of the committee Committee will review effectiveness annually and report on this to Trust Board and Council of Governors	
23.3.2018	6	Attendance – amendments: - Remove Director Corporate Affairs and Head of Corporate Affairs. - Add Executive Medical Director, Executive Lead, Corporate Affairs	Audit Committee
20.02.2020	6	Attendance – amendments - Delete Executive Medical Director, Executive Lead, Corporate Affairs - Change title of Head of Corporate Affairs to Trust Secretary - Replace Director of Integrated Governance with Deputy Director Governance - ADD Governor Observer - Amend Text re: Director attendance	Audit Committee 20.02.2020 Trust Board 25.03.2020
20.02.2020	9	Administration Arrangements - Change title of Head of Corporate Affairs to Trust Secretary	Audit Committee 20.02.2020 Trust Board 25.03.2020
29.07.2022	5	Attendance – amendments - Change title of Deputy Director of Governance to Director of Integrated Governance and Quality - Addition of Deputy Chief Finance Officer and Head of Financial Services	Audit Committee 18.08.2022
29.07.2022	8	Duties & Responsibilities - Change reference to Operational Board to Executive Team - Remove requirement to report Freedom to Speak up arrangements to the Committee. The Strategic People Committee provides oversight	Audit Committee 18.08.2022
22.02.2024	4	Membership - Update to titles - Removal of Deputy Chief Finance Officer & Secretary to the Trust Board - Addition of Associate Director of Finance - Operational	

22.04.2024	5	Authority - Removal of value to professional advice	
22.04.2024	7	Duties & Responsibilities - Update of specific reference to the Quality Assurance Committee to include all Committees of the Board and their respective Chairs. - Removal of reference to the Moving to Outstanding Group	
27.02.24	-	No changes	Audit Committee XX.XX.XX Trust Board XX.XX.XXXX

TERMS OF REFERENCE OBSOLETE	
Date	**Reason**
20.02.2020	**V3, replace with V4, approved by Audit Committee 20.02.2020 + Trust Board 25.03.2020**
18.08.2022	**V4 replace with version 4.1 approved by Audit Committee 18.08.2022**
22.02.2024	**V4.1 replace with version 4.2 approved by Audit Committee 22.02.2024**
27.02.2025	**V4.2 replace with version 4.3 approved by Audit Committee 27.02.2025**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

AUDIT COMMITTEE – CYCLE OF BUSINESS
2025-26

CALENDAR YEAR APRIL 2025 - MARCH 2026								
AGENDA ITEMS	**Reporting Frequency**	**Process**	**Lead**	**2025**				**2026**
				24-Apr	**23-Jun**	**28-Aug**	**27-Nov**	**26-Feb**
OPENING BUSINESS								
Welcome, apologies, declarations of interest, cycle of business, rolling attendance log	Standing Item	Noting	**Chair**	✓	✓	✓	✓	✓
Review Minutes and Action Log	Standing Item	Approval	**Chair**	✓	✓	✓	✓	✓
QPS ASSURANCE								
Update from Chairs of F&SC QAC CFC SPC	Standing Item	For assurance	**JS/CR/SMcG/JJ**	✓	✓	✓	✓	✓
Changes or Updates to BAF	Standing Item	For assurance/approval	**Company Secretary**	✓	✓	✓	✓	✓
INTERNAL AUDIT								
Internal Audit Plan & Fees	Annually	For assurance	**MIAA**					✓
Progress Report on Internal Audit follow-Up actions	Monthly	For assurance	**Chief Finance Officer**	✓		✓	✓	✓
Internal Audit Progress Report on Follow-Up actions	Monthly	For assurance	**MIAA**			✓		✓
Internal Audit Progress Report	Monthly	For assurance	**MIAA**			✓	✓	✓
Head of Internal Audit Opinion	Annually	For Approval	**MIAA**	✓				
Internal Audit Charter Annual Report	Annually	For Approval	**MIAA**	✓				
EXTERNAL AUDIT								
External Audit Plan & Fees		For Approval	**GT**	✓				✓
Report and Updates from External Audit		For assurance	**GT**	✓		✓	✓	✓
Annual Audit Letter (AC following year-end Audit Cttee)		For Approval	**GT**			✓		
Renewal/Refresh of External Audit Contract (at term)		For Approval	**GT/AMcG/JC**			✓		
COUNTER FRAUD								
FINAL Annual Counter Fraud Plan	Annually	For Approval	**MIAA**					✓
Counter Fraud Progress Updates	Monthly	For assurance	**MIAA**			✓		✓
Annual Counter Fraud Annual Report	Annually	For Approval	**MIAA**	✓				
FINANCE								
Review Losses & Special Payments	Monthly	For assurance	**Chief Finance Officer**	✓		✓	✓	✓
Review Quotation and Tender Waivers of Standing Financial Instructions	Monthly	For assurance	**Assoc Director of Finance**	✓		✓	✓	✓
Going Concern Report	Annually	For assurance	**Chief Finance Officer**	✓				
QPS GOVERNANCE AND COMPLIANCE								
Annual report and accounts timetable and plans	Annually	For assurance	**Chief Finance Officer**					✓
Draft Annual Governance Statement	Annually	For assurance	**Company Secretary**	✓				
Draft Annual Report	Annually	For assurance	**Chief Executive**	✓				
Draft unaudited Accounts & Financial Statements	Annually	For assurance	**Chief Finance Officer**	✓				
Annual Report	Annually	For Approval	**Chief Executive**		✓			
Quality Account	Annually	For Approval	**Dir Integrated Gov**		✓			
Draft Annual accounts accounting policies	Annually	For assurance	**Chief Finance Officer**					✓
FINAL and Audited Accounts & Financial Statements	Annually	For Approval	**Chief Finance Officer**		✓			
Review of Schemes Reservation & Delegation (SoRD) & Standing Financial Instructions (SFIs)	Annually/as required	For Approval	**CFO/Company Secretary**				✓	
Head of External Audit Opinion Statement	Annually	to note	**GT**		✓			

Review other reports and policies as appropriate – e.g. changes to standing orders – as arise			**ALL**					
Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors Annual Report	Annually	For Approval	**Company Secretary**		✓			
Risk Management Annual Report update	Annually	For Approval	**Chief Nurse**			✓		
Code of Governance Compliance Declaration – e.g. changes as required	As required	For Approval	**Company Secretary**					
Review of Trust Registers (e.g. Conflicts of Interest)	Annually	For Approval	**Company Secretary**	✓				
Terms of Reference	Annually	For Approval	**Company Secretary**					✓
Fit & Proper Persons Test Annual Report	Annually	For assurance	**Company Secretary**		✓			
Cycle of Business Annual Review	Annually	For assurance	**Company Secretary**					✓
On-Call and Overtime Annual Update Report	Annually	For assurance	**Chief People Officer**			✓		
NW Skills Network Bi-Annual Report	Bi-Annually	For Assurance	**Chief Finance Officer**	✓		✓		
ICON Programme Bi-Annual Report	Bi-Annually	For Assurance	**Chief Finance Officer**	✓		✓		
EFFECTIVENESS								
Committee Chairs Annual Report (for Trust Board & Council of Governors)		For assurance	**CHAIR**			✓		
Committee Effectiveness - annual review	Annually	For assurance	**Company Secretary/Chair**	✓				✓ **advise of survey**
DEEP DIVE REVIEWS								
Commission and receive ANY additional scrutiny projects								
CLOSING								
Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually			**CHAIR**					✓
Any Other Business			**CHAIR**	✓	✓	✓	✓	✓

TERMS OF REFERENCE
STRATEGIC PEOPLE COMMITTEE IN COMMON

1. PURPOSE

The Strategic People Committee in Common (the "Committee") is established to enable collaboration, strategic alignment, and efficient decision-making between Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees the Trusts' people and organisational development strategies to enhance patient care, operational efficiency, and resource use, aligning with NHS regulations and local priorities.

The Committee Supports:

WHH's Strategic Objective 2:

- *We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

BCHT's Strategic Objective 3, 5 and 6:

- *We will… Ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.*
- *We will… Ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.*
- *We will… Work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.*

The Committee provides assurance to both sovereign Trust Boards that people strategies align with quality aims, overseeing the development and implementation of a joint People Strategy, Workforce Equality, Diversity and Inclusion Strategy, and Culture Plan as the Trusts progress toward integration by April 2027.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly at either the Warrington Hospital site or Spencer House.

3. MEMBERSHIP

3.1. Membership of the WHH Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Warrington)
- Chief People Officer (WHH)
- Deputy Chief People Officer (WHH)
- Chief Finance Officer (WHH)
- Chief Nurse (WHH)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director

- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Company Secretary
- Head of Strategic Workforce Development & Culture

3.2. Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Director of People and Organisational Development (BCHT)
- Deputy Director of People and Organisational Development
- Director of Finance (BCHT)
- Chief Nurse and (Deputy Chief Executive BCHT)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Director of Corporate Governance (BCH)

The Joint Chief Executive and other staff members may also be invited/ expected to attend for appropriate agenda items; however, there is no requirement to attend the whole meeting.

3.3. Observers:

- Council of Governors' representative from WHH and BCHT
- Other staff members may also observe the meeting with prior permission of the Committee Chairs.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. However, attendance in person at the meeting is strongly encouraged to facilitate more effective collaboration, engagement, and decision-making. Should the need arise, the Committee in Common may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members NHS email account.

4. QUORUM

A quorum requires four members: two from each Trust, including one Non-Executive Director per Trust and the Chief People Officer/ Director of People and Organisational Development (or nominated Deputy) If a Non-Executive Director is unavailable, a substitute Non-Executive Director from the respective Trust may attend and count toward the quorum.

The Committee shall be quorate provided each Trust each Trust's Committee is quorate; however, if a single Committee of one Trust is quorate, it can undertake business exclusive to that Trust. Each single Committee will reserve the right during a committee meeting to unilaterally decide matters pertaining only to their Trust, should agreement on the matter not be possible across both Committees.

For the avoidance of doubt, a person can count as a member of both committees provided they hold a related in common role.

5. AUTHORITY

The Committee in Common is authorised by both sovereign Trust Boards to investigate matters within its remit, request information from employees (who must comply), and escalate issues requiring further assurance to either Trust's Audit Committee.

The Committee in Common may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee at WHH or BCHT.

The Committee in Common must comply with the provisions of the respective Trust's Schemes of Reservation & Delegations and Standing Financial Instructions, including the declarations concerning conflicts of interest.

The CiC does not inherently make joint decisions that legally bind the sovereign boards of both organisations. It a governance arrangement where separate statutory bodies meet together to coordinate decision-making. Each committee remains accountable to its own sovereign board, and decisions made within a CiC are technically separate but synchronised to achieve a unified outcome.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair(s) of the Committee will provide a written Committee assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee (at BCHT or WHH) any issues that require disclosure to it, approval or require executive action.

The Committee will report to the Trust Boards at WHH and BCHT annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Committee by the Trust Boards.
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Boards.
- To provide overview and scrutiny to the development of the WHH and BCHT People Strategies.
- To ensure the WHH and BCHT People Strategies are designed, developed, delivered, managed and monitored appropriately.
- To ensure the WHH and BCHT Workforce Equality, Diversity and Inclusion Strategies are designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the WHH and BCHT People Strategies are provided.
- To receive, agree and monitor progress on the WHH and BCHT People Strategies through receipt of exception reports and updates.
- To ensure that the Trusts attract and retain their workforce using the principles of Model Employer to become the employers of choice.
- To review the consultation, negotiation and approval of all employment policies on an annual basis, including:

    - Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy,
    - Details of any employee relations negotiations delaying policy approval,
    - Details of extensions to policy dates,
    - Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and,
    - Details of any trends or employment issues associated with external factors influencing policy content.
- To receive the annual National Staff Survey results and to provide a set of recommendations for action by the Trusts.
- To receive, agree and monitor the staff engagement activity at both Trusts, including reward and recognition programmes. Ensuring the effectiveness of these activities on improved morale, increased Quarterly People Pulse scores and subsequent impact on patient experience.
- To ensure that all statutory and regulatory obligations are met in relation to equality, diversity and inclusion. The Committee holds the delegated responsibility on behalf of the Trust Board at BCHT and WHH for the approval of all equality, diversity and inclusion regulated reporting where the Committee is quorate.
- To receive, agree and monitor the Health and Wellbeing activity in both Trusts to be assured of the effectiveness of these activities on improving staff experience.

Duties – advisory:

- Consider any relevant 'people' risks within both Board Assurance Frameworks and corporate level risk registers as they relate to the remit of the Committee, as part of the reporting requirements,
- To ensure that there is a framework in place for Education Governance to support the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor both Trusts' performance against national standards so far as they relate to employment.
- To monitor the effectiveness of both Trusts' workforce performance reporting systems ensuring that the Trust Boards are assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Integrated Performance Indicators relevant to the remit of the Committee.
- To report any areas of significant concern to the Trust Boards as appropriate via the Committee Assurance Report.
- To monitor the implementation of Improving People Practices principles for WHH and BCHT through the adoption of a Just and Restorative Culture, including
    - Details of Employee Relations Cases in respect of numbers,
    - Summary of workforce demographics,
    - Analysis and impact assessment of emerging themes,
    - Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs,
    - Overview of lessons learned and actions taken to address these,
    - Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.
- To monitor the progress with Internal Audit recommendations where there is limited or no assurance identified.

- To monitor the delivery of staff engagement reports, including the NHS Staff Survey results and action plans.
- Monitor ward and maternity staffing data.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

The following Sub-Committees/ Groups will report directly to the Committee:

WHH:
- Operational People Sub Committee
- Workforce Inclusion and Culture Sub-Committee
- Workforce Review Group

BCHT:
- People Organisational Delivery Council (the "POD")
- Medical and Dental Professional Governance
- Flu Group

Each Sub-Committee will submit a Chair Log Report to their respective Boards detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

- The Committee will be supported by a member of the Corporate Governance Team from either WHH or BCHT
- The Terms of Reference will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm one week preceding the Committee.

Papers are to be submitted in the following format:
1. Front sheet – with FOI exemptions duly applied if appropriate and equality and diversity considerations included
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / People Professional Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting unless otherwise agreed with the Chair of the Committee
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair(s) of the Committee.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. By standard, these Terms of Reference will be reviewed

annually by the Committee. From April 2025, these Terms of Reference will be reviewed within three months.

TERMS OF REFERENCE
REVISION TRACKER

Name of Committee:	Strategic People Committee in Common
Version:	V1
Implementation Date:	April 2025
Review Date:	March 2026
Approved by:	TBC
Approval Date:	TBC – April 2025

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
February 2025	**Terms of Reference**	Revised Terms of Reference developed to create a Strategic People Committee in Common	TBC – April 2025

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
April 2025	**WHH v7.1 Strategic People Committee to be replaced by v1 Strategic People Committee in Common**	TBC – April 2025
April 2025	**BCHT v2.3 People Committee to be replaced by v1 Strategic People Committee in Common**	TBC – April 2025

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

STRATEGIC PEOPLE COMMITTEE IN COMMON
CYCLE OF BUSINESS 2025/26

CALENDAR YEAR (APRIL 2025 - MARCH 2026)				2025									2026		
	Reporting Frequency	Process	Lead	April	May	June	July	August	September	October	November	December	January	February	March
OPENING BUSINESS															
Apologies for Absence	Standing Item	**Noting**	Chair	√ WHH	√ BCHT	√ WHH	√ BCHT	√ WHH	√ BCHT	√ WHH	√ BCHT	√ WHH	√ BCHT	√ WHH	√ BCHT
Declarations of Interest	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the last meeting	Standing Item	**Approval**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising / Action log	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
STANDING ITEMS															
Staff Story	Quarterly	**Noting**	CPO/ DoP	√ WHH			√ BCHT			√ WHH			√ BCHT		
Deep Dive	Monthly	**Assurance**	CPO/ DoP	√	√	√	√	√	√	√	√	√	√	√	√
Hot Topic	As required	**Assurance**	CPO/ DoP	√	√	√	√	√	√	√	√	√	√	√	√
BAF & Corporate Risk Register - Workforce	Bi-Monthly	**Assurance/ Approval**	CS/ DoCG		√		√		√		√		√		√
Chief People Officer/ Director of People Report	Monthly	**Assurance**	CPO/ DoP	√	√	√	√	√	√	√	√	√	√	√	√
Workforce Brief on National, Regional, ICB, or Local Workforce Issues – as required	Monthly	**Assurance**	CPO/ DoP	√	√	√	√	√	√	√	√	√	√	√	√
Better Care Together Integration Update (Workforce and Corporate Services)	Monthly	**Assurance**	CPO/ DoP/ CS&PO/ HoSWD	√	√	√	√	√	√	√	√	√	√	√	√
Workforce Integrated Performance Report	Bi-Monthly	**Assurance**	DCPO/ DDoP		√		√		√		√		√		√
Workforce Integrated Performance Recommendations (annual)	Annually	**Assurance**	DCPO/ DDoP											√	
People Strategy Update	Bi-Annually	**Assurance**	DCPO/ DDoP	√ **WHH Bi-annual Report**			√ **BCHT Bi-annual Report**			√ **WHH Bi-annual Report**			√ **BCHT Bi-annual Report**		
Equality, Diversity and Inclusion Strategy Update (WHH - Workforce only)	Bi-Annually	**Assurance**	DCPO/ DDoP		√ **BCHT Bi-annual Report**			√ **WHH Bi-annual Report**			√ **BCHT Bi-annual Report**			√ **WHH Bi-annual Report**	
Culture Plan 2025-2027 Update	Bi-Annually	**Assurance**	CPO/ DoP						√ **Bi-annual Report**						√ **Bi-annual Report**
Workforce Policies and Procedures Overview Report	Bi-Annually	**Assurance**	DCPO/ DDoP		√ **(Q3&Q4)**						√ **(Q1&Q2)**				
Improving People Practices Report (including Employee Relations data)	Bi-Annually	**Assurance**	DCPO/ DDoP			√ **Bi-annual Report**						√ **Bi-annual Report**			
National Staff Opinion Survey	Annually	**Assurance**	CPO/ DoP	√											
Freedom to Speak Up Report	Bi-Annually	**Assurance**	CN/ CFO/ FTSUG		√ **Bi-annual Report**						√ **Bi-annual Report**				
Listening to Staff Voices (BCHT only)	Bi-Annually	**Assurance**	DoN		√ **Bi-annual Report**						√ **Bi-annual Report**				
Health and Wellbeing Update (including the Health & Wellbeing Guardian Report)	Bi-Annually	**Assurance**	DCPO/ H&WBG/ DDoP			√ **Bi-annual Report**						√ **Bi-annual Report**			

Safer Staffing Report – Key Issues Report to include Red Flag data quarterly (WHH only)	Monthly	**Assurance**	CN	√ **(Q4 Red Flag Data)**	√	√	√ **(Q1 Red Flag Data)**	√	√	√ **(Q2 Red Flag Data)**	√	√	√ **(Q3 Red Flag Data)**	√	√
Staffing Systems / Safer Staffing (BCHT only)	Bi-Annually	**Assurance**	DoN/ HoW		√ **Bi-annual Report**						√ **Bi-annual Report**				
Volunteer Report (WHH only)	Annually	**Assurance**	CN		√										
Internal Audit Action Plans	As required	**Assurance**	DCPO/ DDoP	√	√	√	√	√	√	√	√	√	√	√	√
NATIONAL/ STATUTORY REPORTS															
General Medical Council (GMC) Patient Survey Response Report (Workforce)	As required	**Assurance**	EMD	√	√	√	√	√	√	√	√	√	√	√	√
Midwifery Staffing Report	Quarterly	**Assurance**	CN/ DoM		√ **Q4**			√ **Q1**			√ **Q2**			√ **Q3**	
Health Education England (HEE) Monitoring Visit (Annual Assessment Visit)	Annually	**Assurance**	EMD						√						
General Medical Council (GMC) National Trainee Survey	Annually	**Assurance**	EMD						√						
General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA) and Respsonsible Officer Annual Report	Annually	**Assurance**	EMD						√						
NHSE Self Assessment Report for Education and Training	Annually	**Assurance**	CN								√				
National Education and Training Survey (NETS) Report	Annually	**Assurance**	CN	√											
Guardian of Safe Working Hours Report (WHH only)	Quarterly	**Assurance**	EMD		√ **Q4**			√ **Q1**			√ **Q2**			√ **Q3**	
Guardian of Safe Working Annual Report (WHH only)	Annually	**Assurance**	EMD				√								
Facilities Time Off Annual Report	Annually	**Assurance**	DCPO/ DDoP			√									
EQUALITY DIVERSITY & INCLUSION – REGULATED REPORTS															
EDI Annual Report (Public Sector Equality Reporting – Patients and Workforce) – including: - Equality Duty Assurance Report - Workforce Equality Assurance Report - Pay Gap Reporting (Race and Disability) - National EDI Improvement Plan - Anti-Racism Framework Update	Annually	**Approval**	DCPO/ DDoP										√		
Equality Delivery System (EDS) 2025/26	Annually	**Approval**	DCPO/ DDoP										√		
Gender Pay Report	Annually	**Approval**	DCPO/ DDoP		√										
Workforce Race Equality Standard (WRES) including Bank and Medical Workforce Race Equality Standard (as required)	Annually	**Approval**	DCPO/ DDoP					√							
Workforce Disability Equality Standard (WDES)	Annually	**Approval**	DCPO/ DDoP					√							
GOVERNANCE															
Terms of Reference	Annually	**Approval**	CS/ DoCG					√ **Review**							√
Annual Cycle of Business	Annually	**Approval**	CS/ DoCG												√
Committee Chairs Annual Report to Trust Board	Annually	**Approval**	Chair/ CS/ DoCG		√										
Committee Effectiveness – Annual survey **(on hold until committee established)**	Annually	**Assurance/ Approval**	CS/ DoCG												
SUB-COMMITTEE CHAIR'S LOGS															

WHH Workforce Inclusion and Culture Sub-Committee	Bi-Monthly	**Noting**	CPO	√		√		√		√		√		√	
WHH Operational People Committee	Bi-Monthly	**Noting**	CPO		√		√		√		√		√		√
WHH Workforce Review Group	Monthly	**Noting**	CN	√	√	√	√	√	√	√	√	√	√	√	√
BCHT POD Council	Quarterly	**Noting**	DDoP				√				√				√
BCHT Medical and Dental Professional Governance Meeting	Bi-Annually	**Noting**	EMD						√						√
CLOSING MATTERS															
Review of the Meeting	Monthly	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Items for Escalation to the Trust Board & Review of Meeting	Monthly	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Any Other Business	Monthly	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√

Key:
CPO - Chief People Officer (WHH)
DoP - Director of People and Organisational Development (BCHT)
DCPO - Deputy Chief People Officer (WHH)
DDoP - Deputy Director of People and Organisational Development (BCHT)
CS - Company Secretary (WHH)
DoCG - Director of Clinical Governance (BCHT)
CS&PO - Chief Strategy and Partnerships Officer (WHH)
HoSWD - Head of Strategic Workforce Development & Culture (WHH)
CFO - Chief Finance Officer (WHH)
ACPO - Associate Chief People Officer (WHH)
EDIM - Equality, Diversity and Inclusion Manager (BCHT)
DoC&E - Director of Communications and Engagement (WHH)
DDoC - Deputy Director of Communications (BCHT)
CN - Chief Nurse (WHH and BCHT)
FTSUG - Freedom to Speak Up Guardian (WHH and BCHT)
H&WBG - Health and Wellbeing Guardian (WHH)
EMD - Executive Medical Director (WHH and BCHT)
DoM - Director of Midwifery (WHH)
GOSW - Guardian of Safe Working (WHH)
DoN - Director of Nursing (BCHT)
HoW - Head of Workforce (HoW)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/04/22 – BM/25/04/27**	
SUBJECT:	**Supplementary Papers**	
DATE OF MEETING:	2 April 2025	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive	
	SO1: We will.. Always put our patients first delivering safer and effective care and an excellent patient experience.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All Risks	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			
Further Information: ***Each paper is individually marked from September 2023***			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			
3. Foster good relations between people who share a protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			

EXECUTIVE SUMMARY *(KEY ISSUES):*

In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 4 December 2024

No actions are required from the Trust Board they are provided for information only.
The papers provided are:

- **BM/25/04/22** – Learning from Deaths Q3 Update
- **BM/25/04/23 -** Learning From Experience Q3
- **BM/25/04/24 –** Infection Prevention and Control Update Q3

	• **BM/25/04/25 –** Guardian of Safe Working Report Q3 • **BM/25/04/26 –** Digital Strategy Group Update • **BM/25/04/27 –** Charitable Funds Committee - Governing Document and Cycle of Business		
PURPOSE: ***(please select as appropriate)***	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above	
	Agenda Ref.	As listed above	
	Date of meeting	As noted above	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/25/03/25**				
SUBJECT:	**Learning from Deaths Report Q3 2024-2025**				
DATE OF MEETING:	11 March 2025				
ACTION REQUIRED:	**Note**				
AUTHOR(S):	Dr Lalitha Chinnappan, Consultant Gastroenterology, Associate Medical Director for Patient Safety and Trust Mortality Lead. Dr Judith Raper, Palliative Care Consultant and Deputy Trust Mortality Lead Emily Barnett, Clinical Effectiveness Manager				
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director				
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.				
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**	
		X			
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**	
				X	
	Further Information / Comments:				
EXECUTIVE SUMMARY:	This paper summarises 'Learning from Deaths' for Q3 2024 / 2025, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths.				
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision	
RECOMMENDATION:	Quality Assurance committee is asked to note the contents of the paper.				
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable			
	Agenda Ref.				
	Date of meeting				
	Summary of Outcome				

NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Deaths Report Q3 2024 / 2025	AGENDA REF:	QAC/25/03/25

1. BACKGROUND/CONTEXT

The National Guidance on Learning from Deaths requires all Trusts to have processes and systems in place to review, investigate and learn from deaths that occur with due focus on:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved families and carers.

The Trust is committed to learning from both positive and negative aspects of a patient's care with clear processes in place for completing mortality reviews. Learning identified during mortality reviews allows individual specialties to improve their processes; collated learning provides corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

This report provides an overview of the processes and systems that are in place to ensure that deaths are reviewed appropriately and summarises the data for this quarter.

2. KEY ELEMENTS

WHH uses the HED (Healthcare Evaluation Data) system to assess overall mortality data, highlighting any themes or trends that support the requirement for reviews of deaths. The HED report also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report includes:

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

The Mortality Review Group (MRG) at the Trust reviews the HED report monthly. Deaths subject to a Structured Judgement Review (SJR) as per the criteria defined in the Learning from Deaths policy are reviewed at MRG to identify learning and improvement actions.

3. MEASUREMENTS/EVALUATIONS

A Structured Judgement Review will be completed if a patient death meets one or more of the below criteria:

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

NB: If a death is subject to a PSII (Patient Safety Incident Investigation or other Learning Response then an SJR is not undertaken.

MRG – Forward planning

1) Themed workstream continues to be undertaken ensuring that any common pattern in issues identified are addressed with the aim to bring about clinical changes and positively impact both patient care and trust mortality. The current list of workstreams are as follows:
   - DNACPR and DNACPR Palliative Workstream
   - Patient Transfers
   - Specialty Input
   - DoLS/ Capacity
   - SAFER
   - Trainee related learnings
   - Good practice- for positive commendation

2) Yearly appraisals commenced in November 2024 for all MRG reviewers. MRG reviewers are provided with feedback on their role within the MRG and within the wider governance processes. Individualised feedback is sent annually to each reviewer to highlight what is working well and what improvements are required.

3) Reminders continue to be sent out monthly with an aim to ensure that each SJR does not exceed the deadline of 8 weeks. Discussions have taken place with Senior Leadership due to the high number of cases which have exceeded the 8-week time frame. The importance of timely completion is discussed in MRG every

month and uptodate list of outstanding SJR's is shared as an agenda item. 1-1 meetings & discussions have happened with reviewers with the most outstanding requesting action plan and offering support where required to address this issue.

4) Quarterly Mortality reports will be presented at MRG, commencing in March 2025. The reports to be shared are as follows:
    - Trauma Mortality Report
    - Child Death Mortality
    - Maternal and Perinatal Mortality - reported through MBRRACE-UK, cases explored through MNSA/ PMRT. There is heavy sighting of the report through QAC/board on quarterly basis.

5) A stroke focussed review was undertaken into 9 deaths. The findings of this review were presented during December 2024 MRG meeting. Further discussion was had during January 2025 MRG meeting whereby it was confirmed a Meeting will be arranged with the Stroke Consultants to discuss the focussed review findings so that learnings can be taken to wider team through appropriate governance meetings. Discussions are also taking place between the stroke services at both Warrington and Whiston Hospitals. The full Stroke focussed review can be reviewed by clicking on the below:

Stroke-dive Nov2024.pptx

6) A vacancy post for an MRG reviewer is currently in the process of being interviewed.

During Quarter 3 there were between 16 - 26 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring an SJR per month are 22 which is an increase of 1 from the last reporting period. Currently we have 7 Mortality reviewers, with each being allocated up to 5 cases per month, allowing a total monthly allocation of 35 SJRs.

We continue to remain up to date in the allocation of SJR's with currently no major delay from patients' death to ensure timely review. This is due to the changes in relation to the 10% criteria of 'urgent' DoLs cases and has allowed for more focused learning to be shared with the relevant teams to better improve our Quality of Care. We would like to provide assurance that despite the 10% allocation change, all DOLS deaths are screened by the MRG co-ordinator and if any concerns are noted, these are allocated for SJR review.

3.1 Mortality Review Data Q3 2024/2025

- During Quarter 3, 93 deaths met the criteria to be subject to a Structured Judgement Review (SJR). However, based on the criteria selection for allocation, only 10% of the DOLs cases were selected meaning a total figure of 66 SJR's requiring review. This is an increase of 4 from Q2 2024/25.

- During Quarter 3, 75 deaths were allocated to a reviewer for a Structured Judgement Review to be completed.
- 46 SJR's have been completed in Q3, which is a decrease of 6 from Q2.
- Of the 46 SJR's completed, 28 were allocated in Q3 2024/25 and 18 were allocated in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q3	Total LD Deaths Q3	PSII's commenced in Q3 relating to patient deaths	Those meeting SJR criteria Q3	Number of SJR reviews completed in Q3	Number of SJR Reviews that were allocated in Q2 24/25 and completed compared to Q1 24/25	
314	2	0	66	46	Q2 24/25 Total SJR Completed – 52 Out of the 52 SJRs completed, 21 were assigned in Q2.	Q3 24/25 Total SJR Completed – 46 Out of the 46 SJRs completed, 28 were assigned in Q3

Cases rated by reviewers as *1: **overall care very poor*** or *2: **overall care poor*** are reviewed by MRG to agree the overall care rating and then referred to the Governance Department if the consensus rating is Very Poor/Poor for further investigation.

A sample of cases rated as *3: **Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

Cases rated as *4: **Good*** and *5: **Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

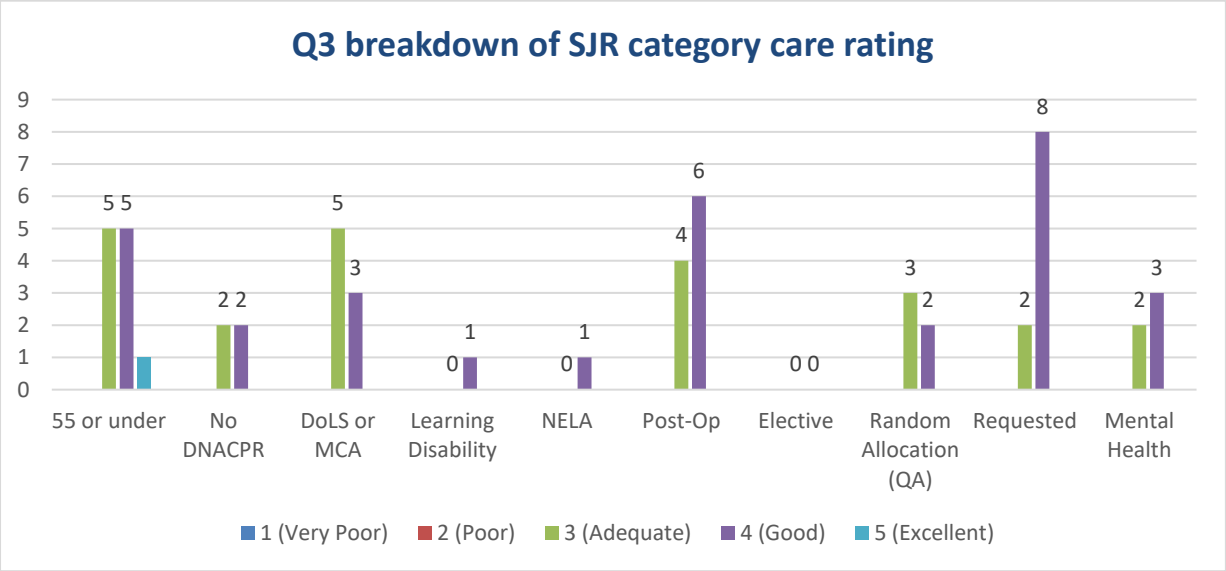
Fig. 2 – Shows the overall and phase of care ratings of the 46 SJRs completed in Quarter 3.

Phase of Care *	N/A	Very Poor	Poor	Adequate	Good	Excellent

First 24 hours/admission	2	0	0	17	23	4
Ongoing care	6	0	0	17	22	1
Care during procedure	34	0	0	6	6	0
End of life care	12	0	1	15	17	1
Patient records/documentation	2	0	0	13	30	1
Overall care	**2**	**0**	**0**	**18**	**25**	**1**

- In SJRs completed within Quarter 3, there has been no 'very poor' and 'poor' care ratings for the 'Overall Care' rating.
- All phases of care and documentation records including overall care had a majority of 'good' ratings with 1 receiving an 'excellent' rating.

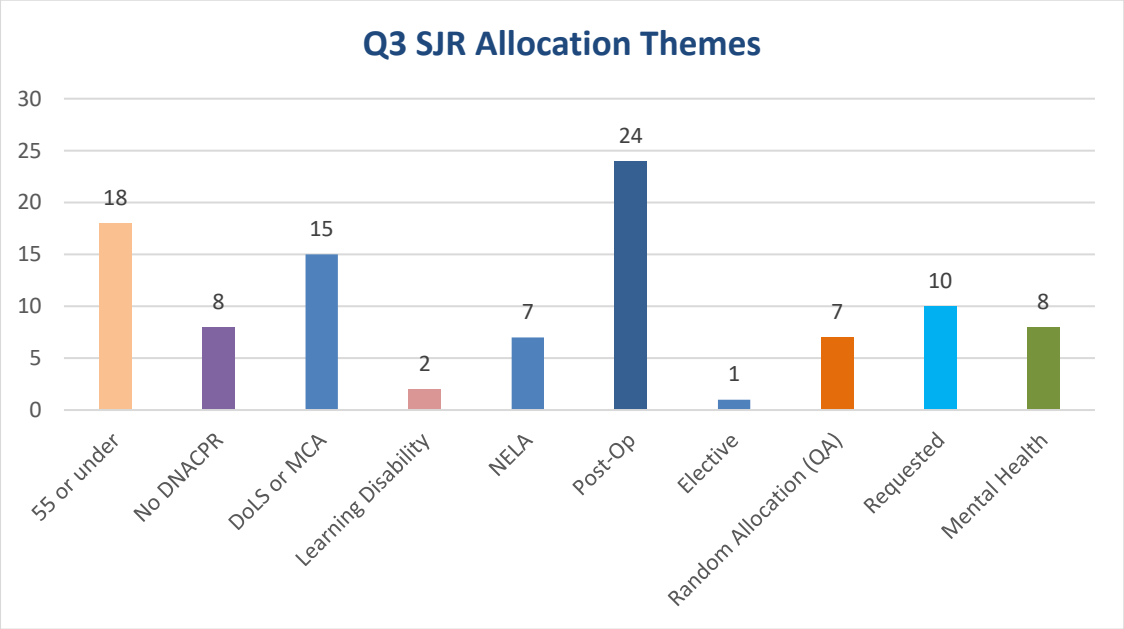
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 3.



- Most categories are predominantly receiving good / adequate care.
- Random Allocation patients show 'good' and 'adequate' care ratings. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

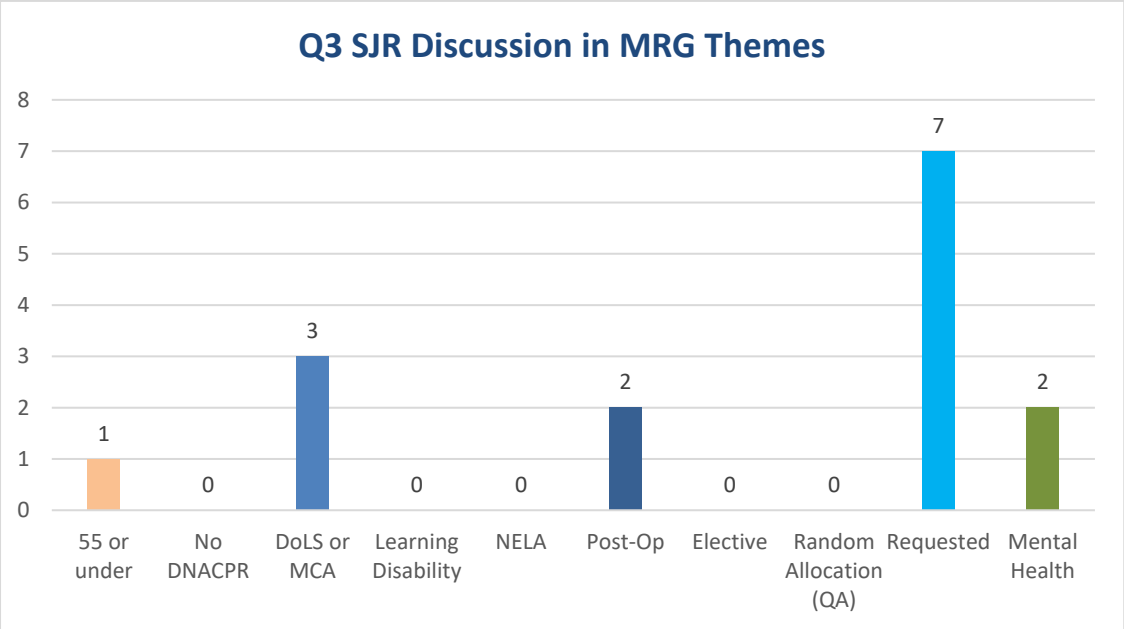
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 3



- 'Post-Op' was the most frequently allocated category to reviewers in Q3.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP.

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 3.



- The category with the highest number of SJR's requiring further discussion at MRG in Q3 is 'Requested', 'DOLs or MCA', 'Post-op' and 'Mental Health'. Requested allocations are used by the Clinical Effectiveness Coordinator when the death does not meet the SJR criteria, but a review has been requested from another organisation.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
Patient was seen by NWAS. 88-year-old patient admitted with weakness and decreased mobility. Past medical history of NSTEMI, CKH3, spinal stenosis, severe LVSD – 30% and patient has a catheter. • Over the course of a week patient was treated for HAP and UTI • Pleural effusion on chest x-ray • Not for chest drain due to anticoagulation • Gastro decision to hold off ERCP due to ductal stone • Sudden deterioration, agitation, decreased sats, hypothermia • Deemed not for further investigation • Patient died prior to palliative review • No frailty review • No palliative care team review	• Mortality lead and Deputy will liaise with Senior Nurse Manager – Planned Care for support if needed when planning training sessions regarding early palliative referrals
55-year-old admitted with low BM's and seizure. MRG reviewer, (Critical Care Consultant) feels an MRG commendation to **Dr Joseph Sabine** is required due to the following – • Excellent review • Excellent summary • Excellent balance of risk and explanation of futility • Good clinical judgement and discussions with family • Very good summary and decision making by ST7	• Clinical Effectiveness Coordinator to create commendation certificate for Dr Sabine and will forward to MRG Chair
90 year old patient admitted following a fall from standing position at home. Patient complaining of right hip pain.	• **Clinical Effectiveness Coordinator to create a certificate for Dr Qaffaf – good, clear forward-thinking plan in place**

Past medical history of COPD, Bronchiectasis, CKD, GCA, PAF, Type 2 Diabetes, proctitis and Hypertension. Patient had long term oxygen use at home. • On examination in ED patient appeared unwell, febrile, tachycardic and in pain • Working diagnosis sepsis (likely pneumonia) and possible right neck of femur fracture • Pelvic and right hip x-ray showed a right, intracapsular neck of femur fracture • Referred to Medics and Orthopaedics • Tazocin was used as antibiotic of choice which differs from antibiotic formulary (guidelines) for community acquired pneumonia – this should have been co-amoxiclav/ clarithromycin • First 24hrs – good input from teams involved (Medical Reg and Orthopaedic Ward) • Documented by FY1 that a CTPA was booked but no documentation to explain why • Good amber care planning from Ortho Geri team • Post operative – patient was switched to IV amoxicillin (as per guideline) • 19/09 noted that the patient had received Keppra from a previous admission due to steroid induced psychosis/ encephalitis – discussion with Walton team regarding dosage. Not clear that the team were aware that the patient had a steroid induced psychosis on a previous admission • regular meds were not prescribed – this led to Bisoprolol not being given this could explain fast heart rate • unable to see palliative input within the notes – unable to find a referral on ICE • Previous failed discharge noted as the stretcher was unable to fit through the door of the property and patient was brought back to ward A6 – prior to this the OTT team had stated the stretcher would be able to fit • after reviewing this case an IMCA wound not have been required and no further DOLS training needed	• **Clinical Effectiveness Coordinator to add this case to the palliative workstream** • **Mortality Chair will forward a summary to Ortho Governance meeting and to Mr Marlow in order to highlight potential gaps in management and address clear learning points requesting feedback.**

MRG Newsletters **Appendix 1** – MRG Newsletters shared during Q3. **October Newsletter** – Holistic Management of Bowel Obstruction **November Newsletter** – How do we know whether mortality for our patients is comparable to similar populations in other areas of the country? **December Newsletter** – Falls, Getting the Basics Right. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

There were no PSII's reported during the quarter 3 period relating to a patient's death.

Mortality Indicators

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation.

To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.

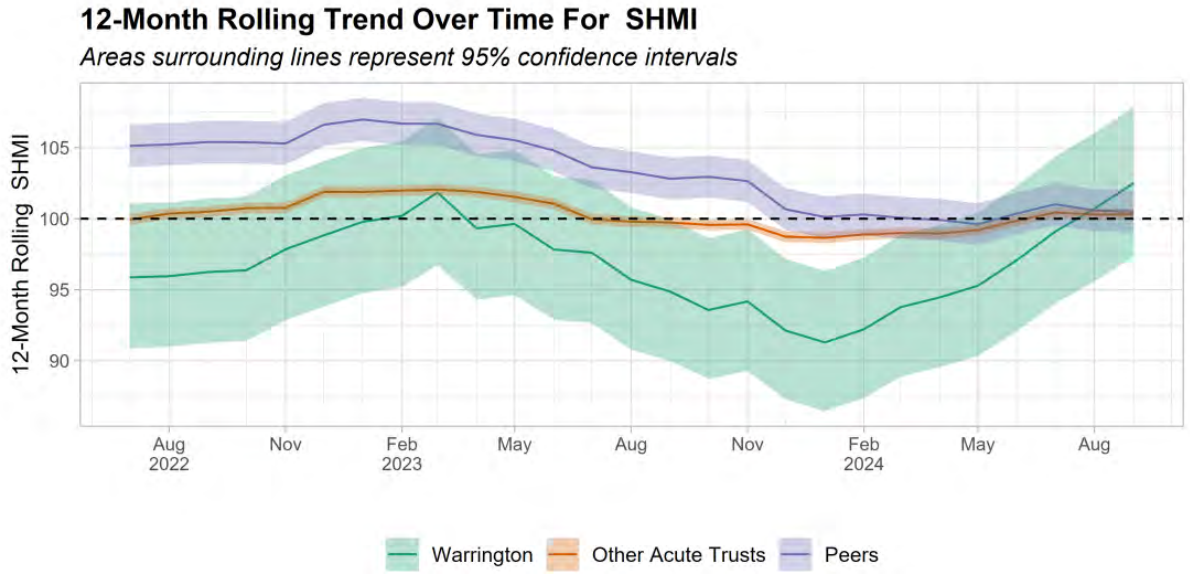
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'.

(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

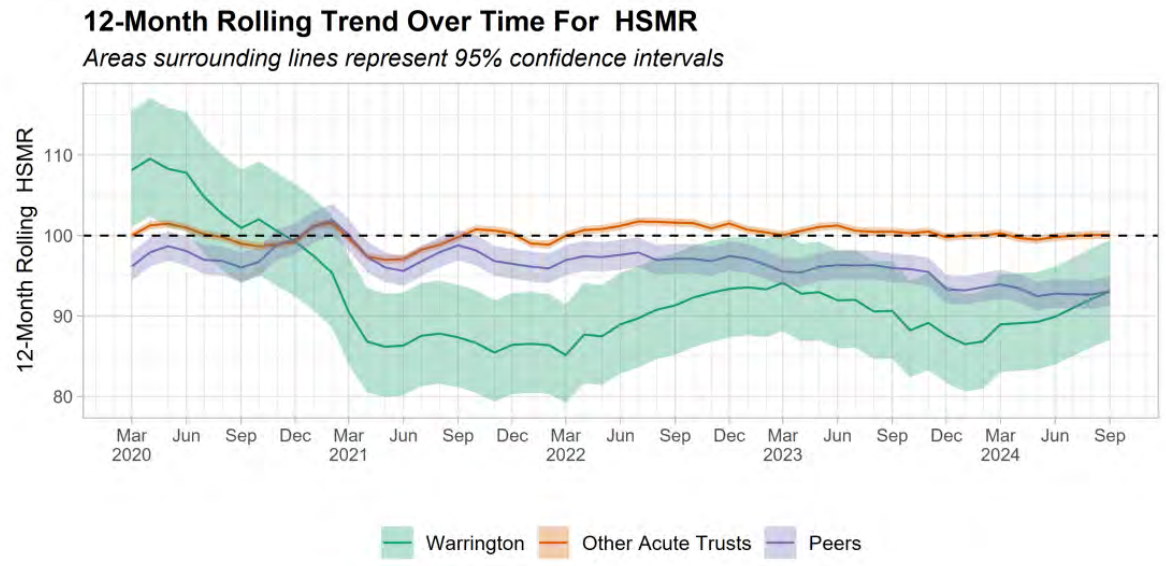
4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
August 2024	90.79	97.98	90
September 2024	92.10	99.71	101
October 20247	93.08	101.62	105

HES SHMI for Warrington is 102.50 (October 2023 - September 2024). This result is not an outlier using an over-dispersed funnel plot and is not an outlier based on the Stricter Poisson method



- The 12-month rolling SHMI trends for the average of the Peer Group and the average of Other Acute Trusts have remained relatively



- The HSMR (for the standard 56 CCS groups) for Warrington is 94.26 (November 2023 - October 2024). This result is not an outlier based on the 95% Poisson method.

4. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub Committee, quarterly to the Quality Assurance Committee and annually to both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

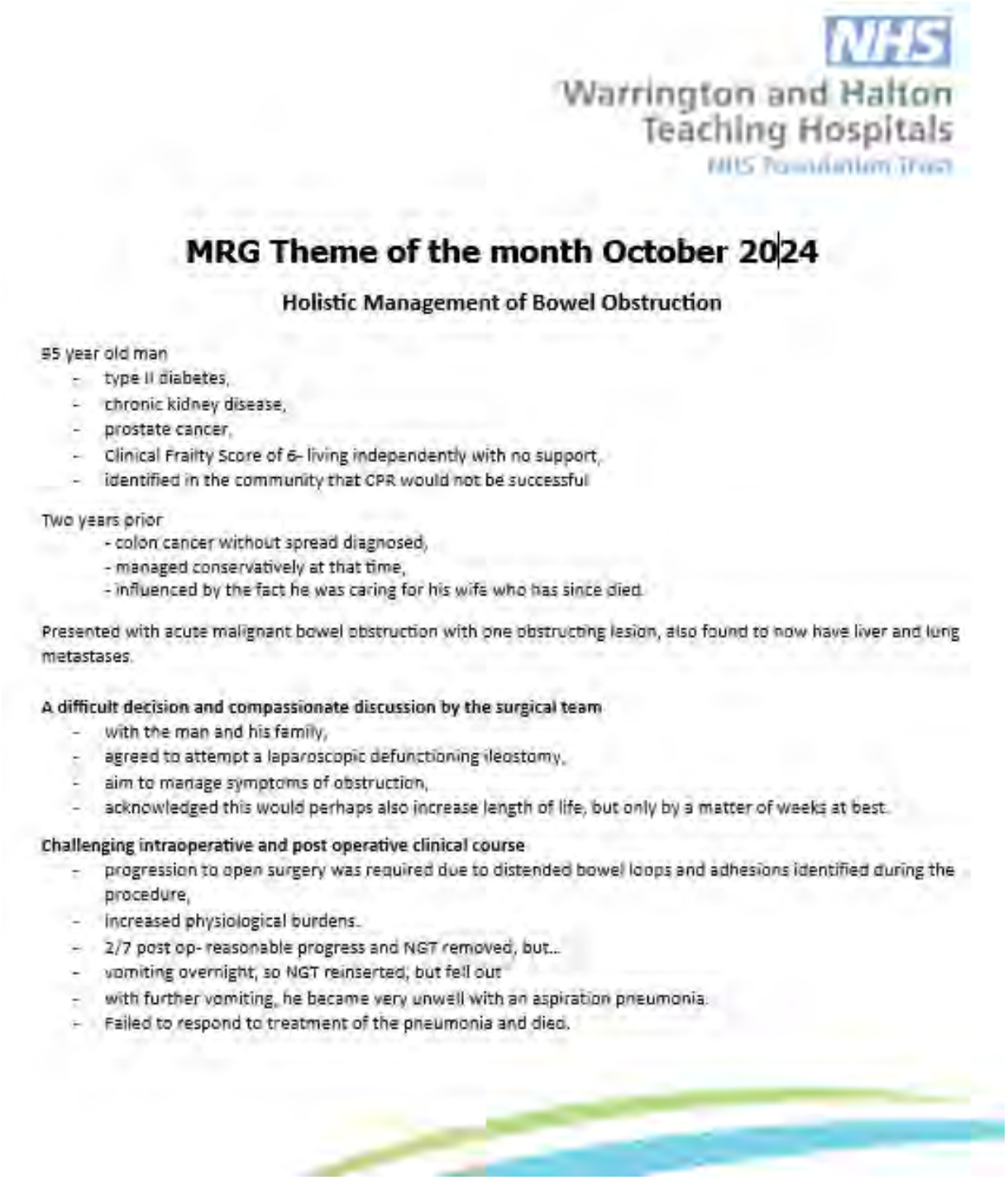
5. TIMELINES

Ongoing - the Mortality Review Group meets monthly (no meeting during August) to review deaths that have been subject to a Structured Judgement Review.

6. RECOMMENDATIONS

The Quality Assurance Committee are asked to note this report.

Appendix One: Monthly MRG Newsletters during Q3:



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MRG Theme of the month October 2024

Holistic Management of Bowel Obstruction

85 year old man
- type II diabetes,
- chronic kidney disease,
- prostate cancer,
- Clinical Frailty Score of 6- living independently with no support,
- identified in the community that CPR would not be successful

Two years prior
- colon cancer without spread diagnosed,
- managed conservatively at that time,
- influenced by the fact he was caring for his wife who has since died

Presented with acute malignant bowel obstruction with one obstructing lesion, also found to now have liver and lung metastases.

A difficult decision and compassionate discussion by the surgical team
- with the man and his family,
- agreed to attempt a laparoscopic defunctioning ileostomy,
- aim to manage symptoms of obstruction,
- acknowledged this would perhaps also increase length of life, but only by a matter of weeks at best.

Challenging intraoperative and post operative clinical course
- progression to open surgery was required due to distended bowel loops and adhesions identified during the procedure,
- increased physiological burdens.
- 2/7 post op- reasonable progress and NGT removed, but..
- vomiting overnight, so NGT reinserted, but fell out
- with further vomiting, he became very unwell with an aspiration pneumonia.
- Failed to respond to treatment of the pneumonia and died.

- In the last 48 hours of his life, it was recognised that he was dying and he was referred to the specialist palliative care team,
- but was never assessed as there is no face-to-face service available over the weekend.

Learning Points and Reflections

The decision whether to operate was incredibly difficult and there are no right or wrong answers here- hindsight is 6/6.

There are some cases in which surgery for malignant bowel obstruction is clearly not possible or is likely to be more risky and burdensome than beneficial.

- when the patient is too frail or with low physiological reserve,
- or when there are multiple obstructing lesions evident on scan

In a case where it is believed before surgery that there is only one area of obstruction, it is less clear

What is the alternative?

- often assumed that surgery is the definitive management of the symptoms of bowel obstruction,
- but remember there are also clear palliative symptom management processes...
- which can successfully manage each individual symptom of vomiting, nausea, pain, colic, bowel secretions
- many people whose mode of dying is bowel obstruction do so in a comfortable and dignified way in their preferred place of death, having had these symptoms well managed for days or even weeks.

Why did he not get Specialist Palliative Care Support?

- Part of our Trust wide Strategy for Palliative and End of Life Care is to achieve a "leftward shift" in referrals to the specialist palliative care team
- many referrals are left until potentially life prolonging or other interventions have been exhausted and the person is dying
- In fact, palliative care should start far earlier than that
- for someone like this patient, may have included palliative medicine outpatient follow up prior to the obstruction developing which can prevent crises,
- and inpatient referral whilst discussions were being held about how to manage the obstruction
- even for someone having surgery, the holistic and palliative management begins far sooner than the dying phase,
- the AMBER Care Bundle is also an evidence-based enabler that ensures that holistic needs are met even when there is a hope and possibility of clinical recovery and potentially life prolonging and disease modifying interventions are still being given- it is not an either/or...
- It is hoped that in the future there will be weekend face to face specialist palliative care in the hospital to provide the palliative and holistic support this man deserved,
- but do not forget that there is always palliative medicine consultant advice available out of hours over evenings and nights and at the weekends via Switchboard.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MRG Theme of the month November 2024

How do we know whether mortality for our patients is comparable to similar populations in other areas of the country?

HED aqua

The MRG review the NHS Healthcare Evaluation Data (HED) Mortality Report each month and also receive the NHS Advancing Quality Annual Integrated Care System (AQUA) quarterly mortality report.

Are comparable populations compared?

The Hospital Standardised Mortality Ratio (HSMR) 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, so the data are controlled for things like age, gender, and social demographics of the population served. HSMR only reports on deaths in hospital using 56 diagnostic groups, which accounts for approximately 80% of death, reported in the HED report.
The Summary Hospital Level Mortality Indicator (SHMI) is similar, but felt to be a more useful comparator as it also takes into account co-morbidities and the emergency/ elective split of the patients. SHMI reports on all inpatient deaths and those within 30 days of discharge which is reported on in both the HED report and AQUA report.
Traditionally, only HSMR excluded patients with identified palliative care needs, but now a modified SHMI is also given, adjusted for those with palliative care needs, which can help to explain when there is a large difference between SHMI and HSMR.

Since November 2023, WHH's SDEC activity is counted within the Emergency Care Data Set (ECDS) and not all trusts have followed suit as yet, the national deadline having been delayed to July 2025, so this means that the SDEC patients (on average less close to death than inpatients) can dilute the mortality data in some other trusts and leave WHH with a falsely higher mortality ratio.

Do the mortality reports show us where we are going right and wrong?
The mortality reports cannot tell us how many avoidable deaths occurred or measure the quality of care given in the community and hospitals in our area, but it can give us statistics and show us outliers which can prompt us to investigate further.

The most recent HED report included a Variable Life Adjusted Display (VLAD) alert (which can look at long term trends) which showed a discrepancy related to acute cerebrovascular disease, indicating that 57% more deaths than could be expected had occurred in the

preceding year. These data are hard to compare for WHH, because there will be a different cohort of people with acute stroke who do well and are discharged home from the tertiary centre in Whiston, and those who are repatriated back to WHH may be sicker on average. This potential discrepancy has prompted our own coding review looking into stroke related deaths, management in ED, and transfers and repatriations between WHH and Whiston- this has led to nine cases being scrutinised in more detail by the mortality reviewers (our consultants) who will report back in December.

The mortality reports often do a deep dive into the statistics for a particular diagnostic area.

What do the latest data tell us?

The 12 month rolling weekday SHMI for WHH is relatively flat and has been consistently lower than expected when compared to other trusts in England and to our peers in the North West.

If we compare the graph above to the one below from the HED report from December 2018, we can see how much has improved since the increased focus on the governance around the mortality review process:

In previous years, both the SHMI and HSMR have been higher over the weekends when compared to weekdays, but now there is significant improvement and WHH patients are not

dying more over the weekends compared with weekdays: in fact our weekend HSMR was statistically significantly low.

The 2024 winter peak in deaths has been higher for WHH than for comparable trusts in the North West and in England, and on average the winter peaks since 2017 have taken longer to resolve in WHH.

What can I do to help improve accuracy and usefulness of the mortality reports?

- Document the current working diagnosis or diagnosis for your patient and update with dates for resolved conditions
  - Avoid 'copy and paste' from previous days.
  - Avoid listing "signs and symptoms" in the wrong section of the clinical record as if those were the primary presenting diagnosis, instead document the working diagnosis (e.g. 'chest infection' or 'treat as chest infection') - *this currently has the biggest impact on the data for our Trust.*
  - Ensure you document the condition / diagnosis and not just the reading, medication or test result as this can affect both mortality reporting and income reimbursement,
    e.g. do not just put "CXR showed consolidation and CRP raised - treat with antibiotics"- you must also put 'chest infection'
- Ensure that all co-morbidities are clearly listed in your clerkings and in ward round notes. If patients have high levels of certain co-morbidities, the expected number of deaths is higher and so both the SHMI and HSMR will be lower, e.g.
  - CKD is commonly not documented as a co-morbidity yet carries a high associated risk of death, just documenting the eGFR alone is not enough,
  - writing LVSD or severe systolic dysfunction is not enough, if they are in heart failure, you must write heart failure
  - writing "multi-organ failure" cannot be coded as a comorbidity with increased risk of death, you must write "respiratory failure, liver failure, etc, etc"
- Ensure that you identify which of your patients have palliative care needs (including and especially those for whom potentially life-prolonging or disease modifying interventions remain appropriate) and refer them to the specialist palliative care team if they meet the referral criteria.
- Ensure you identify patients who are expected to die in the coming weeks/ days and support their care with an Individualised Plan of Care for the Dying Person (IPOC).

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

MRG Theme of the month December 2024

Falls- Getting the Basics Right!

Recently, the NHS Healthcare Evaluation Data (HED) Mortality Report revealed that mortality from stroke in WHH, (both during admission and within 30 days of discharge), was higher than 'expected.'

MRG performed a deep dive into individual deaths, and concluded;

- Quality of care did not contribute to mortality
- Deaths at WHH cannot be compared to peer trusts with acute stroke services
- Patients who stay in WHH as they would not benefit from transfer to Walton acute stroke unit and those repatriated from Walton as they are not progressing well following stroke, are much more likely to have a high number of co-morbidities and/or more extensive strokes.
- Therefore, the increased mortality is not unexpected.

All the cases reviewed had care rated as Good by MRG, except this case of falls in which the care was rated as Adequate;
87 year old male – presented following multiple falls
PMH- Hypertension, Type 2 diabetes, CKD stage 3, Ischaemic heart disease.

- Initial Working Diagnosis- "Social Admission"- no consideration as to why he was having multiple falls, not even an ECG or lying and standing BPs
- Referred to medical team, who deemed medically optimised for discharge the following day, pending OT/PT review
- 3 days later, a PT raised concerns of left weakness and neglect
- Still no formal neurological examination documented, but had a CT head (NAD) and MRI head which revealed an acute ischaemic stroke
- Finally, a neurological examination showed expressive dysphasia, unilateral weakness especially in the lower limb, and an asymmetric smile
- Discussed with Walton consultant, would not have benefitted from transfer- but this discussion and the reasoning not well documented
- Given aspirin and transferred to WHH stroke ward

- Became unwell with a chest infection, phlebitis and a degree of heart failure
- Appropriate conversations held with family and supported with good end of life care, died in hospital.

Although the care would not have adversely affected the outcome for this man, the lack of examination and investigations at the point of presentation with multiple falls could significantly affect other patients and should not be repeated.

Points Identified:

- Monthly Mortality Reports can reveal potential outliers, but deep dives are required to understand relevance
- As WHH does not have an acute stroke unit, those who remain here or are repatriated back here with strokes are more likely to have extensive strokes and/or comorbidities which lead to poorer outcomes compared with other peer Trusts

Learning:

- For anyone who has been living independently alone to change relatively suddenly and present to hospital, a "social admission" should be the last consideration
- For anyone presenting with multiple falls, the very standard and basic examinations, observations and investigations are vital to rule in or out possible causes- this includes thorough neurological and cardiological examinations and at the very least an ECG and lying and standing BPs
- When cases are discussed for potential escalation, such as with an external stroke team, it is important to document not only the decision, but also the reasoning
- Identification of stroke is important, and admission onto a dedicated stroke unit is associated with better outcomes overall

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/25/02/238**			
SUBJECT:	**Learning from Experience, Quarter 3 2024/25**			
DATE OF MEETING:	11 February 2025			
ACTION REQUIRED:	The Quality Assurance Committee is asked to note the contents of this paper and support the recommendation to introduce a Sustained Learning Group.			
AUTHOR(S):	Nicola Edmondson, Associate Director of Governance, with input from Care Group and Corporate Leads.			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Learning from Experience Report Quarter 3 (Q3) 2024/25 demonstrates where effective learning from experience has taken place across the organisation and areas where further focus is required. The information within the report is a direct reflection of the information available on the Datix Risk Management System at the time of reporting and other relevant governance sources. The report relates to data reviewed during the period from 1 October 2024 to 31 December 2024 with reference to the previous quarter (Quarter 2 (Q2) 2024/25), where relevant. The report contains both quantitative and qualitative data analysis, triangulated to demonstrate learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Inquests, Quality Improvement and Research, Compliance and Patient Experience.			
PURPOSE: (please select as appropriate)	Approval	To note √	Decision	
RECOMMENDATION:	The Quality Assurance Committee is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(If relevant)***	Section 41 – confidentiality			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Experience, Quarter 3 2024/25	AGENDA REF	QAC/25/02/238

1. Background / Context

The purpose of this report is to assure the Quality Assurance Committee that Warrington and Halton Hospitals Trust (WHH) is managing Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Inquests, Quality Improvement and Research, Compliance and Patient Experience effectively and demonstrating the focus on learning and improvement to minimise risk to our patients, staff and the organisation.

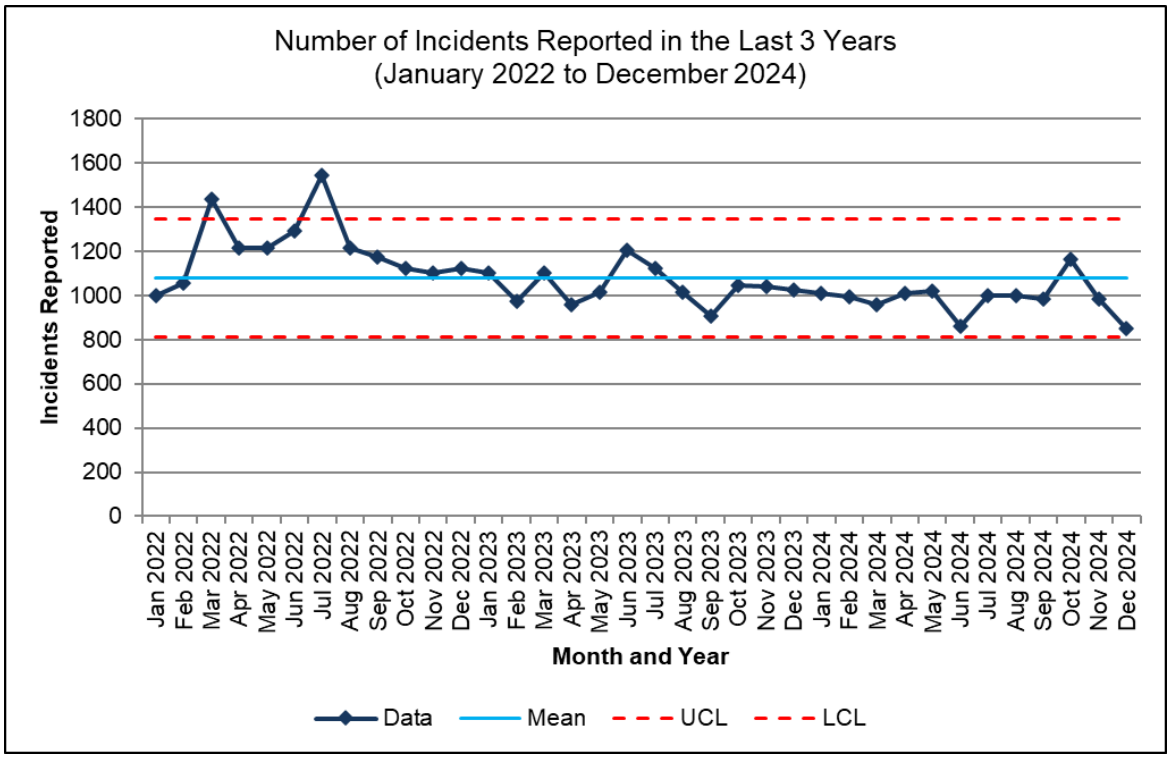
The Learning from Experience Report Quarter 3 (Q3) 2024/25, informs findings about the data reviewed during the period from 1 October 2024 to 31 December 2024, with comparison to Quarter 2 (Q2) 2024/25 where relevant. The report includes both quantitative and qualitative data analysis, using information obtained from the Datix Risk Management System and other relevant Trust governance sources. This methodology has enabled triangulation of the data to demonstrate learning for the key workstreams cited above the report includes a summary of themes, trends and key findings, that have supported learning and action for sustained improvement.

2. Learning from Incidents

2.1 Incident Reporting Position

In Q3, a total of 2998 incidents were reported compared to Q2, where 2977 incidents were reported. This is an increase of 21 incidents (0.7%).

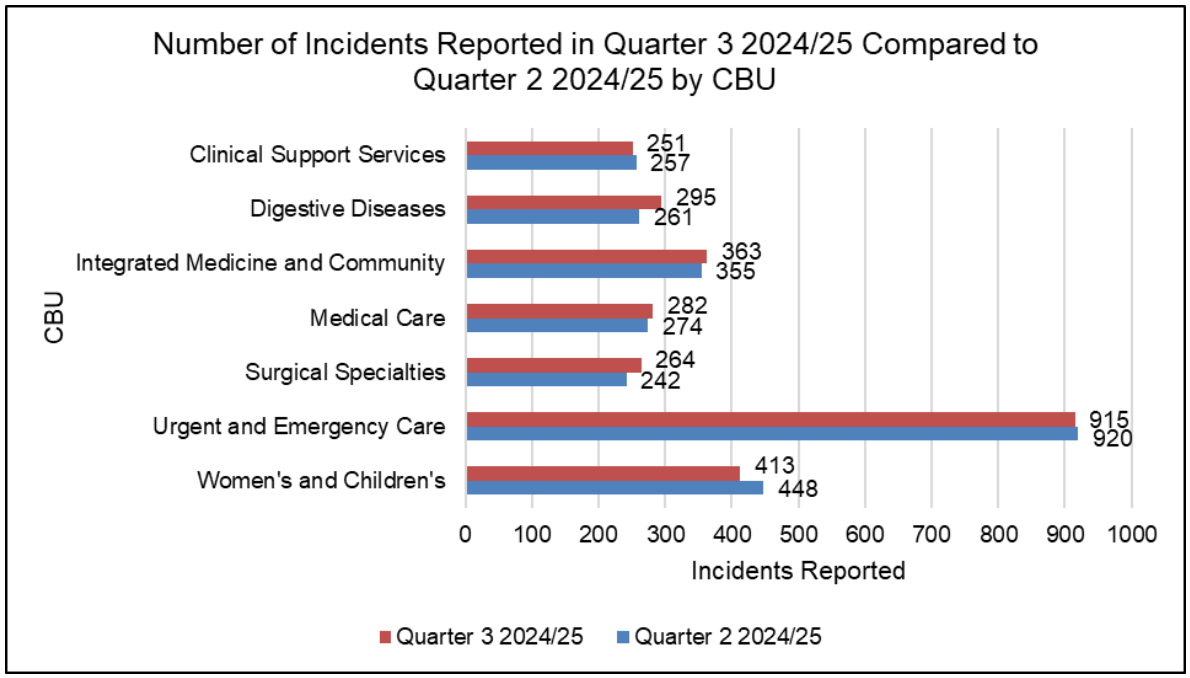
Graph 1



2.2 Incident Reporting Position per Clinical Business Unit (CBU)

In Q3, a total of 2783 incidents were reported across the Clinical Business Units and Clinical Support Services, as shown in Graph 2. The remaining 215 incidents were reported under Corporate Support Services (140) and External Sites/Organisations (75). The top three Corporate Support Services incident reporting specialties were: Estates and Facilities (101), Digital Services (20) and Human Resources (7).

Graph 2



The area with the largest decrease in the number of incidents reported was Women and Children's services, with a decrease of 35 incidents (7.8%). The breakdown in the severity of incidents reported by Women's and Children's across the quarters is as below, see further analysis in 2.3.4.

Severity	Q3	Q2
No Harm	298	315
Low Harm	93	117
Moderate Harm	22	15
Severe Harm	0	1
Fatal	0	0

The area with the largest increase in the number of incidents reported was Digestive Diseases, with an increase of 34 incidents (13%). The breakdown in the severity of incidents reported by Digestive Diseases across the quarters is as below, see further analysis in 2.3.2.

Severity	Q3	Q2
No Harm	251	208
Low Harm	38	51
Moderate Harm	6	2
Severe Harm	0	0
Fatal	0	0

2.3 Themes and Learning from Incidents by Clinical Business Unit (CBU)

2.3.1 Clinical Support Services

There were 251 incidents reported in Q3 compared to 257 in Q2. This is a decrease in 6 incidents (2.3%). The top 3 reporting specialties in Q3 were Radiology (103), Pharmacy (58) and Outpatients (28). This is consistent with the top 3 specialties in Q2. Medication was the top reporting category in both Q3 (54) and Q2 (55). In Q3, this was followed by Treatment and Procedure (38) and Diagnostic Imaging Issues (38). Most incidents reported in Q3 were no harm (181, 72.1%). There were 3 moderate harm incidents reported in Q3 and no severe or fatal harms. The 3 moderate harm incidents related to a treatment delay, diagnostic imaging referral documentation issue and a fall. These have progressed to further investigation in the form of an MDT.

Medication dispensing error learning example

A requisition for a further inpatient supply of Novorapid Flexpen (a short-acting insulin) was received in Pharmacy, however the Pharmacy staff dispensed a Novomix 30 Flexpen (a biphasic insulin containing rapid and intermediate acting insulin). This was identified by the patient's Nurse prior to administration of the prescribed morning dose. As the insulin had been ordered as a "top up" to ensure the patient did not run out of insulin, the Nurse was able to administer the correct insulin from the Flexpen, which was currently in use and there was therefore no delay in administration. The ward informed Pharmacy and the correct medication was dispensed.

Learning and Improvement

- Novorapid and Novomix insulins and are now stored in separate fridges within different areas of the Pharmacy, providing a physical barrier for selection error of the similar sounding medicines.
- "Warning, stop check your insulin" signage has been displayed on all fridges containing insulin.
- A learning from medication incidents focused on NovoMIX and Novorapid insulins was provided for staff in August 2024, the presentation remains available on the Pharmacy Education and Teams channel.
- In December 2024, "wrong insulin" was included within the 12 days of Christmas of Medicines Safety, which was shared with the Pharmacy department and the Trust.
- Novomix and Novorapid products have been changed to utilise Tallman lettering (writing part of a drug's name in upper case letters to help distinguish sound-alike, look-alike drugs from one another) on the Pharmacy dispensing system and are now displayed as NovoMIX and NovoRAPID.

Treatment and procedure (learning example)

A patient attended for an ENT appointment. The patient was waiting for 50 minutes past his appointment time, due to his referral paperwork not being within his notes, or accessible upon Lorenzo. The patient was reviewed by a consultant and required a nasal endoscopy. Upon taking the patient into the endoscopy room, it was noted that endoscope was not clean and ready for use. The On-call Doctor, noting the room was free, had taken a patient from the Emergency Department into the endoscope room and used the scope without communicating to the nurses, hence the scope had not been cleaned and was not ready for use. This caused a further delay in the patient's treatment.

Learning and improvements

- All staff prior to commencement of clinics a ensure that referral paperwork is accessible for doctors to prevent delays.
- For clinic delays over 15 minutes, a member of staff speaks to the patient to advise them of the delay. Reception staff advise patients of delays at the time of booking in for clinic appointments to help manage their expectations.
- It is now ensured all scopes when cleaned now have a green 'I am clean sticker' placed upon them, with the date and time included on the equipment.
- All doctors are now fully aware of the cleaning regime required after each use and the importance of informing staff when the scope has been used for out of hours/ED patients.
- All scope users are required to complete the register with the date and time that the scope has been used.
- All of the above learning outcomes will be monitored via audit processes to ensure that the best practice standards identified are maintained and minimise risk to our patients.

Diagnostic Imaging learning example

A theme emerged within the Breast Screening Service, whereby 3 patients within a short time were screened too early in relation to the recommended time frame. During the investigation it became clear that when asked, the patients involved were confused by the difference in screening and symptomatic imaging, both of which are the same. Investigations were undertaken with all three cases, all of which were reported to Public Health England (PHE) and the Quality Assurance (QA) Teams in line with guidance.

Learning and improvement.

- The three cases were shared at staff meetings as part of learning discussions, to ensure all staff understand the issues and risks and improvement initiatives were agreed to minimise risk to patients.

- Consequently, staff now focus on questions about breast imaging history instead of screening or screened 'to minimise risk of confusion for patients.

- In addition, at the time of booking the Administrative Team complete a a full history taking checklist including planned date for screening/symptomatic imaging, to prevent repeat of incidents, and there is a monitoring process in place to ensure the improvement is sustained.

2.3.2 Digestive Diseases

There were 295 incidents reported in Q3 compared to 261 in Q2. This is an increase of 34 incidents (13%). The top three themes in Q3 were Access, Transfer & Discharge (39), Medication (28) and staffing levels (24). Most incidents reporting in Q3 were no harm (251, 85.1%). There were 6 moderate harm incidents reported. There were 18 Initial Safety Reviews, 1 After Action Review and 2 Multi-Disciplinary Reviews completed. There were no events requiring a PSSI.

Learning and improvement

Access Transfer & discharge:

The most frequently reported subcategory within the Datix incident module is in relation to unexpected transfer (19). These incidents are in relation to 13 patients who were identified as being unwell on the Planned Investigation Unit (PIU) at Halton Hospital. 2 Day case patients who have required an overnight stay either at Captain Sir Tom Moore (CSTM) ward or Post Anaesthetic Care

Unit (PACU) .4 patients on PACU who have deteriorated requiring transfer back to Warrington site or admission to the Critical Care Unit. In Q4 the Senior Nursing Team will complete a retrospective review of the data for PIU transfers using a systems (SEIPS) approach to identify themes and learning. The aim is for a reduction in the number of patients transferred from PIU with the expected outcome being to minimise risks to patients, improve patient experience

Medications:

The in-patient wards complete an omitted medicines report from the LiON database. This report is run twice a week reviewing the subsequent 24 hours. This report is then reviewed by the Matron/Senior Nursing Team who ensure any learning and associated actions for improvement actions are required and implemented at pace. This is to ensure that medications are not being omitted for non-clinical reasons.

Evidence of learning – Improvement seen

The CBU identified issues relating to multiple incidents surrounding the use, monitoring and setting up of the patient-controlled analgesia (PCA) 15 incidents in total have been reported. 9 incidents in Q1 with the primary reason about incorrect setup. 4 incidents in Q2 relating to the level or quality of the PCA observations and 4 in Q3 2 of these relate to failure to change the morphine syringe every 24 hours and 2 relate to the quality of observations. Extensive work has been undertaken by the Pain Team and Senior Nursing Team to improve training regarding the setup of the pumps and due to issues identified with the pump design that can contribute to this error a risk has been added to the corporate risk register. Due to the high number of setup issues the training was revisited, a ward resource file was created with step-by-step instructions and photographs. Labelling on the pump was also improved. A reduction in incidents related to this has been seen with no Datix's relating to setup submitted in Q3. Regarding the need to change the syringe every 24 hours this is a relatively new requirement and alongside ward level teaching a safety alert was issued by the pain team. The requirements of the PCA observations are monitored daily as part of the Matron daily checks Monday-Friday. All PCA documentation is audited by the Matron Team each month with any discrepancies or concerns discussed with the appropriate team member.

The Nursing Team attend the Trust staffing meeting twice daily where staffing levels are discussed. The team constantly review the utilisation of staff and will move/redeploy staff to support wards to reduce the risk if an area has a staffing below establishment or increased acuity/dependency requiring additional staff. NHS Professionals (NHSP) or agency staff are used when required to back fill vacancy and to maintain safety and this is scrutinised by the Senior Team. A revenue request has been submitted to increase the establishment on a number of wards in recognition of an increase in the number of patients requiring enhanced care. This need is currently met by using bank or moving staff from other areas to support where possible. The staff utilise the Safer Nursing Care Tool to input the level and category of patient which gives an indication of the number of staff required to deliver care. This is also reviewed by the Senior Nursing Team who can add in a "professional Judgement" and indicate after their professional and experienced review if the ward is safe with the level of staff provided.

Wrong Prosthesis (Never Event, Q2) update

The wrong sided implant was presented to the surgeon to be cemented into the knee. The surgeon realised it was the wrong implant and removed it before it was cemented in. The Co-ordinator and theatre manager were informed.

The implant was removed, the Theatre Team were all aware, the correct sided implant was brought in, checked, and the procedure was completed. A debrief was undertaken with the Theatre Team, Theatre Coordinator and Theatre Manager

Evidence of Learning and actions for improvement

- Size and expiry date of the prosthesis was checked, but not laterality
- No Formal checklist for prosthesis pause was used.
- A new checklist has now been implemented which includes checking the laterality of the implant being used. This will be included as a regular monthly audit, commencing in Q4.

Note: Review of the lessons learnt during Q2, presented in the previous reporting period show that all actions identified have been completed within identified timeframes Moreover, in Q2 Learning from Experience Report (LFE) learning examples were highlighted relating to cataract surgery and the management of Flexi-seals, no further incidents have been identified during this reporting period, indicating learning and actions for improvement have been effective. These actions included training for staff on Ward A4 and the development of a Flexi Seal SOP to support safe practice and minimise risk.

Surgical Specialties

The number of incidents reported in Surgical Specialities has increased from 215 in Q2, to 240 in Q3. The evidence shows that the increase is due to incidents relating to Access, Transfer and Discharge within areas across Surgical Specialties. Patient activity is being spread across other ward areas (in July 2024 80% of patient's went to the Orthopaedic Ward from ED, compared to August when this was 54% and in September, 48%). The speciality is currently working with ED to develop a pathway, including transferring patients to an Orthopaedic Ward in a timelier way. This data is reviewed monthly and is presented at the 6 weekly Hip Fracture Meeting, with reporting through to the Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC).

The top three themes in Q3 were Access, Transfer and Discharge (46), Treatment and Procedure (21) and Staffing Levels (18). There were 12 moderate harm incidents, and no fatal incidents reported. There were 18 Initial Safety Reviews completed, which progressed into 10 Multi-Disciplinary Team Reviews. In Q2 242 incidents were reported, which was a decrease by 9.1%, with the same top 3 categories and themes.

The top three themes in Q3 remained unchanged from Q2 including Access, Transfer and Discharge (46), Treatment and Procedure (21) and Staffing Levels (18). There were 12 moderate harm incidents, and no fatal incidents reported. There were 18 Initial Safety Reviews completed, which progressed to 10 Multi-Disciplinary Team Reviews. It is acknowledged until the backlog of waiting lists reduces it will remain a challenge to reduce the number of incidents relating to Access, Transfer and Discharge as a category. Although focused improvement work relating to discharge is expected to reduce the number of incidents relating solely to discharge.

Learning and improvement (example)

A patient with a learning disability who was unable to read and write arrived at an Outpatient Urology appointment with their next of kin and keyworker and were informed that the appointment had been cancelled. The patient was subsequently sent a cancellation and further telephone appointment in writing. The patient required a face-to-face appointment due to their communication needs.

Immediate actions followed

- The patient has had a note added to his access plan to ensure face-to-face appointments only, **action completed**.
- Alerts on Lorenzo are read and followed, to support clinical appointments, action completed

- No appointment letters are sent out via written format, due to not being able to read or write, **action actioned**
- Appointments are linked with patient's key worker for support via text message, **action completed**

Evidence of Learning and improvement

- To ensure booking staff are aware that specific patients with special needs may need face-to-face appointments.
- For booking staff to read the notes and alerts added to Lorenzo regarding patient's requirements to support appointments.
- NHS Digital reasonable adjustments flag care plan, from primary care is to be made for each patient and will be introduced as soon as the technology is available. Timeframe being finalised.

No further incidents with similar themes have been noted since.

2.3.3 Women's and Children's – Evidence of reduction of incidents

Themes within the Maternity Service in Q3 include term admissions to the Neonatal Unit (32 cases), postnatal readmissions (23 cases), postpartum haemorrhage (PPH) 1000-1500ml (42 cases) and PPH ≥1500ml (25 cases). 32 cases of term admission to the NNU were reported in Q3. This is a reduction from Q2 when there were 45 cases of term admission. All cases of term admissions are reviewed through the Avoiding Term Admissions into Neonatal (ATAIN) Working Group, and this process identifies both good practice and learning. This is shared via the 'Learning from ATAIN' Newsletter, a formal ATAIN Action Plan is in place to ensure continuous improvement. The Q3 audit of term admissions is currently underway and will report to QAC in March 2025.

23 postnatal readmissions were reported in Q3. This is an improvement from Q2 when there were 27 postnatal readmissions. A quarterly cluster review process of readmissions has been implemented and an action plan is in place. Areas of particular focus are readmission due to wound infections and due to hypertension. Readmission due to wound infections had been identified in Q1 with a comprehensive programme of work implemented. As part of this, a Wound Surveillance Working Group has been established to further explore the issue of wound infections. In addition, further actions are underway as follows:

- Review literature search into 'QI projects to reduce c-section Surgical Site Infection (SSI) at next Wound Surveillance Meeting
- Ongoing audit by Maternity Theatre lead of women readmitted postnatally with wound infection- includes holistic review of care to review if admission avoidable/unavoidable
- Review of health surveillance questionnaire responses when available
- Change in practice to include metronidazole, alongside cefuroxime, as prophylactic antibiotic prior to knife to skin

The Q3 cluster review of post-natal readmissions is underway and will enable the service to assess the impact of the changes implemented to date in relation to wound infections. This will be reported to QAC in March 2025.

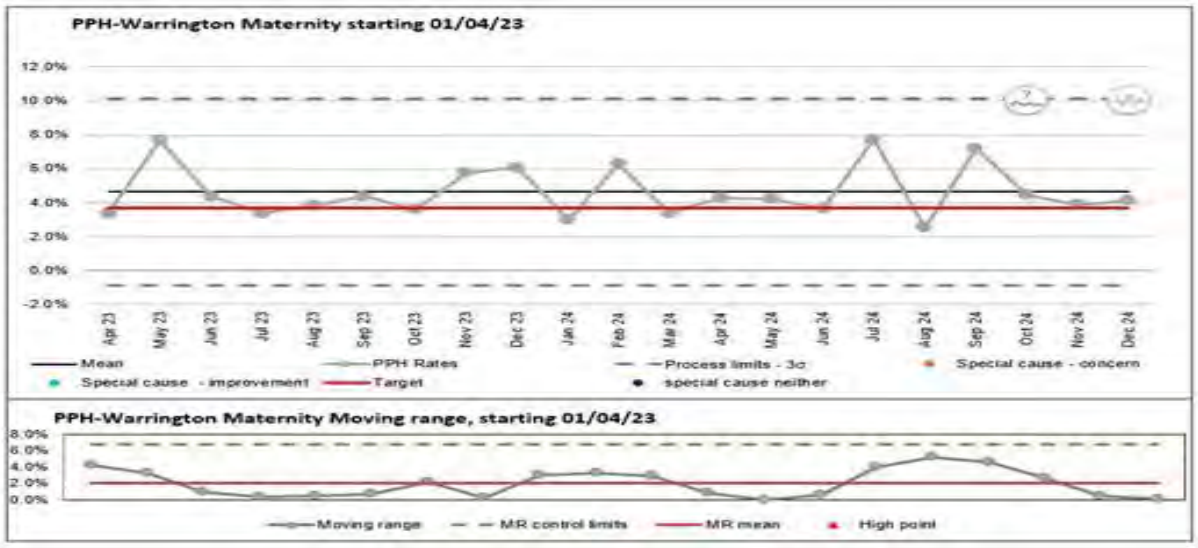
The Q2 review of postnatal readmissions identified several avoidable cases of readmission related to blood pressure management not being optimised prior to discharge home. To further explore this, a cluster review has been completed and further learning identified, and actions agreed

Learning and Improvement

- Theme of increased incidence of postnatal readmissions escalated to Labour Ward Lead Midwife.
- Plan to develop discharge checklist with labour ward lead Midwife for women with known hypertension antenatally or in labour.
- Education around the importance of regular BP monitoring shared with Maternity Ward Team.
- Review of Badger Net system and early warning score to be undertaken by Digital Midwife and Maternity Ward Manager.
- Education to be shared with Maternity Ward Team about 'red/yellow' score and appropriate escalation and monitoring.
- Regional guideline for pre-eclampsia and gestational hypertension in progress which will further inform pathways within the service.

There were 25 PPH ≥1500ml incidents in Q3. This is a reduction from Q2 when there were 35. All cases of PPH ≥1500ml are reviewed via the MDT Intrapartum Review Group (IRG), to ensure any urgent learning is enacted, as well as linking into the PPH QI Project.
The SPC chart for PPH ≥1500mls continues to show common cause variation, with stability over the last 3 months.

Figure 1



Learning and improvement

- The new regional PPH Guideline is anticipated to be launched in February 2025. WHH have contributed to the development of this guideline which will, as a result incorporate change ideas identified as part of the WHH QI project. Rates of PPH ≥1500ml are also reported via the Maternity Dashboard to CBU Governance Meetings, Patient Safety and Clinical Effectiveness, Quality Assurance Committee and the Board of Directors.
- There were 42 PPH 1000-1500ml in Q3. These cases have all been reviewed locally utilising the standardised proforma. Work in relation to reduction of PPH is a key WHH workstream, with reduction in PPH ≥1500ml being a formal QI Project. Alongside the QI project, all cases of PPH ≥1500ml are reviewed via the MDT IRG. Learning identified as part of the local review of PPH 1000-1500ml reflects the learning identified through the more formal IRG process.
- In addition to the learning from patient safety events, the Midwifery Team also work closely with the Maternity & Neonatal Voices Partnership (MNVP) to ensure coproduction of service

development. An MNVP led 15 Steps Challenge took place in November 2024. The challenge group visited all maternity clinical areas and the Neonatal Unit (NNU). Feedback has been shared as follows:

- Positive feedback regarding the attitude of staff including team members being knowledgeable and welcoming. The visiting group had great reflections on the calming feeling of the Nest and Butterfly Suite.
- The group noted the different feelings in each of the areas, some areas with warm welcoming colours, a modern calm feeling, bright, positive and beautiful, whilst other areas felt outdated and clinical. A significant theme throughout the feedback related to signage and direction between the different maternity areas. The possibility of floor arrows or clearer corridor signage was suggested.

Note: Overall, the feedback was very positive. The group highlighted the design, welcome and feel of both the Nest and new induction of labour area and would be keen for other areas to be developed in this.

2.3.4 Integrated Medicine and Community (IMC)

There were 363 incidents reported in Q3 compared to 355 in Q2. This is an increase of 8 incidents (2.3%). There were no fatal or severe harm incidents reported, and 7 moderate harm incidents were reported. The top subcategory within Antisocial/Abusive/Violent Behaviour for Q3 was Physical Assault Patient on Staff (36). This was also the top reporting Antisocial/Abusive/Violent Behaviour subcategory in Q2 The top three themes in Q3 were, Antisocial/Abusive/Violent Behavior (71), Slips, Trips and Falls (61) and Infection Prevention and Control (44). These were the same three themes as Q2. Antisocial/Abusive/Violent Behaviour and Slips, Trips and Falls incidents have decreased in Q3 from Q2, however Infection Prevention Control incidents have increased by 23, this is due to the number of Flu positive patients in the hospital.

Antisocial/Abusive/Violent Behavior

Antisocial/Abusive/Violent Behavior incidents were reported on 71 occasions during Q3, this is a decrease of 8 from Q2. The top three reporting areas within this category were Ward A8 General Medicine, (32), Ward K25 General Medicine (11) and Ward B12 Dementia Ward (11). The reported incidents are a combination of antisocial behaviour by patients and physical assault by patients on staff. Most cases involved a patient who lacked capacity, and therefore use of the Trust's Unacceptable Behaviour Policy was limited, as the stated sanctions in policy would not have been appropriate. All staff are required to complete Conflict Resolution Training, and compliance for IMC is 94.30%.

Learning and Improvement

- The Trust has a considerable number of supportive initiatives to ensure staff safety is maintained and that they feel safe in the workplace. Staff are supported to complete their de-escalation training to facilitate the management of these situations, current compliance for this training for the CBU is 64.38% against a target compliance of 85%. This has been discussed in the Health and Safety Sub Committee and WHH plan to introduce Trauma Based Training. The aim will be to utilise a trauma informed approach to support Violence and Abuse Prevention and Reduction. Staff affected by these incidents are supported by their line manager and CBU Team, with input from Occupational Health and/or the Wellbeing Hub, as required.

Infection Prevention and Control- Decrease in COVID incidents noted.

12 of the 44 Infection, Prevention and Control incidents were related to Covid-19 cases in Q3. During Q1 and Q2, there has been a noted decrease in the total numbers of inpatients

with a positive Covid-19 evaluate. There was no harm to patients, however, there has been an increase in Flu Positive incidents. No learning needs have currently been identified.

Learning and Improvement

- During Q3, there were 4 reported cases of Clostridium Difficile (CDI), 3 of these were hospital onset. Ward B19 has a dedicated individual cubicle accommodation for 4 patients with C difficile. A learning theme is to ensure Intravenous (IV) antibiotics are reviewed and discontinued in a timely manner. There is a Trust wide CDI Prevention Action Plan in place. The Brilliant Basics Action Plan has been coproduced with the Senior Nursing Team and a project implementation plan devised. A communication strategy has been implemented which includes education across all staff groups. A plan is to host a system-wide seminar on CDI, the agenda is being finalised

Slips Trips and Falls- Small reduction in incidents noted.

There were 61 Slips, Trips and Falls reported in Q3 compared to 66 in Q2. 7 of these were moderate harm incidents. Identified themes of learning relate an increased number of unwitnessed falls.

Improvements

- Actions include, a Health Care Assistant (HCA) being allocated to each bay on the wards to provide enhanced care. All ward areas have individualised falls action plans to support learning and improvement in place and minimise risk to patients.

Trust, I Bleep system.

There has been an emerging theme of no harm incident's relating to or referring to the use of the Trust's I Bleep system. A triangulation review of these incidents has shown that the issues are multifaceted, and include the design of the electronic system, the current operational processes being used on the system and the processes surrounding the inputting and reviewing of the tasks put on the I Bleep system The system used is Trust wide, and the issues identified are complex. A full review of the system is currently being undertaken, with any highlighted issues raised at the Deteriorating Patient Group and escalated and actioned accordingly.

2.3.5 Medical Care

There were 282 incidents reported in Q3 compared to 274 in Q2. This is an increase of 8 incidents (3%). Most incidents reported in each quarter were patient incidents. The top 3 reporting specialties in Q3 were Critical Care (117), General Medicine (55) and Cardiology (49). This is consistent with the top 3 specialties in Q2. Most incidents reported in Q3 were no harm (224, 79.4%). There were 5 moderate harm incidents reported in Q3 and 1 severe harm incident. There were no fatal harms.

The severe harm incident relates to a Medical Emergency Team (MET) call referring to a patient with a reduced Glasgow Coma Score (GCS). When the Acute Care Team (ACT) arrived on the ward, this patient had been handed over to the ACT who did not handover an update at the change of their shift to fellow colleagues. An After-Action Review was conducted, learning and actions for improvement have been identified relating to a full review of the Acute Care Team (ACT) handover tool to ensure all information is cascaded between shifts.

The top three themes in Q3 were Access, Transfer and Discharge (72), Antisocial, abusive behavior (37), and Slips, Trips and Falls (25) In Q3 24 Slips, Trips and Falls incidents were reported, which was an increase of 1 incident compared to 24 reported in Q2. The way people are treated in a calm, group setting to facilitate settlement is one of the learning themes found in Anti-

Social Abusive Behavior. This will be supported by the plan to introduce Trauma informed Care as part of the Violence and Reduction Strategy.

Falls - Learning and Improvement

Following earlier efforts to improve quality, WHH is still making progress in reducing the number of falls. WHH has launched the "Think Yellow" campaign to draw attention to patients who are at risk of falling. To ascertain if a patient poses a falls risk, a falls risk assessment must be done within six hours of admission to the Trust. After confirmation, the patient is given a pair of falls socks and a yellow wrist bracelet. Every week, the risk assessment is revisited, or it may be reevaluated if the patient's condition worsens. In addition, the importance of following best practice as described is emphasised in the morning Safety Brief and covered during patient handover. All falls are also presented at the Weekly Harm Free Meeting with the Patient Safety Improvement Nurses to monitor any learning themes and action accordingly.

Single Sex Accommodation – Learning and Improvement

Staff are expected to adhere to the Single Sex Accommodation Guidelines for all patient receiving level 1 care in respect of in respect of Access, Transfer and Discharge, however, mixed sex breaches do happen on the Intensive Care Unit (ICU) due to prolonged stays; in Q3, there were 56 occurrences, which is more than in Q2 (42). "A shortage of beds" and "predictable fluctuation in activity is an exception, which are classed as a clinically justified breach," according to the Trust Policy Eliminating Mixed Sex Accommodation in Critical Care and ICU. The ICU Team cohort level 1 patients whenever feasible, comply with Single Sex Accommodation Guidance, with early escalation to the Patient Flow Team to specify the need for a ward bed.

Identified themes from this is due to a delay in transferring level 1 patients from ICU to ward-based areas due to an increase in capacity and demand within the Trust.

2.3.6 Urgent and Emergency Care (UEC)

There were 917 incidents reported in Q3 compared to 920 in Q2. This is a decrease of 3 incidents (0.3%). The top 3 reporting specialties in Q3 were Emergency Medicine (713), Acute Medicine (200) and Patient Flow (2). This is consistent with the top 3 specialties in Q2. Most incidents reported in Q3 were no harm (762, 83.1%). There were 16 moderate harm and 3 severe harm incidents in Q3. There were no fatal incidents. 2 of the severe harm incidents were external incidents and 1 related to the inadequate handover of care. An MDT was undertaken with learning relating to communication between shifts. This learning has led to an improved handover from the nurse in charge between shifts.

The top three themes in Q3 were Pressure Ulcer - Present on Admission (146), Medication (104) and Access, Transfer and Discharge (94). Medication consistently appears in the top three reported categories in UEC, although the majority are ‘no harm’ incidents, this has increased from 92 in Q2 to 104 in Q3.

skin damage

There has been an increase in the number of patients admitted with Moisture Associated Skin Damage or Other Wound to Skin incidents in comparison to Q2, in Q2 there were 67 incidents compared to 84 incidents in Q3.

Learning and improvement

- ED staff are completing body maps as part of undertaking initial risk assessments for patients arriving to the department, which is highlighting this as an issue. Incidents are

subsequently reported on Datix and shared as interface incidents to the community/other providers for awareness.

Medications

Learning and improvement

- The Trusts Medication Safety Improvement Nurse reviews and monitors any recurring patterns. One such theme is medications that are prescribed frequently combined with PRN, which puts patients at risk of receiving additional doses of medication. This emergent theme is currently being reviewed to identify causes and learning for improvement.

- Within UEC there is a theme of omitted medicines, therefore the Associate Chief Nurse liaised with the Chief Pharmacist and the lead for the Trust in relation to omitted medicines to enable collaborative work to be undertaken, to review and identify actions for improvement which will be reported at future Quality Assurance Committee Meetings.

- There is emergent theme relating to medications that are prescribed frequently combined with as required (PRN) medicines, which puts patients at risk of receiving additional doses of medication through Lorenzo. This is currently under review by the Trust's Medication Safety Nurse and will be reported further at future Quality Assurance Committee Meetings.

- Within UEC there is theme of omitted medicines, therefore the Associate Chief Nurse is in discussion with the Chief Pharmacist and the lead for the Trust to review and develop plan for elimination of this issue.

Antisocial, Abusive, and Violent Behavior

There were 71 Antisocial, Abusive, and Violent Behavior incidents reported in Q3 compared to 66 reported in Q2. 32% were reported as physical abuse which involve a patient, whereby their behaviour was a result of their clinical presentation, for example, a patient with delirium or psychosis. Urgent and Emergency Care (UEC) is the clinical area where most of these types of incidents take place in the Trust. Notably the use of bodycams worn by staff, and the implementation of the Trust's 'Unacceptable Behaviour Policy' are embedded, allowing the 3 strikes policy along with the behaviour warning letter. Security Teams and Police presence is requested when required in line with policy standards.

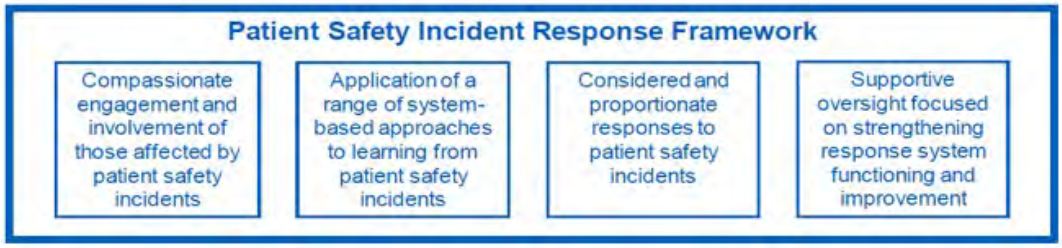
Learning and improvement

A new initiative commenced in January 2024 "Right Care Right Person (RCRP)." This initiative is for police to determine those patients who have absconded and could be at risk. Phase 1 and Phase 2 went live on the 13 May 2024. Cheshire Police, together with UEC staff and the Trust completed the initial 4-week trial of monitoring and feeding back of any issues. Phase 3 roll out commenced in November 2024. Themes identified from these is that since the utilisation of the SBAR Tool staff are sharing the relevant information with Cheshire Police which enables them to make a next step decision promptly, reducing further delays. Cheshire Police have since initiated the utilisation of the SBAR template to other Trusts within the Northwest.

The evidence shows that during Q3, Warrington Hospital made 16 calls to Cheshire Police, for patients who absconded from the hospital site, the Police responded to 7 of these calls and did not respond to the remaining 9, from October 2024 to December 2024. An Engagement Meeting is held monthly to undertake a review of all cases to determine if anything could have been done differently, to support shared learning across the Trust in line with Cheshire Police.

2.4 Patient Safety Incident Response Framework (PSIRF) – Learning and Improving Patient Safety

Figure 2



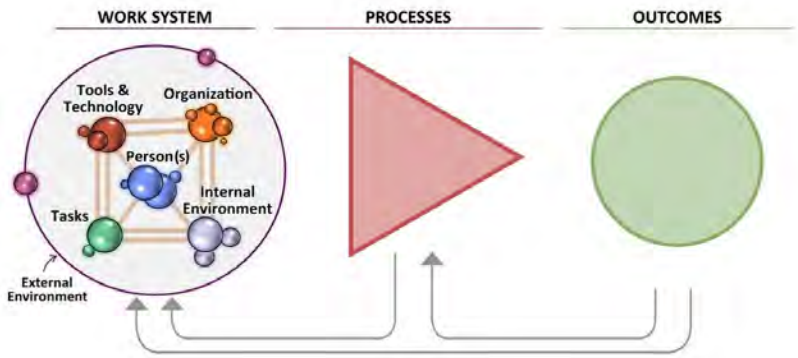
The Patient Safety Syllabus Training is available to staff via the ESR platform and is mandated for staff who have been assessed as part of the Training Needs Analysis. Compliance is monitored weekly by senior managers and Executive Leads and is currently 97.59% for level 1, 84.67% for level 2 and 100% for senior leaders.

Patient Safety Specialists within the organisation have undertaken the level 3 and 4 Patient Safety Training Syllabus, with Loughborough University. Evaluation will take place during Q4 to understand the opportunities for wider sharing of the learning.

Learning and Improvement

- Continue to monitor training figures and support CBU's with new investigation methodologies.
- The Patient Safety Incident Response Framework Policy and Plan has been revised to reflect the new meeting/assurance structures. This being the combined functions of the Weekly Patient Safety Summit (WPSS) and Safety Oversight Meeting (SOM) and the introduction of a Daily Triage Meeting, continuation of Executive Led SOM Meeting and Executive Led PSIRF Group Meetings.
- The Trust has considered the national and local priorities and determined they should remain the same, the executive led decision making to maintain the same local priorities was based on findings from last 12 months data review. However, consultation sessions have been set up and are to take place in Q4 with internal staff and external partners to discuss and determine if they agree with the plan or wish for any changes and the plan will then be finalised accordingly.
- A central record of the compliance for HSSIB Level 2 training is held, to enable appropriate allocation of investigation leads.
- Training Needs Analysis was completed in Q2. PSIRF Training provider (Gateway Training) meeting was held in December 2024 to begin planning training. PSIRF Training dates are currently being finalised with Gateway Training and will take place during Q1 of 2025. Training will be undertaken in line with the TNA, which includes Trust Board of Directors and Senior Leadership Team Training.
- An evaluation of Datix drop in sessions has been undertaken during Q3. Datix drop-in sessions will be replaced with a rolling programme on various workstreams across the governance portfolio, including incident reporting and management. This will commence in Q4.
- A questionnaire has been developed and is being shared across the Trust to enable an evaluation of incident reporting. Questionnaire feedback will be collated during Q4, to give opportunity for focused improvement work

Figure 3



WHH continues to participate with PLACE and Integrated Care Board (ICB) partners across Cheshire and Mersey to share learning to further support embedding of PSIRF and Learning from Patient Safety Events (LFPSE).

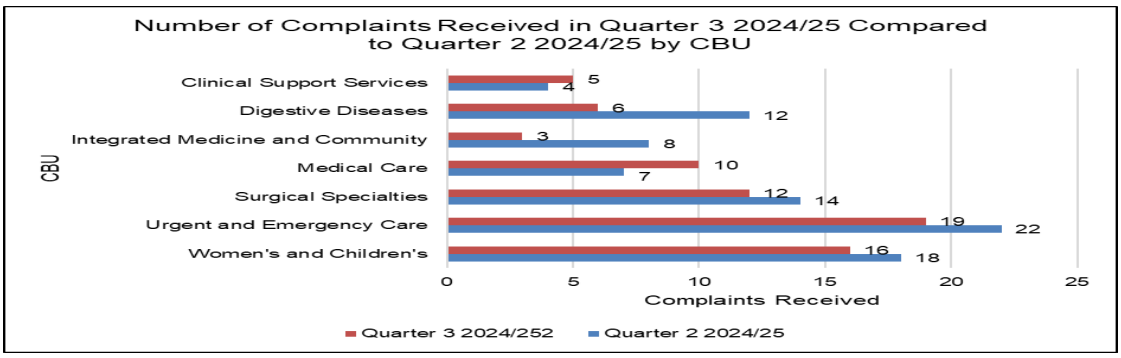
3. Learning from Complaints and PALS

3.1 Complaints

3.1.1 Complaints Received

In Q3, a total of 71 complaints were received compared to Q2, where 85 complaints were received. This is a decrease of 14 complaints (16.5%). This differs to the previous financial year 2023/24, where there was an increase in the number of complaints received in Q3 (54) compared to Q2 (48) by 6 complaints (12.5%). There has been an increase (17 complaints, 31.5%) in the complaints received in Q3 2024/25 compared to Q3 2023/24.

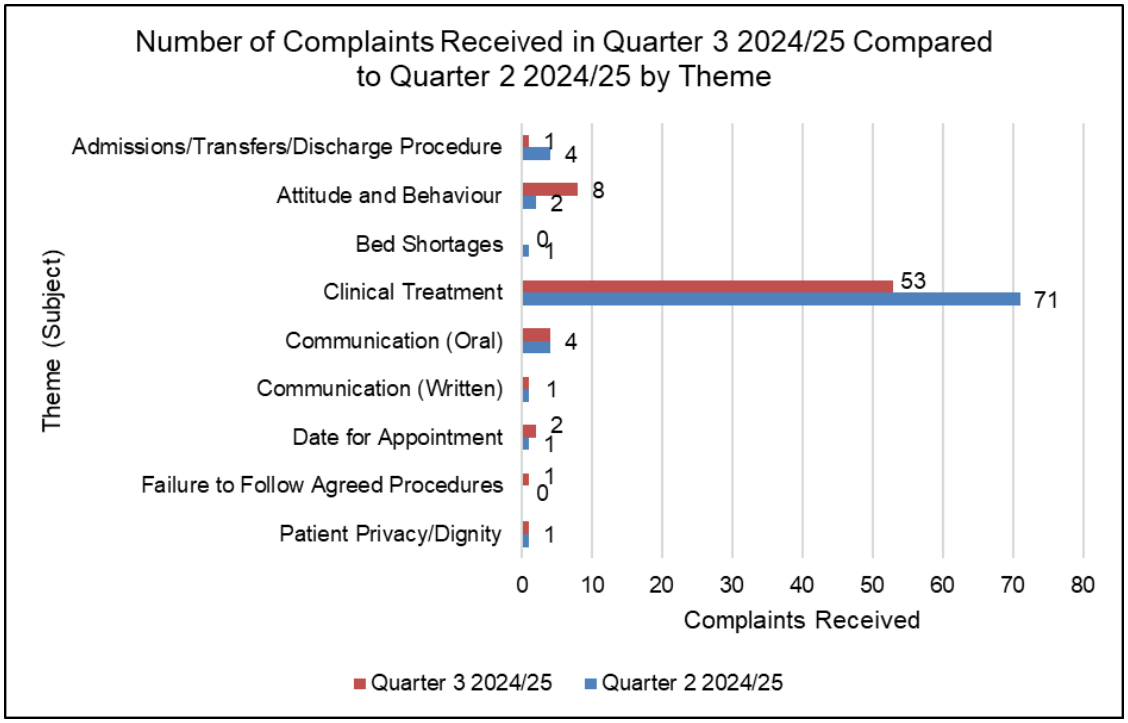
Graph 3



Clinical Treatment remains the most common theme of complaints received, totalling 53 complaints in Q3, which is a decrease of 18 complaints (25.4%) compared to Q2. The top 3 sub-themes of Clinical Treatment in Q3 were: Coordination of Medical Treatment (27), Delay in Treatment (8) and Wrong Diagnosis (7).

The complaints received within the theme Clinical Treatment are present across all the CBUs. In Q3, Urgent and Emergency Care have the highest received at 17 complaints which is 32.1% of all Clinical Treatment complaints received in Q3. This is followed by Women's and Children's and Surgical Specialties, both at 11 complaints (20.8%). These are the same top 3 CBUs as in Q2.

Graph 4



3.1.2 Complaints Closed

In Q3, a total of 91 complaints were closed compared to Q2, where 82 complaints were closed. This is an increase of 9 complaints (11%).

The following table demonstrates the outcomes for the complaints closed in Q3 compared to Q2.

*Partially upheld complaints are those where aspects of the complaint are upheld, but the main issues are not.

Outcome of Complaint	Q2	Q3
Not Upheld	38	42
Partially Upheld	36	41
Upheld	8	8
Total	**82**	**91**

3.1.3 Learning examples resulting from Complaint Investigations

The following table provides examples of complaints raised in Q3, with the learning and actions taken to address the concerns raised.

You Said….	We Did….
Urgent and Emergency Care: Patient attended ED who had Learning Disabilities and Autism. Mum felt that the patient's needs were not met and more	Discussions with Staff within the Emergency Department regarding the importance of scanning health passports onto patients' electronic records.

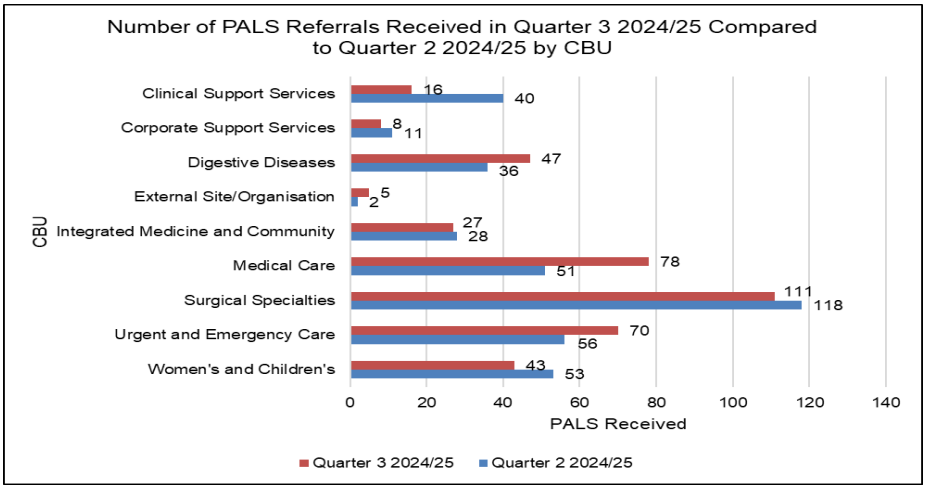
should have been done to make reasonable adjustments.	The family of the patient have been invited to join in consultation pathways regarding hospital passports for patients with Learning Disabilities.
Digestive Diseases: Patient was discharged from Ward A5 (elective) without pain relief medications being administered to relieve pain on discharge.	The concerns have been shared with the Nursing Team, to ensure that patients who are due a further dose of pain medication prior to discharge are provided with this in a timely way, this ensuring effective pain management until patients are at home and able to administer their own medications.
Clinical Support Services: Patient was prescribed Dexamethasone tablets however, no patient information leaflet was included within the medication box. This therefore meant that the patient did not have any information on the possible side effects of the medication	The concerns were discussed during the Pharmacy daily meeting to reiterate the importance of supplying patients with information leaflets for all medications. This includes any medications that are for short courses and single dose prescriptions. Staff were advised to not assume that the information has been provided to patients on the ward.
Women's and Children's Patient raised concerns that she was unable to identify who each staff member was from their uniform and that she had been led to believe that a Maternity Support Worker was a Qualified Midwife.	The Community Midwifery Team are working to develop a new patient information leaflet, which includes information on all staff members within the team and what their roles entail. This is intended to be in place by the end of February 2025.

3.2 Patient Advice and Liaison Service (PALS)

3.2.1 PALS Received

In Q3, a total of 405 PALS concerns were received compared to Q2, where 395 PALS concerns were received. This is an increase of 10 PALS concerns (2.5%). This differs to the previous financial year 2023/24, where there was a decrease in the number of PALS concerns received in Q3 (393) compared to Q2 (436) by 43 PALS concerns (9.9%).

Graph 5

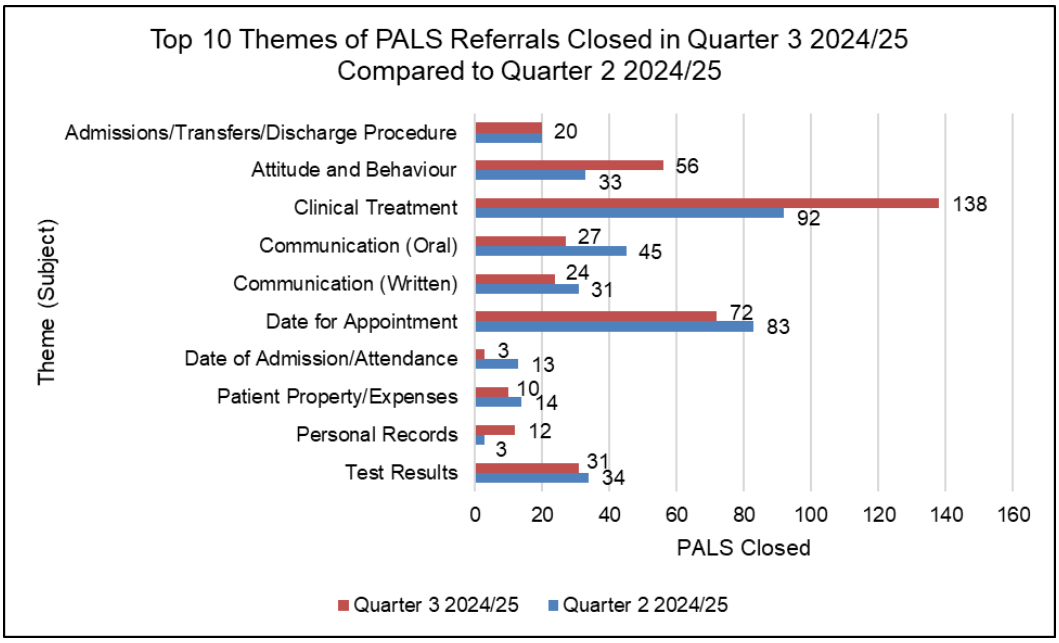


3.2.2 PALS Closed

In Q3, a total of 412 PALS referrals were closed compared to Q2, where 385 PALS referrals were closed. This is an increase of 27 PALS referrals (7%) and is consistent with the increase in PALS referrals received.

The top 2 themes for PALS referrals closed are consistent across both quarters; Clinical Treatment (138 in Q3 compared to 92 in Q2) and Date for Appointment (72 in Q3 compared to 83 in Q2). In Q3, the third highest reporting theme for closed PALS referrals was Attitude and Behaviour (56) compared to Q2 where the third highest reporting theme as Communication (Oral) (45).

Graph 6



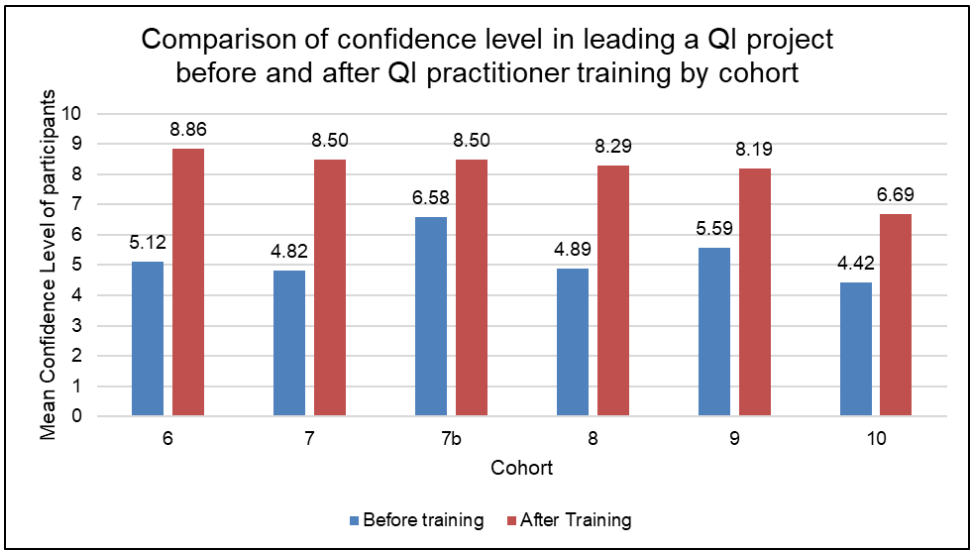
4. Learning from Quality Improvement (QI) and Knowledge and Evidence

4.1 Learning from QI Training Evaluation

Feedback is reviewed following each training session delivered by the Quality Improvement (QI) Team to enable the team to continuously learn and improve the training provided and support the delivery of impactful QI.

Cohort 10 of Level 3 QI Practitioner training took place during Q3. To measure the impact of the training, participants are asked on a scale of 1 – 10 how confident they were to lead a QI project, both before and after the training. The data demonstrates a significant increase in confidence on completion of the training as illustrated by the below figure.

Graph 7



4.2 Further Opportunities for Learning from QI Experience

4.2.1 Quality Improvement Practitioner Community (QIPC)

The aim of QIPC is to offer group coaching and support, provide an avenue for sharing learning, and developing the skills to support QI further within the practitioners' field of work. Our latest QIPC event was held in October 2024, and was attended by 11 staff, focussing on overcoming barriers to QI project progression. Three practitioners presented their challenges to the group, and the coaching circle format was used to consult and advise the coachee to generate several potential solutions. Some of the issues identified benefited from creative thinking generated by the wider group, others required a better understanding of the tools or methodology and therefore on the spot training was provided by the QI faculty. Based on feedback, the next event, in February 2025, will include an option to attend virtually via Teams to make a 'drop in' format more accessible.

4.2.2 Improvement Excellence Celebration Events

Following an evaluation of how the success of QI projects are highlighted and shared, it was recognised that there was a need to share the success of QI work more widely. As a result, since May 2024, the QI Team have updated the practitioner celebration event to include an invitation of all staff involved in the completion of QIPs that have achieved certification criteria or the criteria for meeting a standard of excellence in QI. In December 2024 the team held their latest excellence celebration event where staff presented their QI project progress and received their completion certificates from the Chief Nurse.

Evidence of Learning and Improvement/ongoing QI initiatives

- A 30% reduction in Controlled Drug (CD) administration incidents was achieved through tests of change involving single point lessons and changes to the layout of CD cupboards.
- A project to reduce unnecessary referrals to ED and Social Services for all babies with birth injuries/marks has tested changes to the location of body maps to improve completion, as well as single point lessons and a flow chart. No referrals to ED with Social Service involvement have been made since the project began, however, a higher incidence of missing documentation has been noted.

- The number of patients having at least 1 overnight stay following mid, hind foot or ankle surgery was reduced following the testing of a discharge checklist completed by therapies and ward staff for patients under one Consultant.
- A project is underway to reduce turnaround time by 66% in at least 80% of colorectal specimens biopsied and referred for evaluation by 30 April 2025.
- A project is underway to improve knowledge about side effects and management of long-term usage of opioid analgesics by 5% by January 2025 in patients with mild to moderate level of pain on ward K25.
- Strategies are being tested by the Clinical Audit Team to improve the use of QI methodology to address challenges identified through Clinical Audits.

4.3 Learning from Registered QI Projects Completed Within October – December 2024

Three projects were recorded as complete within Q3 and are highlighted below together with their project score (based on the scoring method used by the Institute of Healthcare Improvement) and impact statement.

Project 1: To improve offer of Nicotine Replacement Therapy (NRT) for current smokers admitted to ward A8 in Warrington Hospital from 31 March 2024 to 27 May 2024 by 5% (from approximately 55% of patients who are offered NRT to 60% of patients).

- Project score: 3.0 (modest improvement).
- One documented PDSA cycle (Ward in reach education) resulted in a modest improvement in the completion of smoking screening assessment, however no change in outcome measure (offer of NRT) was reported.

Project 2: To increase the Trust-wide percentage of completed medical device declarations from 46.9% (February 2024) to 70% by 1st October 2024. Doing so would require an additional ~16000 declarations.

Learning and Improvements

- Project score: 4.0 (significant improvement).
- This project successfully increased completion of staff declarations of competency to use medical devices from 47% in February 2024 to 74% in November 2024. Improved compliance supports patient safety by providing assurance that staff are adequately trained and competent to use medical devices and can identify potential gaps in training. Compliance will continue to be monitored through Operational Patient Safety Group to ensure improvements are sustained.

Project 3: To reduce the volume of inappropriately communicated E-Outcome Task Management System (ETMS) tasks from 64% to 51% by December ‘24 across wards A6, A7 & B12

Learning and Improvement

- Project score: 4.0 (significant improvement).
- The ETMS is the Trust’s digital communication system for out of hours activity. Ward nurses and Pharmacists can use this system to log tasks, ranging from minor tasks such as requests for laxatives or review of routine bloods, to the escalation of patients with elevated National Early Warning Score (NEWS) score or chest pain. Demand currently outstrips capacity to respond to all tasks and therefore appropriate prioritisation is vital. A baseline audit identified 64% of ETMS tasks were inappropriately communicated, making prioritisation difficult, and 3 wards (A6, A&, B12) with significant room for improvement were identified as the focus. This project successfully reduced the percentage of inappropriate tasks to just 12% on these wards and increased the use of SBAR to structure the transfer

of information, by providing face to face teaching to nurses on the wards. To ensure sustainability and spread beyond the 3 wards included, discussions are taking place to include this training in the existing scheduled Acute Illness Management training.

4.4 Learning from the Application of Knowledge and Evidence Service (KES)

4.4.1 Productivity Improvement Oversight Group (PIOG) – Learning from Investigating Did Not Attends (DNAs) and Length of Stay (LOS)

The KES has been working with Head of Improvement, The Service Manager for Digestive Diseases, Endoscopy and Gastroenterology, Therapy Manager, and Transformation Manager for Planned Care, Surgical Specialties to review trends in DNA and LOS.

Gastroenterology DNA Pilot Patient Interviews

A small sample of 8/11 (73%) of patients who DNA between 1 and 3 appointments were interviewed via phone. They were asked:

- What got in the way of attending your last appointment?
- Would anything has made it easier to attend?

Learning findings:

- Avoidable DNAs and solutions:
  - At a patient level, there were clear reasons identified for DNA and patient generated solutions to ensure future avoidance of DNA, although these would involve individual intervention.
  - At hospital level, some of the DNA's do not appear to be patient generated but could be avoided by in house measures. Only 1 DNA appeared to be unavoidable
- Health Inequalities:
  - Existing health inequalities were a significant reason for DNA, meaning it is likely that such health inequalities were further exacerbated by not attending for treatment.

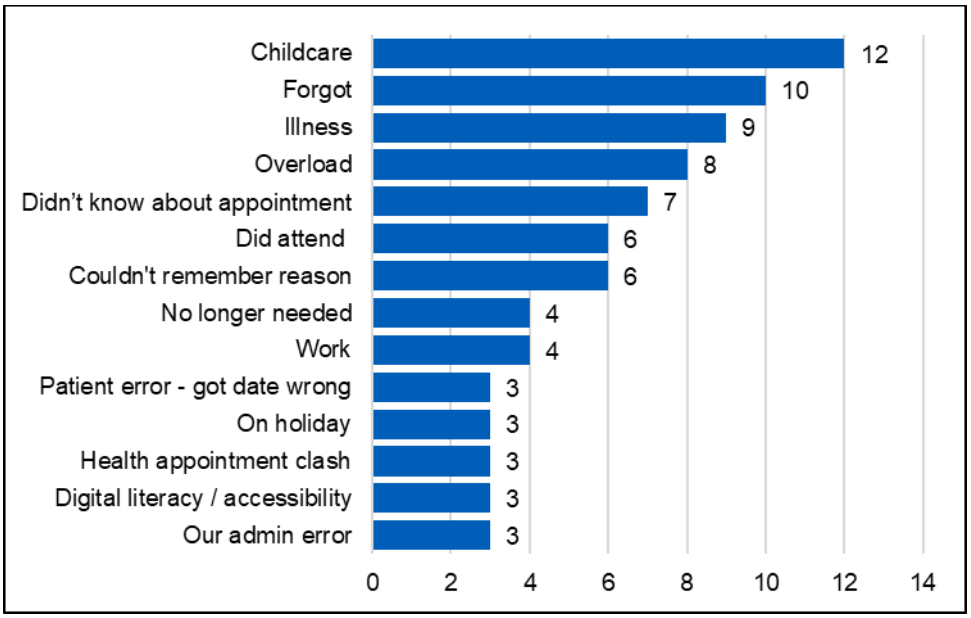
Therapies Musculoskeletal (MSK) DNA Patient Interviews

Applying the same method piloted in the DNA Gastroenterology interviews, the 10 Musculoskeletal (MSK) Clinics with the highest percentage DNAs over 4 months (July to October) were identified, with DNA rates ranging from 16.5% to 71%. 3 attempts were made to reach each of the 138 patients who DNA by telephone. 64% (89/138) were successfully contacted and interviewed.

Summary reasons for DNA:

These are patient reported DNA reasons. It is recognised that desirability bias (the tendency of survey respondents to answer questions in a manner that will be viewed favourably by others) is likely to impact on responses, with under-reporting of less socially desirable reasons such as 'I forgot' and over-reporting of others. However, the responses will allow us to better understand DNAs as we identify trends, barriers and areas within our potential gift to address.

Graph 8



Therapies MSK Data Reviewed

58052 appointments were reviewed from 1 April 2023 to 9 December 2024. This included 52673 attendances and 5379 DNA. Data on age, sex, ethnicity, language spoken and marital status were investigated.

Learning

Increased Risk for DNA was found for:

- People of Black, Asian, Minority Ethnic or of mixed ethnicities who were 33% at greater risk of DNA as compared to people of white ethnicity.
- People who are not married or in a civil partnership are 120% (2 times) more likely to DNA compared to those who are.
- People for whom English is not their first language are 50% more likely to DNA than people whose first language is English.
- The age group least likely to DNA is 65+
  - 18-25 are 3 times (304%) more likely to DNA than 65+
  - 26-34 are 2.5 times (252%) more likely to DNA than 65+
  - 35-49 are 2 times (209%) more likely to DNA than 65+
  - Under 18 are 2 times (218%) more likely to DNA / Was Not Brought than 65+
- People with a recorded disability alert of Autism, Learning Disabilities or Communication Difficulties are 63% (0.63 times) more likely to DNA than those without.

Next steps

A patient consultation and codesign exercise will be carried out at Halton and Warrington by early March 2025 to further investigate barriers to attendance and patient and family generated solutions

to overcome these, using a simple consultation method derived from best practice used by Liverpool City Council.

Length of Stay Knee Arthroplasty

83% (30/36) of patients who underwent total knee arthroplasty in August and September 2024 were interviewed via phone and asked questions around mobilisation, listening to music in recovery, joint school exercises, satisfaction with experience, delays to their going home, suggestions for improvements.

Learning: Correlations

Longer length of stay was associated with:

- Admission to Post Anaesthetic Care Unit (source Lorenzo)
  - LOS ≥5 days - 72% (8/11) admitted to PAC
  - LOS ≤2 or ≤3 days - 0% (0/10) admitted to PAC
- Longer time to mobilise with nurse (patient self-report)
  - LOS ≥5 days
    - 27% (3/11) Next day
    - 9% (1/11) Same day
  - LOS ≤3 days
    - 50% (4/8) Next day
    - 37.5% (3/8) Same day
- Longer time to mobilise independently (patient self-report)
  - LOS ≥5 days
    - 27% (3/11) Next day
    - 0% (0/11) Same day
  - LOS ≤3 days
    - 62.5% (5/8) Next day

The interview explored patient perceived reason for delay which included clinical (e.g. low blood pressure / low potassium) hospital related (x-ray availability), extrinsic factors (stairs at home), reactions to anaesthetic and painkillers.

Satisfaction with the service was overwhelming highly positive which numerous comments from patients praising the level of care received, comfort and cleanliness.

Next steps for improvement:

The study highlighted the need to include several of the questions in real time audit rather than completing in retrospect as the responses appeared to be affected by recall bias. This is being taken forward by the Transformation Manager for Planned Care.

4.4.2 Evidence and best practice inform the #MyflexWHH Campaign and Preference Rostering Trial

People Promise Manager wished to proactively promote the ‘We work flexibly’ strand of the NHS People Promise and asked the Knowledge and Evidence Service to provide evidence to highlight the benefits of flexible working in relation to mental health and wellbeing and to see what was being done in other NHS organisations.

Evidence underpins the Launch of the #MyflexWHH Campaign

Evidence found by the KES demonstrated that flexible working has a positive effect on employee mental health, improves work-life balance which in turn reduces depression, anxiety, stress and burnout. The People Promise Manager highlighted this evidence to the Chief People Officer to gain agreement to be able to explicitly promote flexible working with WHH and to rebrand it with the hashtag #MyflexWHH.

The evidence provided by the review supported the launch of #MyflexWHH campaign.

Evidence used to support the case for change to Preference Rostering Pilot

The evidence review identified best practice from Guy's and St Thomas's NHS Foundation Trust in piloting Preference Rostering on an acute admission ward. This demonstrated participant reports of better work life balance, improved sleep and overall better physical and mental health.

This evidence was used to inform decision making to implement a Preference Rostering' pilot on B19 and ACCU from 20 January 2025.

Improving Documentation and Recording for Birthmarks or Injuries

Lack of documentation leading to inappropriate A&E referrals often with Social Services involvement

There have been several occasions where babies have been brought to ED with birthmarks or injuries and because it was not documented correctly, in the right place, there was no record that the mark had been there since birth. This has then led to unnecessary social services involvement, causing families distress. The Specialist Midwife and Practice Based Educator/NIPE lead, requested an evidence review to see how documentation and recording could be improved to make sure this no longer happens.

Learning and Improvement

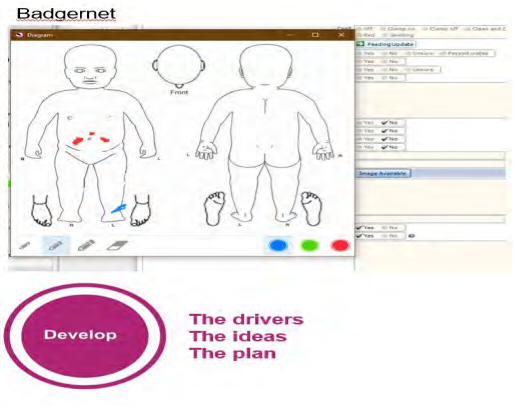
Evidence reviewed highlighted red book and body maps as best methods

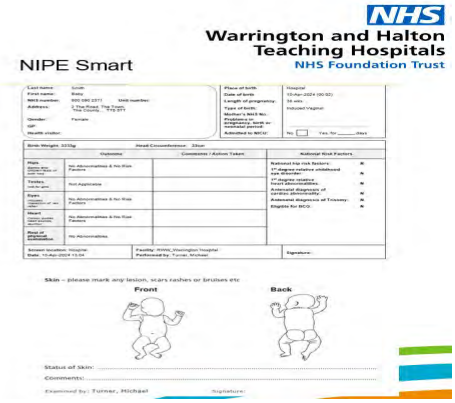
The evidence reviewed highlighted that other Trusts were experiencing similar challenges, reinforced that we need to improve documentation and recording and provided national guidance on documentation of birth injuries/marks highlighting the use of the Red Book and body maps as best practice.

Body maps now included in all documentation

Feedback on inclusion of the body maps was provided by Specialist Midwife and Practice Based Educator/NIPE lead, who shared that a visual prompt is more prominent (figure, 3), and this is included on the digital system, Badger Net.

Figure 4





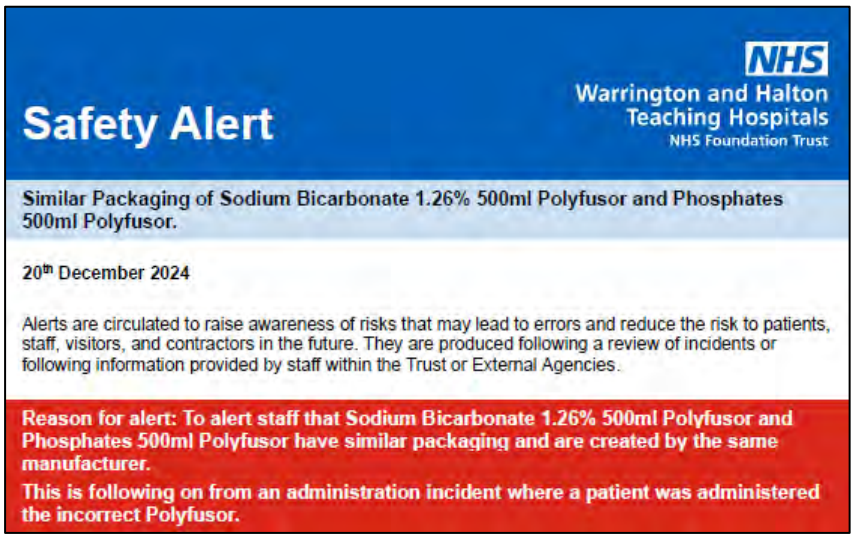
Prevention of referrals to social service and single point lessons- Improvements noted

The Specialist Midwife and Practice Based Educator/NIPE lead, reported that the evidence review has been vital in preventing unnecessary social service referrals. Since commencing body maps and providing a lot of single point lessons there have been no referrals to ED with Social Service involvement.

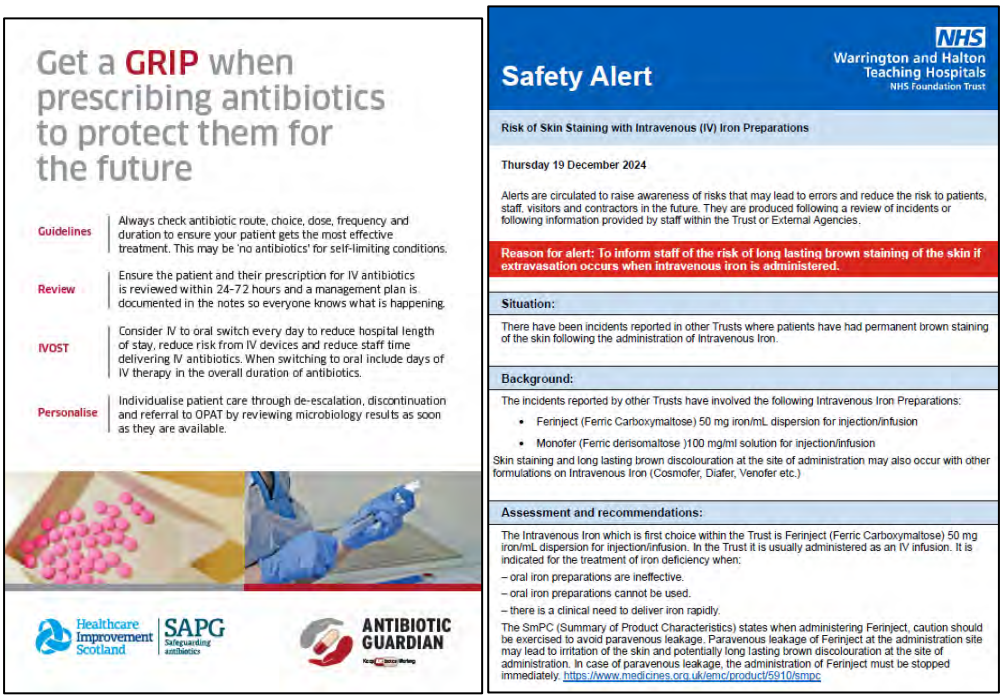
5. Learning from Safety Alerts

WHH uses the Daily Safety Brief to share learning on a wider scale. There were 41 alerts issued throughout Q3: 17 in October 2024, 12 in November 2024 and 12 in December 2024. When alerts are issued, some will be shared over several days, giving staff an opportunity to see the alert. National Patient Safety Alerts are also shared widely and can provide learning from incidents that have occurred. Some examples of the different learning shared are as below:

Figure 5



Figures 6 and 7



Learning and Improvement

World AMR Awareness Week. World Antimicrobial Resistance Awareness Week (WAAW) continued during week commencing 16 December, and the theme was Antimicrobials in clinical practice.

Safety Alert – Risk of Skin Staining with Intravenous (IV) Iron Preparations. There have been incidents reported in other Trusts where patients have had permanent brown staining of the skin following the administration of Intravenous Iron. The Intravenous Iron which is first choice within the Trust is Ferinject (Ferric Carboxymaltose) 50mg iron/ml dispersion for injection/infusion. In the Trust it is usually administered as an IV infusion. This safety alert was shared with appropriate staff and at ward/department Safety Huddles.

Similar Packaging of Sodium Bicarbonate 1.26% 500ml Polyfusor and Phosphates 500ml Polyfusor. There has recently been an incident whereby a patient was incorrectly administered a Sodium Bicarbonate 1.26% Polyfusor when they had been prescribed Phosphate Polyfusor. Both

Polyfusors are made by the same manufacturers and have very similar packaging. All staff administering and supplying medicines have been made aware of the similar packaging and the risk of administering and supplying the incorrect medicine.

6. Learning from Claims

6.1 Clinical Claims

6.1.1 Clinical Claims Received

There were 21 clinical claims received in Q3, 40 were received in the previous quarter.

6.1.2 Clinical Claims Closed

There were 15 ongoing Clinical Claims closed in Q3, 3 with damages totalling £640.000.00 (excluding costs of instructing Trust solicitors), 1 Successfully repudiated and 15 withdrawn including closed due to lack of further correspondence from the claimant.

Specialty	Damages Paid	No of Claims
Acute Medicine	£10,000.00	1
Obstetrics	£33,000.00	1
Spinal Surgery	£597,000.00	1
Grand Total	**£640,000.00**	**3**

6.2 Non-Clinical Claims (Employee Liability / Public Liability)

6.2.1 Non-Clinical Claims Received

There was 1 public liability claim received in Q3.

Specialty	Accident / Incident that may result in Injury / Harm
Maxillofacial Surgery	1

6.2.2 Non-Clinical Claims Closed

Only 1 employer liability claims closed in Q3 which was successful repudiated

6.2.3 Claims Learning and Actions

When a new claim is received by WHH, it is triangulated with the Datix events (incidents) and complaints module and linked accordingly. Details of the learning from claims closed with damages is below.

The incidents below were identified at the time of the incident and prior to receipt of the claim.

One of the claims settled with damages related to spinal services. Spinal services have now been transferred to Walton.

Learning -Clinical Issues	
Incident Date 27/07/2027 Negligently failed to arrange an earlier External cephalic version (ECV) (a procedure that involves manually turning a baby from a breech position to a head-down position at 36 weeks rather than 38 resulting in emergency section rather than planned and consequences.	
Lesson Learned	**Action Taken**
Both experts agree that earlier ECV would likely have been unsuccessful, as it was at 38 weeks. The Claimant's expert states that the unsuccessful ECV would have resulted in the planned caesarean section, on balance, being arranged for earlier than 39+5 weeks (as likely there would be more availability in the elective lists) and if before 39+3 weeks, then the cord prolapse would have been avoided.	Learning from this claim has been disseminated to the team
Clinical Issues	
(Spinal Case reviewed externally as part of Spinal Services review). Negligent spinal surgery – patient in worse condition than before surgery.	
Lesson Learned	**Action Taken**
Patients on ITU after post-operative spinal surgery should have daily reviews by a Spinal Consultant. All patients with hypotension post spinal surgery should be regularly monitored and appropriate measures taken to treat it. Patients with hypotension should be reassessed clinically after interventions such as fluid boluses. A post-operative management pathway needs to be developed. All documentation should be done contemporaneously or if delayed it should be clearly documented that it has been entered retrospectively. Notes should not be dictated to be typed and entered in a patient's Electronic Patient Record 3 days later. A clear escalation policy and pathway needs to be developed by the Neurosurgery Team and in place for patients developing a new neurological deficit post-operatively. There should be shared learning from this investigation within the specialty. Junior medical staff and nursing staffing in Orthopaedics should be educated on complications of spinal surgery, ensuring recognition of hypotension post spinal surgery and the importance of a new neurological deficit, and the appropriate management of these complications.	E-mail sent to all Spinal Consultants informing that there must be daily reviews of spinal post-operative patients Record Keeping Audit Post-operative Spinal Care Pathway developed with clear escalation plans. Process embedded: Monday to Friday dictated records updated within 2 hours by a designated secretary. Critical plan updated in the records. Report shared at the Audit and Governance Meeting and Ward Managers meeting. Teaching sessions undertaken by the spinal team with nursing and doctor teams.

Clinical Issues	
Patient had Hospital Acquired Deep Tissue Injury (DTI) to right bunion which evolved too unstageable.	
Lesson Learned	**Action Taken**
There needs to be an improvement in SSKIN bundle completion, as well as consistency and accuracy of documentation of pressure areas on admission and throughout inpatient stay. Mattresses should be ordered as soon as possible on admission and any delays to this should be escalated. **Recommendations** Increase staff awareness of the need to address the increase in hospital acquired pressure ulcers within the ward. Timely completion of SSKIN Bundle Full ward daily review of SSKIN Bundles. Matron spot checks to be formalised. Compliance for all available clinical staff with Pressure Ulcer Awareness training. Increase knowledge of staff around pressure ulcers. Link nurses for tissue viability and pressure care. Registered staff to ensure completing patient documentation and assessing pressure areas. All HCAs to receive a patient handover. Further discussion regarding amending SSKIN bundle paperwork following trial on AMU. Daily heel checks for all patients. Provide Train the Trainer education from the Tissue Viability Nurse Specialists to the Practice Education Facilitators and the TVN link nurses within Urgent and Emergency Care. Consideration of all patients to be placed on an air flow mattress. Completion of patient risk assessment and care plan documentation on admission to AMU.	Communications regarding increased pressure ulcers shared with staff. Time between pressure ulcers displayed on the ward. Bedside folders implemented for patient documentation. Daily audits completed. Audit tool improved to allow for percentage/ RAG rating. Engaged with “Essential” Mattress company to review alternative methods of pressure area care within the Emergency Department. Provision of a 30-minute session as part of the ED specific induction. Nurse in charge of the shift ensures that all health care assistants receive a patient handover. Full completion of patient risk assessment and care planning on admission. Weekly documentation spot checks alongside monthly quality metrics. Train the trainer education provided to the Practice Education Facilitators to ensure effective training is implemented. Weekly skin bundle and mattress audits with once monthly Matron review to continue. The importance of appropriate personalised prescribed care as per Cheshire Merseyside Pressure Ulcer Steering Group, was highlighted at Safety Huddles When a patient has been reviewed by the Tissue Viability Team, this electronic document is to be printed and placed in patients end of bed notes to highlight to all staff the correct and up to date Pressure Area Care Advice- this was shared at the Ward Safety Huddle Weekly MUST audit.

The Clinical Claims Review Group meets every quarter to assist in the management of claims and the management of risk arising from the claims. The last meeting was held on 15 January 2025 when an update was provided regarding open cases which had previously been reviewed by the group (22 claims) 3 new claims were discussed. The next meeting is scheduled for 30 April 2025.

7. Learning from Inquests

At the time of reporting, there are 20 Coroner's inquests open. Of these inquests, 2 have a linked complaint, 0 have a linked PSII and 4 have legal representation.

There were 9 inquests opened in Q3, compared to 21 inquests opened in Q2. This is a decrease of 12 inquests (57.1%) compared to Q2.

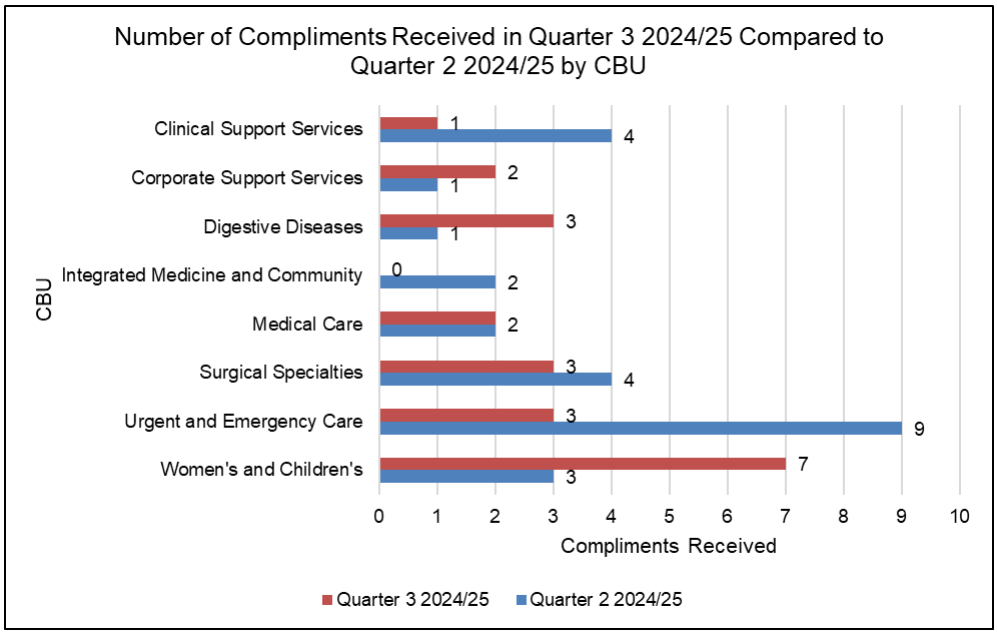
A Mock Coroners Court Awareness event is currently being arranged to take place on 19 March 2025, this annual event is supported by Hill Dickinson and attended by the Multi-Disciplinary Teams, to support awareness of the coronial process and support available.

A handbook is currently being developed to support the inquest policy and aid as guide for staff understanding the inquest process.

8. Learning from Compliments

In Q3, a total of 21 compliments were received compared to Q2, where 26 compliments were received. This is a decrease of 5 compliments (19.2%).

Graph 9



A positive safety culture is one where compliments are fed back to staff in the same way as incident investigations. Compliments are a very useful tool for WHH to be able to identify what areas are working well. It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. However, compliments are likely to be underreported.

In Q4 there will be review of the compliment functionality in Datix in an aim to improve understandings and identify themes from complements to enhance learning.

9. Learning and Improvement relating to Patient Experience and Inclusion

The Patient Experience and Inclusion Team continue to develop patient stories with CBU's. These patient stories have moved to a combination of digital format and face to face presentations from either the patients or a representative. The stories are shared across multiple committees, not limited to: Patient Experience and Inclusion Sub Committee, Quality Assurance Committee and Trust Board of Directors. The purpose is to highlight areas of improvement required and identify good practice for shared learning.

During Q3 patient stories have been shared a Chaplaincy story at the Patient Experience and Inclusion Sub Committee, where systems and processes in place to support a gentleman to receive regular visits when he may not otherwise have had any other visitors. Chaplaincy support for this gentleman enabled support with communication elements of the discharge process with a local church enlisted to support whilst back in the community. Thus, demonstrating a positive patient experience in hospital and after discharge.

The Board of Directors received a patient story from a patient of whom attended to share their experience of the Trust Emergency Department who required additional support due to her additional needs and disabilities. Lessons learned from the patient's experience has enabled the Trust to make improvements in:

- Clarification for staff re location of specialised equipment.
- Moving and handling training refreshed.
- Communication issues addressed in relation to seeing the person in the patient and supporting individual needs with reasonable adjustments.
- The patient is working with the Emergency Department to review the improvements made to ascertain effectiveness.

The Patient Experience and Inclusion Team use several methods to gain valuable qualitative and quantitative data and feedback from patients, carers and their families. This enables WHH to review areas of concern and celebration of good practice. Enabling areas to initiate improvements required from the learning identified via feedback. The range of methods used include:

- The National Friends and Family Test (FFT), via text, QR codes, telephone calls and paper copies.
- Local departmental surveys.
- National surveys.
- Patient Experience and Inclusion Team face to face survey and feedback.
- Patient Experience and Inclusion Team monthly observation rounds.
- Monthly Wayfinding and First Impression observation rounds that are triangulated with PLACE inspections and the Leadership and Governors observations.
- Feedback from complaints/compliments/PALS.
- Feedback from Community Partners and Advocacy Groups.
- Knowledge and Evidence as a resource for best practice.
- Working with Experts by Experience.
- Area specific patient journey mapping.
- Patient specific process and journey mapping.
- CQC mock inspections.
- Datix reporting.

As a result of feedback received from all the methods listed above, examples of improvements planned or undertaken include:

- Volunteers are assisting with nutrition, and hydration rounds in the Emergency Department. The volunteer service provided 177 hours of support during Q3.

- Ward Buddy volunteers have increased with 6 volunteers now in place to support 3 wards. Internal and external communications are in place to increase the number of wards supported by volunteers in Q4.
- Visual digital communication to be prominent in areas. A charity bid is being progressed to procure a digital communication TV screen/including USB to promote patient information, services, volunteer opportunities and FFT to our patients in ED (also for Paediatric ED, Main Outpatients, Children's and Young People Outpatients, Main Entrance and SDEC).
- Accredited Deaf Training sessions are in place commencing in Q4 open to all Trust colleagues to increase deaf awareness in the Trust.
- Deaf café attended by Chief Nurse, Head of Patient Experience and Deputy Head of Patient Experience to work together to drive improvements of this cohort of patients. Improvements made from the session include expanding interpretation provision with the use of an additional accredited company recommended by the deaf community.

During Q3 Trust Board observations took place at Halton supported by Executive Team, Non-Executive colleagues and Governors. Observations were carried out on 4 departments including Patient Catering, Outpatients, Urgent Treatment Centre and CSTM Theatres. Feedback has been collated and shared with the departments and monitored by the Patient Experience and Inclusion Sub Committee. Whilst no formal actions were raised on this occasion it was pleasing to note good practice across all areas observed.

Senior Nurse Walkarounds have also taken place during Q3 with additional attendance from the Trust Chair. 14 wards and departments were reviewed with the theme of kitchen audits under review. Lessons learned included:

- Inconsistent use of green aprons used for refreshment rounds which was addressed by Lead Nurses and Matrons.
- Allergy question was relocated on the menu card to ensure more prominent following feedback received.

10. Learning from Clinical Audit

10.1 Learning from National Audits

National Audit of Dementia (NAD) Timepoint 4 Patient Feedback Report

Summary

The National Audit of Dementia care in general hospitals (NAD) examines aspects of care received by people with dementia in general hospitals in England and Wales.

The data in this report is submitted by participating hospitals using the online patient feedback questionnaire, for people with dementia who are admitted to a general hospital. The questionnaire consists of 3 demographic questions, along with 10 questions intended to capture feedback on the patient's experience while in hospital. The tool can be used as a questionnaire submitted directly by the patient or someone supporting them, or as a semi-structured interview tool when collecting feedback.

Key Findings

Most questionnaires submitted were completed by the person living with dementia (84%) and the other responses were completed by a family member of someone living with dementia (16%). Overall, the feedback received was reflective of a positive experience whilst in hospital for people living with dementia.

Positive results included that eighty-four percent of those that responded had stated that visitors were always allowed to see them during your stay in hospital. This is particularly positive as Johns Campaign, which is a National Campaign supporting opening visiting for Carers, is an integral part of the Trust's Dementia Strategy and associated work plan

Learning and improvement

Areas identified as requiring most improvement were:

Keeping people informed about their care and treatment: Dementia Team to explore options such as using a 'hospital journey' document can improve communication for those individuals who are experiencing short term memory issues but still wish to be updated of their care and treatment.

Thoughts on food options: hot finger food options have since been introduced on ward B12 with plans to support roll out to the other areas.

The actions for improvements will be monitored via the next cycle of the National Audit of Dementia.

Assurance rating (using Trust assurance rating matrix): HIGH Assurance

10.2 Learning from Local Audits

Bone Health Assessment in Fracture Clinics

Summary

- Fragility fractures pose a major financial burden to the NHS.
- Secondary prevention measures are advocated by NICE, National Osteoporosis Society and British Orthopaedic Association (BOA).
- Identifying and potentially treating these patients is crucial in preventing a repeat injury.

This audit aimed to assess compliance to these national guidelines to check if we are screening the patients by calculating Fracture Risk Assessment Tool (FRAX) scores in the fracture clinics.

Key Findings

Good Practices Identified:

- FRAX scores were used for some patients, demonstrating initial steps towards systematic fracture risk assessment.
- Effective communication of results to GPs and treatment adherence for osteoporosis were noted.

Areas for Improvement:

- Low utilization of FRAX scores (6.25%) indicates missed opportunities for comprehensive risk assessment.
- Inconsistent documentation of FRAX scores and DEXA scan history suggests gaps in data completeness.

Key Causes:

- Insufficient training on FRAX score implementation and lack of standardised protocols.
- Resource constraints affecting consistent assessment and documentation practices

Learning

- Importance of Training and Awareness: Lack of awareness and training among healthcare providers contributed to the underutilisation of FRAX scores. Ensuring all staff are proficient in the use of assessment tools like FRAX is crucial.
- The need for Standardised Protocols: Establishing clear protocols for FRAX score calculation and documentation can improve consistency and ensure all patients receive thorough bone health assessments.
- Enhanced Data Management: Implementing systems to better capture and track bone health data, such as integrating FRAX score calculations into electronic health records, can facilitate more effective patient management.
- Continuous Improvement: Regular audits and feedback loops are essential to monitor adherence to protocols and identify ongoing areas for improvement in fracture risk assessment practices.
- To address the learning opportunities identified a standardised protocol is being developed. This will include FRAX score calculation and documentation and procedures for requesting and interpreting FRAX scores. Currently this is in the initial development phase. There is ongoing communication with clinical teams to ensure understanding and adoption. Once the protocol is embedded, discussion will take place regarding implementing the calculator into future patient IT systems. Fracture identification and management forms part of the surgical services Clinical Audit Programme.

Assurance rating (using Trust assurance rating matrix): MODERATE Assurance

11. Compliance

11.1 Self-Assessment Guide and Communications Plan

Staff need to understand the links between the CQC Quality Statements and day to day practice. To support learning, the intranet has been updated with a section for CQC and Compliance. A staff Compliance Communications Guide has been written. It has been publicised, along with an update to staff about the former Moving to Outstanding items which are now being referred to as “Making a Difference”.

Making a difference has become a dedicated space to share good news or describe how staff have made a difference to patients. The aim is to familiarise staff with the concept of linking the quality statements and encouraging them to share good news stories and create new media work, with the relevant CQC Quality Statements being linked.

11.2 Single Assessment Framework progress

Work continues to ensure all departments have self-assessed their evidence against the CQC Quality Statements. The evidence now needs to be scrutinised, and the self-assessment score needs to be validated/amended depending on the evidence review. A task team will be set up to undertake the reviews. It is anticipated that the reviews will be stepped and undertaken by each domain, starting with statements in relation to SAFE. This is a necessary action to ensure a consistent approach. In addition to this internal exercise, other score benchmarking with partner services and the CQC is planned, to provide assurance that the scores being allocated are in line with the CQC scoring approach.

11.3 Compliance, Quality and Oversight Group (CQOG)

Items reported to the QCOG Meeting, held on 11 November 2024, reflected the quality compliance work being undertaken during 2024/25, as well as outlining health and safety compliance visits from other agencies. The learning updates were as follows:

- CQC Engagement Meeting of November 2024 Update
- Update on Single Assessment Guide and Communications Plan
- Update on Warrington Theatres Mock Assessment
- Single Assessment Framework progress
- IPC Pillars of Assurance
- CQC Enquiries
- Health and Safety Inspections

A further QCOG meeting, was held on 30 January 2025, and it was agreed to progress the self-assessment work by collecting the evidence in respect of some of the Safe statements, with a view to analysing the ratings against the evidence, to ensure they have been graded appropriately.

11.4 Learning from the Theatres Mock Assessment at Warrington

Assessments (Inspections) are more likely to occur if the CQC have concerns about a specific area of the Trust, and their other fact-finding methods have not given them the assurance they require.

It is still fundamentally important for all staff to be prepared for a CQC Assessment visit. Assessments have been designed to support, and critique, not criticise. The method is for assessors from all different disciplines (e.g. Nursing, Medical, Pharmacy, Patient Experience Teams, Safeguarding and Infection Prevention Teams) to use a “fresh eyes” approach when assessing a service/department, with the aim to identify notable areas of good practice, as well as highlight areas and aspects of care that represent risk and require closer scrutiny, as well as action for improvement.

A Theatre mock assessment took place in September 2024 at Warrington only (as Halton was temporarily closed at the time of the assessment). A summary was provided in the last Learning Experience Report. An action plan was formulated following the assessment and progress is being made to address issued raised. Regular monitoring is taking place and completion targets are being met. Part of the review highlighted the need to move policy documents across to the central policy library. Considerable work has taken place to critically review all theatres documentation which was held locally, and determine actions required.

- 82 documents that were stored locally have been archived.
- 21 Policies have been reformatted to the revised policy document style and uploaded onto the central store.
- 6 policies have been reviewed and updated and are going through the policy ratification process.
- 20 documents are currently being progressed with the target date for completion being the end of Q4.

11.5 Learning from Mock Assessments and other sources of assurance

Given the changes to the CQC Framework and it’s operating model, other Trusts have temporarily “paused” their mock assessment programmes to reflect, evaluate and consider how they might look going forwards. WHH have initiated a review to examine ways in which information and learning already exists in other forms across the Trust. A wealth of information, which is similar to the assessment themes, features in the Ward Accreditation assessment tool. In addition, other WHH audits and checks, external inspections, peer reviews and accreditations, should also be acknowledged, and contribute to the overall assurance required. A hub and spoke model could be

considered, whereby a variety of information sources feed into a mock assessment profile. The other aspects of learning could be captured from staff interviews and from an information/evidence request process (mirroring the request system that supports a CQC Assessment).
In addition to this, there are still plans in place to assess the speciality work of Pharmacy and safeguarding before year end. These services have been selected, as wherever the CQC might choose to undertake an assessment, these 2 elements of work always form part of the formal assessment process. Medicines are always thoroughly checked, and as our patient profile changes, ensuring appropriate safeguarding measures are in place, and requirements are being met, is critically important. It seems prudent to undertake mock assessments, and examine performance across the Trust, in relation to these specific elements.

11.6 CQC Enquiries

There were 6 new enquiries added to the CQC enquiry log during Q3. Every enquiry addressed offers the opportunity to reflect, evaluate and learn. Measures to address issues are put in place and revisited to ensure they are fit for purpose. Recommendations are tracked through the established systems that are in place. For example, whereby an incident has been raised, the concern, investigation and actions are all tracked through the Datix stayed. Reviews, recommendations and themes are also triangulated across various work streams - incidents, PSII's, complaints, Pals, legal and patient experience.

11.7 Planned work for Q4 which will embrace learning

- Self-assessment ratings for Safety Oversight Framework continues.
- Work with the Associate Directors 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 has commenced in Q3, 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
- Plan and execute both Safeguarding and Pharmacy mock assessments and report on findings. Work with the teams on any action plan requirements.
- Continue the QGOG work.
- Plan and prepare for the next CQC Engagement Meeting scheduled to take place on 31 March 2025.
- Manage all CQC Enquiries.

12. Learning from Research and Development (R&D) Activity

Participant Research Experience Survey (PRES)

The Participant Research Experience Survey (PRES), conducted by the National Institute for Health Research (NIHR) Research Delivery Network (RDN), gathers valuable feedback to enhance the experience of research participants. The RD&I Team has reviewed local PRES feedback from the Warrington and Halton sites, revealing overwhelming positive responses as illustrated by the word cloud below. Some areas for improvement have also been identified.

Figure 8

Key areas for enhancement include improving the accessibility of research locations, ensuring participants are kept updated on research results and addressing participant reimbursement. The team is actively exploring ways to address these challenges and implement meaningful improvement.

In addition, efforts are underway to increase the PRES response rate to gain a more comprehensive understanding or the participants experiences. As part of a Quality Improvement Plan, the team has conducted a process mapping exercise and identified key actions to boost response rates, ensuring a broader and more representative perspective on research engagement.

13. Plan to implement a Sustained Learning Group

The Quality Assurance Committee is requested to support the introduction of a 'Sustained Learning and Improvement Review Group'. The purpose of the group would be to demonstrate learning and Improvement to the Quality Assurance Committee and the Trust Board of Directors that the Trust is safely managing all issues relating to governance via the governance structure and has continued evidence of learning and sustainability. In line with Trust Board assurance requirements the group would be responsible for monitoring incident safety actions, inquest and claims actions and complaint actions, in addition to CAS alerts and to ensure that effective governance arrangements remain in place to sustain learning and improvement.

14. Recommendations

The Quality Assurance Committee is asked to note the contents of this report and support the recommendation to introduce a Sustained Learning Group.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/25/02/239**			
SUBJECT:	**Infection Prevention and Control Report Quarter 3**			
DATE OF MEETING:	11 February 2025			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention & Control			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah Chief Nurse/Director for Infection Prevention & Control			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		N/A	N/A	N/A
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	N/A	N/A	N/A
	Further Information/Comments: Nil			
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 3 (Q3) of the 2024/25 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators. Trust apportioned, mandatory reportable, healthcare associated infection (HCAI) cases to the end of Q3 are: - • E. coli bacteraemia 78 cases • Klebsiella Spp. bacteraemia 22 cases • P. aeruginosa bacteraemia 8 cases • C. difficile 70 cases • MRSA bacteraemia 1 case • MSSA bacteraemia 26 cases (no threshold) The Brilliant Basics in Infection Prevention and Control (IPC), action plan continues in response to the increase in C. difficile cases. Inpatient Covid-19 cases at end of Q3 are: - • 177 (0-2 days)			

	• 54 (3-7 days) • 44 (8-14 days – probable healthcare associated) • 54 (15+ days – definite healthcare associated) One inpatient Covid-19 outbreak was reported in October 24 with a total of 3 outbreaks since Apr 24.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Infection Control Sub-Committee		
	Agenda Ref.	ICSC/25/01/249		
	Date of meeting	16 January 2025		
	Summary of Outcome	Submit to Quality Assurance Committee		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 2	AGENDA REF	QAC/25/02/239

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control (IPC) activity for Q1 to Q3 of the 2024/25 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, continued response to Covid-19 cases and progress towards achieving the Infection Prevention Strategy.

Within the National Action Plan on confronting antimicrobial resistance (2024 to 2029), an aim has been set to prevent any increase in Gram negative bloodstream infections (GNBSI) from the 2019/2020 financial year baseline. GNBSI include: - *Escherichia coli* (*E. coli); Klebsiella species (Klebsiella spp.)* and *Pseudomonas aeruginosa (P. aeruginosa*). This is a revision to the previous 50% reduction target has been implemented following recognition of challenges linked to an aging population with comorbidities and anticipated increase in incidence of GNBSI. There is limited evidence in the literature for interventions which work to prevent GNBSI.

Due to growing concern about the national increase in numbers of *Clostridioides difficile* (*C. difficile*) cases, the **UK Health Security Agency, has set up a national standard incident to review the situation.** This currently involves gaining an understand of how trusts test for *C. difficile* i.e., what samples they test, what tests they use and in what order. To support the UKHSA investigation, we have forwarded our laboratory standard operating procedure and participated in a survey.

NHS England (NHSE) set annual thresholds to minimise rates of *C. difficile* and Gram-negative bloodstream infections (GNBSI).

The thresholds set for WHH for 2024/25 are shown in table 1.

Table 1 WHH HCAI Thresholds for 2024/25

HCAI	WHH Thresholds 2024/25
C. difficile	≤60
E. coli	≤79
Klebsiella spp.	≤28
P. aeruginosa	≤10

Bacteraemia case apportionment is as detailed below: -

- **Hospital-Onset, Healthcare Associated** (HOHA) Any NHS patient specimens taken on the third day of admission onwards (i.e. ≥ day 3 when day of admission is day 1)

- **Community-Onset Healthcare-Associated** (COHA) Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient was discharged from the reporting organisation within 28 days prior to the current specimen date (where date of discharge is day 1)

- Community-Onset, Community Associated (COCA) Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient has not been discharged from the reporting organisation within the past 28 days, to the current specimen date (where date of discharge is day 1)

C. difficile case apportionment is as detailed below: -

- **Hospital-Onset, Healthcare Associated** (HOHA) Any NHS patient specimens taken on the third day of admission onwards (i.e. ≥ day 3 when day of admission is day 1)

- **Community-Onset Healthcare-Associated** (COHA) Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient was discharged from the reporting organisation within 28 days prior to the current specimen date (where date of discharge is day 1)

- Community-Onset, Indeterminate Association (COIA): Any case reported by an NHS acute trust when the patient was not HOHA or COHA but had been an inpatient at the same acute Trust in the 12 weeks prior to the date that their positive specimen was collected (i.e. between 4 and 12 weeks prior to their positive specimen)

- Community-Onset, Community Associated (COCA) Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient has not been discharged from the reporting organisation within the past 84 days, to the current specimen date (where date of discharge is day 1)

HOHA and COHA cases are apportioned to acute Trusts. From April 2024, UK Health Security Agency introduced use of 'decision to admit' date rather than admission date to calculate apportionment. It is predicted this will result in an additional 6% of cases apportioned to acute Trusts.

NHSE also set annual thresholds for all NHS Integrated Care Boards (ICB). These thresholds include all cases (comprising of the acute Trust and community cases). The Cheshire and Merseyside ICB, HCAI thresholds are shown in table 2.

Table 2: NHS Cheshire and Merseyside (C&M) ICB Thresholds for 2024/25

C&M ICB	*C. difficile*	*E. coli*	*P. aeruginosa*	*Klebsiella spp.*
QYG	900	2,124	172	605

The zero-tolerance threshold for avoidable cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia remains in place. There is currently no threshold for Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases.

NHSE case definitions for Covid-19 are as follows with date of admission equalling day 1: -

- Hospital-Onset Indeterminate Healthcare-Associated - First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission to Trust

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

RAG rating of Trust performance for HCAI by month is shown in Table 3, with more detailed information in appendix 1.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	J	A	S	O	N	D	Total	Status
C. difficile	≤60	11	7	11	10	10	7	6	2	6	70	Over Threshold
MRSA BSI	Zero	0	0	1	0	0	0	0	0	0	1	Zero tolerance
MSSA BSI	No threshold	5	4	2	1	4	3	6	1	0	26	No threshold
E. coli BSI	≤79	9	8	9	6	6	15	11	5	9	78	Over Trajectory
Klebsiella spp. BSI	≤28	6	4	1	1	2	3	2	2	1	22	Over Trajectory
P. aeruginosa BSI	≤10	0	0	0	1	2	2	1	1	1	8	Over Trajectory

C. difficile: 70 Trust apportioned cases reported to end of Q3, with a lower number of cases was reported in Q3, than in each of the previous quarters.

Cheshire and Merseyside ICB has produced a toolkit aimed at reducing *C. difficile* infection. This is currently being reviewed and any additional actions identified will be added to the existing *C. difficile* prevention action plan.

Focus areas within the *C. difficile* prevention action plan include: -

- Antimicrobial stewardship
- Environmental hygiene

- Hand hygiene
- Surveillance
- Isolation (and cohorting)
- Timely sampling
- Education

The Brilliant Basics IPC action plan remains in place. The programme includes timely feedback on emerging issues alongside a weekly focus using an A-Z approach. This uses short inspirational messages on the importance of infection prevention and control standards. Updates on activity include: -

Environment

- Pilot (4 wards) of the Well Organised Ward (part of the Productive Ward programme), Using the 5 S model (Sort, Set, Shine, Standardise, Sustain)
- Trust-wide Deep Clean programme, which involves removal of radiators and vacuuming ventilation extract grills and use of hydrogen peroxide vapour (HPV) decontamination – achieved by close working with operational teams. Paused for patient bays/side rooms whilst decanting facilities are unavailable and continued in sluices and toilets/bathroom areas
- Commode spot checks by Matrons
- Mattress cleaning (dynamic and static) – including duty of care visit to the offsite mattress decontamination service facility
- Clarification of roles and responsibilities for cleaning

Education

- C. difficile education across hierarchies on SIGHT mnemonic (training sessions for ward based staff)
- Antibiotic prescribing audits and feedback
- Shared learning from IPC audits to drive targeted actions
- Planning for a Cheshire and Merseyside ICB system-wide C. difficile prevention seminar
- Appropriate use of handwashing sinks (for handwashing only)

Audit

- Multidisciplinary Team efficacy audits

MRSA Bacteraemia: Nil cases in Q3. One case reported in Q1, with cause associated with either skin and soft tissue infection or peripheral cannula.

MSSA Bacteraemia: 26 cases reported to end of Q3.

There are a mixture of primary sources including endocarditis, prosthetic joint infection, skin and soft tissue infection, and IV device associated and 10 with unknown source. Further review of the cases with unknown sources will take place to identify any areas for learning and improvement.

ICU have had a higher number of cases (n=4), with 3 patients identified with MSSA carriage from admission screening. Suppression treatment was prescribed for 2 of the 3 patients in line with the Trusts guidance.

GNBSI: E. coli 78 cases, Klebsiella spp. 22 cases and P. aeruginosa 8 cases reported to end of Q3.

Actions in progress and next steps include: -

- Re-establish the GNBSI Prevention Group and request Clinician engagement
- Relaunch prevention plan and join up with current activity
  - Nutrition and Hydration continued focus
  - Timely Microbiological sampling including blood cultures and urine (align to sepsis workstream)
- Continue to provide education on GNBSI prevention at Mandatory Training

Policy/Guideline/SOP Updates

The IPC Team annual workplan includes a schedule of documents for review in line with the National IPC manual for England. The following documents were updated and approved by the Infection Control Sub-Committee (ICSC) in Q3: -

- Nursing Management of Transmissible Spongiform Encephalopathies Guidelines
- Isolation of Immunosuppressed Patients.
- Operational Policy C. difficile Cohort Isolation Facility (B19)
- Viral Haemorrhagic Fevers Policy
- Urinary Catheter Passport
- Surveillance of Surgical Site Infection Group Terms of Reference
- ANTT Guidelines
- Major Outbreak Guidelines
- Group A Streptococcus Guidelines
- Winter Virus Testing SOP
- Nebuliser SOP
- Hand Hygiene Policy
- Standard and Transmission Based Precautions Guidelines
- Waste Segregation, Handling & Disposal at Ward/Department Level
- Notification policy
- Hand hygiene training strategy

- Hand hygiene training booklet
- Chickenpox and shingles guidelines
- Personal protective equipment guidelines
- Winter virus testing SOP

Audit

During Q3, 26 Infection Prevention and Control (IPC) audits were completed. The IPC audit tool is aligned to the NHS England National Infection Prevention and Control Manual and includes standard precautions.

A summary of areas for improvement (list is not intended to be exhaustive) are included in table 4.

Table 4: Summary of Audit Findings

Element	Areas for improvement
Environment	General tidiness, low/high level dust including extract vents, including clean and dirty utility areas and dusty IT equipment
Patient Equipment (General)	Missing I am clean labels, some items dusty and required cleaning
Care of Peripheral Intravenous Lines	Completion of insertion and ongoing monitoring charts (Visual inspection Phlebitis) scores

Concerns and issues requiring immediate action are reported to the nurse in charge at the time of the audit. Full audit findings are emailed to Ward Managers and an action plan to address findings is requested. Progress against action plans is monitored at the Infection Control Sub-Committee.

The re-audit schedule is set according to findings. For areas with lower scoring results and areas with outbreaks or clusters of infections, re-audit is completed sooner and/or more frequently. All areas are monitored by an IPC and CBU Matron monthly visit and if concerns about IPC standards are identified, a repeat audit is completed.

A quality improvement project is being launched to improve care of peripheral lines.

Antimicrobial Stewardship

Antimicrobial stewardship is a key objective in the IPC Strategy, contributing to reducing the risk of antibiotic resistant organisms emerging and included in the Nation Action Plan for safe and effective care of patients.

Current concerns relating to antibiotic prescribing in the Trust include: -

- point prevalence audits have shown a downward trend in compliance with the Trust's prescribing guidelines
- IV to oral switch data has shown an increase in patients remaining on antibiotics beyond the point they could have switched
- benchmarking data across the NW has flagged the Trust as an outlier for broad spectrum antibiotic use

Concerns about antimicrobial prescribing were taken to Medical Cabinet in December highlighting the need for action, promoting the WHO AWaRE antibiotic classification into different categories to emphasize appropriateness of use.

Figure 1 WHO AWaRE Antibiotic Classification

Agreed actions following the Medical Cabinet meeting included: -

- CBU Clinical Directors to help address non-compliance in their own areas
- Promotion of the IV to oral switch (IVOS) tool ensuring integration into Ward Rounds
- Education on AWaRE campaign
- Open invitation for consultant colleagues to join the Trust Antimicrobial Management Steering Group (AMSG)
- Offer of additional training to Consultants
- Engage junior medical staff to assist in the IV Oral Switch auditing.
- Share the presentations with CBU Governance meetings and the Patient Safety and Clinical Effectiveness Sub-Committee

Awareness Raising Events

World Antimicrobial Resistance Awareness Week









Education and Training

Overall compliance with infection control mandatory training was 91% at the end of December 2024 (table 5). Mandatory training is available via eLearning, face to face training and at corporate induction.

Table 5 Mandatory training Compliance

IPC Mandatory Training	A	M	J	J	A	S	O	N	D
Level 1 – Non-Clinical	95%	94%	94%	94%	95%	94%	95%	95%	95%
Level 2 – Clinical	87%	86%	85%	85%	85%	85%	87%	87%	86%
Overall compliance	**91%**	**90%**	**90%**	**90%**	**90%**	**90%**	**91%**	**91%**	**91%**

Environmental Hygiene

A programme of cleanliness monitoring is in place with frequency of auditing carried out according to the NHS Standards of Healthcare Cleanliness (2021). Audit results are emailed to ward/departmental managers and star ratings awarded according to scoring. All areas are scoring 4-star or 5-star ratings (out of a 5-star rating). Areas with reduced scores are given a 2-to-4-hour timescale to rectify concerns in functional risk 1 (highest risk areas) and functional risk 2 categories.

Efficacy audits, with representation from infection prevention and control, estates, facilities and nursing leaders have been introduced in Q3 and 10 areas within IMC CBU completed. The next steps include action planning to prioritise outstanding estate work and focus on improvements, where identified as required.

Incidents

Covid-19

Covid-19 continued to impact the Trust with details of all inpatient cases as shown in Table 6.

Table 6 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	9	4	9	12	34
May	17	4	3	5	29
Jun	31	9	5	7	52
Jul	47	17	8	10	82
Aug	13	2	4	4	23
Sep	21	11	5	4	41
Oct	19	6	8	8	41
Nov	12	1	2	3	18
Dec	8	0	0	1	9
Total	**177**	**54**	**44**	**54**	**329**

Covid-19 Outbreaks

One Covid-19 outbreak affecting patients was reported in Q3. An Outbreak Control Group was established to manage the outbreak and additional oversight of infection prevention and control precautions implemented. Three outbreaks have been reported between April and December 2024.

Collaboration with Estates

The IPC Team continue to work closely with the Head of Estates Maintenance, Compliance and Risk on water safety and ventilation issues and the Head of Capital Projects on all new builds and upgrade works.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies review plan
- Delivery of the Infection Prevention Strategy
- Provision of infection prevention and control expert advice to colleagues
- Review of escalations in infections jointly with the associated Care Group

4. IMPACT ON QPS?

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Attendance at training assists staff in their role and fulfils mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability and the green plan

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to UK Health Security Agency
- Surveillance of nosocomial Covid-19 cases
- The Infection Prevention and Control Team monitor HCAI. Action is implemented in response to increased incidences of HCAI and infection control related incidents
- The Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI incident investigation reports and audits with agree actions to support care improvements
- Cleanliness monitoring reports and Efficacy Audits

6. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy Objectives

- Prevention of healthcare associated infections

Table 7 HCAI Thresholds 2024/25

HCAI	WHH Thresholds 2024/25
C. difficile	≤60
E. coli	≤79
Klebsiella spp.	≤28
P. aeruginosa	≤10

- Prompt switching of intravenous to oral antibiotics (achieving 15% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria)
- Improving standards of environmental cleanliness
- Implementing action in line with the NHS Waste Strategy

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to: -

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Sub-Committee

DIPC reports are submitted quarterly to: -

- Infection Control Sub-Committee
- Quality Assurance Committee and onwards to Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

Monitoring is in place at the Senior Executive Oversight Group.

8. TIMELINES

2024 – 2025 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

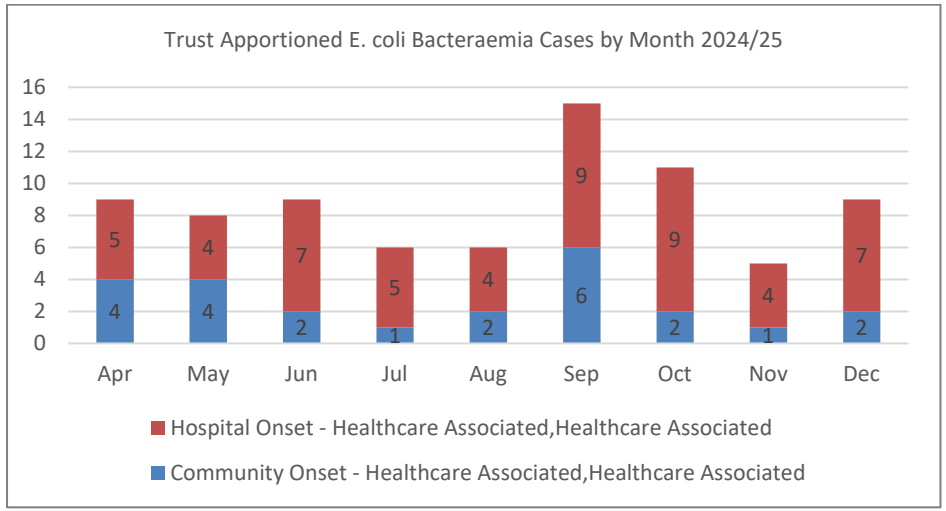
10. RECOMMENDATIONS

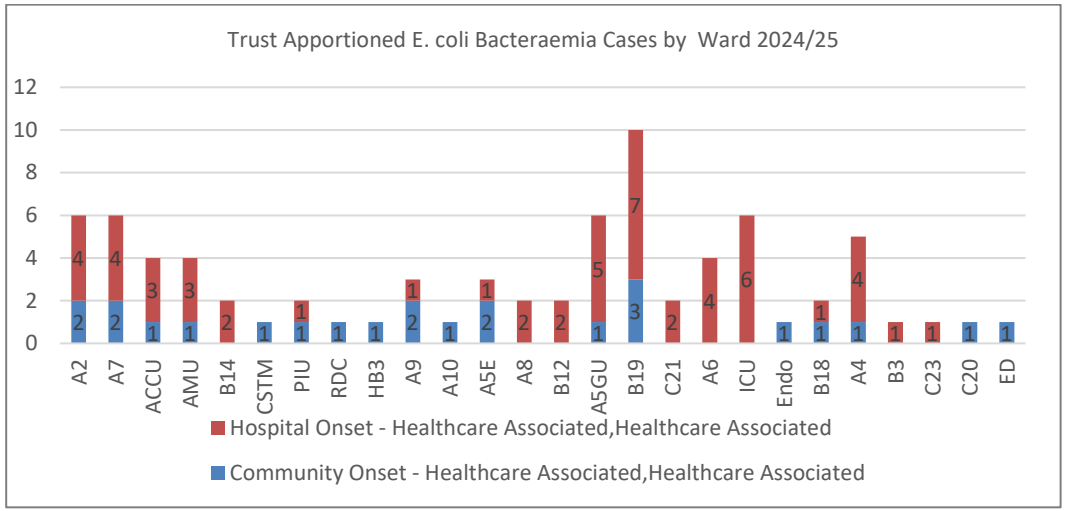
The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported, and progress made.

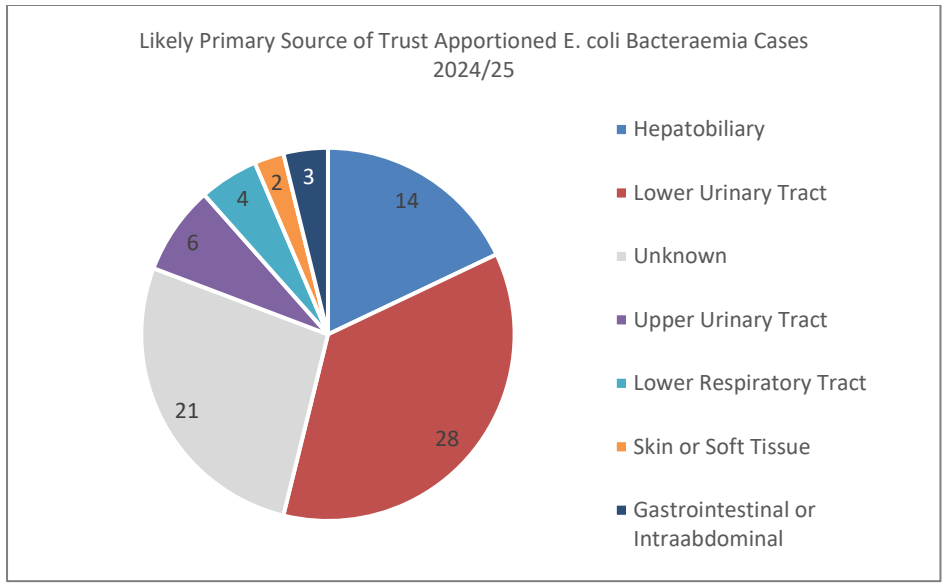
Appendix 1

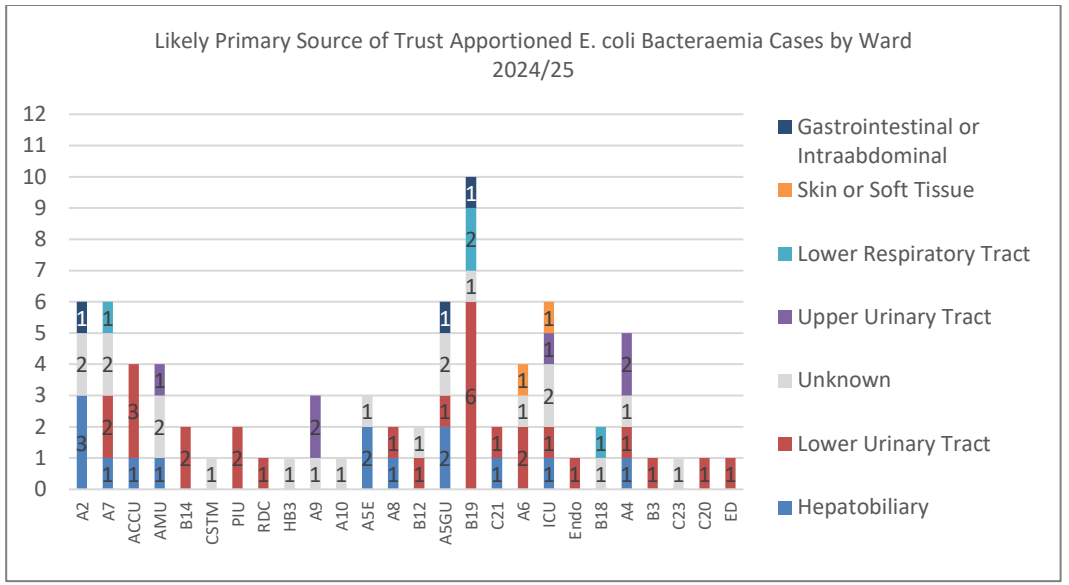
Gram Negative Bloodstream Infection: E. coli April 24 – Dec 24

Threshold	79
YTD Total	78



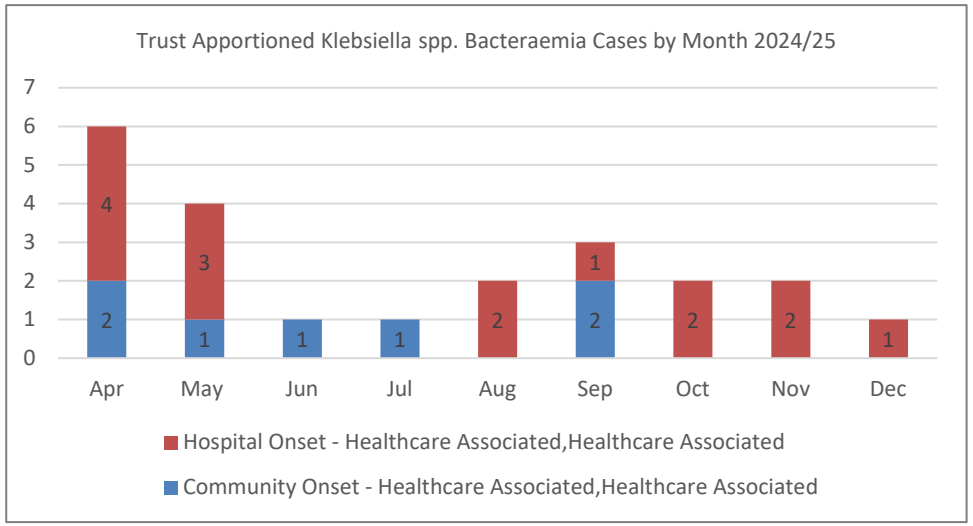


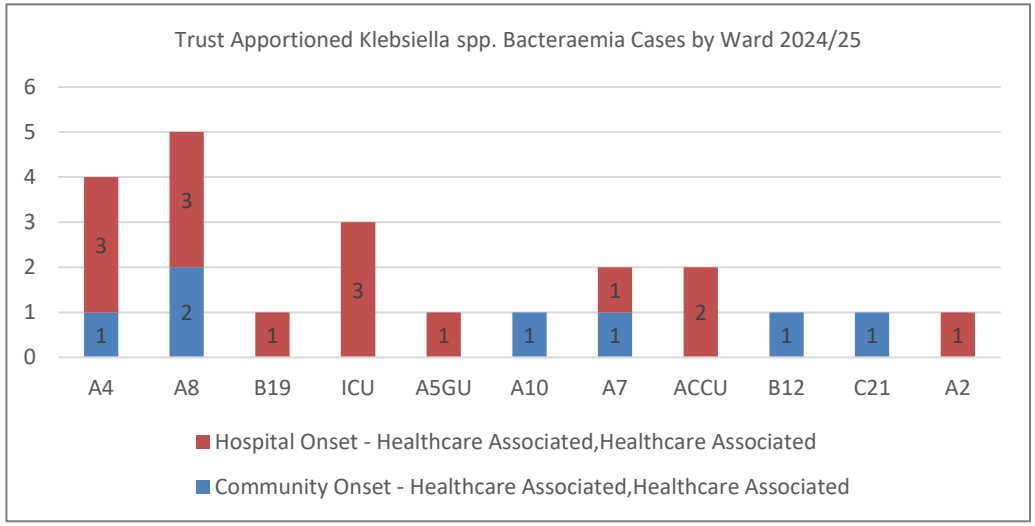


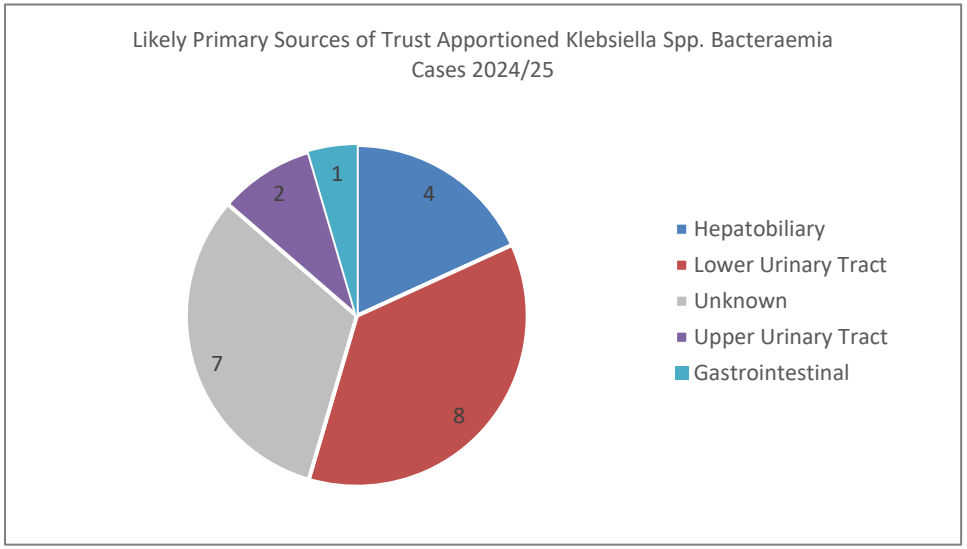


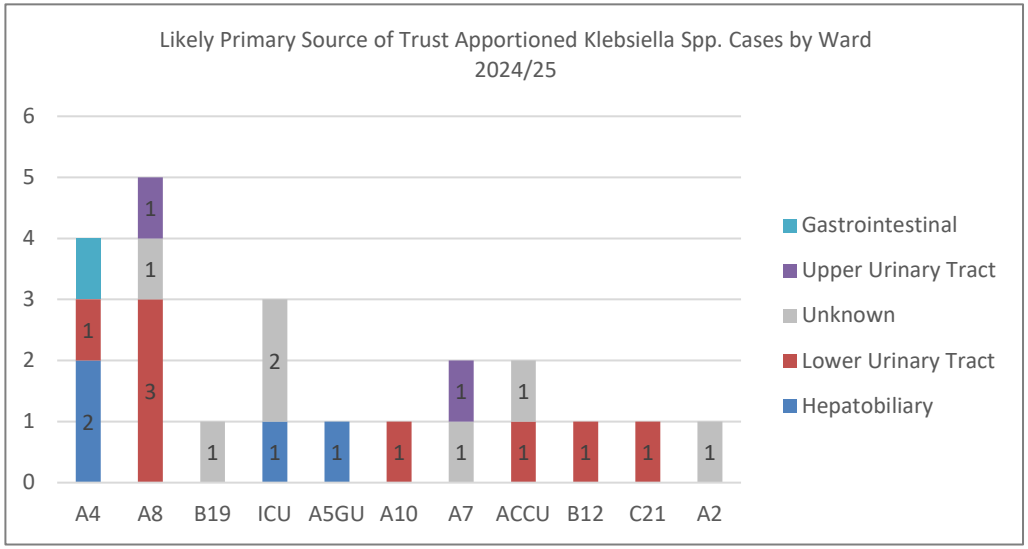
Gram Negative Bloodstream Infection: Klebsiella spp. Apr 24 – Dec 24

Threshold	28
YTD Total	22



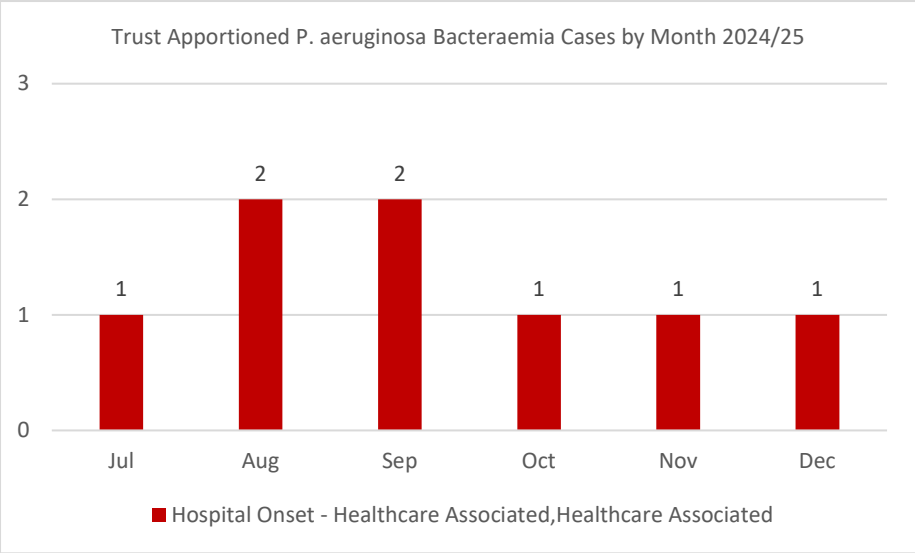


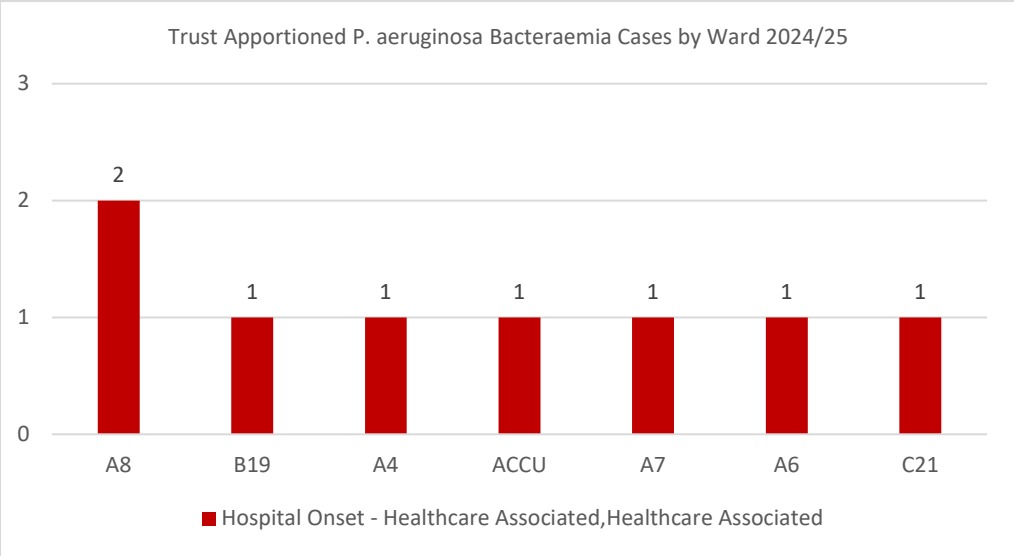


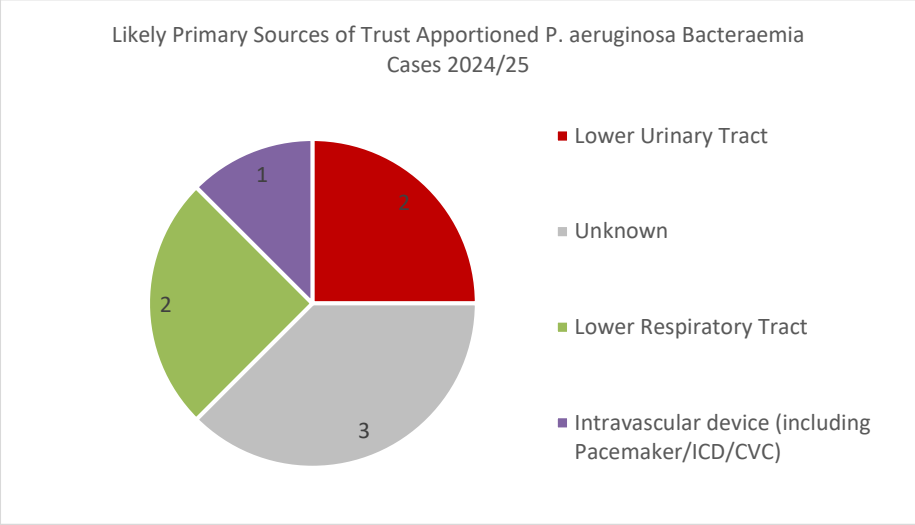


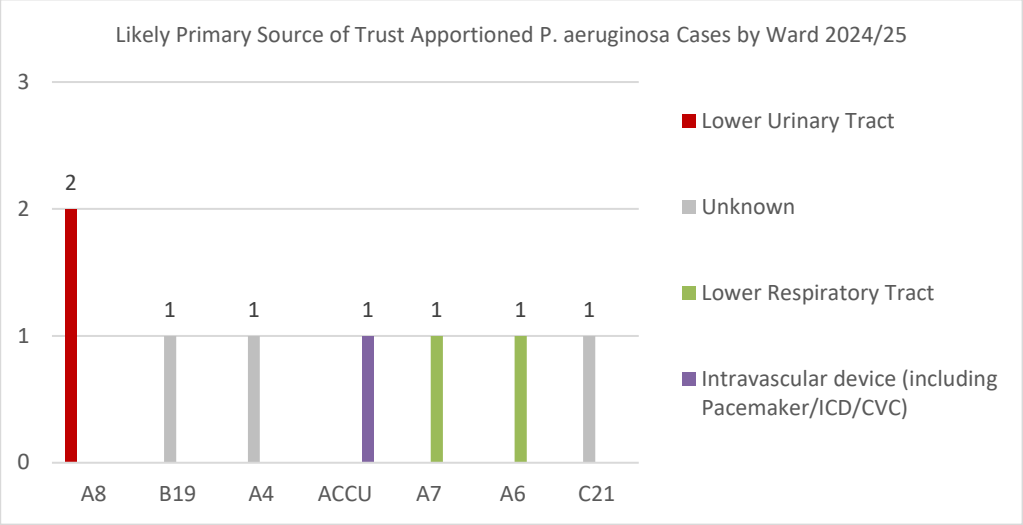
Threshold	10
YTD Total	8

Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr 24 – Dec 24



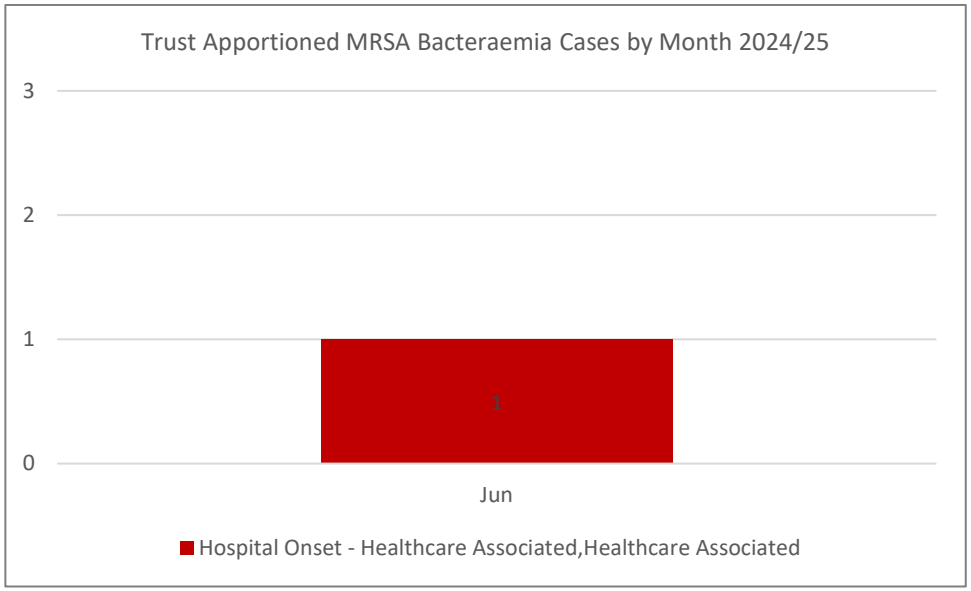


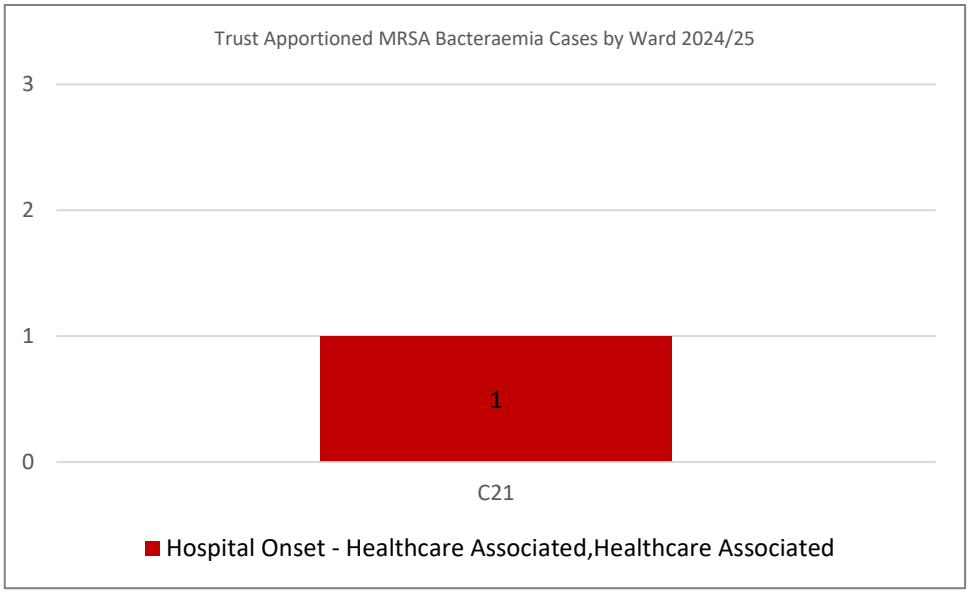


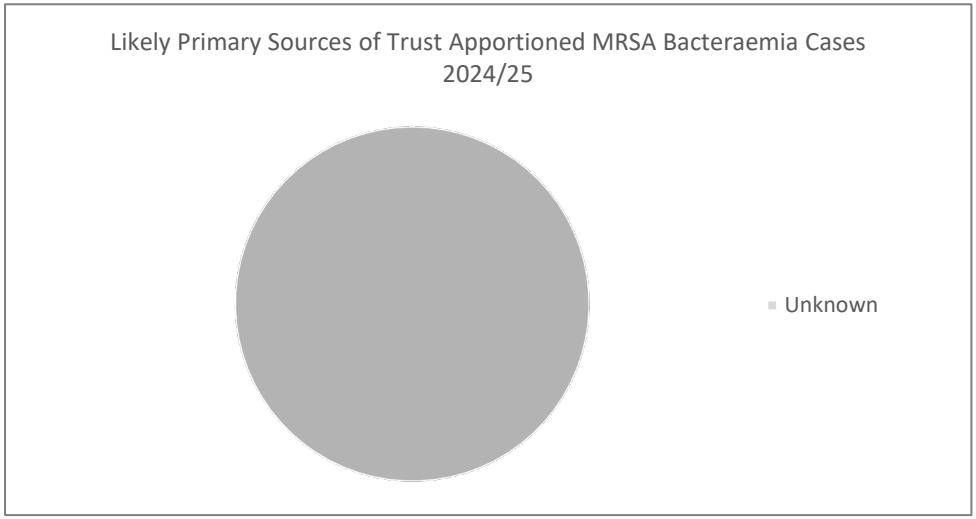


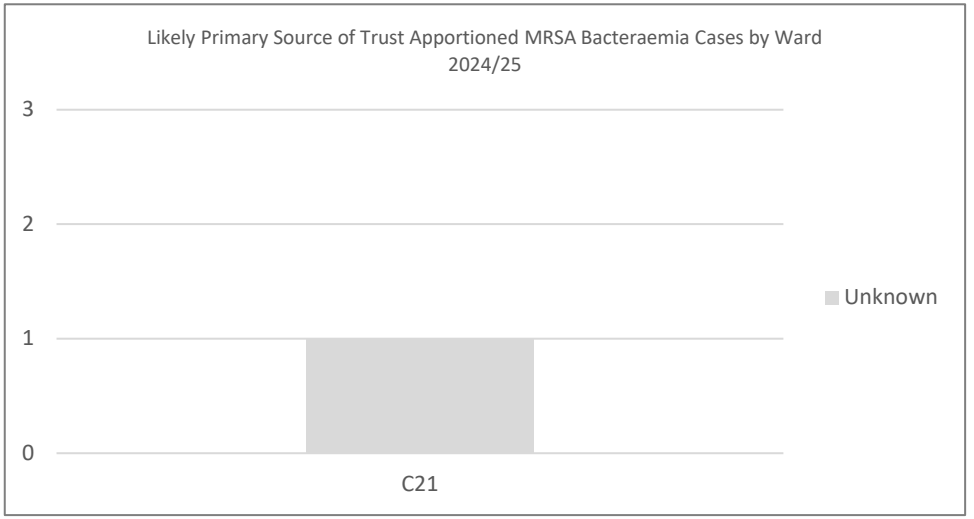
Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr 24 – Dec 24

Threshold	Zero
YTD Total	1



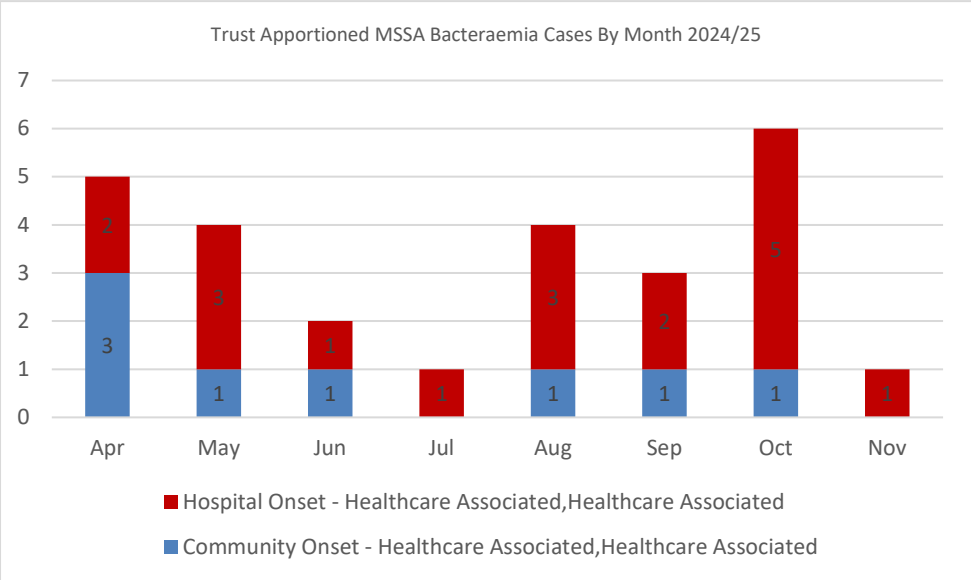


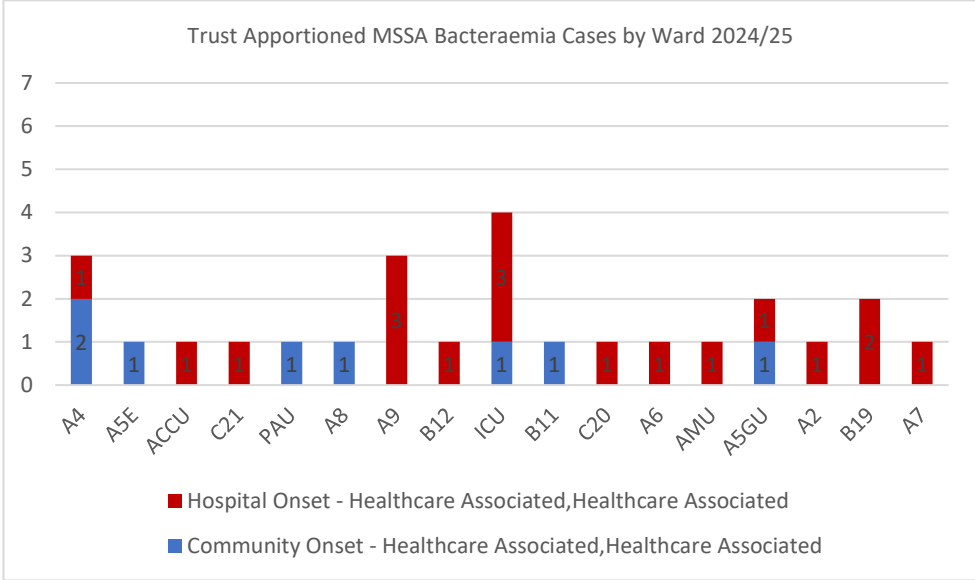


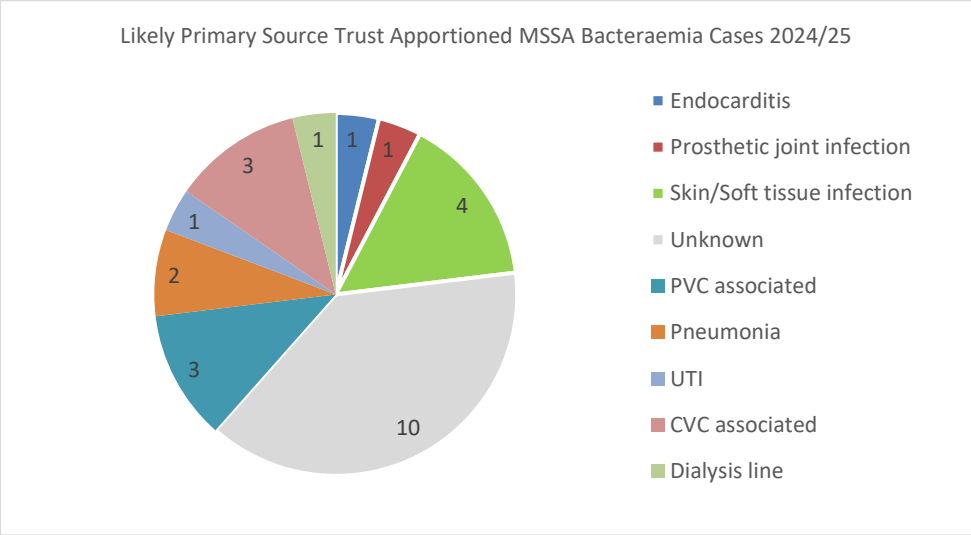


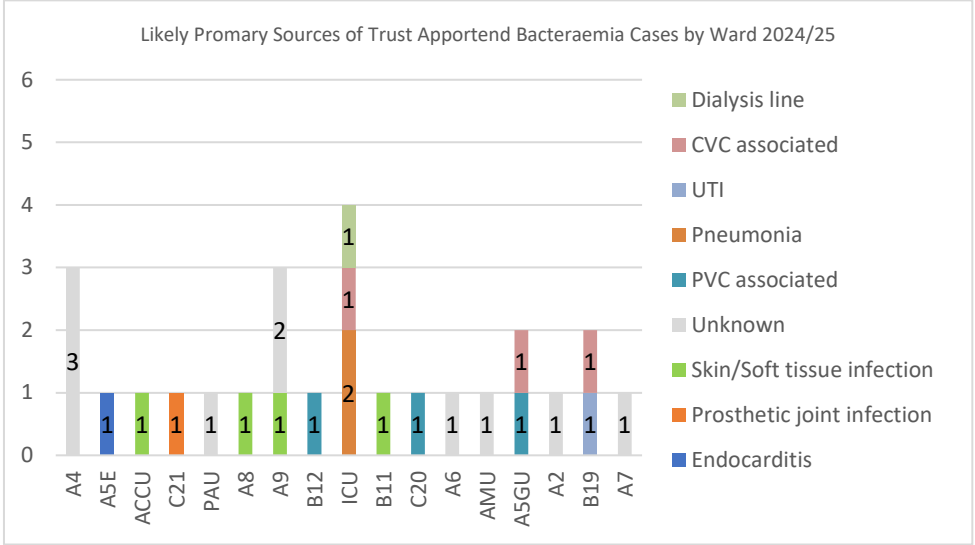
Gram Positive Bloodstream Infection: Staphylococcus aureus Apr 24 – Dec 24

No Threshold	
YTD Total	26



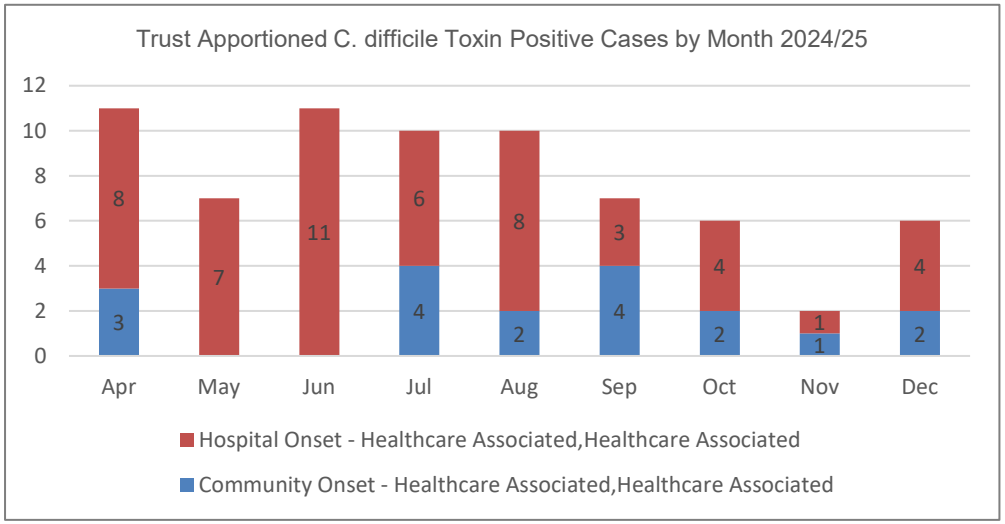


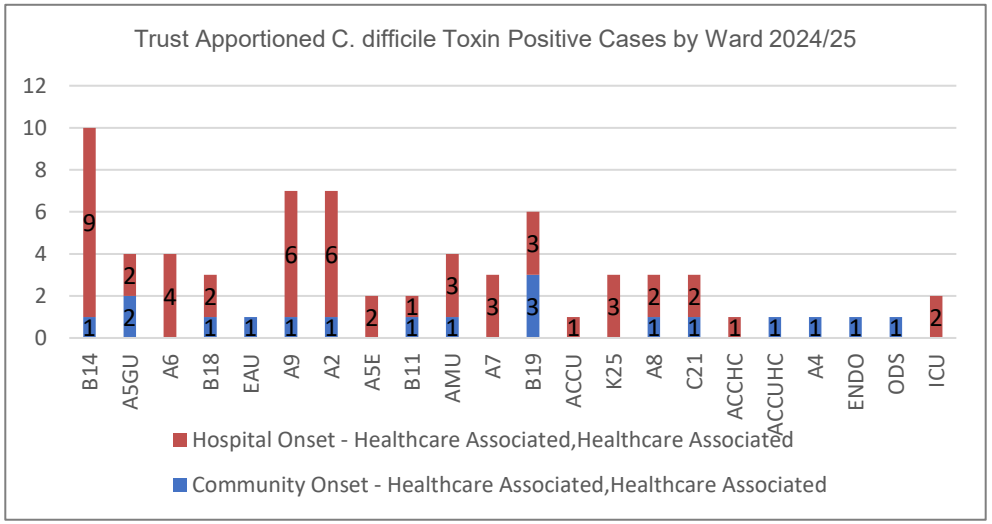


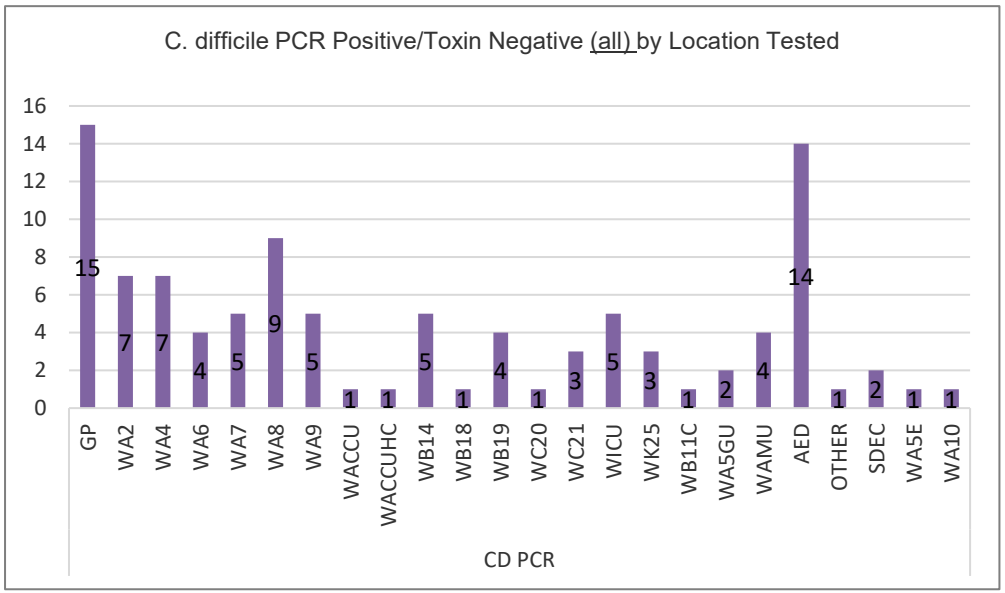


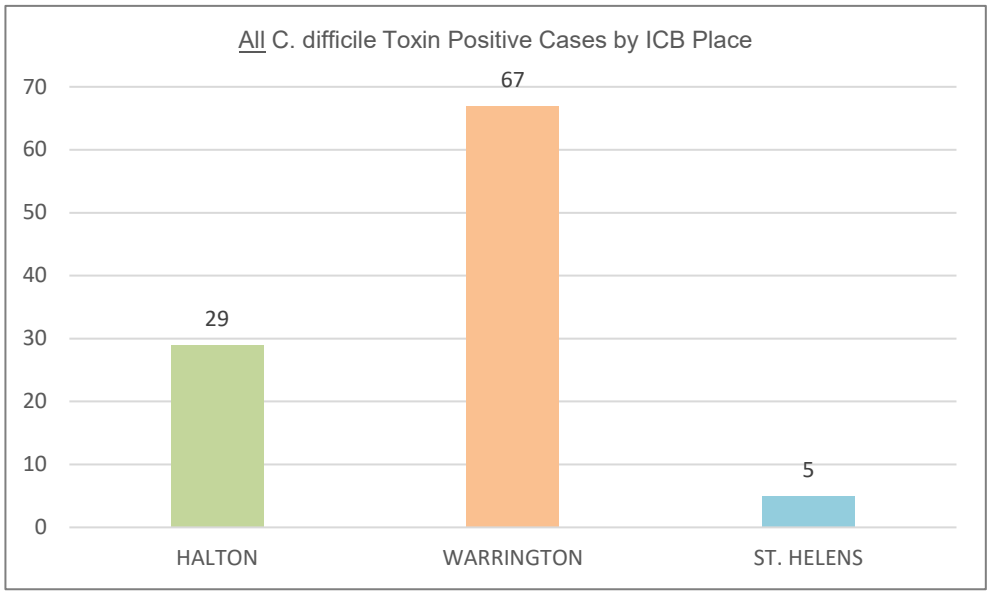
Clostridioides difficile (C. difficile) Toxin Apr 24 – Dec 24

Threshold	60
YTD Total	70

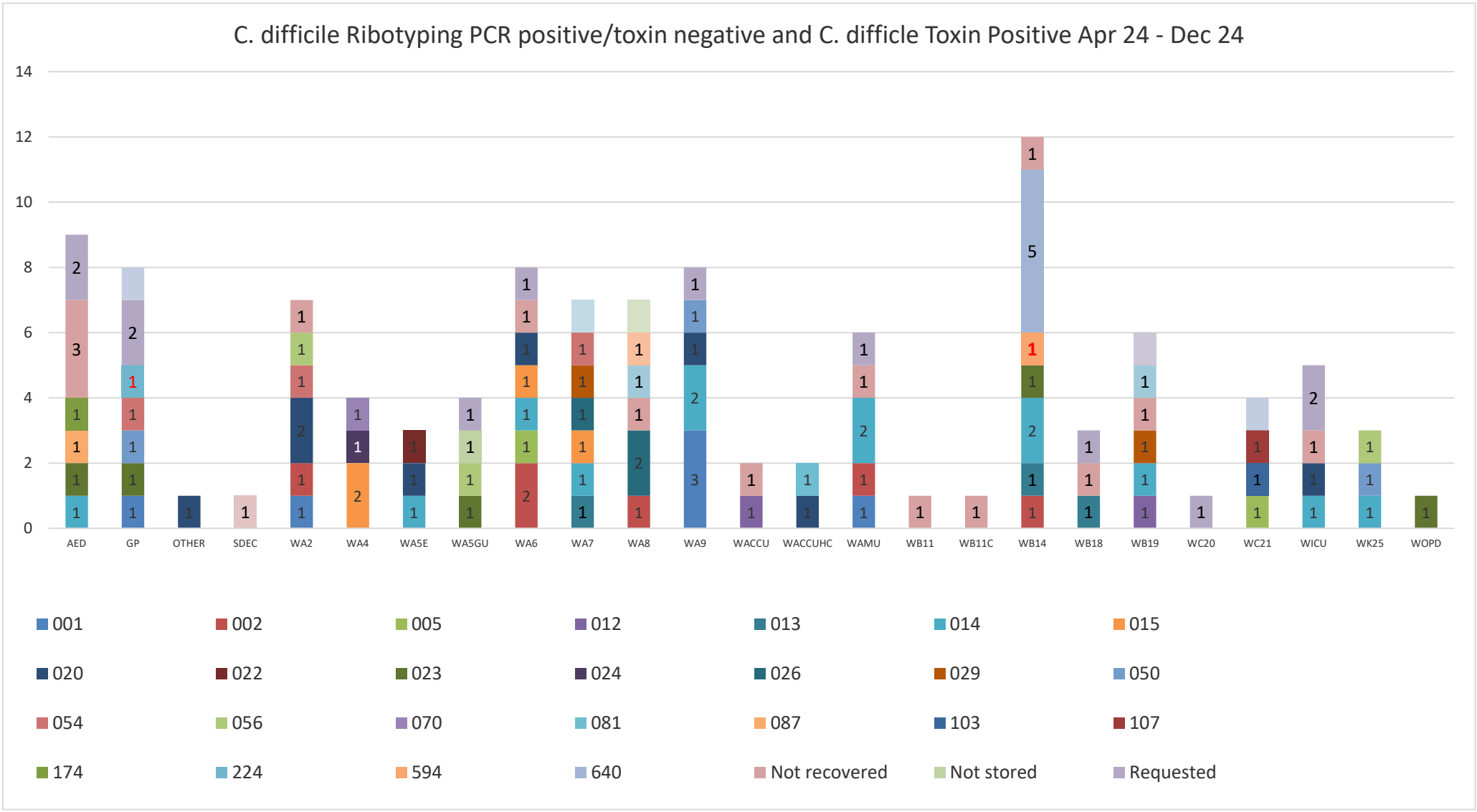




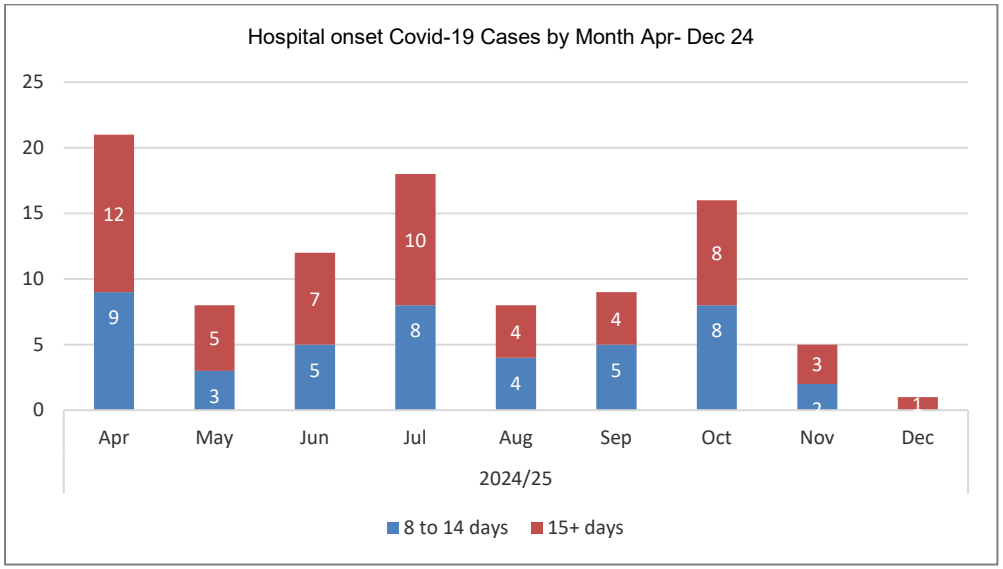


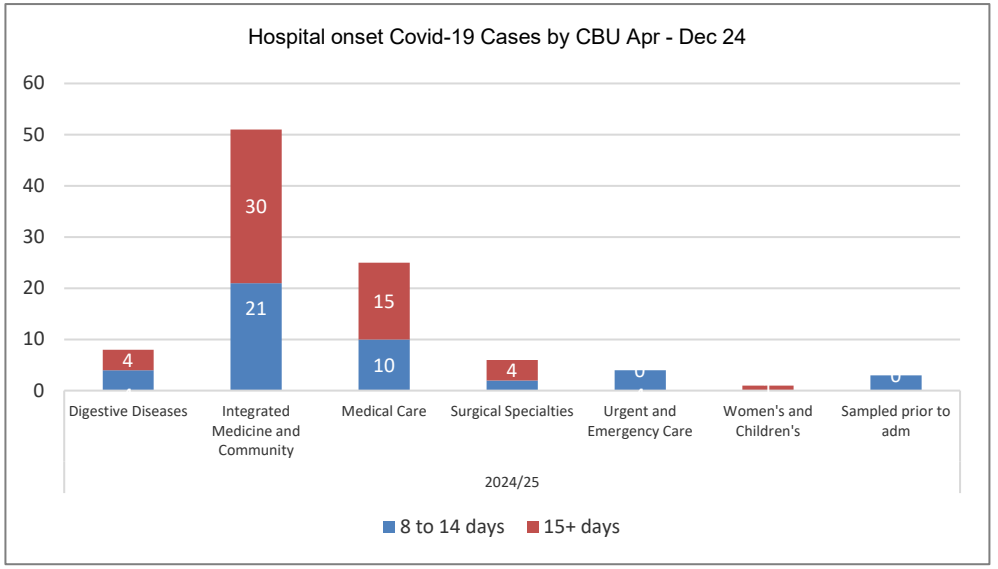


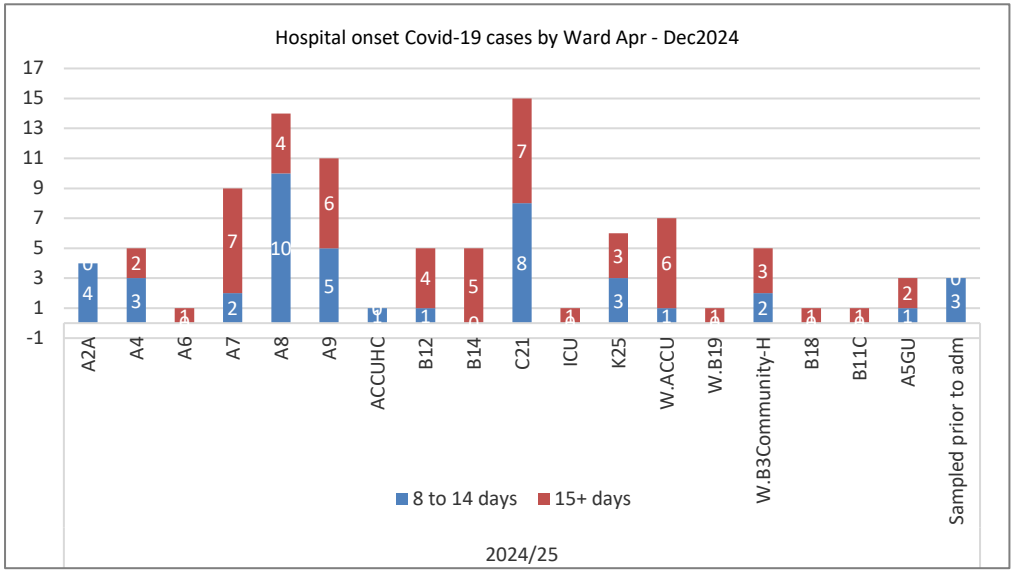
Clostridioides difficile (C. difficile) Ribotyping Results (all) Apr 24 – Dec 24

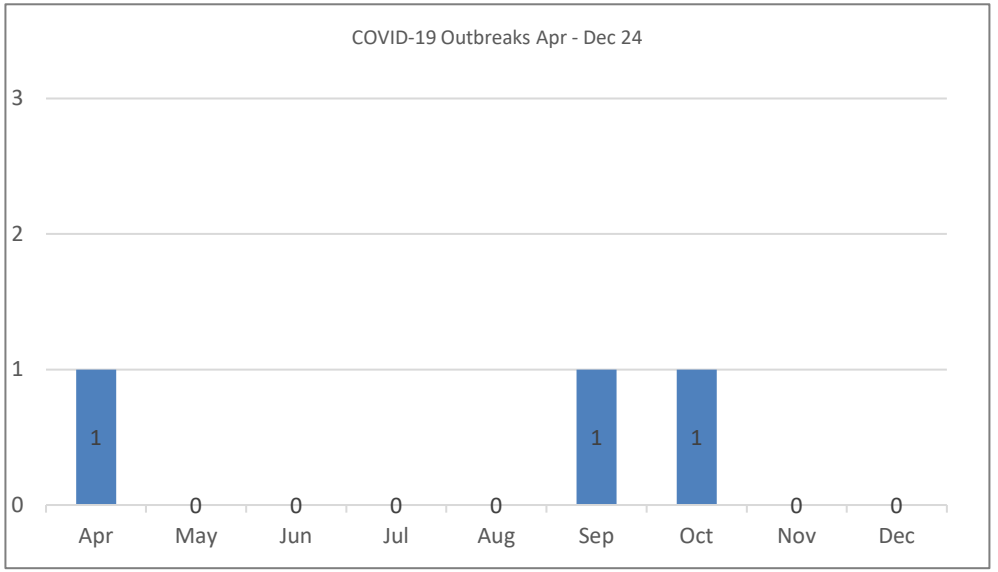


Hospital Apportioned Covid-19 Cases Apr – Dec 24









Appendix 2 IPC Audits by Care Group

Unplanned Care Group

Assessment	ICU	A10	B14	A8	DISCHARGE LOUNGE	Frailty	AMU	EAU	RESP LOW CARE	MAJORS	Resus High care
Environment - General	86%	73%	77%	82%	81%	95%	95%	95%	82%	89%	86%
Environment - Clean Utility	75%	100%	88%	63%	88%	100%	75%	88%	88%	88%	88%
Environment - Dirty Utility	100%	100%	89%	78%	67%	78%	89%	89%	89%	67%	100%
Environment - Cleaners Room	100%	67%	100%	89%	100%	100%	89%	78%	89%	78%	89%
Environment - Toilets & Bathrooms	100%	77%	100%	92%	75%	100%	92%	92%	92%	100%	100%
Ward Kitchens	100%	88%	96%	75%	100%	96%	96%	95%	83%	96%	88%
Handling/Disposal of Linen	100%	83%	100%	100%	92%	100%	92%	100%	92%	100%	100%
Departmental Waste	92%	92%	83%	83%	92%	100%	83%	100%	83%	100%	67%
Safe Handling Disposal of Sharps	94%	94%	94%	94%	100%	100%	94%	100%	89%	87%	94%
Patient Equipment (General)	95%	81%	100%	86%	86%	86%	95%	100%	86%	100%	91%
Personal Protective Equipment	100%	100%	93%	100%	100%	100%	86%	100%	100%	100%	86%
Short Term Catheter Management	100%	94%	94%	100%	100%	100%	94%	100%	100%	100%	100%
Care of peripheral intravenous lines	100%	100%	83%	83%	100%	100%	83%	83%	83%	67%	83%
Isolation precautions	91%	100%	100%	100%	100%	100%	100%	100%	100%	91%	100%
Hand Hygiene	100%	100%	96%	91%	96%	100%	96%	96%	83%	100%	70%
Overall Compliance	**96%**	**90%**	**93%**	**88%**	**92%**	**97%**	**91%**	**94%**	**89%**	**91%**	**89%**
CBU	MC	IMC	IMC	IMC	IMC	IMC	UEC	UEC	UEC	UEC	UEC

Planned Care Group

Assessment	A4	B4	Ophthalmic Clinic Daresbury	A6	UIU	ANDU	B11
Environment - General	86%	100%	77%	73%	95%	86%	95%
Environment - Clean Utility	63%	100%	38%	88%	88%	75%	75%
Environment - Dirty Utility	89%	100%	100%	78%	78%	100%	100%
Environment - Cleaners Room	100%	N/A	89%	78%	78%	100%	100%
Environment - Toilets & Bathrooms	85%	100%	62%	92%	85%	92%	92%
Ward Kitchens	83%	92%	92%	79%	92%	100%	96%
Handling/Disposal of Linen	92%	100%	83%	100%	100%	100%	100%
Departmental Waste	92%	92%	83%	92%	92%	92%	92%
Safe Handling Disposal of Sharps	94%	100%	89%	94%	100%	94%	100%
Patient Equipment (General)	91%	94%	95%	91%	100%	95%	100%
Personal Protective Equipment	100%	100%	100%	100%	93%	100%	100%
Short Term Catheter Management	94%	100%	100%	88%	100%	100%	100%
Care of peripheral intravenous lines	67%	N/A	100%	83%	100%	100%	100%
Isolation precautions	100%	N/A	100%	100%	100%	100%	100%
Hand Hygiene	87%	100%	100%	100%	100%	100%	96%
Overall Compliance	**88%**	**98%**	**87%**	**89%**	**93%**	**96%**	**96%**
CBU	DD	DD	SS	SS	SS	W&C	W&C

Clinical Support Services Care Group

Assessment	BREAST CARE CSTM	MRI /CT CSTM	Anticoag clinic	Main OPD	Audiology	Halton Hub	OT Flat	Ultrasound
Environment - General	86%	91%	95%	100%	82%	95%	92%	95%
Environment - Clean Utility	100%	100%	75%	100%	100%	88%	100%	75%
Environment - Dirty Utility	100%	100%	100%	88%	100%	89%	100%	100%
Environment - Cleaners Room	100%	56%	100%	89%	100%	67%	100%	100%
Environment - Toilets & Bathrooms	100%	100%	100%	91%	100%	92%	82%	100%
Ward Kitchens	100%	77%	100%	90%	100%	86%	94%	100%
Handling/Disposal of Linen	100%	100%	100%	100%	100%	100%	100%	100%
Departmental Waste	100%	100%	100%	92%	92%	92%	100%	83%
Safe Handling Disposal of Sharps	100%	100%	94%	94%	100%	100%	100%	100%
Patient Equipment (General)	88%	88%	100%	88%	57%	100%	100%	100%
Personal Protective Equipment	100%	100%	100%	100%	100%	100%	100%	93%
Short Term Catheter Management	100%	100%	100%	100%	100%	100%	100%	100%
Care of peripheral intravenous lines	100%	100%	100%	100%	100%	100%	100%	100%
Isolation precautions	100%	100%	100%	100%	100%	100%	100%	100%
Hand Hygiene	95%	96%	100%	100%	96%	96%	n/a	100%
Overall Compliance	**98%**	**94%**	**100%**	**95%**	**95%**	**94%**	**91%**	**96%**
CBU	CSS	CSS	CSS	CSS	CSS	CSS	CSS	CSS

Warrington and Halton Teaching Hospitals NHS Foundation Trust

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/25/02/189**			
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q3, 2024/25**			
DATE OF MEETING:	19 February 2025			
ACTION REQUIRED:	**None**			
AUTHOR(S):	Dr Rachel Wallis Guardian of Safe working			
EXECUTIVE DIRECTOR SPONSOR:	Dr Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			√	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			No	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of exception reports via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 3 (1st October 2024– 31st December 2024) 2024-25, 55 exception reports were submitted of which 6 were highlighted as an immediate safety concern. These were immediately responded to and action taken where appropriate. However, on review, the majority of these were incorrectly flagged and guidance and discussion was covered at the most recent RDF to ensure the significance and action required for an ISC was clearly defined and understood. Whilst reporting of immediate safety issues is to be encouraged, a clearer understanding of the criteria and actions required will reduce spurious reporting and ensure reports come under the correct category.			

	The majority (46 individual reports, equating to 84%) of exception reports relate to hours of working. 0 exception reports relate to patterns of work, 5 relates to missed educational opportunities and 4 exception reports submitted relate to service support available to the doctor. However, the narrative, where provided, often indicates an overlap between categories. The total number of exception reports for this quarter has decreased which is in line with trends from previous years.		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
	None		

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – Quarter 3 2024-25 (1st October 2024 – 31st December 2024)	AGENDA REF	SPC/25/02/189

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Resident Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and chaired by the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers, participates in both regional and national Guardian of Safe Working networks and attended the National Guardian of Safe Working Conference in October. Additionally, through the national Guardian network, the GSW participates in consultation with national employers and BMA to negotiate changes as a consequence of the agreement following industrial action in 2024.

Most resident doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

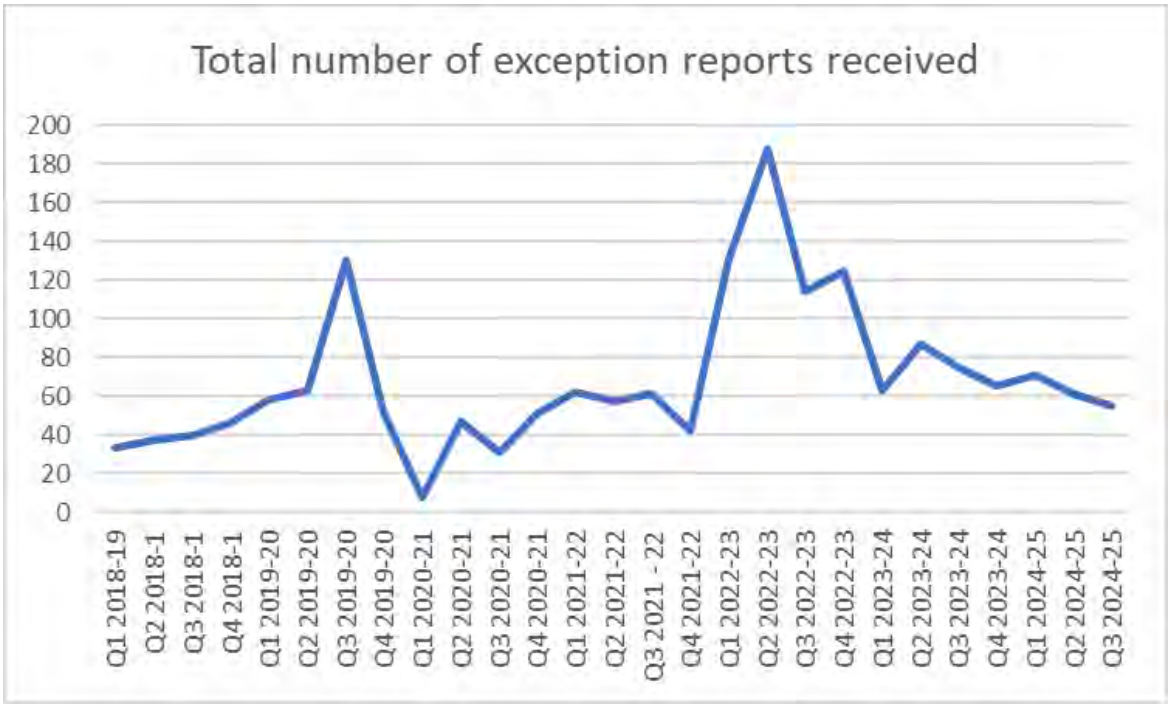
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the trainees hosted by WHH to the Lead Employer Guardian of Safe Working Hours, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

Exception Reporting (Oct 24 – Dec 24)

During Q3, 2024-2025, 55 exception reports (ERs) were submitted which is significantly less than received in Q3 2023-24 (75). This is consistent with reporting trends across the NW. Following change over (as can be noted from previous years) there is a predictable increase in exception reports which generally reduce/resolve following a period of settling in.

Please see Chart 1 for exception reporting trends over previous years.



Fines

The GSW has responsibly for protecting the safeguards contained in the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.

As per the TCS above any of the following breaches will incur a financial penalty.

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13-hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours rest in a 24-hour period has not been achieved (excluding on-call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

Fines: Q3 (Oct 24 – Dec 24)

Grade	No of reports	reason	Fine to doctor (£)	Fine to GoSW (£)	Total (£)
F1	1	>13 hrs	13.9	23.18	37.3
F1	1	>13 hrs	11.92	19.87	31.97
CT1	1	>13 hrs	22.36	37.27	59.63
ST3	1	>13 hrs	113.36	188.92	302.28
Total	4		161.54	269.24	431.18

Fines were applied to exception reports where breaches in the terms and conditions of the 2016 contract had occurred. The majority of these fines occurred in general medicine (3 fines) and have formed part of the dialogue ongoing to resolve issues of pressure of work in the specialty. Fines are calculated as per the guidance set out by NHSE with regard to the contractual breaches. A portion of the fine is paid to the reporting doctor, and the rest sits in a fund ringfenced to improve the working lives and wellbeing of resident doctors under the remit of the Resident Doctors Forum (formerly Junior Doctors Forum)

Themes for Q3 (Oct 24 –Dec 24)
For this quarter there has been widespread exception reporting which may reflect the promotion of the GSW role and all Junior Doctor/trainee induction. Reports have been from many specialties and grades of doctor. There are numerous rota gaps in all specialities, and this continues to be impacting junior doctors across the board.

General and Specialty Medicine – (21)
Exception reports in Medicine were overwhelmingly from the F1/F2 cohort of doctors and applied to extra hours being worked. This also resulted in 3 fines being issued where doctors worked in excess of the maximum 13 hr shift length. However, on a deeper dive, this proved to be partly down to pressures on the wards, with a need for additional support. The CBU are aware of this and have an active project to review the distribution of junior doctors across the medical footprint, the distribution and activities of the consultant team and consider how best to incorporate a number of ACPs who are currently in their second year of training. The GoSW is involved in these discussions. Dr Balawala who has led on the workforce project will attend the JDF in January to present the action plan to the resident doctors.

Surgery including urology (7)
Ongoing issue with surgical foundation doctors, especially urology. They are timetabled to work 08:00 to 16:00, however, they are often asked to participate in ward round activity in the afternoon which results in jobs required, meaning they work beyond their hours. The CBU have agreed to address this to move activity earlier, if this continues to be an issue a group work schedule will be required to review the timing of the dayshift. However, the incidence of exception reporting from this group of doctors has reduced further from Q1 from 20 to 14 in Q2 and 10 in Q3 and will continue to be monitored for the time being.

T&O (10)
Work has continued with the T&O resident doctors to ensure senior support; the reports submitted by the F1/F2 related to additional hours worked to ensure safe cover on the wards. Extra shifts have been put in at weekends and appear to be reducing the incidence of exception reporting in this area. 1 work schedule review (F2) was completed. Additionally, several ERs have been submitted by higher training grades, particularly with regard to NROC at weekends which has seen them working well beyond their resident hours. Following a work schedule review of ST6, the CBU have agreed to amend the weekend NROC hours to reflect the activity of the role. This is also expected to provide additional support to the more junior trainees and will be observed closely. The ISC submissions from T&O (4) all related to a feeling of overwhelm and

being unsupported with the management of medically unwell patients on T&O wards. Strong engagement from the medical management team within the specialty and with support from the AMD for Planned Care has seen considerable improvement in the medical ward cover being introduced imminently. The GSW will continue to monitor this closely and report in the next quarter.

O&G (4)
O&G have continued to show significant reduction in exception reporting from 18 in Q1 following work done to review concerns previously raised. There were no exception reports submitted by O&G resident doctors in Q3 and this will be removed from enhanced observation unless further concerns arise

Summary

- Number of exception reports raised = 55
- Number of work schedule reviews that have taken place = 1
- ERs flagged as immediate safety concerns = 6 reduced to 1 on consultation with reporters.
- Fines that were levied by the Guardian = 4 (total fines £431.18)
-

Exception Reports (ER) over past quarter	
Reference period of report	01/10/24 - 31/12/24
Total number of exception reports received	55
Number relating to immediate patient safety issues	6
Number relating to hours of working	46
Number relating to pattern of work	0
Number relating to educational opportunities	5
Number relating to service support available to the doctor	4

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

We continue to monitor any delays in signing off ERs and regular reminders are sent by the Medical Trainees Workforce Administrator. At the end of Q3 there were 21 unresolved ERs maintained from Q2 (18). The GSW will monitor outstanding ERs and encourage continued engagement from both trainees and educational supervisors.

The JDF meeting took place on the 19th November 2024 with good attendance from the majority of trainee groups and rota administrators. New representatives were welcomed to the trust and a lively discussion took place. Of note, the nomenclature for doctors in training has changed from junior doctors to resident doctors from September 2024, and the forum voted to change the name of the forum to Resident Doctor's Forum. This was be reflected in the Terms of Reference if agreed when ratified in November.

Additionally, GSW has reported to the Lead Employer on the exception reports and activity for Q3 with regard to CT1 and above. In total 14 exception reports were submitted, none of which were identified as an immediate patient safety issue. A fine was levied for an exception report for excess hours for an ST3 doctor in paediatrics

amounting to £302.28. All other exception reports for this group of doctors have been resolved and are not considered likely to recur.

Rota Gaps
As part of the overview of resident doctors' wellbeing and work pressures, the GSW is expected to provide an oversight of rota gaps in training programmes. In common with all trusts both regionally and nationally, WHH has noted an increase in the number of LTFT resident doctors as well as gaps in rotas with lead employer not allocating sufficient doctors to fill all training programme slots. LTFT posts compound the pressure on rotas as they are not backfilled by the lead employer and often leave 20-40% of hours uncovered in such posts. This in turn impacts upon the pressures on the FT doctors working those rotas. Although not within the remit of the GSW, it should be noted that this contributes to the need for locum expenditure and specialties look to mitigate this with the recruitment of locally employed doctors where possible, and consultants/SAS acting down, which has an increased cost pressure.

Grade Q3	Gap
FY1	No gap
FY2	1 LTFT 80%
GPST	1 CAU 1 A&E 1 Medicine 1 Paediatrics 2 Ophthalmology 1 frailty
CT/ST 1-2	1 surgery
ST3+	1 cardiology 1 histopathology 1 radiology 1 general surgery 1 anaesthetics (from Nov) 1 A&E (from Nov) A&E LTFT 80% x 3

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- To continue to monitor areas of high exception reporting.
- To continue to monitor action plan generated by T&O and work to resolve issues raised with regard to non-resident on call for senior trainees and intensity/support for foundation doctors.
- To monitor the effect of the medical workforce review with respect to exception reporting in General and Specialty Medicine and support to resident doctors in specialty
- To report rota gaps in resident doctors rota to SPC.
- To encourage early resolution of exception reports and access to time off in lieu as the preferred outcome where appropriate in line with national recommendations to reduce junior doctor fatigue and promote wellbeing.

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	29
Total number of overtime payments	3
Total number of work schedule reviews	1
Total number of reports resulting in no action	6
Total number of organisation changes	0
Compensation	0
Unresolved	21
Total number of resolutions	**39**
Total resolved exceptions	**40**

Note *:*

** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

6. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours' Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issues raised by the Guardian of Safe Working and to provide relevant advice.

It would also be good practice to share a copy of the report with the Resident Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

7. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q3 – (end of December 2024) – Submit February 2025
- Q4 – (end of March 2025) – Submit April 2025
- Q1 – (end of June 2025) - Submitted August 2025
- Q2 – (end of September 2025) – Submit November 2025

8. ASSURANCE COMMITTEE (IF RELEVANT)

N/A

9. RECOMMENDATIONS

The Committee are asked to consider the contents of the report and consider the assurances made accordingly. The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REF:	**FSC/25/03/296**			
SUBJECT:	**Digital Strategy Group (DSG) update**			
DATE OF MEETING:	**Monday 24th March**			
ACTION REQUIRED:	**To note**			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) meeting took place on the 10th of March. This report provides a summary of the high-level updates/exception escalations received from the DSG feeder groups, providing the following assurance status for key delivery areas: • **Bridgewater Integration** Moderate Assurance • **EPCMS (Electronic Patient Care Management System)** Limited Assurance • **Digital Transformation Highlight Report** Moderate Assurance • **Digital Service Delivery Highlight Report** Moderate Assurance • **Digital Care Delivery Group Highlight Report** Moderate Assurance • **Digital Analytics Highlight Report** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): • **Bridgewater Integration** – work continues developing high-level milestone plans for each of the digital portfolios detailed planning arranged for Single Service Desk arranged in March. • **EPCMS** – Exec to Exec with NHSE/ICB meeting took place 10th March Frontline Digitisation (FD) financial risk continues to be a challenge 3 options being explored with C&M			

<table>
<tr><td></td><td colspan="3">

FDP - The theatre scheduling module is in final go live preparation working towards a go live in March. Go live readiness criteria RAG green and on track.
PEP – Financial deep dive oversights from original business case to be presented back to Execs in April a proposal to support a new financial plan
PACS - Due to issues with migrating data, Philips have pushed WHH go live date back until Summer 2025
2012 Servers – Endoscopy server yet to be switched of and decommissioned due to cyber vulnerability that needs to be rectified.

</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">FSC is asked to note the contents of the report, including assurance levels.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>NEXT STEPS: State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Share with Finance & Sustainability Committee</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">Section 43 – prejudice to commercial interests</td></tr>
</table>

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF:	FSC/25/03/296

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

	Programme/Project	Programme/Project Description	Overall Delivery RAG	Governance RAG	Risk Status RAG
1	**BW and WHH Digital Services Integration**	This workstream will develop and deliver a strategy for Digital Integration of WHH & BW, ensuring the managed consolidation of systems and digital services to achieve quality improvements and efficiencies for both trusts.			
2	**2.1 - Electronic Patient Care Management System (EPCMS) Procurement**	Procurement to replace current Trust EPR Lorenzo with an Electronic Patient Care Management System.			
	2.2 - EPCMS Readiness	Preparedness for a new EPCMS – Organisational and Transformation activity			
3	**Federated Data Platform (FDP)**	FDP a comprehensive data integration and management system designed to centralise, standardise, and securely share inpatient theatre scheduling data across multiple organisations			
4	**Medical Records Digitisation**	As part of EPCMS readiness, this project will look at utilising an Electronic Document Management System (EDMS) and the scanning of Paper records. The project will be split into two phases. Phase 1 – digitisation of outpatient clinics Phase 2 – introduction of scanning bureau and destruction of paper records. A capital funding allocation of £2.2m has been ringfenced for this scheme in 2025/26			
5	**Patient Engagement Portal (PEP)**	Phase 1.1 now complete and Patient Portal is live for hospital appointments in all areas except for Radiology. Phase 2 Clinical correspondence letters, Pre Op Assessment and AI DNA Predictor (NH			
6	**Single C&M Laboratory Information Management System (LIMS)**	A single network LIMS designed to work for a Pathology network to support the transformation of Pathology services in the CMPN			
7	**Infrastructure Capital Projects**	IT infrastructure projects funded by 2024/25 capital – Network refresh, Network Comms Cabinet Improvements, Network Comms Cabinet Expansion (2024/25), Device Refresh and Backup Storage Replacement			
8	**ICS Picture Archive Communication System (PACS)**	Migration to the new C&M PACS cloud solution			
9	**Digital Care - Optimisation**	Clinical optimisation projects are reported at the Digital Care Delivery Group, which oversees clinical delivery, ensures patient safety, facilitates clinical safety sign-off, and prioritises optimisation plans.			
10	**Digital Service Delivery**	This Digital Service Delivery Group report provides an update on digital activity performance internal IT services and external vendor management), digital compliance and cyber monitoring. The slides contained in the report provides individual highlight reports and recommendations.			

Bridgewater and WHH Digital Services Integration

Highlight Report – Warrington and Halton Integration: Digital Workstream
Reporting Period – 3.02.2025 to 3.03.2025
Director Lead – Paul Fitzsimmons
Operational Lead – Tom Poulter and Dave Smith

Overall / Delivery Status	Milestone Status	Risk Status	Issue Status	Financial Benefit Status	Non-Financial Benefit status
Green	Green	Amber	Amber	Amber	Green

Workstream description

This workstream will develop and deliver a strategy for Digital Integration of WHH & BW, ensuring the managed consolidation o f systems and digital services to achieve quality improvements and efficiencies for both trusts.

Key achievements this period	Red and Amber highlights	Next period (action/deliverables)
During this period : • IT network link activated connecting the WHH and BCH networks • Significant 24/25 capital funding from Frontline Digitisation (FD) Cyber PAM solution circa 190kk between BCH & WHH • A procurement options appraisal has been developed to assess the FD's request to include Community Services in the WHH EPR procurement. • Integration digital worksream programme highlevel miletone plan drafted	• Operational challenges for WHH Digital Services due to vacancy freeze - clarity on shared use/pooling of resources required	• Completion of PAM procurement and implementation plan drafted • Meeting with the FD to finalize and approve the preferred procurement option for WHH/BCH Community Services • Develop detailed plan and costing to implement single service desk • To initiate discussions on potential shared use or pooling of resources under an SLA-type arrangement. • All program workstream leads to convene to draft detailed program plans and activities

EPCMS Procurement Update

Joint Procurement Delivery Group ToR and Partnership Procurement and Deployment Agreement endorsed. Both Trust agreed to work towards single Pre-Market Engagement (PME) in April. Following Exec to Exec and NHSE/ICB 10th March meeting work continues in finalising the procurement/deployment plans and finding a solution to funding issue.
Bridgewater inclusion in EPR procurement Option 3 Two Phase ITT WHH/MWL Acute EPR ITT followed by WHH/BW Community EPR ITT.

Digital Transformation Delivery Highlight Report (Moderate Assurance)

Programme Update

- **EPCMS Workstreams Update**
  Work is ongoing to progress with the development/sign off for outstanding work packages. 2 operational leads, Laura James and Thomas Coalbran have been appointed to support the readiness workstreams in anticipation of the upcoming EPCMS.

- **Current State**
  Process mapping is 79% completed (this mean maps are either in draft, in the validation stage or signed off). The EPR manager is in the process of developing a plan to digitise the paper processes which are being identified throughout the process.
  The ward process maps covering 18 areas have been signed off by the Trust CNIO.
  The total number of signed off maps is 96 out of 169.

- **Medical Record Digitisation**
  Sessions have been held with Mizaic and Finance colleagues to review and validate the economic model. Finance colleagues continue to review this to understand any cash releasing benefits before being shared with the wider group.
  Project governance is in process. A steering group is formally established and will take place when financial case is understood. A ToR is in draft. The aim is that the steering group will dually report into EPCMS Project Group and Outpatient Transformation Improvement group.

- **PEP Update**
  Expected overspend of £130,000 by the end of March, due to unaccounted costs for consumables and radiology using Synertec printing services. The project team are working with Finance to address these costs going forwards.
  There are plans to conduct a small pilot for video consultations over three months, using approximately 600 clinical virtual consultations at a cost of £100. The team need to manage expectations and explore other video consultation platforms like Attend Anywhere and AccuRx.
  MSK Therapy group have put a request in to use a digital assessment routing tool (DART) to reduce waiting times. Patients will complete an assessment via a URL link, and the results will help direct them to the appropriate service.
  The Head of Digital Programmes plans to work with finance to create a new plan for the next five years, considering the growth of outpatients, potential savings from digital clinical correspondence, and addressing missing items from the original business case.

- **LIMS**
  A proposal has been approved for a small number of staff to join a 'helicopter team' (this is a collection of seconded posts) to support the delivery of the LIMS programme over the next 6 months. The team have been working on a draft of the data migration strategy that has now been completed. The harmonisation strategy has been out for comment and is close to being finalised.

- **PACS**
  Due to issues with migrating data, Philips have pushed WHH go live date back until Summer 2025. The Trust currently do not have a definitive date planned.
  Migration / Duplication Issue – parent image should be kept and not the child image.
  Hazard workshop by CAMRIN and Philips to investigate issue and find a potential resolution date.
  Report distribution – issue with results from external Trust to originating Trust.
  A provisional migration date of mid-May has been set subject to the remedial works by Philips being achieved.

Infrastructure

- **Device Replacement Tech Refresh 24-25:** 1103 out of the 1170 devices have been replaced meaning 94% of the total target has been completed.
- **Network Refresh Switches wi-fi AP 23-25:** 93% of switches are complete with 163/176 in total installed. 99% of APs are complete with 918/931 in total installed. The project is nearing completion with only North Lodge and AXR work remaining, on track for completion date of the 31/03/25.
- **Network Comms Cabinet Improvement Phase 1 of 3:** Asbestos surveys need to be conducted in certain areas of the Trust by the third-party partner. The project timeline is tight and completion by 31/03/25 is uncertain.
- **Halton Endoscopy/Theatres:** Waiting for the third-party cabling company to complete the works for Theatres**.** Cabling work has currently ceased due to a fire bearing wall needing remedial work. Estates team are working to resolve this issue.
- **CDC New Build:** Still awaiting confirmed dates for the digital work to be scheduled in. The CDC new build handover has been pushed back to May 2025.
- **Bridgewater Network Link:** WHH and BW Wi-Fi is now available across our sites using the new link via the ARO Data Centre. A meeting has been scheduled to discuss routing additional services through the new links.
- **RTLS PoV:** The tagging equipment for the project was delivered to site to be used within the trial. Cisco have informed the project team that the Airista application is not currently available the EU version of the Cisco Spaces platform only the US one. The team are seeking clarity from the Cisco regarding next steps.

- **FDP Update**
  The technical deployment has been achieved, with live data from Lorenzo now coming through. Super users have been identified and granted access, and training and adoption are progressing well.
  The theatre scheduling module is planned to go live on 19th March, involving theatre teams in scheduling and viewing lists, moving away from Excel spreadsheets to using FDP. 2

Phase approach. Phase 1 Theatre Management. Go / No Go call to be set up for 17th March.
The patient booking management module, Phase 2, is planned to go live on 31st March, involving waiting list teams in scheduling and managing patient bookings electronically, improving visibility and reducing paper usage.

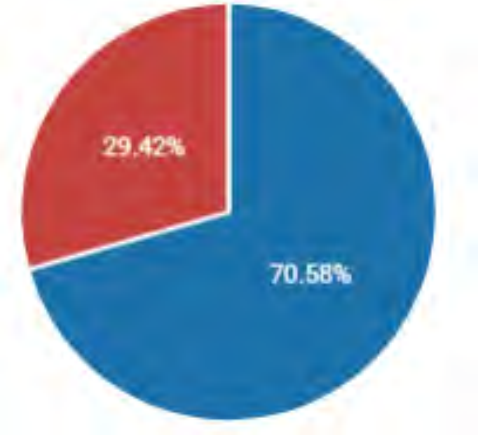
Items for escalation:

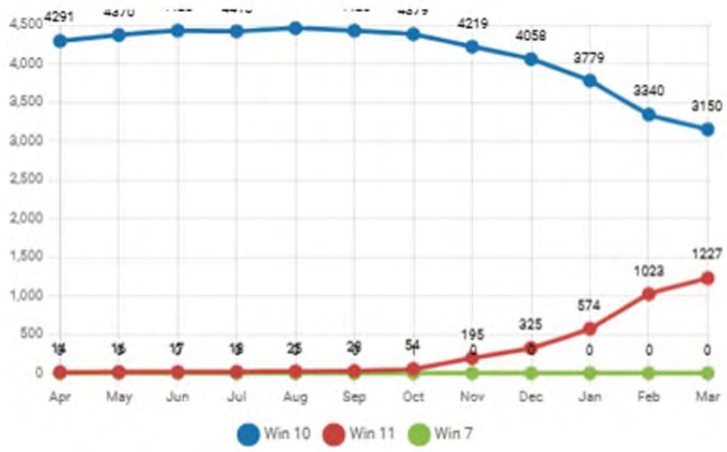
- FDP - theatre scheduling module is planned to go live on 19th March.
- PEP – Forecasted overspend

Digital Service Delivery Highlight Report (Moderate Assurance)

- **IT Health Dashboard Monthly Report**

Windows 11 - 29% of users are now on Windows 11 meaning that the migration is on track for this to be completed by target completion date of October 2025.

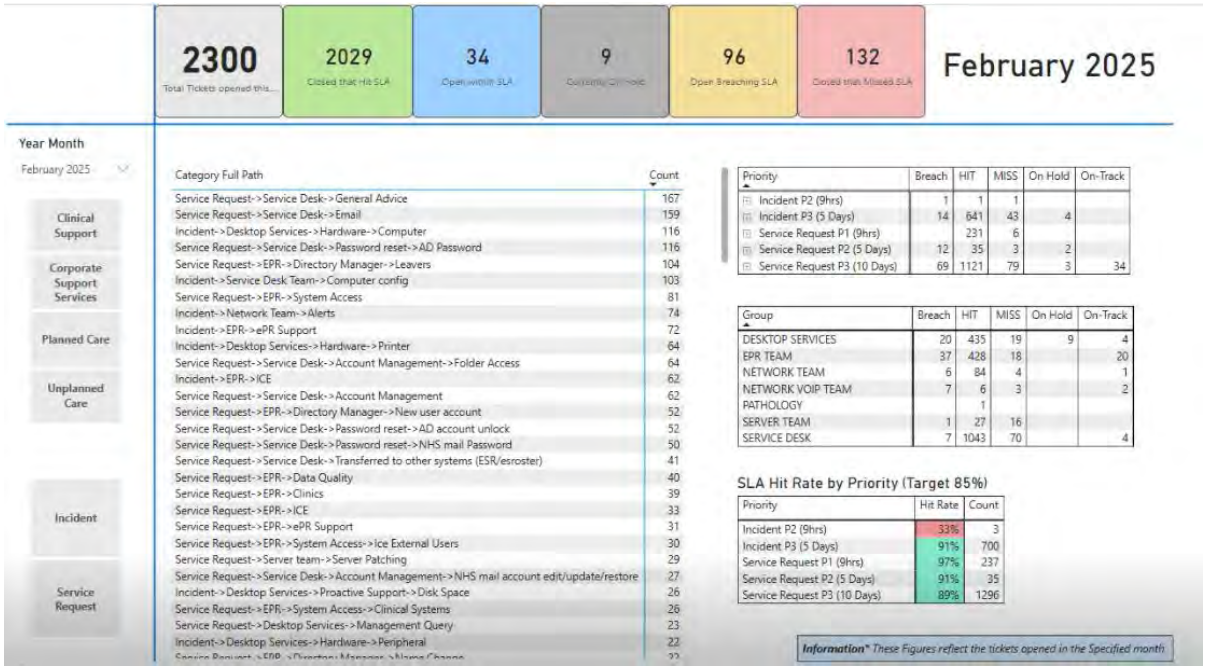




2012 Servers: Endoscopy – A workaround to undertake an in place to upgrade the SOLUS server to remove the cyber vulnerability is in place. This is not a solution, and discussions are continuing regionally with HDclinical around the regional SOLUS system and missing data.

User Accounts - There are numerous active generic accounts across the trust which are posing a clinical safety and security concern. A discussion is needed to understand the clinical impact of removing generic ward accounts.

Digital Services activity and reporting and SLA Performance (Incidents, Requests, Availability, Performance)



Print Server Stats – February 2025

- **Change Advisory Board**
  26 RFCs were processed during February. 20 normal and 6 standard.
  Of those 26 changes, 21 have been completed successfully, 4 are still scheduled and waiting to be completed and 1 change failed - The change that failed was: RFC0000554 - Monthly PACS patching Feb 25. The failure was because the windows update files had not

downloaded so, Phillips were unable to apply the updates. This will be re-scheduled once the files have been downloaded.
There was one change that was completed with exceptions – enabling NHS mail single password trust wide. Unable to complete some of the steps within the implementation window. This was down to an issue at the NHS mail side, from this they discovered the same issue was impacting some other Trusts, A fix was rolled out by the 26th February 2025, 9 days after the change was implemented.

- **Cyber Security**
  IAO/IAA of the status of critical systems documentation, specifically Information Data Flows and System Level Security Policy documents, which are essential for DSPT compliance. We may require SIRO support to facilitate engagement from certain IAOs & IAAs.

Title	Information Asset Owner (IAO)	Information Asset Administrator (IAA)	Department Data Flows	System Level Security Policy Completed	DTAC Completed
Healthroster (Allocate Optima), EOL & Safecare	Debbie Hatton x5615 Nurse Staffing & Workforce Improvement	Nicki Chester x5215/Sarah Hughes x5215 E-Rostering	Started	Started	
AuditBase	Paula Atherton x2420 Audiology	Anna Chan x2420 Audiology	Started	Started	
BadgerNet	Rita Arya x Associate CCIO	Kerry Jones x Midwifery	Started	Started	
Carestream PACS	Mark Jones x5094 Diagnostics	Darren Owens x2015 Radiology	Started		
Clinisys Ice	Gemma Jones x Digital Services	Kelly Halliwell x Digital Services	Started		
CRIS	Mark Jones x5094 Diagnostics	Darren Owens x2015 Radiology			
Data Warehouse	Chris White x2366 Digital Analytics	Michael Lysons x5176 Digital Analytics			
Dawn AC	Paul Mooney x2293 Pharmacy	Rachel Nisbet x 4217Pharmacy			
eOutcome - Inpatients	Gemma Jones x Digital Services	Wendy Bell x Digital Services	Started		
eOutcome - OPD	Gemma Jones x Digital Services	Wendy Bell x Digital Services	Started		
eOutcome - Task Manager (ETMS)	Gemma Jones x Digital Services	Marie Morris x Digital Services	Started		
ePMA (e-Prescribing)	Emma O'Brien x Digital Services	Gemma Jones x5030 Digital Services	Started		
e-Whiteboards	Gemma Jones x Digital Services	Nerys Lamerick x Digital Services	Started		
Forcepoint Firewalls	Brian Rigby x2610 Digital Services	Phil Smith x6633 Digital Services	N/A		
HSCN & Internet (WAN)	Brian Rigby x2610 Digital Services	Phil Smith x6633 Digital Services	N/A	N/A	
Local Area Network (LAN)	Brian Rigby x2610 Digital Services	Phil Smith x6633 Digital Services	N/A	N/A	

Title	Information Asset Owner (IAO)	Information Asset Administrator (IAA)	Department Data Flows	System Level Security Policy Completed	DTAC Completed
Lorenzo	Gemma Jones x Digital Services	Wendy Bell x Digital Services	Started		
MediSIGHT	Elaine Clark x2485 Ophthalmic OP	Elaine Clark x2485 Ophthalmic OP			
Microsoft Defender	Tracie Waterfield x2665 Digital Services	Simon Whitfield x2818/Joe Garnett x6634 Digital Services	N/A	N/A	
MOLIS	Neil Gaskell x2538 Pathology	Terry Koutsopoulos x2537 Pathology			
MUSE	Carol Graham x5262 Medical Care	Madeline Lynch x Cardiology	Started	Started	
NHS Mail 2	Tracie Waterfield x2665 IT Services	Simon Whitfield x2818 Digital Services	Started	Started	
Office365, MS Team & One Drive for Business	Tracie Waterfield x2665 Digital Services	Simon Whitfield x2818 Digital Services	Started	Started	
Power BI (Lion Portal)	Chris White x2366 Digital Analytics	Chris White x2366 Digital Analytics			
SBS	Alison Parker x2177 Supplies	Karen Spencer x2186 Supplies			
Servers / Storage	Brian Rigby x2610 Digital Services	Joe Garnett x6634 Digital Services	Started		
Solus GI Endoscopy	Emma Blackwell x2105 Digestive Diseases	Joanne Ditchfield x 5283 Digestive Diseases			
TIE - Ensemble	Chris White x2366 Digital Analytics	Chris White x2366 Digital Analytics			
Trellix Anti-Virus (Servers)	Brian Rigby x2610 Digital Services	Joe Garnett x6634 Digital Services	N/A	N/A	
VoIP/Contact Centre	Brian Rigby x2610 Digital Services	Phil Smith x6633 Digital Services	Started		
WellSky (formally CMM/JAC)	Paul Mooney x2293 Pharmacy	Maria Keeley x5409 Pharmacy			

System C – Badgernet

- ***Logging In*** - Intermittent issues with logging in to the platform, small number of hospital sites effected. Issue reported was being unable to contact principle cloud, 504 errors. Engineers were called to immediately to investigate and resolve the issue. Upon investigation: A cluster of the Badgernet VM instances were discovered to be in an error state with reduced autoscaling on the app servers. Resolve: forced up-scale up to a minimum of 15 on the scaling parameters. Minimal impact, brief intermittent issue of some users unable to log in at times reported. WHH - No local reports of any impact to the WHH maternity digital team
- ***13.1.25 UK National System Outage*** - HSCN/Redcentric. Although this was not a Badgernet outage, the major incident with connectivity issues, was due to Redcentric. Redcentric is a HSCN consumer network service provider (CN-SP), permitting a connection to both NHS Trust / Hospitals IT infrastructure and users securely onto the HSCN network.All Systems using the Redcentric - HSCN network, were experiencing issues with connectivity. WHH - No local reports of any impact.

Items for Escalation:

- There are noncompliant 2012 servers that need closing down.

Digital Care Delivery Highlight Report (Moderate Assurance)

Clinical Transformation

SOAP D on Wards: The team need to follow up with lead Nurses who were previously engaged with around the assessments. The Nurse who was currently leading this has informed the CNIO that they are due to leave the Trust soon so the team will need to reallocate a new lead for this.

Printing Requirement in Paediatrics (cardiac arrest): The group discussed transitioning paediatric drug information from the current website to a shared drive. The Head of EPR is in the process of reaching out to one of the Trust's Doctors for input on this transition.

Attend Anywhere Video Consultations: A meeting has been held with AccurX and it was noted that this system has many functionalities but there are multiple crossovers with Portal. There is opportunity to explore the video consultation feature that AccurX offer, currently in the process of coordinating a pilot with DrDoctor but the organisation has requested for there to be a competitive pilot.

Lorenzo Browser Modernisation: A release for the next Lorenzo upgrade is ongoing with WHH being scheduled on the 19th of March. Not necessarily bringing new functionality to the system but will fix a few known issues as it will remove the old technology. Fresh build with up to date technology and no memory limit meaning that the crashing currently seen in Lorenzo due to limited memory storage should be significantly reduced. Feedback from other trusts who have already undertaken the upgrade has been positive. There are a few things that will need to be circulated by comms ahead of the upgrade: brand new URL meaning a new icon will need to be pushed out a few days prior to upgrade date. Need to establish the best time for the upgrade to be triggered, other trusts have gone with around 7:30am as least disruptive.

Dental and ENT Digital Notes: Progress of digital notes for Dental and ENT departments has been made, ENT are live and Dental is next. Aiming for clearer documentation for clinical coding

and income improvement. The team are now focusing on moving clinical letters into the PEP, with all letter templates sent to Sylla Tech for final technical steps.

Maternity Update

The Trust's Digital Midwife informed the team about a recently identified issue with the new authorisation requirements in BadgerNet, which now requires midwives to input their username and password four times in one note. Simon and Gemma discussed the inefficiency and potential for negotiation.

Early Warning Score for Maternity: still awaiting the spec from the Northwest Improvement Team.

The national MEWS project requires trust onboarding by the 26th of March.

A data sharing agreement with Halton family hubs is in place which now allows electronic referrals from BadgerNet, improving information flow and support for women in deprived areas.

Pharmacy Update

Successfully went live with ePrescribing across all Outpatient locations of the Trust on the 6th of Feb. EPR/Pharmacy teams provided floorwalking support between 6th - 21st February. Numbers of ePrescriptions placed = 651, Number of White prescription pad sent = 157. 19% still on White Pads.

ACCIO Updates

Paper Results switch off Inpatients: Upcoming switch off of paper results for Microbiology and histology reports in which the team plans to switch off the rest of the paper results by the end of March giving everyone sufficient notice and ensuring a smooth transition to digital results. There is potential that a new date may have to be allocated due to the main ACCIO involved needing to take some urgent annual leave, the team plans to postpone until she returns.
Spoken with Patient Safety AMD around updating Diagnostic policy for ICE Acknowledgement. They raised that DEXA scans and 24-hour Tapes have been switched off which ACCIOs had not been made aware of. Need to clarify if physicians and clinicians who use these have been made aware of the switch off.

Clinical Safety Update

Pricing has been received for the clinical safety course to get further individuals trained, need to investigate obtaining approval of the funding for this.
Queries have been raised around AI products that do not have a DCB0129. Liaised with Alderhey who are conducting trials with a few different suppliers of AI solutions.

AI Clinical Uses

Voice recognition and digital dictation tools are being looked at for clinical purposes throughout the trust. The Big Hand software which allows clinicians to dictate and automate transcriptions is already in use for WHH but there are further opportunities to look at other tools exploring competitive trials with different vendors.
An AI tool for radiology reports is still under development and being tested alongside normal reporting functions

Items for escalation:

- **Blood reporting switch off -** final sign off
- **Support for LBM –** 7:30am timeslot for upgrade on 19th of march.

Digital Analytics Delivery Highlight Report (Moderate Assurance)

14 deliverables have been achieved in February 2025. There are currently 13 deliverables for March 2025. 2 deliverables which are delayed - Waiting list history, truncation issues with the data, awaiting response from Dedalus and Creatinine tests data load – this will be deployed in March 2025.

The Fraxinus and Data Warehouse infrastructure project - Due to BW integration programme the decision to move the Data Warehouse from the server it currently shares with Fraxinus has been paused. The development of a separate reporting server is now being planned to provide resilience.

The Digital Analytics High level milestone plan for the BW integration were developed in partnership with BW colleagues 26 February 2025. These were provided to the Integration Digital Workstream leads.

The refresh of BI servers is being reviewed by CIO in terms of options on Prem or Cloud. Taking into account any potential hosting arrangement with BW

EPCMS OBS rewrite completed. More work now required due to collaboration with MWL

Attendance at FDP events/demonstrations leading to scoping work for theatres module.

Corporate information team and Head of Digital Analytics is part of project team

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. MEASUREMENTS/EVALUATIONS

5. TRAJECTORIES/OBJECTIVES AGREED

6. MONITORING/REPORTING ROUTES

7. TIMELINES

8. ASSURANCE COMMITTEE (IF RELEVANT)

9. RECOMMENDATIONS

FSC is asked to note the contents of the report, including assurance levels.

Warrington and Halton Teaching Hospitals Charity
An NHS Charity

CHARITABLE FUNDS COMMITTEE

AGENDA REFERENCE:	**CFC/25/03/43**			
SUBJECT:	**Warrington & Halton Hospitals Charity Governing Document and Cycle of Business**			
DATE OF MEETING:	06 March 2025			
ACTION REQUIRED:	**Approval**			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement			
LINK TO STRATEGIC OBJECTIVE	All			
EQUALITY CONSIDERATIONS: ***(please select as appropriate)***	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	In order to provide assurance to the Trust Board, the Charitable Funds Committee is required to review the Warrington & Halton Hospitals Charity Governing Document and Charitable Funds Committee Cycle of Business each year to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. Following the review of the Governing Document in September 2024 to include: • Inclusion of a process for reclaiming unspent funds • Inclusion of a process to authorise new campaigns there are no additional changes proposed for 2025/26 There are no amendments to the 2025/26 Cycle of Business, some updates to branding and formatting only.			
PURPOSE: ***(please select as appropriate)***	Approval √	To note	Decision	
RECOMMENDATION:	The Committee is asked to approve the Governing Document and Cycle of Business to recommend to the Board for formal ratification.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***None***	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Warrington and Halton Teaching Hospitals Charity
An NHS Charity

Registered charity number 1051858

CHARITABLE FUNDS COMMITTEE

GOVERNING DOCUMENT

0. THE CHARITY

Warrington and Halton Hospitals Charity is registered in England with the Charities Commission number 1051858. It is the sole Charity of the NHS Foundation Trust known as Warrington and Halton Teaching Hospitals, headquartered at Lovely Lane, Warrington WA5 1QG. The Charity conducts its activities under the auspices of the Corporate Trustee for the benefit of the patients, staff and volunteers at both Halton and Warrington hospitals and the Trust's community facilities.

The Charity is a member of the Institute of Fundraising and NHS Charities Together and abides by the Fundraising Code of Practice.

Its values are:

- **Ethical** - We will never pressure potential donors
- **Transparent** - We will be open and transparent about our charity and keep donors informed of our progress
- **Accountable** - We will ensure that our fundraising costs deliver maximum return
- **Compassionate** - We will ensure that donated funds are distributed for the widest possible benefit of patients and their families
- **Creative** – We will innovate and diversify our fundraising activities to remain an attractive partner to donors

1. PURPOSE

The Board of Directors, acting as Corporate Trustee for the Charitable Funds, hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. AUTHORITY

The Committee is authorised to:

2.1 perform any of the activities within its Governing Document

2.2 obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and

2.3 make recommendations to the Board for actions it deems necessary.

The Trust is Corporate Trustee of charitable funds registered together under charity registration 1051858 and the Committee is appointed as the Trust's agent in accordance with s16 of the NHS Trusts (Membership and Procedures) Regulations 1990.

The Committee is authorised by the Corporate Trustee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

Authorisation of spend of charitable funds

In line with the Trust's Scheme of Reservation and Delegation (SoRD), the following delegated limits are in place for the authorisation of spend of charitable funds, as detailed below:

Charitable Spend – Bids (designated, restricted and unrestricted)	Up to £1,000	Director of Communications & Engagement and Financial Planning Manager
	£1,001 - £5,000	Executive Management Team and Financial Planning Manager
	Over £,5000	Charitable Funds Committee
Charitable Spend – Grants *Following successful grant applications, funds received can only be spent on the intended purpose in line with the original application.	Up to £5000	Director of Communications & Engagement and Financial Planning Manager
	£5,001 - £50,000	Executive Management Team and Financial Planning Manager
	Over £50,000	Charitable Funds Committee

Updates on the use of these delegations will be provided to Charitable Funds Committee by the Director of Communications and Engagement.

Reclaiming unspent funds

Once bids are approved, applicants are notified and given 12 weeks to make their purchase/provide a plan to spend the funds. Applicants with unspent funds are contacted by the charity at eight weeks and at 10 weeks.

If no order has been placed after 12 weeks, or no plan has been shared with the charity, the funds will be automatically returned to the relevant Charity fund and applicants will be notified, with the option to reapply for charitable funds if required.

Reclaimed unspent funds will be reported to Charitable Funds Committee in quarterly finance reports.

Authorisation of new campaigns The charity runs multiple campaigns at any given point in time, aligned to the Charity's purpose and strategy. The Charitable Funds Committee are responsible for authorising the creation of new campaigns.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

- The Committee will be accountable to the Corporate Trustee (the Trust's Board of Directors). A report of the meeting will be submitted and presented to the Corporate Trustee by the Chair in the Private (part 2) session of the Board meeting and who shall draw to the attention of the Board issues that require disclosure to the full Board, or require executive action, through a Chair's Committee Assurance report. The minutes of the Committee meetings will be formally recorded.
- The Committee will report to the Corporate Trustee annually on its work and performance in the preceding year.
- The Trust standing orders and standing financial instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following areas:

- Ensure that the disbursement of funds are in accordance with the founding principles of the charity ie:

  Our purpose as a Charity is to support Warrington and Halton Teaching Hospitals to be outstanding for our patients, our staff and our communities by fundraising to provide:

  1. State of the art equipment, technology or training

2. Funding for WHH-related research and innovation
3. Improving the hospital environment
4. Providing enhancements to support the care and comfort of our patients, carers and visitors while on our premises
5. Support to enable the health and wellbeing of our patients and our staff

....beyond that which the NHS is obliged to provide as part of patient care.

- Ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.
- Obtain plans for all individual funds and approve if/when appropriate.
- Ensure that donations and investment income or losses are attributed to individual funds appropriately.
- Ensure the sources of income and the terms on which donations are received are acceptable to the Trustees.
- Ensure that all funds are correctly allocated as restricted, unrestricted or designated, and accounted for accordingly. This analysis will differentiate between restricted, specific and the General charitable fund.
- Recommend an investment advisor – where market conditions are favourable - to the Corporate Trustee following appropriate tendering procedures and regularly monitor and review their performance.
- Ensure that the investment policy for Charitable Funds set by the Corporate Trustee is implemented and that sufficient funds are kept readily available to meet planned requirements.
- Ensure (through the NHS Foundation Trust's Finance Department and accounting systems) that there is an appropriate system of control over income and expenditure, and that there are robust governance arrangements in place.
- Ensure that the NHS Foundation Trust's Constitution Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.
- Receive and discuss all audit reports on charitable funds and recommend action to the Corporate Trustee
- Review the Charitable Funds annual accounts and comment/ recommend approval to the Corporate Trustee as appropriate.
- Respond to requests from the Corporate Trustee for review or investigation on relating to charitable funds.

- Receive WHH Charity Strategy and forecasted income and expenditure and the WHH Charity Annual Report and Accounts
- Receive the WHH Charity Annual Operational and Financial Plan
- Receive the Charities Commission Guidance for Trustees checklist annually and submit to the Corporate Trustee
- Receive the WHH Charity Risk Statement every three years or as circumstances dictate
- Receive the WHH Charity Risk Register quarterly with any changes or additions to this notified through the Fundraising report
- Conduct an annual committee effectiveness review and submit to the Corporate Trustee with the Chair's Annual Report.

Risk management statement

The Corporate Trustee of WHH Charity believes that sound risk management is integral to both good management and good governance practice. Risk management forms an integral part of WHH Charity decision–making and is incorporated within strategic and operational planning.

Risk assessment is conducted on all new activities and projects to ensure they are in line with WHH Charity objectives and mission. Any risks or opportunities arising are identified, analysed and reported at an appropriate level. Key strategic risks are identified and updated four times per year and more frequently if risks are known to be volatile.

WHH Charity regularly reviews and monitors risk through a risk register which is updated as considered appropriate. Periodic reports are be made to the Corporate Trustee – using the Trustee Checklist relating to continuing and emerging high concern risks and those where priority action is needed to effect better control.

Individual error and incident reports are required from individual staff where a reportable event is identified, reported using the Trusts incident management system.

5. MEMBERSHIP

The Committee shall comprise the individuals responsible for ensuring that corporate Trustee duties of the Trust are fulfilled. They shall be appointed by the

Trust Board and will normally include the Trust's voting Board members. One of the Non-Executive Directors will be appointed as Chair of the Committee

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

6. ATTENDANCE

In addition to the above, the following individuals, or their nominated deputy, shall normally be in attendance at the meetings:

- Director Communications and Engagement (executive lead for the Charity)
- Head of Fundraising
- Deputy Chief Finance Officer
- Head of Financial Planning
- Any Senior Trust employees with clinical and operational expertise as nominated by the Trust Board at the invitation of the Committee
- Company Secretary & Associate Director of Corporate Governance
- Member of Financial Planning Team

Observer

- Nominated Governor

7. QUORUM

A quorum shall be two (2) members, one of whom must be a Non-Executive Director

8. FREQUENCY OF MEETINGS

The Committee will meet at least three times per annum.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 5 days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to

the Trust Board (or an Executive Assistant in the absence of the Secretary to the Trust Board).

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties. This review will inform the Committee's annual report to the Board.

DATE: March 2024

NEXT REVIEW: March 2025

GOVERNING DOCUMENT - REVISION TRACKER

Name of Committee:	**CHARITABLE FUNDS COMMITTEE**
Version:	Issue No12
Implementation Date:	September 2023
Review Date:	12 Months from the approval date i.e. September 2024
Approved by:	Charitable Funds Committee
Approval Date:	Charitable Funds Committee xx.xx.xxxx and Trust Board xx.xx.xxxx

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
June 2018	**Attendance**	- **Delete** Corporate Affairs from Director of Communications + Engagement title	
March 2019	**Membership**	- The Committee shall comprise the individuals responsible for ensuring that corporate	CFC 7.03.2019 Trust Board 31.05.2019

		Trustee duties of the Trust are fulfilled. They shall be appointed by the Trust Board and will normally include: - All the non-executive directors of the Trust (with the exception of the Trust Chairman) one of whom will be appointed as Chair of the Committee by the Trust Board - Up to (three) voting Executive directors to include the Director of Finance and Commercial Development or their nominated deputies	
March 2019	**Attendance**	- Director Community Engagement and Fundraising - Deputy Director of Finance - Head of Financial Services - Nominated Governor (Public Constituency) - Any Senior Trust employees with clinical and operational expertise as nominated by the Trust Board at the invitation of the Committee	CFC 7.03.2019 Trust Board 31.05.2019
March 2019	**Quorum**	A quorum shall be: (2) non-executive directors (2) executive directors (or their nominated deputies)	CFC 7.03.2019 Trust Board 31.05.2019
June 2020	**Attendance**	Replace Head of Financial Services with Financial Planning Accountant Amend title to read - Deputy Director of Finance and Commercial Development	Issue 9 CFC 04.06.2020 Trust Board xx.xx.2020

		Amend title of DoF + Commercial Development to read Chief Finance Officer Add Head of Fundraising Amend title of Director Community Engagement & Fundraising to Director Communications and Engagement	
June 2020	**Charitable Purpose**	To update the charitable purpose following Cttee approval in December 2019	Issue 9 CFC 04.06.2020 Trust Board xx.xx.2020
Sept 2021	**Membership**	To add the Chief People Officer to the membership	Issue 10 CFC Sept 2021 Trust Board 29.9.21
March 2022	**Reporting Arrangements**	Amend 'Key Issue Report' to Committee Assurance Report	Issue 11 CFC March 2022 Trust Board 30.03.2022
March 2022	**Duties & Responsibilities**	Committee to receive risk register on a quarterly basis	Issue 11 CFC March 2022 Trust Board 30.03.2022
March 2022	**Membership**	To add the Chief Nurse to the membership	Issue 11 CFC March 2022 Trust Board 30.03.2022
March 2022	**Attendance**	Add Trust Secretary	Issue 11 CFC March 2022 Trust Board 30.03.2022
March 2022	**Administrative Arrangements**	Update to admin arrangements	Issue 11 CFC March 2022 Trust Board 30.03.2022

September 2023	**Duties and Responsibilities**	Updated frequency of Charities Commission for Trustees Checklist	Issue 12 CFC 23 September 2023
September 2023	**Duties and Responsibilities**	Inclusion of Risk Statement	Issue 12 CFC 23 September 2023
September 2023	**Membership**	Updated to open membership to all Non-Executive Directors	Issue 12 CFC 23 September 2023
September 2023	**Attendance**	Updated titles and clarification that the role of the Governor is to observe the Committee	Issue 12 CFC 23 September 2023
September 2023	**Frequency of Meetings**	Updated frequency requirement from quarterly to at least three per annum	Issue 12 CFC 23 September 2023
September 2023	**Review Date**	Update review date to annual (previously every two years)	Issue 12 CFC 23 September 2023
September 2023	**Administrative Arrangements**	Updated supportive administrative arrangements	Issue 12 CFC 23 September 2023
December 2023	**Delegated Authority**	Details added, as approved by the CFC 9th March 20-23	Issue 12.1 CFC 7 December 2023
December 2023	**Attendance**	Member of Financial Planning Team Head of Financial Planning	Issue 12.1 CFC 7 December 2023
March 2024	**Membership**	Updated to remove specific reference to which Executive Directors are members	Issue 12.2 CFC 13 March 2024
March 2024	**Quorum**	Updated quoracy to two (2) members	Issue 12.2 CFC 13 March 2024
September 2024	**Authority**	Inclusion of process for reclaiming upsent funds	Issue 12.3 CFC 12.09.2024
September 2024	**Authority**	Inclusion of process to authorise new campaigns	Issue 12.3 CFC 12.09.2024
September 2024	**N/A**	No amendments	Issue 12.4 CFC XX.XX.XXXX

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

04.06.2020	**Issue 8 replaced with Issue 9**	CFC 04.06.2020
10.09.21	**Issue 9 replaced with issue 10**	CFC 10.9.21
30.03.2022	**Issue 10 replaced with issue 11**	Issue 11 CFC March 2022 Trust Board 30.03.2022
23.09.2023	**Issue 11 replaced with issue 12**	CFC 23 September 2023
07.12.2023	**Issue 12 replaced with issue 12.1**	CFC 7 December 2023
13.03.2024	**Issue 12.1 replaced with issue 12.2**	CFC 13 March 2024
12.09.2024	**Issue 12.2 replaced with issue 12.3**	CFC 12 September 2024
12.09.2024	**Issue 12.3 replaced with issue 12.4**	CFC XX. XXXXXXX.XXXX

Warrington and Halton Teaching Hospitals Charity
An NHS Charity

CHARITABLE FUNDS COMMITTEE
CYCLE OF BUSINESS 2025/26

Item	Reporting Frequency	Process	Exec Lead		12-Jun	04-Sep	11-Dec	05-Mar
Opening Business								
Apologies for Absence	Standing Item	**Noting**	Chair		✓	✓	✓	✓
Declarations of Interest	Standing Item	**Noting**	Chair		✓	✓	✓	✓
Minutes of the Last Meeting	Standing Item	**Noting**	Chair		✓	✓	✓	✓
Matters Arising & Action Log	Standing Item	**Noting**	Chair		✓	✓	✓	✓
Rolling attendance	Standing Item	**Noting**	Chair		✓	✓	✓	✓
Impact Story	Standing Item	**Noting**	Various		✓	✓	✓	✓
Fundraising								
Fundraising Report & 1/4ly workplan	Quarterly	**For assurance**	Director of Communications & Engagement		✓	✓	✓	✓
Charity Annual Impact Report – Progress against Strategy	Annually	**For assurance**	Director of Communications & Engagement			✓		
Operational Plan	Annually	**For Approval**	Director of Communications & Engagement					✓
Finance								
Finance Report	Quarterly	**For assurance**	Chief Finance Officer		✓	✓	✓	✓
Bid applications	Quarterly	**For assurance/approval**	Director of Communications + Engagement		✓	✓	✓	✓
Review of Reserves Policy	Annually	**For Approval**	Financial Planning Accountant			✓		
Charity Budget (Financial Plan)	Annually	**For Approval**	Financial Planning Accountant					✓
Investment update	Annually	**For assurance**	Financial Planning Accountant					✓
Governance and Compliance								
Governing Document	Annually	**For Approval**	Chair/Trust Secretary					✓
Cycle of Business	Annually	**For Approval**	Chair/Trust Secretary					✓
Charities Commission Checklist	Annually	**For Approval**	Director of Communications + Engagement				✓	
Charity Risk Register & Risk Statement	Annually	**For assurance/approval**	Director of Communications + Engagement			✓		
Overhead Policy Review **(March 25)**	Annually	**For Approval**	Financial Planning Accountant					✓
Annual Report and Accounts	Annually	**For Approval**	Chief Finance Officer			✓ **Draft**	✓ **Final**	
Committee Chair's Annual Report to Board	Annually	**For Approval**	Chair			✓		
Committee Effectiveness Annual Review	Annually	**For assurance**	Chair/Trust Secretary			✓ **Advise Survey**	✓ **Circulate Report**	
Closing								
Items for Escalation to the Trust Board & Review of Meeting	Standing Item	**Noting**	Chair		✓	✓	✓	✓
Any Other Business	Standing Item	**Noting**	Chair		✓	✓	✓	✓